THE WORKERS' COMPENSATION
RATING AND INSPECTION BUREAU

MASSACHUSETTS WORKERS' COMPENSATION STATISTICAL PLAN

PART I: UNIT STATISTICAL REPORTING

The Workers' Compensation Rating and
Inspection Bureau of Massachusetts
101 Arch Street, Boston, MA 02110

PREFACE

A. *The Commissioner of Insurance first issued general instructions, known as the Massachusetts Workers' Compensation Statistical Plan, on January 2, 1929, for the preparation and filing of experience with The Workers' Compensation Rating and Inspection Bureau of Massachusetts on all policies effective in Massachusetts on and after January 1, 1929. The plan has been reprinted in amended form and supplemented by circular letters from time to time.*

On June 30, 2000 the Massachusetts Commissioner of Insurance ordered that effective immediately the Commissioner's Statistical Plan shall consist of two components, first the unit statistical data and second the aggregate financial data.

B. *The instructions and definitions for the reporting of unit statistical data are contained in the "Part I – Unit Statistical Reporting" portion of the Statistical Plan. The instructions, definitions, and sample forms for the reporting of aggregate financial data are contained in the "Part II – Aggregate Financial Reporting" portion of the Statistical Plan.*

C. *Any future changes in the instructions or amendments of the rules of this plan will be made by means of reprinted pages. Changes will be indicated by bold italic print with a Times New Roman font. Elimination of text will be indicated by a shaded area.*

D. *The Statistical Plan is reprinted and approved by the Massachusetts Commissioner of Insurance.*

E. *Self-Insured Groups report unit statistical data under part one of this plan, but are not required to report the aggregate financial data under Part II of this plan.*

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INTRODUCTION

Every insurance company or Self Insurance Group authorized to transact the business of workers' compensation insurance within the Commonwealth of Massachusetts shall file with The Workers' Compensation Rating and Inspection Bureau of Massachusetts, 101 Arch Street, Boston, MA 02110, complete statistical information in accordance with the instructions contained herein, on every policy:

1. Which afforded coverage under the provisions of Chapter 152, of Massachusetts General Laws, and acts amendatory thereof and supplementary thereto, including policies which are covered primarily in another state with Massachusetts coverage extended by endorsement, and policies where Massachusetts exposure was written on an "if any basis" and subsequently did not develop Massachusetts exposure.

2. Which afforded coverage for experience under the [redacted] Government Agency Atomic Energy Projects.

3. Which afforded coverage for liability, at Massachusetts rates, under the United States Longshoremen's and Harbor Workers' Compensation Act.

4. Which afforded coverage for liability under Admiralty Jurisdiction, at Massachusetts rates under either coverage I or II for the operation of vessels or for dredging or marine wrecking.

5. Insurance companies and Self Insurance Groups must continue the reporting for all policies written to completion without regard to current authorization status.

PART I

UNIT STATISTICAL REPORTING

SECTION II

GENERAL INSTRUCTIONS

SECTION II - GENERAL INSTRUCTIONS

A. Validity of the Unit Report

The unit statistical reports submitted to this Bureau are edited for accuracy and validity based on the following criteria:

1. The unit conforms to the rating rules found in the Massachusetts Workers' Compensation and Employers' Liability Insurance Manual, Experience Rating Manual, Retrospective Rating Manual and other guides and manuals distributed by or on behalf of the Bureau. Nothing in the Statistical Plan should be construed to supersede any rules or procedures set forth in the above mentioned manuals.

2. The unit reflects coverage and benefits afforded under Massachusetts statutes.

3. The statistical codes and other elements contained in the unit conform to this Statistical Plan.

4. Codes are consistent between report levels.

5. Each field is consistently coded with all other fields.

6. The classifications, exposure act, exposure, and premium reported on the unit are consistent with the ***approved rates and rating procedures as well as*** the final audit of the policy.

7. ***The reported rate and the reported manual premium are both within tolerances acceptable to the Bureau when compared to the expected rate and expected manual premium based on the Bureau filed and approved rates.***

8. All claims are reported in accordance with the carriers' claim files at the appropriate valuation date. For exceptions to loss valuations, see Section III.

9. All reported injuries that incurred medical or indemnity loss, attorney fees or allocated loss adjustment expense must be reported as claims within the unit statistical reports of the policy.

10. ***The unit statistical data when aggregated by policy year and compared to the aggregate financial data reported in Part II of this plan is within reasonable tolerances as specified in Part II of this plan. The acceptable tolerances account for evaluation timing and other inherent differences in the data sets.***

B. Experience Rated Risks

For all interstate experience rated risks, a duplicate copy of the Massachusetts experience shall also be filed with the National Council on Compensation Insurance (NCCI).

C. Date of Valuation and Filing

1. First Reports

   a. The premium and losses of each policy are first valued as of eighteen (18) months after the policy effective date and reported no later than twenty (20) months after the policy effective date.

   b. Revisions to first reports are required:

      i. Upon the identification of mistakes in previously reported exposures or loss information by either the Bureau or carrier.

      ii. When a revision to the loss is required due to the reasons listed in Section II, Part D, Item 4 (Revision to Losses).

2. Subsequent Reports

   a. The subsequent valuations are at 30, 42, 54, 66, 78, 90, 102, 114, and 126 months respectively after the policy effective date. The subsequent reports must be submitted no later than 32, 44, 56, 68, 80, 92, 104, 116, and 128 months respectively after the policy effective month.

   b. Re-calculations of losses and the subsequent reports are required when:

      i. The previous valuation contained open claim(s).

      ii. One or more claims are reopened.

      iii. Previously unreported claim(s) have become known.

      iv. There are changes in the loss valuation of one or more claims.

   c. Subsequent valuations of losses are reported in the same manner as loss corrections as described in Section III.

3. Filings Due

   All experience must be reported on a monthly basis, but can be submitted more frequently at the carrier's options.

4. Revision of Losses

   See correction of losses in Section III for instructions concerning the reporting procedures to revise losses due to the circumstance listed below.

   It is not permissible to revise values between two valuations because of departmental or judicial decisions or because of developments in the nature of injury.

   Revisions of losses between valuations are acceptable only when:

   a. There are errors in the previously reported information. All reports containing the error must be revised.

   b. Reimbursement from the Second Injury Fund is anticipated. All previously reported valuations that did not reflect the anticipated recovery must be revised.

   c. A claim is found to have caused aggravated inequity in the experience rating modification as defined in the Experience Rating Plan by either the carrier or the Bureau.

d. A claim, or any part thereof, has been declared noncompensable as defined in Section III – A-2. All prior reports (valuations) of the claim must be revised within 60 days.

e. The carrier has received subrogation recovery due to an action against a third party. The subrogation may be the result of an action by either the carrier or claimant. All valuations (reports) of the loss must be revised within 60 days of receipt of the recovery.

f. It has been determined that one or more claims should be reported with catastrophe code 48. Refer to Section VII Loss Data, page 22 catastrophe code.

D. Fraction of Dollars

Report all monetary amounts in whole dollars only. **DO NOT REPORT CENTS**.

E. Reinsurance

No deduction is made from earned premiums and incurred losses for, or as a result of, reinsurance ceded. Premiums earned and losses incurred as a result of reinsurance received by the reporting carriers are excluded from the experience.

F. Uncollectible Premiums

1. For those policies on which an audit has been conducted and the earned premium is known, but uncollectible, report all earned premiums, corresponding exposure, and losses.

2. Policies on which a final audit is not possible and therefore the audited earned premium and exposure is not known, report the estimated earned premium and exposure corresponding to the term of coverage. Also report the losses for the corresponding term of coverage.

G. Group Claim Option

Beginning with losses that occur on policies effective on January 1, 2007 it is no longer permissible to group any claims for reporting of unit statistical losses.

H. Method of Transmittal

All submissions must be accompanied by a transmittal record in the electronic submission.

I. Three-year Fixed Rate Policies

Experience incurred under three-year fixed rate policies written in accordance with Section XI of the Massachusetts Workers' Compensation & Employers' Liability Insurance Manual must be reported by the following method:

1. Unit Reporting Basis for Electronic Submissions:

   a. Form of Report: The complete three-year experience incurred under each policy shall be reported on the current appropriate unit report with "Y" entered in the three-year fixed rate policy indicator.

   b. Date of Valuation and Filing: Losses included in the reporting of a given policy shall be valued as of exactly 42 months after the inception date of the policy and the reports shall be filed no later than 44 months after the effective date of the policy. These reportings shall be specifically identified as three-year fixed rate policy experience (this may be done by entering "Y" in the "Three-year Fixed Rate Indicator).
   c. Data to be Reported: The data required shall be the data specified under the Statistical Plan, i.e., all data elements are required.

   d. Second, through tenth reports are not required on these three-year policies. However, all corrections and revisions to first reports are required as specified for reporting of information under the Statistical Plan.

   e.

2. Summarized Basis:

   Beginning with policies effective on January 1, 2006 summarized reporting of three year fixed data is not permissible.

J. Other Multiple Year Policies

Other multiple year policies: Multiple year policies not specified above shall be considered as separate annual policies for reporting purposes and reports for each unit of twelve months or less shall be filed at the time all other reports on policies with the same effective date are being filed. Losses are valued eighteen months after the effective date of each unit of experience and at annual periods thereafter. Reports are due 20 months after the effective date of each unit of experience.

Examples:

(a) The reports on a three-year annual policy effective on July 1, 1996 shall be filed with the regular reports on policies effective July 1996, July 1997, and July 1998. Losses shall be valued January 1, 1998, January 1, 1999, January 1, 2000, respectively.

(b) The reports on a policy covering the period July 1, 1996 to October 1, 1997 with the first three months specified as the first reporting unit on the policy period endorsement, shall be filed with the regular reports on policies effective July 1996 and October 1996. Losses shall be valued January 1, 1998 and April 1998, respectively.

(c) The reports on a policy covering the period July 1, 1996 to October 1, 1997 with the first twelve months specified as the first reporting unit on the policy period endorsement shall be filed with the regular reports on policies effective July 1996, and July 1997. Losses shall be valued January 1, 1998 and January 1, 1999, respectively.

K. Special Rules for Reporting Disease Experience

1. General: In Massachusetts, the disease obligation of the employer comes under the Workers' Compensation Act and the Manual Rates include provision for disease coverage.

2. Exposure, Manual Rate and Premium: The exposure, rates and premium reported on the unit by manual classification shall include the unmodified authorized rates and corresponding premium for complete coverage under both coverage A and B of the policy including coverage for diseases.

3. Incurred Losses: Disease losses shall be identified in the type of loss field by the appropriate code for disease loss.

   The total losses reported shall be the total of traumatic losses and disease losses incurred and shall exclude any allocated claim expense for coverage A, but shall include allocated claim expense for coverage B.

4. Reporting of Incidental Foundry, Abrasive or Sand Blasting Experience: Massachusetts Workers' Compensation & Employers' Liability Insurance Manual rules provide that the payroll of all employees exposed to (a) a foundry hazard (except payrolls properly assignable to certain specific codes) or (b) an abrasive or sand blasting hazard (except for employees rated under a classification where the manual rate provides coverage for silicosis) must be specifically stated and a special supplementary disease rate shall be charged on this payroll in addition to the manual rate. The payroll to which the supplementary disease rate is applicable, together with the manual premium derived from such charges, shall be assigned to the appropriate code-either 0065, 0066, 0067, or 0059. The payroll reported for code 0065, 0066, 0067 or 0059 shall be shown in parenthesis and shall not be added to the payrolls shown for other manual classifications in determining the standard exposure. However, the premium resulting from the application of such supplementary disease rate shall be included in the total premium reported in the standard premium.

   Dust disease losses incurred in connection with payrolls reported under code 0065, 0066, 0067 or 0059 shall likewise be assigned to the same code and shall be further identified by the appropriate code for disease loss in the type of loss field. These losses shall also be included in the total losses reported.

   Note: The elimination of disease classes 0133 and 0179 is effective with the premium algorithm on January 1, 2008.

L. Experience Under the National Defense Projects Rating Plan

The experience of policies written under the National Defense Projects Rating Plan shall not be reported on Unit Statistical Plan forms. Note: The elimination of computation of Earned Premium is effective immediately with data reported after January 1, 2007.

M. Radiation Exposure-Government Agency Atomic Energy Projects

Experience in connection with atomic energy projects performed for or under the direction in any government agency shall be reported under this plan. Code 9984 has been reserved for use in connection with the above type of projects.

N. Other Than Government Agency Atomic Energy Projects

The Massachusetts Workers' Compensation & Employers' Liability Insurance Manual provides that a supplemental rate, subject to the approval of the Bureau, may be applied to operations involving research, manufacturing, handling, transportation, use of exposure to radioactive materials, where such operations are not performed for or under the directions of a Government Agency. The exposure to which such supplemental rate is applicable together with the premium derived from such charge shall be reported under code 9985. The exposure reported for code 9985 shall not be added to the exposure shown for other manual classifications in determining the risk exposure total. The rate and premium reported under code 9985 shall be entered in the appropriate columns and the premium reported shall be included in the total standard premium. Similarly, radiation losses on risk where a supplemental loading has been applied shall be assigned to code 9985. If no supplemental radiation loading has been applied to the risk, all losses shall be assigned to the appropriate industrial classifications.

The elimination of code 9408 (unemployment or emergency relief employees) was effective July 1, 1980.

PART I

UNIT STATISTICAL REPORTING

SECTION III

CORRECTIONS
and
RE-VALUATIONS

SECTION III - CORRECTIONS AND RE-VALUATIONS

A. Corrections are to be Submitted between Valuations for only the Following Situations:

1. Errors

An error occurs ***whenever the standards specified in "SECTION II - GENERAL INSTRUCTIONS, A. Validity of the Unit Report" are not met.***

Upon identification of an error by either the Bureau or the carrier on a previously submitted unit report, a correction must be immediately filed.

The Bureau routinely requests verification of reported data. It is the responsibility of the carrier to distinguish between Bureau requests for corrections and verifications. For example, the Bureau may question the reported premium discount. If a review of the final audit ***and manual rules and rates for premium discount*** indicates that the discount was ***calculated and*** reported accurately, the carrier must communicate the verification to the Bureau, and no correction is required. If the review shows an ***error in the unit report***, a correction is required and must be immediately submitted to the Bureau.

Corrections must be submitted for all previous report levels (valuations) that contained the error. ***However,*** it is not necessary to ***revise*** correction reports that were submitted between report levels that may also contain the error. Corrections are applied to the report levels (valuation), and once a correction has been received the valuation reflects the corrected data.

2. Non-compensable Claims

A claim is determined to be non-compensable if:

(i.) There is an official ruling denying benefits under the Workers' Compensation Law,
(ii.) A claimant fails to file for benefits during the period of limitation allowed by the Workers' Compensation Law, or
(iii.) The claimant fails to prosecute his claim when a carrier contends, prior to the valuation date, that the claimant is not entitled to benefits under the Workers ' Compensation Law.

If a claim is determined to be non-compensable after the first or subsequent reports have been reported to the Bureau, ***a correction report must be submitted*** within 60 days of such determination for each report level (valuation) that revises the Loss Condition Code to 05 (non-compensable). If a claim is determined to be non-compensable before the first reporting, the first report and all subsequent reports must reflect a Loss Condition Code of 05. All

report levels (valuations) whether at the first reporting or by correction should reflect accurate amounts paid by the carrier net of any recovery, if any.

3. Recovery from Second Injury Fund

Corrections must be submitted upon receipt of reimbursement from the Second Injury Fund. Paid and incurred loss amounts of all prior reports (valuations) of the claim must be adjusted to reflect the impact of the recovery. All prior reports (valuations) that exceed the carrier's final paid amount must be corrected. Cost of recovery is added into the final paid amount in a recovery from Second Injury Fund situation.

4. Receipt of Subrogation Recovery from a Third Party

Corrections must be submitted within 60 days of obtaining a subrogation recovery from a third party. Paid and Incurred Loss amounts of all prior reports (valuations) of the claim must be adjusted to reflect the impact of the recovery. All prior reports (valuations) where the amounts exceed the carrier's final paid amount must be corrected. Cost of recovery is added into the final paid amount in a subrogation situation.

5. Aggravated Inequity

Corrections must be submitted when the Bureau (upon request) or the carrier determines that the difference between the reported incurred and the final paid losses of a claim, that closes prior to the issuance of the experience rating modification, constitutes an aggravated inequity. The necessary corrections and report levels are to be submitted upon the Bureau's request or once the carrier determines that the change between reported incurred and final paid losses constitutes an aggravated inequity.

6. Formerly Self-Insured's Deposit Adjustments

If any of the formerly self-insured's rating plan deposit is returned to the insured, then a correction to the first report must be submitted when the deposit is returned.

7. Completion or Change in the Audit

Corrections to the first report must be submitted whenever an audit is revised, or upon completion of the audit when the first report was submitted based on estimated exposure.

8. Extraordinary Loss Events

Corrections must be submitted when it has been determined that one or more claims should be reported with a catastrophe code identifying an extraordinary loss event. (see definition of Extraordinary Loss Events in Section VII, Page 21).

B. Re-valuation's

Losses are revalued and reported annually as subsequent report***s*** of losses ***which are*** described in Section II Part D. Subsequent valuations are reported in the same manner as corrections to losses.

C. Adjustment of Losses between Valuations

Losses can not be revised between two valuations because of departmental or judicial decision or because of developments in the nature of the injury except as listed in Section II, Part D-4.

D. Method of Reporting Corrections and Re-valuations

1. Link Data Corrections - (Header Corrections)

Link data is the set of header elements which uniquely identifies a unit and groups units as the statistical reports to a policy for a specified policy period.

a. The link elements are:

i. report
ii. correction number
iii. carrier code
iv. policy number
v. policy effective date
vi. exposure state

b. For corrections to link elements use correction type code "H". Link elements are corrected by ***using previous data fields for*** the dual and simultaneous display of the element as it was reported on the prior report and the revised content of the field.

There are two separate and distinct fields for the correction of link elements. For example, there are both policy number and previous policy number fields. To correct a policy number the revised policy number is inserted as the policy number field, and the policy number as it appeared on the prior unit(s) is inserted in the previous policy number field.

c. Link data corrections are applied directly to each individual report. If three reports (1st, 2nd, and 3rd) have already been submitted and an error in the link data is discovered, then corrections for all three reports are necessary. A link data correction to only one of the previously filed reports will cause that corrected report to match (link) with another policy and set of unit reports or to become "unmatched".

If a correction report is submitted with the "wrong" link data, then the correction can not be correctly applied to the Bureau's files. Invalid

carrier code, policy number, or policy effective date, report or exposure state on a correction report will cause the correction to be rejected or incorrectly applied to previously submitted data. The carrier must replace or amend these corrections ***and contact Bureau Statistical Data Services staff for assistance.***

2. Header Corrections (Non link Data Elements)

Correction to all other non-link header or policy information is accomplished by use of the correction type code "H" applied to the 1st report. Non-link Header policy information is required only on 1st reports of data. ***Corrections*** and subsequent reports will inherit header information from the 1st report.

a. The policy/header non link data elements eligible for carrier update as header corrections are:

i. policy expiration date
ii. state effective date
iii. interstate risk ID (Bureau File Number)
iv. insured's name
v. insured's address
vi. federal employers ID number
vii. three-year fixed rate indicator
viii. multi-state indicator
ix. interstate indicator
x. estimated exposure indicator
xi. retro policy indicator
xii. canceled mid term indicator
xiii. mco indicator
xiv. type of coverage
xv. plan indicator
xvi. non standard policy indicator
xvii. deductible type
xviii. deductible percent
xix. deductible amount per claim/accident
xx. deductible amount aggregated

b. A carrier can not ***revise*** correction type, ***report level or correction sequence number.*** If a situation arises

that requires modification of these fields, contact the Bureau Statistical Data Services staff.

c. Since modification effective date and rate effective date are tied to the exposure records by split period indicator, they are updated as an exposure record correction.

3. Update Type for Exposure, Loss and Experience Modification Records

All corrections and subsequent reports must contain Update Type codes. The Bureau processes Add and Delete Update Type codes in the same manner as the Previous and Revised Update Types.

i.

