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							
(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 NCCI PRIOR TO THE RATING EFFECTIVE DATE.

ERM-6 (Rev. 99)
NC1816(0628d)

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. 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 NCCI classification codes(s) that best describes your type of business. If you have any questions regarding these classifications, please contact Customer Service at 800-**NCCI** 1-2-3.
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 should you desire this information on the modification worksheet. 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 disabililty 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

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 sum of incurred (paid plus reserved) 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 NCCI ***Experience Rating Plan Manual for Workers Compensation and Employers Liability Insurance*.** However, because we do not verify the accuracy of the data submitted by non-affiliates, 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 _____ 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 NCCI PRODUCE EXPERIENCE MODIFICATION FACTORS ON EACH OF THE RISKS LISTED AND AGREE TO PAY THE FEES FOR THIS SERVICE. In consideration of NCCI's agreement to produce the requested experience modifications, we release and discharge NCCI, 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 _____