NON-AFFILIATE FORMAT

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

Effective 01 Dec 2003

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. 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 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**-123.
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 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

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 _____

Guide to the ERM-6 Form—
Workers Compensation Experience Rating for Self-Insureds

ERM-6 Form Key Definitions:

Risk Identification No.—A 9-digit number that NCCI assigns to each rated insured.

State of Coverage—The state for which the policy was written; this is not necessarily the state in which the insured is located.

Effective Date of Rating—This is the first day of the rating period for an experience rating modification. This date is based on the effective date of the most current policy that ran a full year. For example, if last year's policy effective date was 4/4/03, then the effective date of the experience rating would be 4/4/04.

What Fits on a Rating—A total of three years of experience can be included on a rating. Do not include the year immediately prior to the effective date of the rating.

For example, payroll and losses that would be included on a 4/4/04 rating would be:

4/4/00–4/4/01

4/4/01–4/4/02

4/4/02–4/4/03

The 4/4/03–4/4/04 experience will not be included on an experience rating effective 4/4/04.

Please Keep the Following in Mind When Preparing an ERM-6 Form:

It is extremely important that everything be filled out completely and accurately. If handwritten, please print clearly.

Payroll—It is not possible to have losses without payroll. All payroll amounts must be submitted in **whole dollars only** (e.g., correct $1; incorrect $1.25).

Each payroll amount must have the appropriate class code assigned to it.

Claims—Remember to fill out the Injury Code field for claims information, including whether the claim is open (O) or closed/final (F).

When consolidating small claims ($2,000 or less), remember to specify whether they are Injury Code 5 or 6, and put an asterisk (*****) in the open/closed column.

Each claim amount must be submitted in whole dollars only.

When submitting multiple pages of ERM-6 data, each page must have the following information printed at the top:

- Risk Name
- Risk ID No.
- Effective Date of Rating
- Policy Effective/Expiration Date
- State of Coverage

Loss runs, worksheets, or any other forms are not accepted in lieu of the approved NCCI ERM-6 form.

All information must be submitted on the approved NCCI ERM-6 form. No other attachments can be accepted (e.g., Excel spreadsheets).

Information to Accompany Request:

If the insured has current coverage on file with NCCI, please provide a letter of authority on the current carrier's letterhead.

If no current coverage is on file with NCCI, please include a $75 payment via credit card, check, or account and site number.

You can also fax the ERM-6 form to our Customer Service Center at 561-893-1191.

ERM-6 Form in PDF Format

The ERM-6 form is now available to our customers in a PDF document that can be updated. You can now electronically enter Workers Compensation Experience Rating Information for Self-Insureds directly onto the form.

This is a filed and approved form. NCCI has protected the content in order to avoid any changes to the document. The form can only be printed; it cannot be saved to your system. **Please print a copy for your records.**

Helpful Hints for Completing the ERM-6 Form in the PDF Format:

- In order to easily navigate through the form, use your **Mouse** or **Tab** key. (Please note: The Enter key will bring you to the end of the form.)

- You will be able to enter information in the allotted space provided on the form. **Please be aware that if the information you have typed exceeds the space provided, not all the information will be viewed on the form.**

- You will need to print out the form in order to obtain the authorized signature of the person who has the authority to execute this agreement on behalf of the self-insured entity requesting the rating.

- If you do not already have Adobe® Acrobat® installed, you can download the latest version of Acrobat® Reader® for free from the Adobe Web site at adobe.com.

NON-AFFILIATE FORMAT

WORKERS COMPENSATION EXPERIENCE RATING FOR SELF-INSUREDS

NAME OF RISK ABC Inc

ADDRESS OF RISK 88 Mount Vernon Avenue CITY Wellington STATE FL

ZIP 33414 RISK IDENTIFICATION NO. 091 197 188 EFFECTIVE DATE OF RATING 4/14/2004

FEDERAL IDENTIFICATION NUMBER 123123123 STATE OF COVERAGE Florida

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)
4/14/2000	4/14/2001	8810	1,000,000	No.1	6	*	5
		4902	88,000,000	1969	5	F	20,000
				1986	5	O	32,000
4/14/2001	4/14/2002	8810	1,500,000	No. 2	6	*	97
		4902	100,000,000	1954	5	O	50,000
4/14/2002	4/14/2003	8810	2,000,000	1994	5	F	20,500
					6	*	141
		4902	200,000,000	No. 3	5	F	1,000
				1971	5	O	5,000
				1972	5	F	10,000
				1978	5	O	15,000
				1979	5		

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)

NON-AFFILIATE FORMAT

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	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 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 ABC Inc

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

Address 88 Mount Vernon Avenue _____ City Wellington_____

State Florida_____ Zip 33414-7630 _____ Phone 1-800-555-1212_____ Fax 1-888-729-1234 _____ E-mail _____

agibson@abcinc.com

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 "Please print form to include signature"_____ Date May 24,2004_____

Printed Name of Signer Alfred Gibson IV _____ Title President & CEO _____

