

**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 _____

Coverage Period		(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)
(1) Effective Month/Day/ Year	(2) Expiration Month/Day/ Year						

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.

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| 1 = Death | 6 = Medical Only |
| 2 = Permanent Total Disability | 7 = Contract Medical or Hospital Allowance |
| 5 = Temporary Total or Temporary Partial Disability | 9 = Permanent Partial Disability |

- 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 _____