Update Type Code	Function
A	Record is added to previously submitted data
D	Record is deleted from previously submitted data
P	Record is matched to previously submitted record. The "P" Update Type record locates the record to be revised (when paired with R) or deleted (when alone) in the Bureau's data base.
R	When reported as a pair record located by "P" Update Type is revised by the information contained in the "R" Update Type record. When reported alone, the "R" Update Type record is added to the previously submitted data.
S	Matching previously reported record is revised with the data on this transaction for subsequent valuations

ii. All Update Types require the full reporting of all fields on the header, total and detail records.

iii. Corrections and re-valuations (subsequent reports through 10) ***must*** be reported using only the "P/R" pairs or Delete type.

iv. Claims not previously submitted on any prior reports or corrections may be added with a single record with Update Type "R".

v. Claims may be deleted from a report level by a single record with Update Type "P" submitted on a correction report. When a claim is removed from a specific report level, the claim remains as reported on prior and subsequent report levels (valuations).

Note: if a claim is being removed due to the claim becoming non compensable, closed without payment, or receipt of recovery, the "R" record must be reported so that information is coded in the loss condition fields.

E. Offset or Deletions of Detail Loss or Exposure Records

1. Entire units (reports or corrections) are deleted only by contacting the ***WCRIBMA***

2. Exposure records are deleted by a correction to the first report with stand alone "P" records containing the codes and amounts previously submitted.

3. Loss records are deleted by correction reports.

a. Loss records are deleted from a report level by a correction using the single "D" or "P" Update Type record containing the codes and amounts previously submitted. The claim will be deleted from that specific report level, prior and subsequent reports of the claim will not be impacted without corrections to the prior or subsequent levels.

b. A subsequent report can not be used to delete a claim in a prior report level. If a claim appeared on the first report, but at the second valuation it is determined that the claim should never have been reported, then a correction to the first report deletes the claim from the first report and that claim is not expressed on the second report. If a claim appropriately appeared on the first, but should not appear on the second report then the second report must contain the claim on a pair of P/R Update Type records. The "P" record contains the codes and amounts as previously reported. The "R" Update Type records contains the codes as previously reported and zero loss amounts and the appropriate coding to indicate non compensable or received recovery. The result is that the claim will contribute to the first report of losses only.

RESERVED FOR FUTURE USE

PART I

UNIT STATISTICAL REPORTING

SECTION IV

STATISTICAL CLASSES

SECTION IV – STATISTICAL CLASSES

A. Alphabetical List of Statistical Classes

Premium charges or credits and the corresponding losses are reported with statistical class codes. The codes and appropriate characteristics are listed first alphabetically by program name. Refer to IV, Part B for a numeric list of the statistical codes.

1. Aircraft Operation-Passenger Seat-Code 0088

Class code 0088 is used to report the passenger seat premium surcharge associated with aircraft operations and the losses to employees other than members of the flying crew. Class 0088 must be reported in conjunction with class code 7421 aircraft-transport employees. Exposure basis is number of seats.

The surcharge is subject to experience rating modifications, and is a component of standard premium. ***Losses can not be coded to class Code 0088.***

2. All Risk Adjustment Program-Code 0277

The premium surcharge resulting from the All Risk Adjustment Program is to be reported with class code 0277. The ARAP premium is not subject to experience rating and is not added into the standard premium total. Losses can not be coded to class code 0277.

3. Construction Classification Premium Adjustment Program-Code 9046

The premium credit resulting from the Construction Classification Premium Adjustment Program is to be reported with class code 9046. This premium ***adjustment*** is assumed to be a negative. The construction credit is not subject to experience rating, but is a component of standard premium. Losses can not be coded to class code 9046.

4. Policies with Deductible-Class Codes 9663 and 9664

a. Small Deductible programs

i. Massachusetts Benefits Claim Deductible Program

Premium credits associated with the Massachusetts Benefits Deductible Program are to be reported with class code ***9664***. The deductible amount (500, 1,000, 2,000, 2,500 or 5,000) is to be reported in the header record in the claim deductible amount. The deductible type is 0301 (electronic).

ii. Massachusetts Benefits Claim and Aggregate Deductible Program

Premium credits associated with the Massachusetts Benefits Claim and Aggregate Deductible Program are to be reported with class code 9664. The deductible amount of $2,500 is to be reported in the header record in the claim deductible amount. When the aggregate deductible amount is $10,000, it is reported in the deductible amount aggregate and the deductible type is 0309 (electronic).

Small deductible premium credits are subject to experience rating and are a component of standard premium.

b. Large Deductible programs

i. Not subject to experience rating

The reduction in premium prior to reimbursement, due to deductible programs where the reduction is not subject to experience rating, is reported with the statistical class code 9663.

The amount reported with class code 9663, large deductible programs not subject to experience rating, is not a component of standard premium.

ii. Subject to experience rating

The reduction in premium, prior to reimbursements, due to deductible programs, where the reduction is subject to experience rating, is reported with the statistical class code 9664.

The amount reported with class code 9664 is a component in standard premium.

c. All losses for claims incurred on a deductible policy are reported on a gross (first dollar) basis. The loss amounts are not reduced by employer reimbursement. Losses are coded to the manual classes.

d. The reduction in premium, prior to reimbursement is assumed to be a negative.

e. Losses can not be coded to class codes, 9663 and 9664.

5. Premium Discount-Class Codes 0063-0064

a. Effective May 1, 1996 the premium discount credit derived from type A discount selection is reported with class code 0063. The premium discount derived from type B discount selection is reported with class code 0064.

b. The discount ***adjustment*** is assumed to be a negative.

c. Premium discount is not subject to experience rating, and is not a component of standard premium.

d. Losses can not be coded to class codes 0063 or 0064.

6. Disease Classes-Codes 0059, 0065, 0066 ***and*** 0067

a. The premium for supplementary disease rates and any resulting losses are reported as follows:

Code	Description
0059	Occupational Disease-Abrasive/Sand Blast
0065	Occupational Disease-Steel
0066	Occupational Disease-Non-Ferrous Metals
0067	Occupational Disease-Iron

b. In Massachusetts the disease obligation of the employer comes under the Workers' Compensation Act and the Manual Rates include provision for disease coverage.

c. The exposure, rates, and premium reported on the manual classification shall include the unmodified authorized rates and corresponding premium for complete coverage under both coverage A and coverage B of the policy including coverage for Diseases.

d. Disease losses shall be identified in the "type of loss" code for disease loss.

e. The payroll to which the supplementary disease rate is applicable is not added into the standard exposure total.

f. The disease rate classes are subject to experience rating, and are a component of standard premium.

7. Employers' Liability-Increased Limits-Class Codes 9803 through 9816

a. The premium charge for increased employers' liability limits on standard coverage is reported with the class code appropriate to the limits.

Code	Limits (000 Omitted) per accident each accident/ per disease each employee/ per disease each policy
9803	$ 100/100/1,000
9804	$ 100/100/2,500
9805	$ 100/100/5,000
9806	$ 100/100/10,000
9807	$ 500/500/500
9808	$ 500/500/1,000
9809	$ 500/500/2,500
9810	$ 500/500/5,000
9811	$ 500/500/10,000
9812	$ 1,000/1,000/1,000
9813	$ 1,000/1,000/2,500
9814	$ 1,000/1,000/5,000
9815	$ 1,000/1,000/10,000
9816	[redacted] ***See Note**
9848	Increased Limits, additional premium to balance to minimum premium.

b. The employers' liability increased limits codes are subject to experience rating and are a component of standard premium.

c. Losses can not be assigned to class codes 9803-9816 or 9848.

Note: Statistical code 9816 will cover all those not otherwise defined.

8. Expense Constant-Class Code 0900

The policy charge (expense constant) is reported with class code 0900. The expense constant is not subject to experience rating, and is not a component of standard premium. Losses can not be coded to 0900.

9. Formerly Self-Insureds-Class Codes 9129 and 9136

A policy for a risk which was formerly self-insured and is now insured by a standard workers' compensation policy is subject to both an insurance charge and a rating plan deposit.

a. The insurance charge is to be reported with class code 9136. The insurance charge for formerly self-insureds is not subject to experience rating, and is not ***a component of*** standard premium.

b. The formerly self-insured rating plan deposit is reported with class code 9129. If any of the deposit is returned to the insured, then a correction to the first report must be submitted adjusting the rating plan deposit to the amount retained by the carrier. This adjustment can be made no sooner than thirty (30) months after the coverage expiration date. All claims must be closed and all incurred losses finalized prior to the submission of the adjustment. The formerly self-insured rating plan deposit is not subject to experience rating, and is not ***a component of*** standard premium.

c. Losses can not be coded to class codes 9129 and 9136.

10. Independently filed Carrier Program Premium Adjustments

a. The statistical class codes for independently filed carrier programs (here in item 11) are NEVER to be used to report premium credits due to independently filed large deductible programs, managed care, or scheduled rating programs. The appropriate codes for these programs are found in items 5, 13, and 21 of this section.

b. Four statistical codes have been established for independent carrier filings of credit/debit programs.

i. 9721 - Independent Carrier Filing - Premium credit applied before modification

ii. 9722 - Independent Carrier Filing - Premium credit applied after modification

iii. 9723 - Independent Carrier Filing - Premium debit applied before modification

iv. 9724 - Independent Carrier Filing - Premium debit applied after modification

c. Before reporting any of the independent carrier filing codes, notification of the program must be provided to the Bureau's ***Statistical Data Services*** Department.

d. Carrier filed premium adjustments before modification are subject to modification and are components of standard premium.

e. Carrier filed premium adjustments after modification are components of standard premium.

f. Losses can not be coded to class codes 9721, 9722, 9723, or 9724.

11. Loss Constant-Code 0032

The loss constant charge is reported with class code 0032. Loss constant is not subject to experience rating. Loss constant is *not* a component of the standard premium total. Losses can not be coded to class 0032.

12. Merit Rating-Class Codes 9885 and 9886

a. ***A unity merit rating is reported with class code 9884.***

b. The premium credit due to a merit rating is reported with class code 9885. Merit rating replaces experience rating. The merit rating credit is a component of standard premium. The merit rating credit is assumed to be a negative value.

c. The premium debit due to a merit rating is reported with class code 9886. The merit rating replaces experience rating. The merit rating debit is a component of standard premium.

d. Losses are not to be coded to class codes 9885 or 9886.

e. The merit rating factors must not be expressed as an experience rating factor.

13. Minimum Premium-Class Code*s* 0990 and 9849

a. The premium required to bring the policy premium to minimum is reported with class code 0990. The exposure, manual, and modified premium that result from the extension of the exposure must be reported. Class code 0990 is used to report the difference between the policy minimum and the premium resulting from the extension of exposure. The loss constant, expense constant, and employers' liability premium must be reported separately and not included in premium amount reported with class 0990. Code 0990 is not subject to experience rating and is not a component of standard premium. Losses must not be coded to class 0990.

b. The premium required to bring the Admiralty and/or FELA premium to minimum is reported with class code 9849. Class code 9849 is used to report the difference between the Admiralty and/or FELA policy premium and the Code 9849 is not subject to experience rating and is not a component of standard premium. Losses must not be coded to class 9849.

14. No-Massachusetts Exposure-Code 1111

When a policy was issued either on an "if any" basis, or as a multi-state policy, and upon audit it is determined that Massachusetts exposure did not develop on such policy, the first report unit is submitted with a single exposure record employing class code 1111. There are no corresponding exposure totals, or losses for this class code. Class Code 1111 is a device to notify the Bureau of a zero exposure situation for Massachusetts.

15. Non-Ratable Elements-Class Codes 0770, 0773, 0774, 0775, 0776, 0779, 0799, 7445 and 7453

Some classifications require a non-ratable element which is reported with a statistical class code and the rate and premium of the non-ratable element. Non-ratable element class codes must only be reported in conjunction with the corresponding basic classification ratable classes. The payroll for each of the paired classes must be equal. The exposure reported with the non-ratable element is not added into the total standard exposure. However, the exposure reported on the basic manual classification is added into the total standard exposure.

The non-ratable elements and corresponding ratable elements are as follows:

Non-Ratable Element	Basic Classification	Phraseology
0770	4770	Bag Loading Explosives or Ammo Mfg. and Drivers
0773	4773	High Explosive Mfg. and Drivers
0774	4774	Smokeless Powder-1 Base and Drivers
0775	4775	Explosives or Ammo Base Loading
0776	4776	Projective, Bomb, etc., Loading and Drivers
0779	4779	Cap, Fuse, etc., Explosive or Ammo Mfg. and Drivers
0799	4799	Black Powder, Mfg. and Drivers
7445	7405	Air Carrier-Other Flying Crew
7453	7431	Air Carrier, Commuter Flying Crew

The non-ratable elements are not subject to experience rating, but are a component of standard premium. Losses must be coded to the basic classifications corresponding to non-ratable elements.

16. Qualified Loss Management Program Premium Credit-Class Code 9880

The premium credit associated with the Qualified Loss Management Program is to be reported with class code 9880. The adjustment is assumed to be a negative value. The QLMP credit is not subject to experience rating, and is not a component of standard premium. Losses can not be coded to class 9880.

17. Radiation Exposure-Class Code 9985

[redacted]

a. [redacted] Other Than Government Agency Atomic Energy Projects-Code 9985

The Massachusetts Workers' Compensation & Employers' Liability Insurance Manual provides that a supplemental rate, subject to the approval of the Bureau, may be applied to operations involving research, manufacturing, handling, transportation, use of, exposure to radioactive materials, where such operations are not performed for or under the direction of a government agency. The

exposure to which such supplemental rates are applicable together with the premium derived from such charge shall be reported under code 9985. The exposure reported for code 9985 shall be shown in parenthesis and shall not be added to the exposures shown for other manual classifications in determining standard exposure total. Similarly radiation losses on risk where supplemental loading has been applied shall be assigned to code 9985. If no supplemental radiation loading has been applied to the risk, all losses shall be assigned to the appropriate industrial classifications. Experience under other than government agency atomic energy project is not subject to experience rating ***but is*** a component of standard premium.

18. Rate Deviation Credit-Code 9037 and 9034

a. Any company that has received approval from the Division of Insurance for a downward rate deviation, must report the premium adjustment due to any deviation with class code 9037.

i. Class 9037 is used to report rate deviations that are applied before the experience rating modification and is a component of standard premium.

ii. Class 9034 is used to report rate deviations that are applied after the experience rating modification, and are not a component of standard premium. Carrier filed programs for rate deviations that are applied after the experience rating modification will expire upon rate changes ***effective 9/1/08.***

b. Rate deviation classes 9037 and 9034 are assumed to be negative values.

c. Losses must not be coded to either 9034 or 9037.

19. Scheduled Rating Plans-Codes 9887 and 0887

a. Premium credits associated with scheduled rating plans that are not subject to experience rating are to be reported with class code 9887. The adjustment is assumed to be a negative value. Carrier filed scheduled rating plans applied after experience rating modification will expire with rate changes ***effective 9/1/08.***

b. Premium adjustment associated with scheduled rating plans that are subject to experience rating are to be reported with class code 0887.

The adjustment is assumed to be a negative value. Class 0887 is a component of standard premium.

c. Losses are not to be coded to class 9887 or 0887.

[redacted]

20. Short Rate Penalty Premium-Code 0931

The penalty premium which results from a short rate cancellation is reported with class code 0931. The short rate penalty premium is ***not*** subject to experience rating, and is ***not*** a component of standard premium. Losses can not be reported with class code 0931.

Note: Class code 0111 (strike duty) was eliminated effective January 1, 1998.

21. Terrorism Insurance Program Premium Debit

Terrorism Insurance Program, as amended and extended by the Terrorism Risk Insurance Reauthorization Act of 2007, premium debit is reported with class code 9740. The Terrorism Insurance Program premium debit is not subject to experience rating, and is not a component of standard premium. Losses associated with certified terrorists acts will be identified with a unique catastrophe code, and reported with the normal exposure class code. Losses can not be reported with class code 9740.

22. Waiver of Subrogation-Code 0930

The premium charge under the waiver of the carriers' right to recover from others endorsement is reported with class code 0930. The additional premium charged for waiver of subrogation is subject to experience rating, and is a component of standard premium. Losses can not be coded to class code 0930.

B. Numeric List of Statistical Classes

Class	Phraseology	Assumed to be a Positive Value	Subject to Experience Mod.	Is the Premium added into the Standard Premium Total	How is the Exposure Expressed	Can Losses be Coded to this Class
0032	Loss Constant	Yes	No	***No***	Blank	No
0059	Occupational Disease-Abrasive/Sand Blast	Yes	Yes	Yes	Limited	Yes
0063	Stock/Type A Premium Discount	No	No	No	Blank	No
0064	Non-Stock/Type B Premium Discount	No	No	No	Blank	No
0065	Occupational Disease-Steel	Yes	Yes	Yes	Limited	Yes
0066	Occupational Disease-Non Ferrous Metals	Yes	Yes	Yes	Limited	Yes
0067	Occupational Disease-Iron	Yes	Yes	Yes	Limited	Yes
0088	Aircraft Surcharge	Yes	Yes	Yes	Seats	***No***
	Effective 1/1/98					
0277	All Risk Adjustment Program	Yes	No	No	Blank	No
0770	Non Ratable Element-Bag Loading Explosive or Ammo MFG.-& DR-NR	Yes	No	Yes	Limited	No
0773	Non Ratable Element-High Explosive MFG. & DR-NR	Yes	No	Yes	Limited	No
0774	Non Ratable Element-Smokeless Powder MFG.-1 Base & DR-NR	Yes	No	Yes	Limited	No
0775	Non Ratable Element-Explosives or Ammo Case Loading & DR-NR	Yes	No	Yes	Limited	No
0776	Non Ratable Element-Projectile Bomb ETC. Loading & DR-NR	Yes	No	Yes	Limited	No

Class	Phraseology	Assumed to be a Positive Value	Subject to Experience Mod.	Is the Premium added into the Standard Premium Total	How is the Exposure Expressed	Can Losses be Coded to this Class
0779	Non Ratable Element-Cap Fuse Etc. Explosive or Ammo MFG. & DR-NR	Yes	No	Yes	Limited	No
0799	Non Ratable Element-Black Powder MFG. & DR-NR	Yes	No	Yes	Limited	No
0887	Premium Credit for Scheduled Rating Plan-Subject to Experience Rating	No	Yes	Yes	Blank	No
0900	Expense Constant	Yes	No	No	Blank	No
0930	Additional Premium-Waiver of Subrogation	Yes	Yes	Yes	Blank	No
0931	Short Rate Penalty Premium	Yes	***No***	***No***	Blank	No
0990	Risk Minimum Premium	Yes	No	***No***	Blank	No
1111	No Massachusetts Exposure	Must be Zero	No	No	Blank	No
7445	Non Ratable Element-Air Carrier-Other Flying Crew-NR	Yes	No	Yes	Limited	No
7453	Non Ratable Element-Air Carrier-Commuter Flying Crew-NR	Yes	No	Yes	Limited	No
9034	Rate Deviation-Not Subject to Experience Rating	No	No	***No***	Blank	No
9037	Rate Deviation-Subject to Experience Rating	No	Yes	Yes	Blank	No
9046	Construction Class Premium Adjustment	No	No	Yes	Blank	No
9129	Former Self-Insured Rating Plan Deposit	Yes	No	No	Blank	No
9136	Former Self-Insured Insurance Charge	Yes	No	No	Blank	No
9663	***Large*** Deductible ***Adjustment***-Not ***Subject to*** Experience ***Rating***	No	No	No	Blank	No
9664	Deductible- ***Adjustment Subject to - Experience Rating***	No	Yes	Yes	Blank	No
9721	Carrier Filed Premium Credit-Subject to Experience Rating	No	Yes	Yes	Blank	No

Class	Phraseology	Assumed to be a Positive Value	Subject to Experience Mod.	Is the Premium added into the Standard Premium Total	How is the Exposure Expressed	Can Losses be Coded to this Class
9722	Carrier Filed Premium Credit-Not Subject to Experience Rating	No	No	Yes	Blank	No
9723	Carrier Filed Premium Debit-Subject to Experience Rating	Yes	Yes	Yes	Blank	No
9724	Carrier Filed Premium Debit-Not Subject to Experience Rating	Yes	No	Yes	Blank	No
9740	Premium Debit for Terrorism Insurance Program, as amended and extended by the Terrorism Risk Insurance Program Reauthorization Act of 2007	Yes	No	No	Blank	No
9803	Employers Liability 100/100/1,000	Yes	Yes	Yes	Blank	No
9804	Employers Liability 100/100/2,500	Yes	Yes	Yes	Blank	No
9805	Employers Liability 100/100/5,000	Yes	Yes	Yes	Blank	No
9806	Employers Liability 100/100/10,000	Yes	Yes	Yes	Blank	No
9807	Employers Liability 500/500/500	Yes	Yes	Yes	Blank	No
9808	Employers Liability 500/500/1,000	Yes	Yes	Yes	Blank	No
9809	Employers Liability 500/500/2,500	Yes	Yes	Yes	Blank	No
9810	Employers Liability 500/500/5,000	Yes	Yes	Yes	Blank	No
9811	Employers Liability 500/500/10,000	Yes	Yes	Yes	Blank	No
9812	Employers Liability 1,000/1,000/1,000	Yes	Yes	Yes	Blank	No
9813	Employers Liability 1,000/1,000/2,500	Yes	Yes	Yes	Blank	No
9814	Employers Liability 1,000/1,000/5,000	Yes	Yes	Yes	Blank	No
9815	Employers Liability 1,000/1,000/10,000	Yes	Yes	Yes	Blank	No
9816	Employers Liability	Yes	Yes	Yes	Blank	No

Class	Phraseology	Assumed to be a Positive Value	Subject to Experience Mod.	Is the Premium added into the Standard Premium Total	How is the Exposure Expressed	Can Losses be Coded to this Class
9848	Employers Liability Minimum Premium	Yes	Yes	Yes	Blank	No
9849	Admiralty/Fela Balance Minimum	Yes	No	No	Blank	No
9874	MCO Credit	No	No	No	Blank	No
9880	Qualified Loss Management Program Credit	No	No	No	Blank	No
9884	***Merit Rating Unity***	***Must be Zero***	***No***	***No***	***Blank***	***No***
9885	Merit Rating Credit	No	No	Yes	Blank	No
9886	Merit Rating Debit	Yes	No	Yes	Blank	No
9887	Premium Credit for Scheduled Rating Plan-Not Subject to Experience Rating	No	No	No	Blank	No
9985	Radiation-Atomic Energy-Other Than Government Projects	Yes	No	Yes	Limited	Yes

PART I

UNIT STATISTICAL REPORTING

SECTION V

POLICY INFORMATION

Including Link, Header, Name, and Address Records

The policy information is data specific to the coverage of the policy. These elements include the link data which connect all records to a unit and each unit to a policy. Also included in the policy information is the insured's name, address, and premium totals.

