NYCIRB
New York Compensation
Insurance Rating Board
733 Third Avenue
New York, NY 10017
Tel: (212) 697-3535

January 7, 2020

R.C. 2504

Re: Revised Form ERM-6 (Self-Insured Data) of the New York Experience Rating Plan
Effective Date: July 1, 2020

Members of the Rating Board:

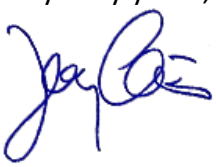
I write to inform you that the New York State Department of Financial Services ("Department") approved an amendment to the Rating Board's New York Experience Rating Plan Manual, which is detailed herein, attached hereto, and is effective on July 1, 2020.

Specifically, the approved revisions are designed to conform Form ERM-6 with the Rating Board's New York Statistical Plan wherein injury type codes 10 (Permanent Partial Disability - Scheduled Loss of Use) and 11 (Permanent Partial Disability - Non-Scheduled) were added and code 9 (Permanent Partial Disability) was eliminated.

Modified and final versions of Form ERM-6, reflecting the approved revisions, are attached for your convenience.

If you have any questions or concerns, please do not hesitate to contact Mr. Mark Battistelli, Vice President of Underwriting Services, at (212) 697-3535, ext. 113 or at underwriting services@nycirb.org.

Very truly yours,



Jeremy Attie
President and CEO

Enclosures

WORKERS' COMPENSATION EXPERIENCE RATING DATA 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** _____

Coverage Period							
(1) Effective Month/Day/ Year	(2) Expiration Month/Day/ Year	(3) Class Code	(4) Payroll	(5) Claim Identification Number Assigned	(6) Injury Type Code	(7) Open/Closed -Final (O/F)	(8) Incurred Losses (Paid plus Reserves)

PLEASE FOLLOW THE INSTRUCTIONS ON THE BACK PAGE FOR COMPLETING THIS WORKSHEET AND RETURN IT TO THE RATING SERVICES DIVISION OF THE RATING BOARD PRIOR TO THE 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.

1 = Death
2 = Permanent Total Disability
5 = Temporary Total or Temporary Partial Disability
6 = Medical Only
7 = Contract Medical or Hospital Allowance
~~9 = Permanent Partial Disability~~
10 = Permanent Partial Disability – Scheduled Loss of Use
11 = Permanent Partial Disability – Non-Scheduled

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) _____

Street and City _____

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 _____

WORKERS' COMPENSATION EXPERIENCE RATING DATA 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** _____

Coverage Period							
(1) Effective Month/Day/ Year	(2) Expiration Month/Day/ Year	(3) Class Code	(4) Payroll	(5) Claim Identification Number Assigned	(6) Injury Type Code	(7) Open/Closed -Final (O/F)	(8) Incurred Losses (Paid plus Reserves)

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

Street and City _____

State_____ Zip_____ Phone_____ Fax_____ E-Mail _____

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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 _____