January 31, 2000

Contact:  Grace Mascitelli
Rating Division
Extension: 139

R.C. 1931

To the Members of the Board

Re:  New York Workers Compensation
     Experience Rating Plan
     Revised ERM-6 Form

The Rates Committee has adopted, and the New York State Insurance Department has approved, effective February 1, 2000, a revision to the New York Experience Rating Plan to incorporate a revised form for the reporting of experience rating data by self-insured employers.

The New York Experience Rating Plan, as well as the rating plans in several other jurisdictions, provide a form for the reporting of statistical data by self-insureds for the purpose of requesting that the rating organization calculate their experience modifications. The form (ERM-6) is a countrywide form and has not been updated since 1984. The NCCI is revising the form in its jurisdictions to reflect current usage and reporting rules, and the Rating Board is also revising its ERM-6 for use in New York.

The revised ERM-6 form is attached for your reference.

Manual pages will be included in the 2000 edition of the New York manual to be distributed early this year.

Very truly yours,

Monte Almer

President

MA/ab
Encl.
WORKERS COMPENSATION EXPERIENCE RATING
FOR SELF-INSUREDs

NAME OF RISK ________________________________________________

ADDRESS OF RISK _____________________________ CITY _______ STATE _______
ZIP _______ RISK IDENTIFICATION NO. ___________ EFFECTIVE DATE OF RATING ________

FEDERAL IDENTIFICATION NUMBER ___________ STATE OF COVERAGE ___________

<table>
<thead>
<tr>
<th>Coverage Period</th>
<th></th>
<th></th>
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<th></th>
<th></th>
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<tbody>
<tr>
<td>(1) Effective</td>
<td></td>
<td></td>
<td>(2)</td>
<td></td>
<td>(3)</td>
<td></td>
</tr>
<tr>
<td>Month/Day/Year</td>
<td></td>
<td></td>
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<td>Class</td>
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<td>Code</td>
<td></td>
</tr>
<tr>
<td>(5) Claim</td>
<td></td>
<td></td>
<td></td>
<td>(6)</td>
<td>Injury</td>
<td>Open/Closed</td>
</tr>
<tr>
<td>Identification</td>
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<td></td>
<td></td>
<td></td>
<td>Type</td>
<td></td>
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<tr>
<td>Number Assigned</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Code</td>
<td>(O/F)</td>
</tr>
<tr>
<td>(7) Incurred Losses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Paid plus Reserves)</td>
</tr>
<tr>
<td>(8)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

PLEASE FOLLOW THE INSTRUCTIONS ON THE BACK PAGE FOR COMPLETING THIS WORKSHEET AND RETURN IT TO THE RATING BOARD PRIOR TO RATING EFFECTIVE DATE.
INSTRUCTIONS FOR SUBMITTING EXPERIENCE RATING DATA

PAYROLL AND LOSSES MUST BE ROUNDED TO THE NEAREST WHOLE DOLLAR.

COLUMN 1 Fill in the effective month, day and year of the period for which information will be provided. In accordance with Rating Board rules, a total of three years of experience can be included in the rating, not including the year immediately prior to the effective date of this rating. Each year’s payroll and losses should be listed separately.

COLUMN 2 Fill in the expiration month, day and year of the period for which information will be provided.

COLUMN 3 Fill in the workers compensation classification code(s) that best describes your type of business. If you have any questions regarding these classifications, please contact the Classification Division of the Rating Board.

COLUMN 4 Fill in the payroll amounts associated with the classification code(s) for each year being reported.

COLUMN 5 Provide the claim number used for internal record keeping for each claim. If claim numbers are not used for internal record keeping, leave column blank.

COLUMN 6 Fill in the appropriate injury type code (see following list). Only one injury type code is applicable per claim. Medical only claims should be listed as a “6”, but claims that include both medical and disability or death benefits should be listed under the applicable disability or death code, such as “5” (Temporary Total or Temporary Partial Disability). Injury types must be noted for each entry.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Death</td>
</tr>
<tr>
<td>2</td>
<td>Permanent Total Disability</td>
</tr>
<tr>
<td>5</td>
<td>Temporary Total or Temporary</td>
</tr>
<tr>
<td>6</td>
<td>Medical Only</td>
</tr>
<tr>
<td>7</td>
<td>Contract Medical or Hospital Allowance</td>
</tr>
<tr>
<td>9</td>
<td>Permanent Partial Disability</td>
</tr>
</tbody>
</table>

COLUMN 7 Indicate whether the claim is open or closed/final by placing an O or F in the column.

COLUMN 8 In Column 8, fill in the incurred (sum of paid plus reserves) losses per row. If no claims occurred, place a 0 in that space. Claims must be reported individually regardless of claim amount.

The experience rating will be completed in accordance with the New York Experience Rating Plan. However, because we do not verify the accuracy of the data submitted by non-members, the modification factor will be issued with a disclaimer.

Name of the self-insured entity requesting the rating ________________________________

Name of the entity submitting the data (if different) ________________________________

Address __________________________________________

State _____  Zip ____________  Phone ____________  Fax ____________  E-Mail ____________

AGREEMENT

We hereby certify that the information given in this report is correct to the best of our knowledge and belief. BY SUBMISSION OF THIS INFORMATION, WE REQUEST THAT THE NEW YORK COMPENSATION INSURANCE RATING BOARD PRODUCE EXPERIENCE MODIFICATION FACTORS ON EACH OF THE RISKS LISTED AND AGREE TO PAY THE FEES CHARGED FOR THIS SERVICE. In consideration of the Rating Board’s agreement to produce the requested experience modifications, we release and discharge the Rating Board, its officers, directors, employees and agents from all liability (except for gross negligence) in connection with the production or application of the same.

The person signing this agreement certifies that he/she has the authority to execute this agreement on behalf of the self-insured entity requesting the rating. Authorized signers include the risk, the group self-insured and the TPA ONLY.

Signed __________________________________________  Date __________________________

Printed Name of Signer ____________________________  Title __________________________