	SECTION V DATA ELEMENT INDEX	
NO.	**DATA ELEMENT**	**PAGE**

SECTION V – HEADER, NAME and ADDRESS DATA

1. Carrier Code

a. Characteristic: Numeric

b. Length: 5

c. Definition: A unique code assigned by the (NCCI) to each company that supplies data.

d. Requirement: Report the 5-digit numeric code assigned to the reporting company by NCCI.

2. Policy Number

a. Characteristic: Alpha/Numeric

b. Length: 18

c. Definition: A unique identifier assigned to a policy. This number must be identical to the policy number shown on the policy information page.

d. Requirements: Report the alpha/numeric code that uniquely identifies the policy under which experience occurred excluding blanks, punctuation marks, and special characters. This number must be identical to the number set forth on the policy information page, or as endorsed.

The complete policy number including prefixes or suffixes, if used, must remain the same throughout the life of the policy, and the reporting of all experience under that policy.

3. Certificate Number

a. Characteristic: Alpha/Numeric

b. Length: 7

c. Definition: Certificate number of master policy.

d. Requirement: Not applicable to Massachusetts.

4. Exposure State

a. Characteristic: Numeric

b. Length: 2

c. Definition: A code that identifies the state of the employer's (insured's) facility. The state under which exposure is rated on the policy.

d. Requirement: Report the 2-digit numeric code that represents the state in which coverage has been provided for the classifications and corresponding exposures, to which the payrolls of injured workers have been assigned.

Massachusetts claims are those that relate to Massachusetts exposures used to calculate Massachusetts premiums.

Massachusetts is code 20.

5. Policy Effective Date

a. Characteristic: Numeric – YYMMDD

b. Length: 6

c. Definition: The inception date of the policy as shown on the policy information page.

d. Requirements: Report the month, day, and year upon which the policy became effective. This date must be identical to the date set forth in item 2 of policy information page or as endorsed.

For interstate policies endorsed after the policy effective date to provide coverage for Massachusetts, report the effective date of the policy.

For the second and third periods of three-year variable rate policies, report the effective date as one and two-years, subsequent to the policy effective date as set forth in item 2 of the policy information page. For the first period, report the policy effective date as shown on the policy information

page, or as endorsed. In the event the policy contains a policy period endorsement, then the effective date must coincide with the dates indicated on the schedule of that endorsement.

For the second period of extended-term policies, report the effective date as the date the second period began as shown in the policy period endorsement.

6. Report Number

a. Characteristic: Alpha/Numeric

b. Length: 1

c. Definition: A code appearing on a unit report that indicates the number of times the loss data has been reported excluding correction reports that correspond to the number of valuations.

d. Requirement: For normal annual policies, 3-year variable rate policies and policies extended beyond one year. Report the code that corresponds to the loss valuation date. Losses are valued based on the policy effective date.

Code	Report Level	Loss Valuation Schedule
1	First Report	Valued 18 months from policy or period effective month
2	Second Report	Valued 30 months from policy or period effective month
3	Third Report	Valued 42 months from policy or period effective month
4	Fourth Report	Valued 54 months from policy or period effective month
5	Fifth Report	Valued 66 months from policy or period effective month
6	Sixth Report	Valued 78 months from policy or period effective month
7	Seventh Report	Valued 90 months from policy or period effective month
8	Eighth Report	Valued 102 months from policy or period effective month
9	Ninth Report	Valued 114 months from policy or period effective month
A	Tenth Report	Valued 126 months from policy or period effective month

Three-year-fixed rate policies are reported with the 1-digit numeric code that corresponds to the loss valuation date.

Code	Report Level	Loss Valuation Schedule
1	First Report	Valued 42 months from policy effective date

7. Correction ***Sequence*** Number

a. Characteristic: Alpha/Numeric

b. Length: 1

c. Definition: An indicator that identifies the unit report as a "correction" report versus an "original" unit report. Also the number of corrections submitted within a particular report level.

d. Requirement: Report the sequential number that corresponds to the number of correction reports submitted within a particular report level.

Use 1 through 9, then A through Z as correction number within a report level.

Example: 3rd correction to a first report = Report Number "1", Correction Sequence Number "3". Report "0" in correction sequence if original report level submission.

Examples:

	Report No.	Correction Sequence
Original 1st Report	1	0
Original 2nd Report	2	0
First Correction to 2nd Report	2	1
Second Correction to 2nd Report	2	2
Third Correction to 2nd Report	2	3
Original 3rd	3	0
-	-	-
-	-	-
-	-	-
-	-	-
Seventh Correction to 5th Report	5	7
Eighth Correction to 5th Report	5	8
Ninth Correction to 5th Report	5	9
Tenth Correction to 5th Report	5	A

8. Policy Expiration ***or Cancellation*** Date

a. Characteristic: Numeric – YYMMDD

b. Length: 6

c. Definition: The end of coverage date of the policy as shown on either the policy information page or the cancellation.

d. Requirements: Report the month, day, and year upon which the policy expired.

For canceled policies, report the cancellation date as the expiration date.

For policies issued not longer than one year plus sixteen days (considered standard one-year term policies), report the expiration date as set forth on the policy information page or endorsement.

For the first and second periods of three-year variable rate policies, report the expiration date as one and two-years, subsequent to the policy effective date as set forth in item 2 of the policy information page. For the third period, report the policy expiration date as shown on the policy information page or as endorsed. In the event the policy contains a policy period endorsement, then the expiration date must coincide with the date indicated in the schedule of that endorsement.

For the first and second periods of extended-term policies, report the associated expiration date as shown in the policy period endorsement.

9. Risk Identification Number

a. Characteristic: Alpha/Numeric

b. Length: 9

c. Definition: A code assigned by Bureau which uniquely identifies the insured.

d. Requirement: Report the risk identification number assigned to the risk by the Bureau issuing the experience rating. For interstate risks, report the 9-digit NCCI-assigned number, or the 9-digit MA Bureau number which appears as combinable identification number (combo id) on experience and merit ratings. For intrastate risks, report the 9-digit MA Bureau assigned combinable identification number (combo id). Not required for non-rated risks.

10. Replacement Report Indicator

a. Characteristic: Alpha/Numeric

b. Length: 1

c. Definition: A code to identify a replacement report.

d. Requirement: Enter code R when replacing a previously submitted unit statistical report. For all reports other than replacements this field should be blank. Submission of a replacement will delete previously reported unit statistical reports from the Bureau's data base. Replacements can be submitted for units which are accepted, rejected or failed. Replacement USR can be used instead of a correction report. (Effective immediately at carriers option).

11. Correction Type

a. Characteristic: Alphabetic

b. Length: 1

c. Definition: A code for correction reports which indicates the record types that change.

d. Requirements: Report the 1-digit alphabetic code that indicates the type of correction report being submitted. Subsequent reports cannot be coded with correction types H or E.

Code	Description
H	Header Record Correction (link all reports, non-link elements first report only)
E	Exposure Record Correction (first reports only)
L	Loss Record Correction - Not an Aggravated Inequity
T	Total Record Correction
M	Corrections to Multiple Record Types - Combinations of corrections to header, exposure, loss, or total records**,** Aggravated inequity corrections must be reported separately.
A	Loss Record Correction due to an aggravated inequity. This type of correction can not be reported on a multiple record type.

Note: A loss correction due to an Aggravated Inequity is submitted upon the Bureau's request or when the carrier identifies the circumstances that qualify the experience rating for a revision under the Aggravated Inequity Rule of the Experience Rating Plan Manual.

12. State Effective Date

a. Characteristic: Numeric – YYMMDD

b. Length: 6

c. Definition: The date Massachusetts coverage begins. For interstate policies when Massachusetts is added mid-term.

d. Requirement: Report the endorsement effective date if the Massachusetts coverage was endorsed mid-term. Otherwise, leave blank.

13. Federal Employers' Identification Number

a. Characteristic: Numeric

b. Length: 9

c. Definition: A code assigned to the employer by the federal government for federal tax purposes, as reported on the policy information page, or as endorsed.

d. Requirements: Report the federal employers' identification number of the insured as shown on the policy information page, or as endorsed.

14. Business Segment Identifier

a. Characteristic: ***Numeric***

b. Length: ***7***

c. Definition: ***Any series of identifying codes maintained and reported by the data provider.***

d. Requirements: ***Report the business segment identification number of the data provider.***

15. Three-Year Fixed Rate Indicator

a. Characteristic: Alphabetic

b. Length: 1

c. Definition: Indication that policy was written on a three-year fixed rate basis.

d. Requirement: Y = Policy is a three-year fixed rate policy.
N = Policy is not a three-year fixed rate policy.

16. Multi-state Indicator

a. Characteristic: Alphabetic

b. Length: 1

c. Definition: A code to indicate if the policy covered a single state or several states.

d. Requirement: Y = Policy is multi-state policy.
N = Policy is a Massachusetts single-state policy and not a multi-state policy.

17. Interstate Indicator

a. Characteristic: Alphabetic

b. Length: 1

c. Definition: A code to indicate if the policy was subject to an experience rating modification issued by the interstate rating bureau and applicable to multiple jurisdictions.

d. Requirement: Y = Policy is interstate rated.
N = Policy is not interstate rated.

18. Estimated Exposure Indicator

a. Characteristic: Alphabetic

b. Length: 1

c. Definition: A code indicating the status of the policy audit.

d. Requirement: Y = Exposures expressed on unit report are estimated.
N = Exposures expressed on unit report are result of the audit.

19. Retrospective Rating Indicator

a. Characteristic: Alphabetic

b. Length: 1

c. Definition: A code indicating that the policy was subject to a retrospective or other loss sensitive rating plans.

d. Requirement: Y = Policy is retrospective rated as defined in the Retrospective Rating Manual.
N = Policy is not retrospective rated.

20. Canceled Mid-Term Indicator

a. Characteristic: Alphabetic

b. Length: 1

c. Definition: A code to indicate a canceled policy.

d. Requirement: Y = Policy term has been shortened by a cancellation and not subsequently reinstated.
N = Policy is full term and policy has not been canceled, or if the policy was canceled, it was reinstated on the cancellation date.

21. Managed Care Organization Indicator

a. Characteristic: Alphabetic

b. Length: 1

c. Definition: A code to indicate that the policy has provisions for administration of claims under a MCO.

d. Requirement: Y = Policy has provisions for the administration of losses under an approved managed care organization.
N = Policy does not have provisions for the administration of losses by an approved managed care organization.

22. Policy Type Identification Code

a. Characteristic: Numeric

b. Length: 6

c. Definition: A code structure which distinguishes between voluntary and assigned risk business, identifies the type of assignment, and identifies both non-standard W. C. coverage and the type of coverage.

d. Requirement: Report the 3-segment code that corresponds to the type of coverage, plan indicator and non-standard indicator of the policy being reported.

Type of Coverage First Position		Plan Indicator Second Position		Non-Standard Indicator Third Position	
Code	Description	Code	Description	Code	Description
01	Standard Workers' Compensation Policy other than 05 & 09	01	Voluntary Policy	01	Standard Workers' Compensation
		02	Normal Assigned Risk Policy-excluding Codes 5 & 6 below	99	Self-Insured Coverage
05	Massachusetts Large Risk Rating Option (Alternative Retrospective Rating)	05	Assigned Risk Policy written under MA Voluntary Direct Assigned Risk Program		
09	Non-Standard Workers' Compensation coverage used only in conjunction with other than Code 01 in the Non-standard Indicator				

Example:

	Code
Standard Voluntary Policy	010101
Standard Normal Assigned Risk Policy	010201
Non-Standard Voluntary Self Insured	090199

23. Deductible Type

a. Characteristic: Numeric
b. Length: 4
c. Definition: A code that identifies the way in which a deductible applies to a policy.
d. Requirement:

Losses Subject to Deductible Code	Code	Description
Medical	01	Deductible applies to the medical portion of the loss only.
Indemnity	02	Deductible applies to the indemnity portion of the loss only.
Medical & Indemnity	03	Deductible applies to the total of medical and indemnity portions of the loss.
Basis of Deductible Calculation Code	Code	Description
Per Claim	01	The deductible amount applies to each claim arising from the Policy and there is no aggregate deductible. ***(small deductibles only)***
Per Policy and Accident (Aggregate)	09	The deductible amount applies to each accident up to an aggregate limit and there is no per claim deductible.
Per Claim and Policy (Aggregate)	10	The deductible amount applies to each claim up to an aggregated limit and there is no per accident deductible.
Variable	12	Carrier program not described above.

Claim is defined as one injured worker per accident. Accident is defined as one occurrence which could result in one or more claims.

24. Deductible Percent

a. Characteristic: Numeric

b. Length: 2

c. Definition: A code that identifies the percentage of the deductible as defined by deductible type.

d. Requirement: Not applicable.

25. Deductible Amount Per Claim/Accident

a. Characteristic: Numeric

b. Length: 9

c. Definition: The single amount of claim costs which is paid by the insured.

d. Requirement: Report the loss amount by claim/accident to be paid by the insured, if applicable, as defined by the deductible program.

26. Deductible Amount Aggregate

a. Characteristic: Numeric

b. Length: 9

c. Definition: The maximum aggregate amount of claim costs which would be paid by the insured.

d. Requirement: Report the maximum loss amount for all claims to be paid by the insured, if applicable as defined by the deductible program.

27. Previous Report Number

a. Characteristic: Alpha/Numeric

b. Length: 1

c. Definition: The report number which appeared on the previously submitted unit.

d. Requirement: Not applicable to Massachusetts. If a unit statistical report has been accepted with the wrong report number, contact the Bureau to arrange for the deletion of the incorrect unit and replacement with proper report number.

28. Previous Correction Sequence Number

a. Characteristic: Alpha/Numeric

b. Length: 1

c. Definition: The correction number which appeared on the previously submitted unit.

d. Requirement: Not applicable to Massachusetts. If a unit statistical report has been accepted with the wrong correction number, contact the Bureau to arrange for the deletion of the incorrect unit and replacement with proper correction number.

29. Previous Carrier Code

a. Characteristic: Numeric

b. Length: 5

c. Definition: The carrier code which appeared on the previously submitted unit.

d. Requirement: The previous carrier code is entered only to amend the carrier code of a previously submitted unit. The electronic header record contains a separate and distinct field for the previous carrier code.

Note: On electronic correction reports which change the carrier code, the carrier code field functions as the revised carrier code.

30. Previous Policy Number

a. Characteristic: Alpha/Numeric

b. Length: 18

c. Definition: The policy number which appeared on the previously submitted unit.

d. Requirement: The previous policy number is entered only to amend the policy number of a previously submitted unit. The electronic header record contains a separate and distinct field for the previous policy number.

Note: Correction reports which change the policy number, the policy number field functions as the revised policy number.

31. Previous Policy Effective Date

a. Characteristic: Numeric – YYMMDD

b. Length: 6

c. Definition: The policy effective date which appeared on the previously submitted unit.

d. Requirement: The previous policy effective date is entered only to amend the policy effective date of a previously submitted unit. The electronic header record contains a separate and distinct field for the previous policy effective date.

Note: Correction reports which change the policy effective date, the policy effective date field functions as the revised.

32. Previous Exposure State

a. Characteristic: Numeric

b. Length: 2

c. Definition: The exposure state which appeared on the previously submitted unit.

d. Requirement: Units submitted to The Workers' Compensation Rating and Inspection Bureau of MA with exposure states other than 20 are rejected. Rejected units must be replaced. The previous exposure state is entered only to amend exposure state code 20 to a non-Massachusetts code. The result will be that the unit is dropped from our data base. The electronic header record contains a separate and distinct field for the previous exposure state.

Note: Correction reports which change the exposure state, the exposure state field functions as the revised exposure state.

33. Insured's Name

a. Characteristic: Alpha/Numeric

b. Length: 79-Bureau retains the first 45 digits of the insureds name on our data base.

c. Definition: The person or business with whom an insurance contract is made and who is specifically designated by name in item 1 of the policy information page, or as endorsed.

d. Requirement: Report the name of the person or business with whom an insurance contract is made and who is specifically designated by name in item 1 of the policy information page, or as endorsed.

34. Insured's Address

a. Characteristic: Alpha/Numeric

b. Length: 79

c. Definition: The street address, city, state, and zip code of the insured as shown in item 1 of the policy information page, or as endorsed.

d. Requirement: Optional for Massachusetts.

PART I

UNIT STATISTICAL REPORTING

SECTION VI

EXPOSURE DATA

The exposure records contain the information that determines the premium (cost) developed by the policy.

SECTION VI DATA ELEMENT INDEX

SECTION VI - EXPOSURE PREMIUM DATA

The exposure data elements are used to report the class, coverage, exposure, premium and manual rate that correspond to the earned policy premium.

1. Class Code

a. Characteristic: Numeric

b. Length: 4

c. Definition: A Code used in rating the policy which is assigned to a type of work based on the nature of the business of the employer, or a statistical code as defined by the rating bureau.

d. Requirement: Report the numeric code corresponding to the classification assigned to the insured according to the rules of the manual for Workers' Compensation.

2. Experience Modification Factor

a. Characteristic: Numeric

b. Length: 4 X.XXX decimal is assumed.

c. Definition: A factor applied to subject premium to reflect a risk's variation from the average risk within the same class code. Using the risk's past experience, the experience modification is determined by comparing the actual losses to expected losses.

d. Requirement: Report the experience modification factor used to develop the charged premium.

3. Modification Effective Date

a. Characteristic: Numeric – YYMMDD

b. Length: 6

c. Definition: Normally this is the effective date of the policy. However, when there is an anniversary rating date or late mod involvement, it is necessary to indicate the effective date on which the mod is effective and applicable to this portion of the unit report.

d. Requirement: Report the mod effective date on which the mod is effective and applicable to this portion of the unit report. If the modification changes in accordance with Experience Rating Plan Manual rules, report the effective date of the modification which applies to the reported exposure(s).

Normally this is the effective date of the policy. If the anniversary rating date is different than the inception date then the mod effective date equals the anniversary rating date.

