ERM-6 FORM WORKERS COMPENSATION EXPERIENCE RATING FOR NON-AFFILIATE DATA

Effective 01 Dec 2003

NAME OF RI	SK						
ADDRESS OF RISK				CITY			STATE
ZIPRISK IDENTIFICATION NO			EFFECTIVE DATE OF RATING				
FEDERAL ID	ENTIFICATIO	N NUMBE	R	STATE OF	- COVEF	RAGE	
Coverag	je Period						
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Effective Month/Day/ Year	Expiration Month/Day/ Year	Class Code	Payroll	Claim Identification Number Assigned	Injury Type Code	Open/Closed -Final (O/F)	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. 12/03)

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 years of experience can be included in the rating, not date of this rating. Each year's payroll and losses sho	including the year immediately p	
COLUMN 2	Fill in the expiration month, day and year of the period	• •	vided.
COLUMN 3	Fill in the NCCI classification codes(s) that best desc regarding these classifications, please contact Custo	ibes your type of business. If you	
COLUMN 4	Fill in the payroll amounts associated with the classifi		g reported.
COLUMN 5	Provide the claim number used for internal record kee modification worksheet. If claim numbers are not use	eping should you desire this infor	mation on the
COLUMN 6	Fill in the appropriate injury type code (see following l Medical only claims should be listed as a "6," but clai benefits should be listed under the applicable disabili Temporary Partial Disability). Injury types must be no	ns that include both medical and y or death code, such as "5" (Te	disability or death
	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 D	isability
COLUMN 7	Indicate whether the claim is open or closed/final by p	lacing an O or F in the column.	
COLUMN 8	In Column 8, fill in the sum of incurred (paid plus rese in that space. Claims must be reported individually re		s occurred, place a 0
	tted by non-affiliates, the modification factor will be insured entity requesting the rating		
Name of the self-in Name of the entity	submitting the data (if different)		
Name of the self-in Name of the entity	nsured entity requesting the rating		
Name of the self-in Name of the entity	submitting the data (if different)		
Name of the self-in Name of the entity Address State We hereby cert SUBMISSION of FACTORS ON consideration of NCCI, its office	submitting the data (if different) Zip Phone	Fax City to the best of our knowledge CI PRODUCE EXPERIENCE AY THE FEES FOR THIS SEI	E-mail and belief. BY EMODIFICATION RVICE. In use and discharge
Name of the self-in Name of the entity Address State We hereby cert SUBMISSION of FACTORS ON consideration of NCCI, its office the production of	submitting the data (if different) ZipPhone AGREEMENT tify that the information given in this report is correct OF THIS INFORMATION, WE REQUEST THAT NO EACH OF THE RISKS LISTED AND AGREE TO P. of NCCI's agreement to produce the requested expers, directors, employees and agents from all liability	to the best of our knowledge CI PRODUCE EXPERIENCE AY THE FEES FOR THIS SEI rience modifications, we relea (except for gross negligence)	E-mail and belief. BY MODIFICATION RVICE. In use and discharge in connection with
Name of the self-in Name of the entity Address State We hereby cert SUBMISSION of FACTORS ON consideration of NCCI, its office the production of The person sign self-insured ent ONLY.	submitting the data (if different) ZipPhone AGREEMENT tify that the information given in this report is correct OF THIS INFORMATION, WE REQUEST THAT NO EACH OF THE RISKS LISTED AND AGREE TO P. of NCCI's agreement to produce the requested expers, directors, employees and agents from all liability or application of the same. ning this agreement certifies that he/she has the autity requesting the rating. Authorized signers include	to the best of our knowledge CI PRODUCE EXPERIENCE AY THE FEES FOR THIS SEI rience modifications, we relea (except for gross negligence)	end belief. BY MODIFICATION RVICE. In use and discharge in connection with ent on behalf of the ed and the TPA
Name of the self-in Name of the entity Address State We hereby cert SUBMISSION of FACTORS ON consideration of NCCI, its office the production of The person signself-insured ent ONLY. Signed	submitting the data (if different)	to the best of our knowledge CI PRODUCE EXPERIENCE AY THE FEES FOR THIS SEI rience modifications, we relea (except for gross negligence) hority to execute this agreement the risk, the group self-insure	E-mail and belief. BY MODIFICATION RVICE. In use and discharge in connection with ent on behalf of the ed and the TPA