4. Rate Effective Date

a. Characteristic: Numeric – YYMMDD

b. Length: 6

c. Definition: [redacted]***–This is the effective date of the rate revision that is applicable to this portion of the unit.***

d. Requirement: [redacted]***For each reported class code, report the effective date of the rate revision that is applicable to this portion of the unit.***

5. Exposure Amount

a. Characteristic: Numeric

b. Length: 10

c. Definition: The measurement used to determine how much premium should be charged to the insured. This measurement is generally the final audited payroll amount, in whole dollars, for class codes covered by the policy. Other exposure bases include number of employees (per capita), and number of aircraft passenger seats and number of days.

d. Requirement: Report the exposure amount for all classifications assigned to the policy, except those specifically indicated as exceptions (see below). The entire whole dollar exposure must be reported. Do not truncate.

When reporting a "no exposure developed" unit report, using class code 1111, leave the exposure field blank.

Payroll base: Report the estimated or audited payroll amount in whole dollars.

Per Capita base: (Class Codes 0908, 0909, 0912 and 0913) Report the number of employees(s) covered, based on the duration of coverage for one year intervals. Do not add per capita expense to the total standard exposure.

For example, one employee covered for one year is reported as 1.0. ***Coverage for one employee working less than a year is rounded and reported to the nearest tenth position.***

Note: Table is for 365 day year.

Duration of Coverage	Factor
1 day - 17 days	.0
18 days – ***52 days***	.1
53 days- 89 days	.2
90 days- 125 days	.3
126 days- 162 days	.4
163 days- 198 days	.5
199 days- 235 days	.6
236 days- 271 days	.7
272 days- 308 days	.8
309 days - 344 days	.9
345 days- 365 days	1.0

Note: The decimal is implied on electronic reports.

Exposure continued...

Aircraft Operation - Passenger Seat Surcharge: (Class Code 0088) Report the number of seats on the aircraft. For example one seat = 1.0. Do not add seat surcharge total to standard exposure. Note: *The decimal is implied on electronic reports*.

Note: Class code 0111 (strike duty) was eliminated effective January 1, 1998.

Disease Experience: (Class Codes 0059, 0065, 0066, 0067) Report the payroll to which the supplementary disease rate is applied. Do not add this amount into the total standard exposure.

Radiation Exposure: (Class Codes 9984 and 9985) Report the payroll to which the supplementary radiation rate is applied. Do not add this amount into the total standard exposure.

Non-Ratable Elements: (Class Codes 0770, 0773, 0774, 0775, 0776, 0779, 0799, 7445, and 7453) Report the payroll to which the non-ratable portion of the rate is applied. Do not add this amount into the total standard exposure. The exposure on the non-ratable class record and corresponding manual class should be equal.

6. Premium Amount

a. Characteristic: Numeric

b. Length: 9

c. Definition: The premium for a class normally developed from unit of exposure times the manual rate, or the premium assigned to a statistical class code.

d. Requirement: Report the premium amount corresponding to each classification.

By Extension of Payroll: (Exposure x manual rate) ÷ 100

Other Premium: As defined by the classification/statistical code.

The Bureau identifies the sign of the premium by the class code.

Note that for non-statistical classes the Bureau will calculate an expected manual premium based on the reported exposures and the approved Bureau rates. The expected manual premium will be compared to the reported manual premium. Periodically the Bureau will provide a report to the Division of Insurance of the carrier groups that fall outside of the reconciliation tolerances. Refer to section XII.

7. Manual Rate

a. Characteristic: Numeric

b. Length: 7

c. Definition: The charge per unit of exposure for a specific class code.

d. Requirement: Report the applicable charge per unit of exposure for each classification. The approved applicable manual rate prior to deviations or discounts is to be reported.

Implied decimal

Note the Bureau will edit this information as compared to approved Bureau rates. Periodically the Bureau will provide a report to the Division of Insurance of the carrier groups that fall outside of the reconciliation tolerances. Refer to section XII.

8. Split Period Code

a. Characteristic: Numeric

b. Length: 1

c. Definition: Identifies the class exposure records that are contained within an exposure split.

d. Requirement: Beginning with code 0 report the one digit numeric code that identifies the exposure records that belong to the same exposure split and contain equal modification factor, rate effective date and modification effective date. Policies with no change in manual rates or modification factors, report 0 on all exposure records. For policies with changes in manual rates, modification factors, modification effective date or rate effective date report '0' for the first split period, '1' for the second period, '2' for the third period etc., through '9'.

Statistical classes whose premium is subject to the split must report the associated split exposure code. Statistical classes whose premium is based on the entire policy should be reported with the last exposure period and the highest exposure split code.

9. Update Type

a. Characteristic: Alphabetic

b. Length: 1

c. Definition: Code that identifies purpose of a correction record within a unit.

d. Requirement: Report the one digit alphabetic code that identifies the activity of the exposure record on all correction reports.

Code	Description
P	Previously Reported Record
R	Revised Record

The Massachusetts Bureau will pair "P" and "R" records to process as a change to previously submitted data. Unpaired Previous and Revised records will be processed as a ***d***elete from previously reported data, and ***a***dd to reported data.

Each carrier will be required to select and employ one set of codes.

10. Exposure Coverage Act

a. Characteristic: Numeric

b. Length: 2

c. Definition: The type of coverage is associated with the manual class code, and distinguishes between state and federal coverage.

d. Requirement:

Code	Description
00	***Statistical Codes***
01	State Act
02	USL&H "F" or USL&H coverage on Non "F" Classes

11. Premium Discount Amount

a. Characteristic: Numeric

b. Length: 9

c. Definition: The amount deducted from the total standard premium in recognition of the smaller relative expense of servicing large policies.

d. Requirement: Report the premium adjustment resulting from the application of the premium discount plan reported under class code 0063 (stock or type A) or 0064 (non-stock or type B). Do not include the premium discount amount in the total standard premium.

12. Expense Constant Amount

a. Characteristic: Numeric

b. Length: 9

c. Definition: A flat dollar charge added to the total standard premium to cover expenses.

d. Requirement: The expense constant is reported with class code 0900 as an exposure record.

For multi-state policies, apply the expense constant to the state with the highest applicable expense constant. If two or more states have the same highest expense constant, apply it to the state developing the highest standard premium.

13. Total Modified Premium

a. Characteristic: Numeric

b. Length: 10

c. Definition: Total subject premium times the experience modification.

d. Requirement: Not applicable to Massachusetts.

14. Total Standard Exposure

a. Characteristic: Numeric

b. Length: 11

c. Definition: The sum of the payroll exposures.

d. Requirement: Report the sum of the all dollar value (payroll) exposures.

15. Total Standard Premium

a. Characteristic: Numeric

b. Length: 11

c. Definition: (Total subject premium x experience modification) plus premium not subject to experience modification.

d. Requirement: Report the sum of all premium dollars (subject and not subject to modification).

The statistical classes reported for the following premium charges and credits are not subject to experience rating but are added (or subtracted) during the calculation of total standard premium.

Non-ratable Elements: Codes: 0770, 0773, 0774, 0775, 0776, 0779, 0799, 7445, 7453
Construction Credit: Code: 9046
Merit Rating: Code: 9885, 9886
Independent Carrier Filing Credit: Code: 9722
Independent Carrier Filing Debit: Code: 9724
Radiation – Atomic Energy other than Government Projects: Code: 9985

The following discounts, credits, and surcharges must not be included in the total standard premium.

Class	Description
0032	Loss Constant
0063	Stock/Type A Premium Discount
0064	Non-Stock/Type B Premium Discount
0277	All Risk Adjustment
0900	Expense Constant
0931	Short Rate Penalty
0990	Balance to Risk Minimum Premium
9034	Rate Deviation
9129	Formerly Self-insured Rating Plan Deposit
9136	Formerly Self-Insured Deposit & Insurance Charge
9880	Qualified Loss Management
9663	Deductible Experience - Not Experience Rated
9740	Premium Debit for Terrorism Insurance Program, as amended and extended by the Terrorism Risk Insurance Program Reauthorization Act of 2007
9849	Balance to Admiralty and/or Fela Minimum
9874	Managed Care Arrangement Premium Credit
9887	Scheduled Rating Plans

The following additional charges or adjustments associated with the policy must not be reported on the unit and must not be added to the standard premium total:

Retrospective Adjustments, DIA Assessment, Dividends to Policyholders, Premium Tax.

16. Total Subject Premium

a. Characteristic: Numeric

b. Length: 10

c. Definition: The sum of premium amounts subject to experience modification.

d. Requirement: Report the sum of premium amounts subject to experience modification.

Premium amounts subject to experience rating include all premium resulting from the extension of manual rate to exposure for manual classes including the following industry groups of classes.

State Manufacturing	Federal Classes	Fed. Empl. Liability Act Classes
State Construction	"A" Rate Classes	
State All Other Classes	Admiralty Classes	

The statistical classes for the following premium charges or credits are also subject to experience rating:

Employers' Liability: Codes: 9803-9816, 9848

Occupational Disease: Codes: 0059, 0065, 0066, 0067

Additional Premium for Waiver of Subrogation: Code: 0930

Independent Carrier Filing Credit: Code: 9721

Independent Carrier Filing Debit: Code: 9723

Schedule Rating Plans: Code: 0887

Aircraft Surcharge: Code: 0088

Massachusetts Benefits Claim Deductible and Massachusetts Benefit Claim and Aggregate Programs: Code: 9664

PART I

UNIT STATISTICAL REPORTING

SECTION VII

LOSS DATA

The loss records contain the information specific to the benefit (claim) paid or reserved for injuries covered by the policy.

	SECTION VII DATA ELEMENT INDEX	
NO.	**DATA ELEMENT**	**PAGE**

SECTION VII - LOSS DATA

1. Loss Class Code

a. Characteristic: Numeric

b. Length: 4

c. Definition: The class code where the payroll of the injured worker was reported.

d. Requirement: Report the class code where the payroll or other exposure of the injured worker was reported.

2. Number of Claims

a. Characteristic: Numeric

b. Length: 4

c. Definition: The number of claims reported on the corresponding loss record.

d. Requirement: Number of claims must be 1 which is the Bureau default on individually reported claims.

3. Accident Date

a. Characteristic: Numeric - YY-MM-DD

b. Length: 6

c. Definition: The date on which the injury occurred.

d. Requirement: Report the month, day, and year on which the injury occurred. The accident date of a claim can range from the policy effective date to the last full day of coverage. The last full day of coverage on a policy is the day prior to the policy expiration date. Claims that occur on the expiration date of one policy and the effective date of renewal must be reported on the renewal policy.

For cumulative injury claims, report the last date of exposure within policy period, or date injury was reported

to the carrier, whichever occurred first. If the exposure occurred over a period of time during the policy period, report the last full day of exposure within the policy period. Given that policies expire at 12:01 AM on the expiration date, the last possible full day of exposure coincides with the day prior to the expiration date.

For example: If there are policies effective 1/1/06-1/1/07 and 1/1/07-1/1/08, report any accident occurring prior to 12:01 AM on 1/1/07 on the 1/1/06 policy and report any accident occurring at 12:01 AM or later on 1/1/07 on the renewal policy effective 1/1/07.

4. Claim Number

a. Characteristic: Alpha/Numeric

b. Length: 12

c. Definition: A unique number assigned by the insurance company to a claim for the life of that claim.

d. Requirement: Report the alpha-numeric code that uniquely identifies the claim and represents one injured worker for both medical and indemnity benefits. Exclude blanks, punctuation marks, and special characters.

The complete claim number, including suffixes and prefixes, if used, must remain the same throughout the life of the claim.

Any claim with payments or case outstanding reserves greater than zero as of the valuation date, must be reported on the unit. The reportable amounts include medical losses, indemnity losses, claimants' attorney fees, employers' attorney fees, and allocated loss adjustment expense.

A unique and consistent claim ID number must report all payments and outstanding case reserves incurred due to the injury of a worker for a single accident or injury.

For example: a claim may involve medical, indemnity, and employers' liability losses, but if these payments or reserves are the result of a single worker injured due to a single accident or injury, then the losses must be reported

with one claim ID number as one loss record per unit report. That claim ID number must be consistent throughout all reports and corrections of the claim.

5. Status

a. Characteristic: Numeric

b. Length: 1

c. Definition: A code that identifies claims where final payment has been made.

d. Requirement: Report the 1-digit numeric code that indicates the status of the claim.

Code	Claim Status
0	Open (final payment not made)
1	Closed (final payment has been made)

6. Injury Code

a. Characteristic: Numeric

b. Length: 2

c. Definition: A code that identifies under which provision(s) of the law benefits are paid or expected to be paid.

d. Requirement: Report the 2-digit numeric code that identifies under which provision of the law benefits are paid or expected to be paid.

Code	Description
01	Death
02	Permanent Total Disability
05	Temporary Injury
06	Medical Only
09	Permanent Partial Disability

PLEASE SEE PAGE ***4*

Injury-Code & Description	Reporting Instructions for Injury Code
1 - Death	Enter as death claim, each claim where the injured worker has died, unless it has been established that the carrier has incurred no liability. The amount shall include all paid and outstanding benefits, including compensation paid to the deceased prior to death, burial expense, and payments to the state.
2 - Permanent Total	Enter as permanent total each claim which has been adjudged to constitute permanent total disability or which is defined as such under the law, or which, in the judgment of the carrier will result in permanent total disability.
5 - Temporary	Enter as temporary every case which involves or is expected to involve indemnity benefits but which does not constitute a case of death, permanent total or permanent partial.
6 - Medical	Enter as a medical only claim each claim where there are only medical payments and there are no indemnity losses.
9 – Permanent Partial	A permanent partial loss is defined as: a. Any permanent injury which does not involve permanent total disability. ***b.*** Any case where the extent of future payments is indeterminate in the judgment of the carrier. The amount entered as indemnity incurred shall include specific benefits and compensation for temporary disability as well as loss of earning capacity.

7. Catastrophe Code

a. Characteristic: Numeric

b. Length: 2

c. Definition: A code that identifies any accident (one occurrence) resulting in two or more reported claims on a policy for exposure within MA, or claims identified as Extraordinary Loss Events (ELE) and assigned a catastrophe code by ISO.

d. Requirement: Two or more claims arising out of the same occurrence (accident or contagion) are identified as being associated for accident limitation purposes by sequentially assigned and reported two digit catastrophe codes. The claims resulting from the first occurrence are reported with catastrophe code 01. The claims resulting from the second occurrence are coded with the catastrophe code 02. The process continues up to and including "10". A separate series of catastrophe numbers beginning with "01", shall be used for each policy. Each succeeding catastrophe number shall be increased by 1. After the number "10" is assigned the next number in the sequence will begin with number "01" again. Numbers "11" through "99" are reserved for Extraordinary Loss Events (ELE) catastrophe codes, as assigned by ISO.

EXCEPTION:
Report catastrophe code 48 on claims directly attributable to the September 11, 2001 terrorist attacks that have accident dates of September 11, 2001 through September 14, 2001. Stress claims, respiratory claims, and claims attributable to recovery and clean-up efforts that have accident dates of September 11, 2001 through September 14, 2001 are also reported as catastrophe code 48. Any claims (including stress, respiratory, and recovery/clean-up claims) directly attributable to the September 11, 2001 terrorist attacks that have accident dates after September 14, 2001 are not reported as catastrophe code 48. Those claims shall be reported in accordance with the appropriate unit statistical reporting provisions of the Massachusetts Workers' Compensation Statistical Plan.

Catastrophe Code is required on medical only claims including the medical only claims that qualify for catastrophe code "48".

8. Incurred Indemnity

a. Characteristic: Numeric

b. Length: 9

c. Definition: The whole dollar amount paid or expected to be paid to an injured employee and/or dependents due to the employees lost wage benefits. The incurred indemnity losses encompass all paid and outstanding wage compensation, burial expenses, sums designated for specific injuries or disfigurements, claimants' attorney fees, vocational rehabilitation, employers' liability losses and employers' liability expenses.

Note: Since 1986 the MA Second Injury Fund has been funded through premium assessments paid by the insureds. These employer paid DIA assessments shall not be reported as part of the losses.

d. Requirement: Report the whole dollar amount of incurred indemnity losses as of the loss valuation date. Except for death and permanent total claims, incurred indemnity losses reported on unit statistical reports should consist of the sum of all paid losses and outstanding case reserves for benefits (such as employee's lost wages) due to an employee's inability to work caused by a work related accident. The outstanding case reserves are the company's estimates of future payments for individual claims.

Generally, for purposes of reporting death and permanent total claims, Section IX pension tables should be used to estimate the future payments component of the incurred indemnity loss. Consequently, the incurred indemnity loss should consist of the sum of all paid losses and the estimated future payments derived using the Section IX pension tables for benefits (such as employee's lost wages) due to an employee's inability to work caused by a work related accident.

The incurred indemnity loss should consist of the sum of all paid losses and the carrier's best estimate of future payments for benefits (such as employee's lost wages) due to an employee's inability to work caused by a work related accident .

e. NON USL&HW ACT DEATH AND PERMANENT TOTAL CLAIMS

1. In valuing a surviving spouse's benefits in death claims where benefits are payable to the surviving spouse (widow or widower) until death or remarriage, use TABLE IE-398.

2. In valuing the portion of the reserve for death claims where there is not a surviving spouse, but a parent, brother or sister where benefits are payable for life, use TABLE IIE-398.

3. In valuing the disabled life portion of the reserve for a permanent total claim where benefits are payable for life, TABLE IIIEM-398 shall be used for male claimants. TABLE IIIEF-398 shall be used for female claimants.

4. For Permanent Total claims present values are to be further adjusted to allow for survivorship benefits according to the following procedure:

   i. Establish the pension value for the disabled worker based on the appropriate table.

   ii. Determine the pension value for the spouses with surviving spouse benefits based on the appropriate table or for dependent other than spouse based on the appropriate table.

   iii. Determine the pension value difference of item (ii) minus item (i). If this produces a negative result, there is no additional increment to be added to the reserve for survivorship benefits.

   iv. Multiply the pension value difference from item (iii) by one-third(1/3) the annual benefit that would be payable to the worker's spouse or dependents if the worker dies. This produces the amount to be added to the reserve for survivorship.

f. USL&HW ACT DEATH AND PERMANENT TOTAL CLAIMS

1. For all death claims incurred under the United States Longshoremen and Harbor Workers' Act, PENSION TABLE UI-USLH shall be used in valuing the surviving spouse's benefit. Additionally, in valuing the present value or the remarriage dowry TABLE UII-USLH shall be used. For claims where there is

2. not a surviving spouse, TABLE UIV-USLH Present Value of Survivorship benefits shall be used.

3. For all permanent total claims incurred under the United States Longshoremen and Harbor Workers' Act and the benefits payable for life, PENSION TABLE UIIIM-USLH or UIIIF-USLH shall be used in valuing the claimant's benefits. Additionally, TABLE UIV-USLH shall be used in valuing the present value of the survivorship benefits.

g. REPORTING OF REIMBURSEMENT FROM A SPECIAL FUND

In all cases where a claim has been determined to be eligible for reimbursement to the carrier from a special fund (such as Second Injury Fund, etc.) the gross incurred cost of the claim (i.e., prior to any reimbursement) shall be reduced by the amount of any paid recovery from such Fund and the net incurred cost of the claim shall be reported.

h. EXPENSES INCLUDED IN LOSSES

1. Legal Expenses Incurred for the Benefit of the Claimant.

Legal court expenses incurred for the benefit of the claimant, or that the carrier is required to produce for the benefit of the claimant, shall be reported as either an indemnity or medical loss depending upon the nature of the expense.

2. Employers' Liability Loss Adjustment Expenses.

Unlike workers' compensation losses, ***e***mployers' liability losses include allocated loss adjustment expenses. The entire amount of losses and allocated loss adjustment expenses shall be reported as incurred losses on the unit report.

3. Impartial Examinations by Industrial Board.

Expenses for impartial examinations ordered by an Industrial Board are to be considered as incurred losses and reported on the unit report.

Note: Filing fees paid by the carrier to fund impartial examinations pursuant to Section 11A of Chapter 152 of the Massachusetts General Laws are to be considered an expense when the carrier prevails. When the claimant prevails and the carrier reimburses the claimant's filing fees which were paid to fund impartial examinations pursuant to Section 11A, the reimbursement of the claimant's filing fees by a carrier is to be considered and reported as losses.

4. Awards.

When an award to a claimant includes the cost of witness fees, attorneys' fees, and other court costs or expert medical witness fees, the amount so awarded shall be considered as part of the cost of benefit and shall be included with the indemnity reported. Such costs include those incurred under Section 11A, 11B, 12A and 39 of Chapter 152, Massachusetts General Laws.

With respect to claims brought by persons against whom an employee has brought a third party common law action, such special costs shall be reported as an indemnity loss whether or not recovery is made against the third party by the employee.

5. Vocational Rehabilitation Evaluation/Testing Expense.

Evaluation expenses (which are defined as costs incurred in testing and evaluating the claimant's ability, aptitude, or attitude in determining suitability for vocational rehabilitation or placement) shall be reported as incurred indemnity loss if such evaluation services are purchased from outside vendors.

Evaluation expenses incurred by carrier personnel may be reported as incurred loss if such expenses are related to the activities of individuals (other than claims supervisors or claims adjusters engaged in efforts to return an injured worker to gainful employment) that, at a minimum, satisfy the qualifications established by the Division of Industrial Accidents.

i. PENALTIES FOR DELAYS IN MAKING COMPENSATION PAYMENTS.

Penalties for which the carrier is liable for reasons beyond its control and that accrue as benefits to the injured worker or his or her dependents, such as for interest on awards or for penalties imposed upon the employer for improper controversies of awards, shall be chargeable to indemnity losses and so reported; other penalties shall be chargeable to unallocated loss adjustment expense. Whenever the reason for penalty is within the carrier's control, it shall

not be reported as a loss, nor charged to expense. Specifically penalties for which the carrier is liable pursuant to Sections 7(2), 8(1), 10(5), 13A (1), and 14(1) of Chapter 152 of the Massachusetts General Laws shall not be reported as a loss or charged to expense.

j. SUBROGATION.

In all cases where there has been recovery of loss due to subrogation, the amount of loss reported shall be the net incurred loss. The net incurred loss is defined as the gross incurred loss (value of the claim had there been no recovery) minus the amount recovered less recovery expenses. When the recovery expenses exceed the amount recovered, report the gross incurred loss instead of the net incurred loss. ***Such recovery must be allocated to medical and indemnity. If there is insufficient information regarding the recovery received to make specific allocations,*** the net incurred loss must be divided between indemnity and medical losses in the same proportion as the original gross incurred indemnity and medical amounts.

k. LUMP SUM CLAIMS.

Where a claim involves a lump sum which represents a commuted value of a specific award or benefit, report the actual loss payment subdivided according to indemnity and medical. In instances where this can not be readily determined, report amounts which the carrier believes to be the most likely breakdown.

l. VOCATIONAL REHABILITATION.

Vocational rehabilitation costs, including evaluation and testing, incurred due to the purchase of vocational rehabilitation services from outside vendors, shall be reported as part of incurred indemnity losses.

m. EXPENSES EXCLUDED FROM LOSSES.

1. Allocated Loss Adjustment Expenses (see definition of Allocated Loss Adjustment Expenses in Section VII, Page 35)

   Note: This exclusion does not apply to employers' liability claims.

2. Unallocated Loss Adjustment Expenses are loss adjustment expenses that are not defined above. These include but are not limited to:

   i. Carrier employees' salaries, overhead and traveling expenses which are considered loss adjustment expense and are not incurred while doing activities listed as allocated expenses.

ii. Fees paid to independent claims professionals or attorneys (hired to perform the function of claim investigation normally performed by claim adjusters), for developing and investigating a claim so that a determination can be made of the cause, extent of responsibility for the injury or disease, including evaluation and settlement of covered claims.Note: As stated on Page VII-9, item i, expenses incurred to recover subrogation are added to the losses and therefore **can not** be reported as either allocated or unallocated loss adjustment expense.

9. Incurred Medical

a. Characteristic: Numeric

b. Length: 9

c. Definition: The payments and outstanding reserves for the cost of adequate and reasonable health care services and medicines, together with the expenses necessarily incidental to such services, which were incurred by an injured employee because of a work related injury.

d. Requirement:

1. Report the whole dollar amount of incurred medical losses, as of the loss valuation date. These losses consist of all paid and outstanding case reserves incurred by the insurer for future payments.

2. Medical losses shall not include any ALAE or unallocated loss adjustment claim expense.

3. Medical losses encompass, but are not limited to the following health care services:

A. Physicians care for home, office or hospital visits.

B. Other health care providers for home, office or hospital visits.

C. Diagnostic Tests and Procedures.

D. Hospital or Skilled Nursing Facility Charges for service and supplies including room and board.

E. Medical, Occupational, Surgical or other health related Services, Training, Therapy, or Procedures.

F. Prescribed Drugs and Medicine, including Prosthetics

G. Mental Health Care.

H. Medical, Occupational, Surgical or other health-related supplies and devices.

I. Medically necessary Transportation Services.

J. Prosthetic Services and Devices.

K. Medical examinations to diagnose the injury and determine the proper treatment including specialist's opinion and second opinions.

L. Medical Testimony: Where the claimant calls in the attending physician to give medical testimony in his behalf, or where the carrier is required to produce the claimant's physician at the hearing and the employer or the insurance carrier is required to pay such physician's fee, the payment of the fee shall be reported as a medical loss. Such costs include those incurred under Section 9A of Chapter 152, General Laws.

M. Physical Rehabilitation Expenses: Expenses incurred by the carrier due to the purchase of physical rehabilitation services from outside vendors shall be reported as incurred medical loss.

Expenses incurred by the carrier for the physical rehabilitation activities listed below may be included in incurred losses if performed by carrier personnel (other than claims supervisor and claims adjusters engaged in efforts to return an injured worker to gainful employment) that are trained in health care services:

i. Various necessary evaluations and therapies including physical, occupational, speech, and hearing.

Incurred Medical continued...

ii. Coordination of services such as necessary medical equipment or special nursing care in a facility or the home.

iii. Necessary consultation(s) with physician(s).

iv. Monitoring the treatment and progress of claimant's medical condition.

v. Coordination of family, agency, and community services to provide optimal recovery.

For such expenses associated with the above, the carrier personnel performing the activities must be trained in one of the following disciplines:

i. Physicians

ii. Licensed registered nurses

iii. Licensed speech therapists

iv. Registered physical therapists

v. Dentists and dental technicians

vi. Occupational therapists

vii. Chiropractors

viii. Podiatrists

ix. Licensed physician assistants

x. Licensed cardio-pulmonary technicians

N. Plant Hospital Contributions: If the carrier furnished first aid equipment or contributes to the cost of plant hospitals maintained by the insured or pays the salaries, in whole or in part, of medical personnel or in any other way contributes to the cost of medical facilities maintained by the insured shall be reported in the column captioned "Medical".

If the carrier loans hospital equipment to the insured, 20% of the replacement costs new shall be treated as actual losses paid for each year during which such equipment is on loan and also shall be reported in the column captioned "Medical".

Contributions reported pursuant to this rule shall be assigned to the governing classification of the risk and shall be designated by the code "7" in the injury type field.

O. Clinical Medical: When a carrier maintains a medical clinic, the cost of each treatment given shall be charged against the individual risk in accordance with a fixed schedule or charges per treatment and such costs shall be assigned to the proper manual classification. The schedule of charges may distinguish between types of treatment, and shall apply without exception to all risks with cases treated by the clinic, and shall be frequently revised and adjusted if necessary so that the total charges for a given period will be equivalent to the total cost of maintaining the clinic, including salaries, rent, light, heat, depreciation of equipment, cost of supplies, etc.

10. Social Security Number

a.	Characteristic:	Numeric
b.	Length:	9
c.	Definition:	The code assigned by the Social Security Administration to the claimant.
d.	Requirement:	Zero fill. Social Security Number is not to be reported. When reported, the Bureau will not store or make Social Security Number available for view.

11. Update Type

a. Characteristic: Alphabetic

b. Length: 1

c. Definition: Code that identifies purpose of a correction or subsequent record within a unit.

d. Requirement: Report the one digit alphabetic code that identifies the activity of the loss record on all correction and subsequent reports.

Code	Description
P	Previously Reported Record
R	Revised Record

The Massachusetts Bureau will pair "P" and "R" records and process as a change to previously submitted data. Unpaired Previous and Revised records will be processed as ***d***elete from previously reported data and ***a***dd to reported data.

12. Loss Condition Act Code

a. Characteristic: Numeric

b. Length: 2

c. Definition: A code that identifies the basis of liability for the claim.

d. Requirement:

Part	Description	Code	Definition
ACT	State Act or Federal Excluding USL&H	01	A claim for which benefits are determined in accordance with the Massachusetts Workers' Compensation Law.
	USL&H "F"	02	A claim for which benefits are determined in accordance with the United States Longshore and Harbor Workers' Compensation Act.

13. Loss Condition Type of Loss

a. Characteristic: Numeric

b. Length: 2

c. Definition: A code that describes the circumstances of the injury.

d. Requirement:

Part	Description	Code	Definition
Type of Loss	Trauma	01	An injury caused by work related accident.
	Occupational Disease	02	An abnormal condition or disorder, other than a work place injury, caused by extended exposure to environmental factors associated with employment, including acute and chronic illness or disease caused by inhalation, absorption, ingestion or direct contact.
	Cumulative Injury other than Disease	03	An injury occurring from repetitive mental or physical traumatic activities extending over a period of time, the combined effect of which caused disability or need for medical treatment (other than disease).

14. Loss Condition Type of Recovery

a. Characteristic: Numeric

b. Length: 2

c. Definition: Code that identifies the types of reimbursements that the carrier has received.

d. Requirement:

Part	Description	Code	Definition
Type of Recovery	No Recovery	01	Insurer has not received any recovery reimbursement.
	Second Injury Only	02	Carrier has received reimbursements from the Second Injury Fund. The Second Injury Fund is established to reimburse the carriers when a subsequent injury is caused by or made substantially greater due to the combined effects of physical impairment, or previous accident, disease or congenital condition.
	Subrogation Only (Third Party)	03	Carrier has received reimbursement from an entity other than the employer, with legal liability due to circumstances of the injury.
	Subrogation with Second Injury (Third Party)	04	Carrier has received reimbursement from both the Second Injury Fund and a third party.

Loss Condition Type of Recovery continued...

Part	Description	Code	Definition
Type of Recovery	Joint Coverage not including subrogation or second injury	05	Coverage furnished by other than the one policy for which experience is being reported is pertinent to a division of the total incurred loss. Such claims usually result from one of the following causes: a. The injured party has co-employers. b. Overlapping coverage for the same employer. c. Injury developed over an extended period. When a carrier has determined that the loss is chargeable to two or more policies written by such carrier, or when two or more carriers have accepted liability for a part of the total incurred loss, it shall be considered the equivalent of a determination by adjudication that the coverage furnished by other than the one policy. Joint coverage claims with either second injury fund or subrogation recovery are coded with codes 2, 3, and 4 above.

15. Loss Condition ***Type of*** Claim

a. Characteristic: Numeric

b. Length: 2

c. Definition: A code that identifies under which part of the standard Workers' Compensation and Employers' Liability Policy that the claim is incurred.

d. Requirement:

Part	Description	Code	Definition
Line of Business	Workers' Comp. only	01	The entire loss is incurred under provisions of part one of the Workers' Compensation and Employers' Liability Insurance Policy.
	Employers' Liability Only	02	The entire loss is incurred under provisions of part two of the Workers' Compensation and Employers' Liability Insurance Policy. For situations of Liability Over, refer to 04.
	Workers' Comp. & Employers' Liability	03	The loss is incurred under provisions of both part one and part two of the Workers' Compensation and Employers' Liability Insurance Policy. For situations of Liability Over, refer to 04.
	Liability Over	04	Refers to a particular employer's liability coverage situation where a third party, who is being sued by an employee, in turn sues the employer. If recovery against the employer is permitted by law, then any damages incurred to the employer are classified as liability over, and are in addition to compensation payments made to the injured employee under part one of the Workers' Compensation and Employers' Liability Insurance Policy.

16. Loss Condition Settlement Code

a. Characteristic: Numeric

b. Length: 2

c. Definition: A code that identifies certain claim settlement situations.

d. Requirement: Report the 1-digit code that corresponds to the type of settlement:

Type of Settlement	Description
00	No settlement applicable to the claim.
05	Claim has been determined to be non-compensable as defined in Section III-A-2.
09	All Other Settlements

17. Jurisdiction State

a. Characteristic: Numeric

b. Length: 2

c. Definition: The governing body/territory, who will administer the claim and whose statutes will apply to the claim adjustment process.

d. Requirement: Report the 2-digit state code of the governing territory who will administer the claim and whose statutes will apply to the claim adjustment process when that state is not Massachusetts.

18. Managed Care Organization Type

a. Characteristic: Numeric

b. Length: 2

c. Definition: A code that indicates the claim was administered by a managed care organization.

d. Requirement:

Not applicable.

19. Injury Description - Code - Part/Nature/Cause

a.	Characteristic:	Numeric
b.	Length:	6
c.	Definition:	A code comprised of three individual data elements, part of body, nature of injury and cause of injury that describes the injury.
d.	Requirement:	Refer to pages 24 and 25 for Part of Body codes, pages 26 through 28 for Nature of Injury codes, and pages 29 through 30 for Cause of Accident codes.

Injury Description Coding	
Code	**Narrative Description**
- PART OF BODY -	
I. HEAD	
10. Multiple Head Injury	Any combination of Below Parts
11. Skull	
12. Brain	
13. Ear(s)	Includes: Hearing, Inside Eardrum
14. Eye(s)	Includes: Optic Nerves, Vision, Eye Lids
15. Nose	Includes: Nasal Passage, Sinus, Sense of Smell
16. Teeth	
17. Mouth	Includes: Lips, Tongue, Throat, Taste
18. Soft Tissue	
19. Facial Bones	Includes: Jaw
II. NECK	
20. Multiple Neck Injury	Any Combination of Below Parts
21. Vertebrae	Includes: Spinal Column Bone, "Cervical Segment"
22. Disc	Includes: Spinal Column Cartilage, "Cervical Segment"
23. Spinal Cord	Includes: Nerve Tissue, "Cervical Segment"
24. Larynx	Includes: Cartilage and Vocal Cords
25. Soft Tissue	Other Than Larynx or Trachea
26. Trachea	
III. UPPER EXTREMITIES	
30. Multiple Upper Extremities	Any Combination of Below Parts, Excluding Hands and Wrists Combined
31. Upper Arm	Humerus and Corresponding Muscles, Excluding Clavicle and Scapula
32. Elbow	Radial Head
33. Lower Arm	Forearm-Radius, Ulna and Corresponding Muscles
34. Wrist	Carpals and Corresponding Muscles
35. Hand	Metacarpals and Corresponding Muscles-Excluding Wrist or Fingers
36. Finger(s)	Other Than Thumb and Corresponding Muscles
37. Thumb	
38. Shoulder(s)	Armpit, Rotator Cuff, Trapezius, Clavicle, Scapula
39. Wrist(s) and Hand(s)	
IV. TRUNK	
40. Multiple Trunk	Any Combination of Below Parts
41. Upper Back Area	(Thoracic Area) Upper Back Muscles, Excluding, Vertebrae, Disc, Spinal Cord
42. Lower Back Area	(Lumbar Area and Lumbo Sacral) Lower Back Muscles, Excluding Sacrum, Coccyx, Pelvis, Vertebrae, Disc, Spinal Cord
43. Disc	Spinal Column Cartilage Other than Cervical Segment
44. Chest	Including Ribs, Sternum, Soft Tissue
45. Sacrum and Coccyx	Final Nine Vertebrae
46. Pelvis	
47. Spinal Cord	Nerve, Tissue Other than Cervical Segment
48. Internal Organs	Other than Heart and Lungs
49. Heart	
60. Lungs	

Injury Description Coding	
Code	**Narrative Description**
- PART OF BODY - continued	
61. Abdomen Including Groin	Excluding Injury to Internal Organs
62. Buttocks	Soft Tissue
63. Lumbar & or Sacral Vertebrae (Vertebra NOC Trunk)	Bone Portion of the Spinal Column
V. LOWER EXTREMITIES	
50. Multiple Lower Extremities	Any Combination of Below Parts
51. Hip	
52. Upper Leg	Femur and Corresponding Muscles
53. Knee	Patella
54. Lower Leg	Tibia, Fibula and Corresponding Muscles
55. Ankle	Tarsals
56. Foot	Metatarsals, Heel, Achilles Tendon and Corresponding Muscles - Excluding Ankle or Toes
57. Toes (Other than Great Toe)	
58. Great Toe	
VI. MULTIPLE BODY PARTS	
64. Artificial Appliance	Braces, Etc.
65. Insufficient Info to Properly Identify-Unclassified	Insufficient Information to Identify Part Affected
66. No Physical Injury	Mental Disorder
90. Multiple Body Parts (Including Body Systems & Body Pans)	Applies when More than One Major Body Part has been Affected. Such as an Arm and a Leg and Multiple Internal Organs
91. Body Systems and Multiple Body Systems	Applies when the Functioning of an Entire Body System has been Affected Without Specific Injury to Any Other Part, as in the Case of Poisoning, Corrosive Action, Inflammation, Affecting Internal Organs, Damage to Nerve Centers, Etc. Does NOT Apply When the Systemic Damage Results from an External Injury Affecting an External Part Such as a Back Injury Which Includes Damage to the Nerves of the Spinal Cord.
99. Whole Body	

NATURE OF INJURY	
I. SPECIFIC INJURY	
01. No Physical Injury (damage to artificial appliance)	Glasses, Contact Lenses, Artificial Appliance, Replacement of Artificial Appliance
02. Amputation	Cut Off Extremity, Digit, Leg, Arm, Protruding Part of Body, Usually by Surgery
03. Angina Pectoris	Chest Pain
04. Burn	(Heat) Burn or Scald. The Effect of Contact with Hot Substances. (Chemical) Burns, Tissue Damage Resulting from the Corrosive Action Chemicals, Fume, ETC. (Acids, Alkalies)
07. Concussion	Brain, Cerebral
10. Contusion	Bruise-Intact Skin Surface. Hematoma
13. Crushing	Grind, Pound or Break into Small Bits
16. Dislocation	Pinched Nerve, Slipped/Ruptured Disc, Herniated Disc, Sciatica, Complete Tear, HNP Subluxtion, M***edical*** D***octor*** Dislocation
19. Electric Shock	Electrocution
22. Enucleation	Removal of Organ or Tumor
25. Foreign Body	
28. Fracture	Breaking of a Bone or Cartilage
30. Freezing	Frostbite and Other Effects of Exposure to Low Temperature
31. Hearing Loss or Impairment	Traumatic Only, A Separate Injury, Not the Sequel of Another Injury
32. Heat Prostration	Heat Stroke, Sun Stroke, Heat Exhaustion, Heat Cramps and other Effects of Environmental Heat. Does not include Sunburn.
34. Hernia	The Abnormal Protrusion of an Organ or part Through the Containing Wall of its Cavity
36. Infection	The Invasion of a Host by Organisms such as Bacteria, Fungi, Viruses, ***Mold,*** Protozoa or Insects, With or Without Manifest Disease
37. Inflammation	The Reaction of Tissue to Injury Characterized Clinically by Heat, Swelling, Redness and Pain
40. Laceration	Cut, Scratches, Abrasions, Superficial Wounds, Calluses. Wound by Tearing
41. Myocardial Infarction	Heart Attack, Heart Conditions, Hypertension, The Inadequate Blood Flow to the Muscular Tissue of the Heart, Excluding Angina Pectoris
42. Poisoning-General (Not OD or Cumulative Injury as defined by type of loss)	A Systemic Morbid Condition Resulting from the Inhalation, Ingestion, or Skin Absorption of a Toxic Substance Affecting the Metabolic System, the Nervous System, the Circulatory System, the Digestive System, the Respiratory System, the Excretory System, the Musculoskeletal System, Etc. Includes Chemical or Drug Poisoning, Metal Poisoning, Organic Diseases, and Venomous Reptile and Insect Bites. Does NOT Include Effects of Radiation, Pneumoconiosis, Corrosive Effects of Chemicals; Skin Surface Irritations, Septicemia or Infected Wounds.
43. Puncture	A Hole Made by the Piercing of a Pointed Instrument
46. Rupture	
47. Severance	Separation, Division or Removal
49. Sprain	Internal Derangement, A Trauma or Wrenching of a Joint, Producing Pain and Disability Depending Upon Degree of Injury to Ligaments

NATURE OF INJURY continued	
52. Strain	Internal Derangement, The Trauma to the Muscle or the Musculotendinous Unit from Violent Contraction or Excessive Forcible Stretch
53. Syncope	Swooning, Fainting, Passing Out, No Other Injury
54. Asphyxiation	Including Strangulation, Drowning
55. Vascular	Cerebrovascular and other Conditions of Circulatory Systems, NOC. Excludes, Heart and Hemorrhoids. Includes, Strokes, Varicose Veins-Non Toxic
58. Vision Loss	
59. All Other Specific Injuries, NOC other than O.D. and Cumulative or Multiple Injuries	
II. OCCUPATIONAL DISEASE or CUMULATIVE INJURY	
60. Dust Disease, NOC	All Other Pneumoconiosis
61. Asbestosis	Lung Disease, A Form of Pneumoconiosis, Resulting from Protracted Inhalation of Asbestos Particles
62. Black Lung	The Chronic Lung Disease of Pneumoconiosis Found in Coal Miners
63. Byssinosis	Pneumoconiosis of Cotton, Flax and Hemp Workers
64. Silicosis	Pneumoconiosis Resulting from Inhalation of Silica (Quartz) Dust
65. Respiratory Disorders	Gases, Fumes, Chemicals, Etc.
66. Poisoning-Chemical, (Other Than Metals)	
67. Poisoning-Metal	
68. Dermatitis	Rash, Skin or Tissue Inflammation including Boils, Etc. Generally Resulting from Direct Contact with Irritants or Sensitizing Chemicals such as Drugs, Oils, Biologic Agents, Plants, Woods or Metals Which May be in the Form of Solids, Pastes, Liquids or Vapors and which may be contacted in the Pure State or in Compounds or in Combination with Other Materials. Do NOT Include Skin Tissue Damage Resulting from Corrosive Action of Chemicals, Burns from Contact with Hot Substances, Effects of Exposure to Radiation, Effects of Exposure to Low Temperatures or Inflammation or Irritation Resulting from Friction or Impact.
69. Mental Disorder	A Clinically Significant Behavioral or Psychological Syndrome or Pattern Typically Associated with Either a Distressing Symptom or Impairment of Function, i.e. Acute Anxiety, Neurosis, Stress, Non-Toxic Depression
70. Radiation	All Forms of Damage to Tissue, Bones or Body Fluids Produced by Exposure to Radiation
71. All Other Occupational Disease Injury, NOC	
72. Loss of Hearing	
73. Contagious Disease	
74. Cancer	
76. VDT-Related Diseases	Video Display Terminal Diseases Other than Carpal Tunnel Syndrome
77. Mental Stress	

NATURE OF INJURY continued	
78. Carpal Tunnel Syndrome	Soreness, Tenderness and Weakness of the Muscles of the Thumb Caused by Pressure on the Median Nerve at the Point at which it goes through the Carpal Tunnel of the Wrist
79. Hepatitis C	***Diagnosis of Hepatitis C***
80. All Other Cumulative Injury, NOC	
III. MULTIPLE INJURIES	
90. Multiple Physical Injuries Only	
91. Multiple Injuries Including Both Physical and Psychological	
CAUSE OF ACCIDENT	
I. BURN or SCALD-HEAT or COLD EXPOSURES-CONTACT with	
01. Chemicals	
02. Hot Objects or Substances	
11. Cold Objects or Substances	
03. Temperature Extremes	
04. Fire of Flames	
05. Steam or Hot Fluids	
06. Dust, Gases, Fumes or Vapors	
07. Welding Operation	
08. Radiation	
14. Abnormal Air Pressure	
84. Electrical Current	
09. Contact With, NOC	
II. CAUGHT IN, UNDER or BETWEEN	
10. Machine or Machinery	
12. Object Handled	
20. Collapsing Materials (Slides or Earth) Either Man Made or Natural	
13. Caught In, Under or Between, NOC	
III. CUT, PUNCTURE SCRAPE INJURED BY	
15. Broken Glass	
16. Hand Tool, Utensil: Not Powered	
17. Object Being Lifted or Handled, other than objects specified in codes 15, 16 & 18	
18. Powered Hand Tool, Appliance	
19. Caught, Puncture, Scrape, NOC	

CAUSE OF ACCIDENT continued	
IV. FALL, SLIP or TRIP INJURY	
25. From Different Level (Elevation)	Off Wall, Catwalk, Bridge, Etc.
26. From Ladder or Scaffolding	
27. From Liquid or Grease Spills	
28. Into Openings	Shafts, Excavations, Floor Openings, Etc.
29. On Same Level	
30. Slipped, Do Not Fall	
32. On Ice or Snow	
33. On Stairs	
31. Fall, Slip or Trip, NOC	
V. MOTOR VEHICLE	
40. Crash of Water Vehicle	
41. Crash of Rail Vehicle	
45. Motor Vehicle Collision or Sideswipe With Another Vehicle, other than Water, Rail or Airplane	Both Vehicles in Motion
46. Motor Vehicle Collision with a fixed object, other than Water, Rail or Airplane	Standing Vehicle or Stationary Object
47. Crash of Airplane	
48. Vehicle Upset	Overturned or Jackknifed, No Crash or Collision
50. Motor Vehicle, NOC	
VI. STRAIN or INJURY BY	
52. Continual Noise	
53. Twisting	
54. Jumping	
55. Holding or Carrying	
56. Lifting	
57. Pushing or Pulling	
58. Reaching	
59. Using Tool or Machinery	
61. Throwing	
97. Repetitive Motion	Carpal Tunnel Syndrome
60. Strain or Injury By, NOC	
VII. STRIKING AGAINST or STEPPING ON	
65. Moving Part of Machine	
66. Object Being Lifted or Handled	
67. Sanding, Scraping, Cleaning Operation	
68. Stationary Object	
69. Stepping on Sharp Object	

CAUSE OF ACCIDENT continued	
70. Striking Against or Stepping On, NOC	
VIII. STRUCK or INJURED BY	
74. Fellow Worker, Patient or Other	Not in Act of a Crime, Accidental
75. Falling or Flying Object	
76. Hand Tool or Machine in Use	
77. Motor Vehicle	
78. Moving Part of Machine	
79. Object Being Lifted or Handled	
80. Object Handled By Others	
85. Animal or Insect	
86. Explosion or Flare Back	
81. Struck or Injured, NOC.	Includes Kicked, Stabbed, Bit, Etc., Not in Act of Crime
IX. RUBBED or ABRADED BY	
94. Repetitive Motion	Callous, Blister, Etc.
95. Rubbed or Abraded, NOC	
X. MISCELLANEOUS CAUSES	
82. Absorption, Ingestion or Inhalation, NOC	
87. Foreign Matter (Body) in Eye(s)	
88. Natural Disaster	Earthquake, Hurricane, Tornado, etc
89. Person in Act of A Crime	Robbery or Criminal Assault
90. Other Than Physical Cause of Injury	Mental or Physiological only
91. Mold	
93. Gunshot	***Injury is caused by the discharge of a firearm. Included instances where injury arises from being struck by the fired projectile, burned by muzzle blast or deafened by report of gunshot.***
96. Terrorism	Terrorism – for use with assigned catastrophe code only
98. Cumulative, NOC	All Other
99. Other Miscellaneous, NOC	

20. Occupation Description

a. Characteristic: Alpha/Numeric

b. Length: 18

c. Definition: A narrative description of the regular occupation of the claimant.

d. Requirement: Optional reporting for Massachusetts.

21. Vocational ***Rehabilitation*** Indicator

a. Characteristic: Alphabetic

b. Length: 1

c. Definition: Code identifying claims which include vocational rehabilitation.

d. Requirement:

Part	Description	Code	Definition
Vocational Rehab.	Does not include Voc. Rehab.	N	Indemnity losses do not include any Vocational rehabilitation costs.
	Includes Voc. Rehabilitation	Y	The indemnity losses include non-medical services to restore a disabled employee to suitable employment. Such services may include vocational evaluation, counseling, education, work place modification, and retraining, including on the job training for alternative employment with the same employer and job placement assistance. It shall also include reasonably necessary related expenses such as tuition, books, tools, transportation, and additional living expenses.

22. Lump Sum Indicator

a. Characteristic: Alphabetic

b. Length: 1

c. Definition: Code identifying claims that have been settled by an agreement between the carrier and the injured worker, with the employer's approval, to redeem the liability for compensation by payment of specified amount representing a discounted or commuted value of the benefit.

d. Requirement:

Description	Code	Definition
Claim is settled by Lump Sum	Y	Lump Sum is a claim settled by the agreement of the insurer and claimant to redeem the liability for compensation by payment from insurer to the claimant of a specified amount representing a discounted or commuted value of a specific award or benefit.
Claim is not Settled by Lump Sum	N	The situation as described above is not applicable because either the claim is not settled or the claim was settled by other than a lump sum agreement.

23. Fraudulent Claim Indicator

a. Characteristic: Numeric

b. Length: 2

c. Definition: A code identifying claims that are partially or fully fraudulent in the opinion of the carrier, employer, claim resolution or jurisdiction.

d. Requirement: Not applicable to Massachusetts.

24. Deductible Indicator - Loss

a. Characteristic: Numeric

b. Length: 2

c. Definition: A code that identifies whether the deductible amount has been fully recovered.

d. Requirement: Not required for Massachusetts.

25. Paid Indemnity

a. Characteristic: Numeric

b. Length: 9

c. Definition: The whole dollar amount paid to an injured employee and/or dependent as of the loss valuation date due to the employee's lost wages or inability to work. Refer to definition of incurred indemnity losses.

d. Requirement: Report the whole dollar amount of paid indemnity losses for the claim as of the loss valuation date. Refer to definition of Reporting Requirements for Incurred Indemnity Losses.

26. Paid Medical

a. Characteristic: Numeric

b. Length: 9

c. Definition: The whole dollar amount paid as of the loss valuation date for medical or hospital treatment to an injured employee. Refer to definition of incurred medical losses.

d. Requirement: Report the whole dollar amount of medical losses paid for the claim as of the loss valuation date. Refer to the reporting instructions for incurred medical.

27. Claimant's Attorneys Fees

a.	Characteristic:	Numeric
b.	Length:	9
c.	Definition:	Amount incurred by the insurance company for the claimant's legal representation during the settlement of a workers' compensation claim. (This amount should include all fees incurred by the insurer due the claimant's attorney pursuant to proceeding before any claim resolution board and lump sum settlements.)
d.	Requirement:	Report the whole dollar amount paid plus outstanding case reserves incurred by the insurer for claimant's legal representation during the settlement of the claim as of the loss valuation date.

28. Employer's Attorneys Fees

a.	Characteristic:	Numeric
b.	Length:	9
c.	Definition:	Amount incurred by the insurance company for the employer's legal representation during the settlement of a workers' compensation claim.
d.	Requirement:	Report the whole dollar amount paid plus outstanding reserves for employer's legal representation incurred by the insurer during the settlement of the claim as of the loss valuation date.

29. Paid Allocated Loss Adjustment Expense

a. Characteristic: Numeric

b. Length: 9

c. Requirements: Report the whole dollar amount of allocated loss adjustment expense paid for each claim as of the loss valuation date.

d. Definition: Allocated Loss Adjustment Expenses encompass the following costs of a carrier which can be directly allocated to a particular claim.

1. Fees of attorneys or other authorized representatives where permitted for legal services, whether by outside or staff representative.

2. Court, Alternate Dispute Resolution and other specific items or expense such as:

Medical examinations of a claimant to determine the extent of the carrier's liability, degree of permanence or length of disability, but not including payments reported under incurred medical;

Expert medical or other testimony;

Autopsy;

Witnesses and summonses;

Copies of documents such as birth and death certificates, medical treatment records;

Arbitration fees;

Surveillance;

Appeal bond costs and appeal filing fees;

Laboratory and x-ray;

Stenographic.

Paid Allocated Loss Adjustment Expense continued...

3. Medical cost containment expenses incurred with respect to a particular claim, whether by an outside vendor or done internally by an employee for the purpose of controlling losses to ensure that only reasonable and necessary costs or services are paid. The expenses include:

   a. Bill auditing expenses for any medical or vocational services rendered, including hospital bills (inpatient or outpatient), nursing home bills, physician bills, chiropractic bills, medical equipment charges, pharmacy charges, physical therapy bills, medical or vocational rehabilitation vendor bills.

   b. Hospital and other treatment utilization reviews, including pre-certification/pre-admission, concurrent or retrospective reviews.

   c. Preferred Provider Network Organization Expenses, which are incurred for a particular claim.

   d. Medical fee review panel expenses.

4. Expenses which are not defined as losses and are directly related to and directly allocated to the handling of a particular claim for services which are required to be performed by statute or regulation.

5. Expenses incurred to recover subrogation are added to the losses and therefore **can not** be reported as either allocated or unallocated loss adjustment expense.

30. Incurred Allocated Loss Adjustment Expense

a. Characteristic: Numeric

b. Length: 9

c. Definition: Refer to Paid ALAE

d. Requirement: Incurred Allocated Loss Adjustment Expense is not applicable to reporting for Massachusetts.

The Bureau will not edit, store or display any amounts reported in Incurred ALAE.

31. Total Claim Count
Total Incurred Indemnity
Total Incurred Medical
Total Paid Indemnity
Total Paid Medical
Total Paid ALAE
Total Incurred Claimants' Attorneys Fees
Total Incurred Employers' Attorneys Fees

a. Characteristic: Numeric

b. Length: Claim Count - 5
Loss Amounts - 10

c. Definition: A summation of each of the loss counts and totals.

d. Requirement: Report the arithmetic total of the count or amount for the policy. Note these totals would be comparable to the revised totals at each valuation or correction.

RESERVED FOR FUTURE USE

PART I

UNIT STATISTICAL REPORTING

SECTION VIII

REPORTING OF INFORMATION REGARDING INDIVIDUAL DEATH AND PERMANENT AND TOTAL DISABILITY CLAIMS

SECTION VIII - INFORMATION REGARDING DEATH OR PERMANENT TOTAL CLAIMS

A. Reporting Requirements

Every company shall maintain, store and be prepared to report at least the following information for every death claim and every permanent and total disability claim:

1. ***Identifying information listed below must match to the unit statistical report of the claim and is defined and coded as specified in the previous sections of this Statistical Plan.***

    a. ***Accident Date***
    b. ***Carrier Code***
    c. ***Claim ID Number***
    d. ***Class Code***
    e. ***Policy Effective Date***
    f. ***Policy ID Number***
    g. ***Report Number***
    h. ***Claim Status Code***

2. ***The additional claim information listed below which is defined and coded as specified in the NCCI's Detailed Claim Information Reporting Guidebook, issued January 1, 2008. The information listed in this section shall be reported at such times and in such manner as is set forth in NCCI Circular DCI-2008-01, dated January 18, 2008.***

    a. ***Accident State Code***
    b. ***Attorney or Authorized Representative Indicator***
    c. ***Benefit Amounts Paid***
        i. ***Death Benefits Paid***
        ii. ***Permanent Total Disability Benefits Paid***
        iii. ***Scheduled Permanent Partial Benefits Paid***
        iv. ***Unscheduled Permanent Partial Benefits Paid***
        v. ***Temporary Total Injury Benefits Paid***
        vi. ***Disfigurement Benefits Paid***
        vii. ***Temporary Partial Benefits Paid***
        viii. ***Employers Liability Paid***
        ix. ***Supplemental Benefits Paid***
    d. ***Birth Year***
    e. ***Claim Closing Date***
    f. ***Claimant Gender Code***
    g. ***Controverted / Disputed Case Indicator***
    h. ***Hire Date***
    i. ***Impairment Percentage Basis Code***
    j. ***Impairment / Disability Percent***

- ***k. Lump Sum Benefits Paid***
  - ***i. Death Benefits Lump Sum Settlement***
  - ***ii. Permanent Total Disability Benefits Lump Sum Settlement***
  - ***iii. Scheduled Permanent Partial Benefits Lump Sum Settlement***
  - ***iv. Unscheduled Permanent Partial Benefits Lump Sum Settlement***
  - ***v. Temporary Total Injury Benefits Lump Sum Settlement***
  - ***vi. Disfigurement Benefits Lump Sum Settlement***
  - ***vii. Temporary Partial Benefits Lump Sum Settlement***
  - ***viii. Supplemental Benefits Lump Sum Settlement***
- ***l. Maximum Medical Improvement Date***
- ***m. Medical Extinguishment Indicator***
- ***n. Average Weekly Wage***
  - ***i. Post-Injury Average Weekly Wage***
  - ***ii. Pre-Injury Average Weekly Wage***
- ***o. Reported to Insurer Date***
- ***p. Return to Work Date***
- ***q. Return to Work Status Indicator***
- ***r. Vocational Rehabilitation***
  - ***i. Education Expense Amount Paid***
  - ***ii. Evaluation Expense Amount Paid***
  - ***iii. Maintenance Expense Amount Paid***
  - ***iv. Other Amount Paid***

3. The requirements under this section may be satisfied by participation in the NCCI's Redesigned Detailed Claim Information Program as set forth in NCCI Circular DCI-2008-01.

PART I

UNIT STATISTICAL REPORTING

SECTION IX

PENSION TABLE & EXAMPLES OF PENSION CALCULATIONS

PENSION TABLES

Purpose

The reporting of incurred indemnity amounts for pension payments associated with fatal and permanent total injuries should reflect a case reserve based on the annuity values contained in this section. The annuity values are an estimate of the present value of an annual indemnity benefit which begins with a value of one dollar but is subject to applicable cost of living adjustments (escalation). The duration of the pension payments is a function of the beneficiary type - injured worker, surviving spouse, or dependents other than the surviving spouse.

Pension benefits for a permanent total injury are paid to the injured worker until death. A surviving spouse is entitled to benefits until death or remarriage. Lastly, dependents other than a surviving spouse are entitled to benefits until death or they are fully self-supporting. The statute presumes that a child is self-supporting upon reaching the age of eighteen unless they are physically or mentally incapacitated from earning.

The pension tables reflect the applicable provisions of the Massachusetts workers' compensation law, life expectancies derived from life tables published by the Centers for Disease Control, and remarriage probabilities from the 1979 NCCI Remarriage Table. In the case of Table III-Permanent Total Claimants, the tables also vary as to the gender of the injured worker.

To be consistent with the expansion of unit statistical reporting to ten unit reports, the pension tables display annuity values for up to ten years from the age as of date of the accident.

General Assumptions Underlying the Pension Tables

To reflect the time value of money, all of the tables assume an annual discount rate of 3.5%.

An escalation provision consistent with the current law is reflected in the derivation of all the tables. The escalation rate is based on statewide average weekly wage and CPI data. The assumed annual escalation rate is 2.9%.

Specific Assumptions Underlying the Pension Tables

Table IE-398: Surviving Spouse Fatal Claims utilizes female life expectancies and reflects the probability of remarriage.

Table IIE-398: Other than Surviving Spouse Fatal Claims utilizes total population life expectancies.

Table IIIEM-398-Male: Permanent Total Claimants utilizes male life expectancies and reflects a Social Security offset of 2.4%. The purpose of the offset is to recognize that claimants are ineligible to receive workers' compensation cost-of-living adjustments that reduce their Social Security Disability payments.

Table IIIEF-398-Female: Permanent Total Claimants utilizes female life expectancies and reflects a Social Security offset of 2.4%. The purpose of the offset is to recognize that claimants are ineligible to receive workers' compensation cost-of-living adjustments that reduce their Social Security Disability payments.

Table IE-398
Pension Table - Surviving Spouse - Fatal Claims
(for Claims after December 23, 1991 Excluding Claims Incurred Under U.S.L. & H. W. Act, with Escalation)

Age at Widowhood (x)	- a (x)	- a (x) + 1	- a (x) + 2	- a (x) + 3	- a (x) + 4	- a (x) + 5	- a (x) + 6	- a (x) + 7	- a (x) + 8	- a (x) + 9	- a (x)+10
16	11.963	12.213	13.845	14.674	16.201	17.545	18.690	19.756	20.736	21.630	22.439
17	13.249	13.546	15.232	15.983	17.494	18.813	19.892	20.886	21.795	22.618	23.358
18	14.557	14.896	16.616	17.270	18.746	20.024	21.032	21.954	22.791	23.545	24.214
19	15.872	16.245	17.983	18.522	19.948	21.173	22.108	22.958	23.726	24.407	24.999
20	17.181	17.583	19.323	19.734	21.097	22.257	23.120	23.900	24.594	25.198	25.712
21	18.474	18.899	20.626	20.898	22.188	23.276	24.068	24.775	25.391	25.916	26.352
22	19.739	20.182	21.886	22.012	23.220	24.230	24.949	25.576	26.113	26.560	26.918
23	20.966	21.423	23.092	23.067	24.188	25.116	25.755	26.303	26.760	27.128	27.410
24	22.142	22.607	24.233	24.054	25.084	25.927	26.485	26.952	27.331	27.622	27.830
25	23.257	23.727	25.303	24.969	25.904	26.660	27.137	27.525	27.826	28.043	28.181
26	24.304	24.775	26.294	25.807	26.646	27.314	27.711	28.021	28.247	28.393	28.463
27	25.276	25.744	27.202	26.566	27.308	27.889	28.207	28.442	28.596	28.673	28.678
28	26.169	26.632	28.025	27.244	27.891	28.385	28.628	28.789	28.874	28.886	28.829
29	26.979	27.434	28.762	27.841	28.394	28.805	28.974	29.065	29.084	29.034	28.919
30	27.706	28.151	29.411	28.357	28.820	29.149	29.247	29.272	29.228	29.120	28.952
31	28.347	28.781	29.972	28.795	29.169	29.420	29.451	29.413	29.310	29.147	28.929
32	28.903	29.324	30.448	29.154	29.444	29.620	29.587	29.490	29.332	29.119	28.853
33	29.375	29.781	30.838	29.437	29.646	29.751	29.659	29.507	29.298	29.037	28.728
34	29.765	30.155	31.146	29.646	29.780	29.818	29.670	29.466	29.210	28.905	28.557
35	30.073	30.448	31.375	29.785	29.848	29.824	29.624	29.371	29.071	28.726	28.342
36	30.305	30.662	31.528	29.858	29.854	29.771	29.522	29.225	28.884	28.503	28.086
37	30.461	30.801	31.609	29.867	29.801	29.663	29.369	29.031	28.654	28.240	27.793
38	30.548	30.871	31.622	29.817	29.692	29.502	29.168	28.793	28.382	27.938	27.463
39	30.568	30.874	31.570	29.710	29.530	29.293	28.921	28.513	28.071	27.599	27.099
40	30.526	30.814	31.458	29.549	29.320	29.039	28.633	28.194	27.724	27.226	26.702
41	30.425	30.694	31.288	29.339	29.064	28.743	28.305	27.838	27.342	26.820	26.275
42	30.268	30.519	31.065	29.083	28.766	28.407	27.941	27.447	26.927	26.384	25.820
43	30.060	30.292	30.792	28.784	28.428	28.035	27.542	27.024	26.482	25.919	25.338
44	29.803	30.016	30.474	28.445	28.053	27.627	27.111	26.570	26.009	25.429	24.834
45	29.501	29.696	30.112	28.068	27.643	27.188	26.649	26.089	25.510	24.916	24.308
46	29.158	29.334	29.711	27.656	27.201	26.718	26.159	25.582	24.988	24.381	23.762
47	28.777	28.934	29.272	27.212	26.728	26.220	25.644	25.052	24.446	23.828	23.200

Source: based on the 2004 United States Life Table for the Female Population

Table IE-398
Pension Table - Surviving Spouse - Fatal Claims
(for Claims after December 23, 1991 Excluding Claims Incurred Under U.S.L. & H. W. Act, with Escalation)

Age at Widowhood (x)	- a (x)	- a (x) + 1	- a (x) + 2	- a (x) + 3	- a (x) + 4	- a (x) + 5	- a (x) + 6	- a (x) + 7	- a (x) + 8	- a (x) + 9	- a (x)+10
48	28.361	28.498	28.797	26.736	26.228	25.698	25.107	24.502	23.885	23.258	22.622
49	27.912	28.028	28.291	26.234	25.703	25.154	24.550	23.934	23.307	22.672	22.031
50	27.432	27.527	27.756	25.707	25.156	24.591	23.975	23.349	22.715	22.074	21.429
51	26.923	26.999	27.194	25.157	24.590	24.010	23.385	22.751	22.111	21.466	20.818
52	26.390	26.446	26.610	24.589	24.007	23.414	22.781	22.141	21.497	20.850	20.202
53	25.834	25.871	26.006	24.004	23.409	22.805	22.166	21.522	20.875	20.228	19.582
54	25.259	25.277	25.384	23.405	22.798	22.186	21.542	20.896	20.250	19.603	18.956
55	24.667	24.667	24.747	22.793	22.177	21.558	20.912	20.266	19.620	18.973	18.326
56	24.062	24.043	24.097	22.171	21.549	20.925	20.279	19.633	18.987	18.339	17.692
57	23.443	23.407	23.437	21.541	20.915	20.289	19.643	18.997	18.350	17.703	17.059
58	22.814	22.761	22.769	20.906	20.278	19.651	19.005	18.358	17.711	17.067	16.426
59	22.178	22.109	22.097	20.269	19.640	19.011	18.364	17.717	17.073	16.432	15.797
60	21.535	21.452	21.422	19.631	18.999	18.368	17.722	17.077	16.437	15.801	15.172
61	20.890	20.794	20.745	18.990	18.357	17.725	17.081	16.440	15.804	15.175	14.552
62	20.244	20.134	20.067	18.348	17.714	17.083	16.442	15.807	15.177	14.554	13.937
63	19.597	19.473	19.387	17.705	17.072	16.444	15.808	15.179	14.556	13.939	13.331
64	18.949	18.810	18.706	17.064	16.433	15.809	15.180	14.557	13.940	13.332	12.733
65	18.327	18.175	18.056	16.453	15.828	15.180	14.557	13.941	13.333	12.734	12.146
66	17.653	17.486	17.352	15.792	15.171	14.558	13.941	13.333	12.734	12.146	11.567
67	17.007	16.829	16.681	15.164	14.549	13.942	13.333	12.735	12.147	11.567	10.995
68	16.365	16.176	16.017	14.542	13.933	13.333	12.735	12.147	11.567	10.996	10.434
69	15.729	15.530	15.359	13.927	13.326	12.735	12.147	11.567	10.996	10.434	9.888
70	15.098	14.890	14.708	13.320	12.728	12.147	11.568	10.996	10.434	9.888	9.361
71	14.474	14.257	14.066	12.723	12.141	11.568	10.996	10.434	9.888	9.361	8.852
72	13.858	13.633	13.434	12.136	11.562	10.996	10.434	9.888	9.361	8.852	8.360
73	13.249	13.018	12.813	11.557	10.990	10.434	9.889	9.361	8.852	8.360	7.884
74	12.650	12.414	12.200	10.986	10.429	9.889	9.361	8.852	8.360	7.884	7.427
75	12.063	11.819	11.596	10.426	9.884	9.361	8.852	8.360	7.884	7.427	6.991
76	11.484	11.232	11.004	9.881	9.357	8.852	8.360	7.884	7.427	6.991	6.574
77	10.912	10.656	10.427	9.354	8.849	8.360	7.884	7.427	6.991	6.574	6.175
78	10.352	10.095	9.870	8.846	8.357	7.884	7.427	6.991	6.574	6.175	5.794
79	9.807	9.554	9.332	8.354	7.881	7.427	6.991	6.574	6.175	5.794	5.433

Source: based on the 2004 United States Life Table for the Female Population

Table IE-398
Pension Table - Surviving Spouse - Fatal Claims
(for Claims after December 23, 1991 Excluding Claims Incurred Under U.S.L. & H. W. Act, with Escalation)

Age at Widowhood (x)	- a (x)	- a (x) + 1	- a (x) + 2	- a (x) + 3	- a (x) + 4	- a (x) + 5	- a (x) + 6	- a (x) + 7	- a (x) + 8	- a (x) + 9	- a (x)+10
80	9.280	9.032	8.812	7.879	7.424	6.991	6.574	6.175	5.794	5.433	5.089
81	8.773	8.526	8.309	7.423	6.989	6.574	6.175	5.794	5.433	5.089	4.765
82	8.281	8.038	7.826	6.987	6.572	6.175	5.794	5.433	5.089	4.765	4.458
83	7.807	7.569	7.365	6.570	6.173	5.794	5.433	5.089	4.765	4.458	4.169
84	7.351	7.121	6.924	6.172	5.793	5.433	5.089	4.765	4.458	4.169	3.899
85	6.916	6.693	6.502	5.792	5.431	5.089	4.765	4.458	4.169	3.899	3.646
86	6.500	6.283	6.100	5.430	5.088	4.765	4.458	4.169	3.899	3.646	3.411
87	6.103	5.893	5.718	5.087	4.763	4.458	4.169	3.899	3.646	3.411	3.193
88	5.724	5.522	5.355	4.763	4.457	4.169	3.899	3.646	3.411	3.193	2.994
89	5.364	5.170	5.011	4.456	4.169	3.899	3.646	3.411	3.193	2.994	2.815
90	5.022	4.836	4.687	4.168	3.898	3.646	3.411	3.193	2.994	2.815	2.656
91	4.699	4.522	4.382	3.898	3.645	3.411	3.193	2.994	2.815	2.656	2.505
92	4.394	4.226	4.096	3.645	3.410	3.193	2.994	2.815	2.656	2.505	2.359
93	4.107	3.949	3.828	3.410	3.193	2.994	2.815	2.656	2.505	2.359	2.220
94	3.839	3.690	3.580	3.193	2.994	2.815	2.656	2.505	2.359	2.220	2.086
95	3.588	3.449	3.350	2.994	2.814	2.656	2.505	2.359	2.220	2.086	1.959
96	3.355	3.226	3.139	2.814	2.656	2.505	2.359	2.220	2.086	1.959	1.836
97	3.139	3.023	2.949	2.656	2.504	2.359	2.220	2.086	1.959	1.836	1.720
98	2.942	2.839	2.782	2.504	2.359	2.220	2.086	1.959	1.836	1.720	1.608
99	2.765	2.677	2.621	2.359	2.219	2.086	1.959	1.836	1.720	1.608	1.502
100	2.608	2.522	2.467	2.219	2.086	1.959	1.836	1.720	1.608	1.502	1.400
101	2.458	2.373	2.320	2.086	1.958	1.836	1.720	1.608	1.502	1.400	1.303
102	2.315	2.231	2.179	1.958	1.836	1.720	1.608	1.502	1.400	1.303	1.211
103	2.177	2.095	2.044	1.836	1.720	1.608	1.502	1.400	1.303	1.211	1.123
104	2.046	1.965	1.914	1.720	1.608	1.502	1.400	1.303	1.211	1.123	1.039

Source: based on the 2004 United States Life Table for the Female Population
Remarriage Table
Annual Rate of Interest = 3.5%
Annual Rate of Escalation after year 2 = 2.9%

Table IIE-398
Pension Table – Other than Surviving Spouse - Fatal Claims
(for Claims after December 23, 1991 Excluding Claims Incurred Under U.S.L. & H. W. Act, with Escalation)

Age (x)	- a (x)	- a (x) + 1	- a (x) + 2	- a (x) + 3	- a (x) + 4	- a (x) + 5	- a (x) + 6	- a (x) + 7	- a (x) + 8	- a (x) + 9	- a (x)+10
0	50.153	51.242	52.044	48.506	47.806	47.100	46.389	45.673	44.952	44.226	43.495
1	50.256	51.023	51.806	48.277	47.574	46.866	46.153	45.435	44.712	43.984	43.250
2	50.037	50.786	51.557	48.039	47.333	46.623	45.908	45.188	44.463	43.733	42.998
3	49.800	50.537	51.298	47.792	47.084	46.372	45.655	44.933	44.205	43.473	42.739
4	49.553	50.279	51.030	47.536	46.827	46.112	45.393	44.668	43.939	43.207	42.475
5	49.295	50.011	50.752	47.272	46.560	45.843	45.121	44.395	43.666	42.936	42.206
6	49.028	49.734	50.465	46.998	46.284	45.564	44.841	44.115	43.388	42.661	41.935
7	48.751	49.448	50.168	46.714	45.998	45.277	44.554	43.829	43.105	42.382	41.659
8	48.466	49.151	49.860	46.421	45.703	44.983	44.261	43.539	42.819	42.098	41.378
9	48.170	48.845	49.542	46.119	45.401	44.682	43.963	43.245	42.528	41.810	41.091
10	47.865	48.528	49.214	45.809	45.093	44.377	43.662	42.947	42.232	41.515	40.797
11	47.549	48.201	48.878	45.493	44.780	44.067	43.355	42.643	41.929	41.213	40.494
12	47.223	47.866	48.535	45.172	44.462	43.753	43.043	42.332	41.619	40.903	40.184
13	46.890	47.524	48.186	44.846	44.139	43.433	42.724	42.014	41.300	40.584	39.865
14	46.549	47.177	47.833	44.515	43.811	43.105	42.397	41.687	40.973	40.256	39.535
15	46.203	46.824	47.474	44.179	43.475	42.770	42.062	41.351	40.637	39.918	39.194
16	45.852	46.467	47.108	43.834	43.131	42.426	41.717	41.006	40.289	39.568	38.841
17	45.495	46.102	46.734	43.481	42.778	42.072	41.363	40.649	39.931	39.206	38.477
18	45.132	45.730	46.351	43.119	42.416	41.709	40.998	40.281	39.559	38.832	38.100
19	44.761	45.348	45.958	42.748	42.043	41.334	40.620	39.901	39.176	38.446	37.712
20	44.381	44.957	45.555	42.366	41.659	40.947	40.230	39.508	38.780	38.048	37.311
21	43.991	44.555	45.141	41.972	41.262	40.547	39.827	39.102	38.372	37.637	36.898
22	43.591	44.142	44.714	41.566	40.853	40.135	39.412	38.684	37.951	37.214	36.474
23	43.181	43.717	44.273	41.146	40.430	39.709	38.983	38.253	37.518	36.779	36.037
24	42.758	43.279	43.819	40.713	39.994	39.270	38.542	37.809	37.073	36.332	35.589
25	42.321	42.827	43.350	40.267	39.545	38.819	38.088	37.354	36.615	35.873	35.129
26	41.872	42.360	42.867	39.808	39.083	38.355	37.622	36.885	36.146	35.403	34.658
27	41.408	41.880	42.370	39.336	38.608	37.877	37.143	36.405	35.664	34.921	34.177
28	40.931	41.386	41.858	38.850	38.121	37.388	36.652	35.913	35.172	34.429	33.684
29	40.440	40.878	41.333	38.351	37.620	36.886	36.149	35.409	34.668	33.925	33.182
30	39.936	40.357	40.794	37.840	37.107	36.372	35.634	34.894	34.153	33.412	32.669
31	39.419	39.822	40.242	37.316	36.582	35.846	35.108	34.369	33.629	32.888	32.147

Source: based on the 2004 United States Life Table for the Total Population
Annual Rate of Interest = 3.5%
Annual Rate of Escalation after year 2 = 2.9%

Table IIE-398
Pension Table – Other than Surviving Spouse - Fatal Claims
(for Claims after December 23, 1991 Excluding Claims Incurred Under U.S.L. & H. W. Act, with Escalation)

Age (x)	- a (x)	- a (x) + 1	- a (x) + 2	- a (x) + 3	- a (x) + 4	- a (x) + 5	- a (x) + 6	- a (x) + 7	- a (x) + 8	- a (x) + 9	- a (x)+10
32	38.888	39.274	39.676	36.781	36.046	35.310	34.572	33.833	33.094	32.354	31.614
33	38.345	38.713	39.098	36.234	35.498	34.762	34.025	33.287	32.549	31.810	31.071
34	37.789	38.140	38.507	35.675	34.940	34.204	33.468	32.731	31.994	31.257	30.519
35	37.221	37.555	37.904	35.106	34.371	33.636	32.901	32.165	31.429	30.693	29.958
36	36.642	36.958	37.291	34.526	33.793	33.059	32.324	31.589	30.855	30.121	29.389
37	36.052	36.351	36.666	33.937	33.205	32.471	31.738	31.004	30.272	29.541	28.811
38	35.451	35.734	36.032	33.339	32.606	31.874	31.142	30.411	29.681	28.953	28.225
39	34.841	35.106	35.387	32.730	31.999	31.268	30.538	29.809	29.082	28.356	27.631
40	34.222	34.470	34.733	32.113	31.383	30.654	29.926	29.200	28.475	27.751	27.028
41	33.593	33.824	34.069	31.487	30.759	30.032	29.307	28.583	27.860	27.138	26.417
42	32.956	33.169	33.397	30.853	30.128	29.403	28.680	27.958	27.237	26.517	25.799
43	32.310	32.506	32.717	30.213	29.490	28.767	28.046	27.326	26.607	25.890	25.174
44	31.657	31.836	32.030	29.566	28.845	28.124	27.405	26.687	25.970	25.255	24.542
45	30.998	31.160	31.336	28.913	28.193	27.474	26.757	26.041	25.327	24.615	23.904
46	30.333	30.478	30.636	28.254	27.535	26.819	26.104	25.390	24.679	23.968	23.259
47	29.663	29.790	29.931	27.588	26.872	26.158	25.445	24.734	24.024	23.316	22.609
48	28.987	29.097	29.219	26.918	26.204	25.492	24.781	24.072	23.365	22.659	21.956
49	28.308	28.399	28.503	26.244	25.532	24.822	24.113	23.406	22.701	21.998	21.300
50	27.624	27.697	27.783	25.566	24.856	24.148	23.441	22.736	22.034	21.337	20.645
51	26.936	26.992	27.060	24.884	24.176	23.470	22.766	22.064	21.367	20.675	19.992
52	26.246	26.284	26.334	24.200	23.494	22.790	22.089	21.392	20.701	20.017	19.342
53	25.554	25.574	25.605	23.513	22.810	22.109	21.412	20.721	20.038	19.363	18.697
54	24.860	24.862	24.874	22.825	22.124	21.428	20.738	20.055	19.380	18.714	18.054
55	24.165	24.149	24.143	22.137	21.441	20.751	20.068	19.394	18.728	18.068	17.414
56	23.469	23.435	23.412	21.451	20.761	20.078	19.404	18.738	18.079	17.425	16.777
57	22.773	22.722	22.683	20.768	20.086	19.412	18.746	18.087	17.434	16.786	16.145
58	22.078	22.012	21.958	20.092	19.418	18.752	18.093	17.440	16.792	16.152	15.520
59	21.387	21.306	21.241	19.422	18.757	18.098	17.444	16.797	16.157	15.525	14.902
60	20.700	20.607	20.531	18.760	18.101	17.448	16.800	16.160	15.528	14.906	14.293
61	20.020	19.917	19.829	18.103	17.450	16.802	16.162	15.531	14.908	14.296	13.692
62	19.348	19.234	19.133	17.451	16.804	16.164	15.532	14.910	14.297	13.694	13.101
63	18.684	18.557	18.443	16.805	16.165	15.533	14.911	14.299	13.696	13.102	12.519

Source: based on the 2004 United States Life Table for the Total Population
Annual Rate of Interest = 3.5%
Annual Rate of Escalation after year 2 = 2.9%

Table IIE-398
Pension Table – Other than Surviving Spouse - Fatal Claims
(for Claims after December 23, 1991 Excluding Claims Incurred Under U.S.L. & H. W. Act, with Escalation)

Age (x)	- a (x)	- a (x) + 1	- a (x) + 2	- a (x) + 3	- a (x) + 4	- a (x) + 5	- a (x) + 6	- a (x) + 7	- a (x) + 8	- a (x) + 9	- a (x)+10
64	18.026	17.886	17.759	16.166	15.534	14.912	14.299	13.696	13.103	12.520	11.950
65	17.373	17.220	17.082	15.535	14.912	14.300	13.697	13.103	12.520	11.951	11.395
66	16.726	16.562	16.413	14.913	14.300	13.697	13.104	12.521	11.951	11.396	10.852
67	16.087	15.913	15.755	14.300	13.697	13.104	12.521	11.951	11.396	10.852	10.319
68	15.455	15.273	15.107	13.697	13.104	12.521	11.952	11.396	10.852	10.319	9.798
69	14.833	14.643	14.469	13.104	12.521	11.952	11.396	10.853	10.319	9.798	9.293
70	14.221	14.023	13.840	12.521	11.952	11.396	10.853	10.319	9.798	9.293	8.805
71	13.619	13.412	13.224	11.952	11.396	10.853	10.319	9.798	9.293	8.805	8.337
72	13.025	12.813	12.621	11.396	10.853	10.319	9.798	9.293	8.805	8.337	7.885
73	12.443	12.227	12.033	10.853	10.319	9.798	9.293	8.805	8.337	7.885	7.450
74	11.874	11.655	11.458	10.319	9.798	9.293	8.805	8.337	7.885	7.450	7.031
75	11.319	11.096	10.893	9.798	9.293	8.805	8.337	7.885	7.450	7.031	6.630
76	10.775	10.548	10.342	9.293	8.805	8.337	7.885	7.450	7.031	6.630	6.247
77	10.243	10.012	9.806	8.805	8.337	7.885	7.450	7.031	6.630	6.247	5.880
78	9.722	9.492	9.291	8.337	7.885	7.450	7.031	6.630	6.247	5.880	5.531
79	9.217	8.991	8.795	7.885	7.450	7.031	6.630	6.247	5.880	5.531	5.199
80	8.731	8.509	8.317	7.450	7.031	6.630	6.247	5.880	5.531	5.199	4.884
81	8.263	8.045	7.856	7.031	6.630	6.247	5.880	5.531	5.199	4.884	4.585
82	7.812	7.598	7.413	6.630	6.247	5.880	5.531	5.199	4.884	4.585	4.303
83	7.377	7.167	6.988	6.247	5.880	5.531	5.199	4.884	4.585	4.303	4.037
84	6.959	6.755	6.582	5.880	5.531	5.199	4.884	4.585	4.303	4.037	3.787
85	6.560	6.361	6.195	5.531	5.199	4.884	4.585	4.303	4.037	3.787	3.552
86	6.177	5.985	5.825	5.199	4.884	4.585	4.303	4.037	3.787	3.552	3.333
87	5.812	5.626	5.474	4.884	4.585	4.303	4.037	3.787	3.552	3.333	3.129
88	5.464	5.285	5.140	4.585	4.303	4.037	3.787	3.552	3.333	3.129	2.940
89	5.133	4.961	4.824	4.303	4.037	3.787	3.552	3.333	3.129	2.940	2.767
90	4.819	4.655	4.526	4.037	3.787	3.552	3.333	3.129	2.940	2.767	2.611
91	4.522	4.365	4.244	3.787	3.552	3.333	3.129	2.940	2.767	2.611	2.461
92	4.242	4.092	3.979	3.552	3.333	3.129	2.940	2.767	2.611	2.461	2.317
93	3.977	3.836	3.731	3.333	3.129	2.940	2.767	2.611	2.461	2.317	2.180
94	3.729	3.595	3.499	3.129	2.940	2.767	2.611	2.461	2.317	2.180	2.048
95	3.496	3.370	3.283	2.940	2.767	2.611	2.461	2.317	2.180	2.048	1.922

Source: based on the 2004 United States Life Table for the Total Population
Annual Rate of Interest = 3.5%
Annual Rate of Escalation after year 2 = 2.9%

Table IIE-398
Pension Table – Other than Surviving Spouse - Fatal Claims
(for Claims after December 23, 1991 Excluding Claims Incurred Under U.S.L. & H. W. Act, with Escalation)

Age (x)	- a (x)	- a (x) + 1	- a (x) + 2	- a (x) + 3	- a (x) + 4	- a (x) + 5	- a (x) + 6	- a (x) + 7	- a (x) + 8	- a (x) + 9	- a (x)+10
96	3.278	3.161	3.083	2.767	2.611	2.461	2.317	2.180	2.048	1.922	1.801
97	3.076	2.968	2.900	2.611	2.461	2.317	2.180	2.048	1.922	1.801	1.686
98	2.889	2.791	2.734	2.461	2.317	2.180	2.048	1.922	1.801	1.686	1.576
99	2.718	2.631	2.575	2.317	2.180	2.048	1.922	1.801	1.686	1.576	1.471
100	2.564	2.478	2.423	2.180	2.048	1.922	1.801	1.686	1.576	1.471	1.371
101	2.415	2.331	2.278	2.048	1.922	1.801	1.686	1.576	1.471	1.371	1.275
102	2.274	2.191	2.138	1.922	1.801	1.686	1.576	1.471	1.371	1.275	1.184
103	2.138	2.056	2.005	1.801	1.686	1.576	1.471	1.371	1.275	1.184	1.097
104	2.008	1.928	1.877	1.686	1.576	1.471	1.371	1.275	1.184	1.097	1.015

Source: based on the 2004 United States Life Table for the Total Population
Annual Rate of Interest = 3.5%
Annual Rate of Escalation after year 2 = 2.9%

Table IIIEM-398-Male
Pension Table – Permanent Total Claimants
(for Claims after December 23, 1991 Excluding Claims Incurred Under U.S.L. & H. W. Act, with Escalation)

Age at Accident Date	- a (x)	- a (x) + 1	- a (x) + 2	- a (x) + 3	- a (x) + 4	- a (x) + 5	- a (x) + 6	- a (x) + 7	- a (x) + 8	- a (x) + 9	- a (x)+10
0	45.634	46.965	47.666	44.384	43.695	42.998	42.295	41.587	40.873	40.153	39.426
1	46.020	46.687	47.359	44.086	43.391	42.691	41.985	41.274	40.556	39.832	39.102
2	45.743	46.382	47.037	43.775	43.077	42.374	41.665	40.950	40.228	39.500	38.768
3	45.440	46.061	46.700	43.453	42.753	42.046	41.334	40.614	39.889	39.159	38.429
4	45.121	45.726	46.352	43.122	42.418	41.708	40.991	40.268	39.540	38.813	38.089
5	44.788	45.381	45.993	42.779	42.072	41.357	40.636	39.911	39.186	38.465	37.758
6	44.444	45.024	45.623	42.426	41.713	40.995	40.272	39.549	38.831	38.126	37.433
7	44.090	44.656	45.240	42.059	41.343	40.623	39.902	39.186	38.483	37.793	37.114
8	43.725	44.276	44.844	41.681	40.963	40.244	39.530	38.830	38.143	37.466	36.799
9	43.347	43.883	44.435	41.293	40.577	39.865	39.167	38.482	37.808	37.144	36.487
10	42.957	43.477	44.016	40.898	40.189	39.493	38.811	38.140	37.478	36.824	36.173
11	42.554	43.061	43.589	40.502	39.809	39.129	38.460	37.802	37.150	36.502	35.857
12	42.141	42.637	43.161	40.114	39.436	38.770	38.114	37.465	36.820	36.178	35.539
13	41.721	42.213	42.742	39.733	39.069	38.416	37.769	37.127	36.488	35.852	35.215
14	41.300	41.796	42.329	39.358	38.707	38.063	37.423	36.787	36.154	35.520	34.882
15	40.887	41.387	41.923	38.987	38.346	37.708	37.075	36.444	35.813	35.178	34.536
16	40.480	40.983	41.522	38.617	37.982	37.351	36.724	36.095	35.462	34.823	34.177
17	40.079	40.584	41.121	38.246	37.617	36.992	36.366	35.736	35.099	34.455	33.804
18	39.683	40.186	40.719	37.871	37.248	36.625	35.997	35.363	34.722	34.074	33.419
19	39.287	39.786	40.313	37.494	36.873	36.248	35.616	34.977	34.332	33.679	33.021
20	38.889	39.383	39.905	37.110	36.487	35.857	35.221	34.578	33.928	33.271	32.610
21	38.489	38.976	39.489	36.715	36.087	35.453	34.812	34.164	33.510	32.851	32.187
22	38.085	38.563	39.061	36.306	35.674	35.035	34.389	33.737	33.080	32.418	31.752
23	37.674	38.137	38.618	35.883	35.246	34.603	33.953	33.298	32.638	31.973	31.305
24	37.251	37.698	38.161	35.446	34.804	34.156	33.503	32.845	32.183	31.517	30.848
25	36.815	37.244	37.688	34.995	34.349	33.698	33.041	32.381	31.716	31.049	30.380
26	36.364	36.774	37.200	34.529	33.880	33.226	32.567	31.904	31.239	30.572	29.902
27	35.898	36.291	36.698	34.051	33.398	32.741	32.080	31.417	30.752	30.084	29.414
28	35.419	35.792	36.182	33.560	32.904	32.245	31.583	30.920	30.253	29.585	28.917
29	34.925	35.281	35.652	33.056	32.399	31.738	31.076	30.411	29.745	29.078	28.410
30	34.419	34.756	35.108	32.541	31.882	31.221	30.558	29.893	29.228	28.562	27.895
31	33.899	34.218	34.553	32.015	31.355	30.693	30.030	29.366	28.701	28.037	27.371

Source: based on the 2004 United States Life Table for the Male Population (adjusted for the life expectancy of injured workers)
Annual Rate of Interest = 3.5%
Annual Rate of Escalation after year 2 = 2.9%
Annuity Values reduced by 2.4% to reflect the expected offset of Massachusetts benefits by Social Security benefits.

Table IIIEM-398-Male
Pension Table – Permanent Total Claimants
(for Claims after December 23, 1991 Excluding Claims Incurred Under U.S.L. & H. W. Act, with Escalation)

Age at Accident Date	- a (x)	- a (x) + 1	- a (x) + 2	- a (x) + 3	- a (x) + 4	- a (x) + 5	- a (x) + 6	- a (x) + 7	- a (x) + 8	- a (x) + 9	- a (x)+10
32	33.367	33.669	33.986	31.479	30.818	30.156	29.493	28.830	28.167	27.502	26.836
33	32.824	33.108	33.409	30.932	30.271	29.609	28.948	28.286	27.623	26.958	26.292
34	32.270	32.538	32.821	30.376	29.715	29.055	28.394	27.732	27.068	26.404	25.739
35	31.707	31.957	32.223	29.811	29.152	28.492	27.831	27.169	26.505	25.842	25.180
36	31.134	31.367	31.616	29.239	28.580	27.920	27.259	26.596	25.934	25.274	24.616
37	30.553	30.769	31.001	28.659	28.000	27.339	26.678	26.017	25.357	24.700	24.044
38	29.963	30.163	30.379	28.071	27.411	26.750	26.090	25.431	24.775	24.120	23.466
39	29.367	29.550	29.748	27.474	26.814	26.154	25.496	24.841	24.187	23.534	22.882
40	28.764	28.930	29.108	26.869	26.210	25.553	24.899	24.245	23.593	22.942	22.292
41	28.154	28.301	28.461	26.259	25.602	24.948	24.296	23.644	22.994	22.345	21.698
42	27.537	27.666	27.809	25.644	24.991	24.339	23.688	23.039	22.390	21.744	21.101
43	26.913	27.025	27.152	25.027	24.375	23.725	23.076	22.428	21.782	21.140	20.500
44	26.285	26.381	26.493	24.406	23.756	23.107	22.460	21.814	21.173	20.533	19.893
45	25.655	25.735	25.830	23.781	23.133	22.486	21.841	21.200	20.560	19.921	19.282
46	25.023	25.087	25.164	23.154	22.507	21.863	21.222	20.583	19.944	19.305	18.667
47	24.388	24.436	24.497	22.525	21.880	21.239	20.601	19.962	19.324	18.685	18.047
48	23.753	23.783	23.826	21.894	21.253	20.615	19.977	19.339	18.700	18.063	17.427
49	23.116	23.129	23.156	21.264	20.626	19.988	19.350	18.712	18.074	17.439	16.808
50	22.477	22.475	22.487	20.634	19.996	19.359	18.721	18.083	17.448	16.817	16.194
51	21.839	21.822	21.818	20.003	19.365	18.727	18.090	17.454	16.824	16.201	15.587
52	21.204	21.171	21.148	19.370	18.732	18.095	17.459	16.829	16.206	15.592	14.988
53	20.569	20.518	20.476	18.735	18.098	17.463	16.832	16.209	15.596	14.992	14.397
54	19.934	19.865	19.804	18.100	17.465	16.835	16.212	15.598	14.994	14.400	13.813
55	19.298	19.210	19.131	17.467	16.837	16.214	15.600	14.996	14.402	13.815	13.235
56	18.661	18.556	18.460	16.838	16.215	15.601	14.997	14.403	13.816	13.236	12.662
57	18.025	17.903	17.794	16.215	15.602	14.998	14.404	13.817	13.237	12.663	12.099
58	17.390	17.255	17.135	15.602	14.998	14.404	13.817	13.238	12.664	12.100	11.545
59	16.761	16.615	16.485	14.999	14.404	13.818	13.238	12.664	12.100	11.545	11.002
60	16.138	15.984	15.847	14.404	13.818	13.238	12.664	12.100	11.546	11.002	10.469
61	15.525	15.363	15.218	13.818	13.238	12.664	12.100	11.546	11.002	10.469	9.947
62	14.921	14.751	14.597	13.238	12.664	12.100	11.546	11.002	10.469	9.947	9.433
63	14.327	14.148	13.983	12.664	12.100	11.546	11.002	10.469	9.947	9.433	8.933

Source: based on the 2004 United States Life Table for the Male Population (adjusted for the life expectancy of injured workers)
Annual Rate of Interest = 3.5%
Annual Rate of Escalation after year 2 = 2.9%
Annuity Values reduced by 2.4% to reflect the expected offset of Massachusetts benefits by Social Security benefits.

Table IIIEM-398-Male
Pension Table – Permanent Total Claimants
(for Claims after December 23, 1991 Excluding Claims Incurred Under U.S.L. & H. W. Act, with Escalation)

Age at Accident Date	- a (x)	- a (x) + 1	- a (x) + 2	- a (x) + 3	- a (x) + 4	- a (x) + 5	- a (x) + 6	- a (x) + 7	- a (x) + 8	- a (x) + 9	- a (x)+10
64	13.741	13.552	13.376	12.100	11.546	11.002	10.469	9.947	9.433	8.933	8.449
65	13.161	12.961	12.779	11.546	11.002	10.469	9.947	9.433	8.933	8.449	7.983
66	12.588	12.381	12.192	11.002	10.469	9.947	9.433	8.933	8.449	7.983	7.533
67	12.024	11.811	11.616	10.469	9.947	9.433	8.933	8.449	7.983	7.533	7.098
68	11.470	11.252	11.053	9.947	9.433	8.933	8.449	7.983	7.533	7.098	6.677
69	10.926	10.704	10.499	9.433	8.933	8.449	7.983	7.533	7.098	6.677	6.272
70	10.394	10.166	9.956	8.933	8.449	7.983	7.533	7.098	6.677	6.272	5.886
71	9.872	9.638	9.427	8.449	7.983	7.533	7.098	6.677	6.272	5.886	5.519
72	9.359	9.124	8.914	7.983	7.533	7.098	6.677	6.272	5.886	5.519	5.172
73	8.859	8.626	8.421	7.533	7.098	6.677	6.272	5.886	5.519	5.172	4.840
74	8.376	8.147	7.945	7.098	6.677	6.272	5.886	5.519	5.172	4.840	4.523
75	7.911	7.684	7.484	6.677	6.272	5.886	5.519	5.172	4.840	4.523	4.219
76	7.461	7.237	7.038	6.272	5.886	5.519	5.172	4.840	4.523	4.219	3.934
77	7.027	6.804	6.610	5.886	5.519	5.172	4.840	4.523	4.219	3.934	3.664
78	6.607	6.388	6.201	5.519	5.172	4.840	4.523	4.219	3.934	3.664	3.413
79	6.203	5.991	5.813	5.172	4.840	4.523	4.219	3.934	3.664	3.413	3.181
80	5.818	5.615	5.446	4.840	4.523	4.219	3.934	3.664	3.413	3.181	2.963
81	5.453	5.258	5.094	4.523	4.219	3.934	3.664	3.413	3.181	2.963	2.759
82	5.107	4.917	4.759	4.219	3.934	3.664	3.413	3.181	2.963	2.759	2.567
83	4.776	4.592	4.437	3.934	3.664	3.413	3.181	2.963	2.759	2.567	2.388
84	4.461	4.280	4.135	3.664	3.413	3.181	2.963	2.759	2.567	2.388	2.221
85	4.158	3.987	3.850	3.413	3.181	2.963	2.759	2.567	2.388	2.221	2.065
86	3.875	3.711	3.584	3.181	2.963	2.759	2.567	2.388	2.221	2.065	1.921
87	3.607	3.453	3.339	2.963	2.759	2.567	2.388	2.221	2.065	1.921	1.788
88	3.358	3.216	3.108	2.759	2.567	2.388	2.221	2.065	1.921	1.788	1.667
89	3.128	2.992	2.891	2.567	2.388	2.221	2.065	1.921	1.788	1.667	1.558
90	2.912	2.783	2.688	2.388	2.221	2.065	1.921	1.788	1.667	1.558	1.465
91	2.709	2.587	2.499	2.221	2.065	1.921	1.788	1.667	1.558	1.465	1.376
92	2.520	2.403	2.322	2.065	1.921	1.788	1.667	1.558	1.465	1.376	1.291
93	2.343	2.233	2.157	1.921	1.788	1.667	1.558	1.465	1.376	1.291	1.209
94	2.178	2.074	2.005	1.788	1.667	1.558	1.465	1.376	1.291	1.209	1.131
95	2.025	1.927	1.864	1.667	1.558	1.465	1.376	1.291	1.209	1.131	1.056

Source: based on the 2004 United States Life Table for the Male Population (adjusted for the life expectancy of injured workers)
Annual Rate of Interest = 3.5%
Annual Rate of Escalation after year 2 = 2.9%
Annuity Values reduced by 2.4% to reflect the expected offset of Massachusetts benefits by Social Security benefits.

Table IIIEM-398-Male
Pension Table – Permanent Total Claimants
(for Claims after December 23, 1991 Excluding Claims Incurred Under U.S.L. & H. W. Act, with Escalation)

Age at Accident Date	- a (x)	- a (x) + 1	- a (x) + 2	- a (x) + 3	- a (x) + 4	- a (x) + 5	- a (x) + 6	- a (x) + 7	- a (x) + 8	- a (x) + 9	- a (x)+10
96	1.883	1.792	1.736	1.558	1.465	1.376	1.291	1.209	1.131	1.056	0.985
97	1.753	1.669	1.620	1.465	1.376	1.291	1.209	1.131	1.056	0.985	0.919
98	1.634	1.558	1.522	1.376	1.291	1.209	1.131	1.056	0.985	0.919	0.862
99	1.528	1.464	1.428	1.291	1.209	1.131	1.056	0.985	0.919	0.862	0.831
100	1.437	1.374	1.338	1.209	1.131	1.056	0.985	0.919	0.862	0.831	0.806
101	1.350	1.288	1.251	1.131	1.056	0.985	0.919	0.862	0.831	0.806	0.780
102	1.267	1.205	1.169	1.056	0.985	0.919	0.862	0.831	0.806	0.780	0.755
103	1.187	1.126	1.090	0.985	0.919	0.862	0.831	0.806	0.780	0.755	0.729
104	1.111	1.051	1.015	0.919	0.862	0.831	0.806	0.780	0.755	0.729	0.703

Source: based on the 2004 United States Life Table for the Male Population (adjusted for the life expectancy of injured workers)
Annual Rate of Interest = 3.5%
Annual Rate of Escalation after year 2 = 2.9%
Annuity Values reduced by 2.4% to reflect the expected offset of Massachusetts benefits by Social Security benefits.

Table IIIEF-398-Female
Pension Table – Permanent Total Claimants
(for Claims after December 23, 1991 Excluding Claims Incurred Under U.S.L. & H. W. Act, with Escalation)

Age at Accident Date	- a (x)	- a (x) + 1	- a (x) + 2	- a (x) + 3	- a (x) + 4	- a (x) + 5	- a (x) + 6	- a (x) + 7	- a (x) + 8	- a (x) + 9	- a (x)+10
0	47.939	49.244	50.022	46.620	45.940	45.254	44.562	43.864	43.161	42.453	41.739
1	48.286	49.030	49.780	46.383	45.699	45.010	44.315	43.614	42.909	42.198	41.483
2	48.071	48.788	49.522	46.135	45.448	44.756	44.059	43.356	42.648	41.936	41.219
3	47.830	48.531	49.254	45.878	45.188	44.493	43.794	43.089	42.379	41.665	40.949
4	47.574	48.263	48.974	45.611	44.919	44.222	43.519	42.812	42.101	41.388	40.673
5	47.307	47.985	48.685	45.335	44.640	43.941	43.236	42.528	41.817	41.105	40.395
6	47.030	47.696	48.385	45.049	44.352	43.650	42.944	42.236	41.527	40.820	40.115
7	46.742	47.398	48.076	44.754	44.055	43.351	42.646	41.939	41.235	40.533	39.832
8	46.445	47.089	47.755	44.449	43.748	43.045	42.341	41.639	40.940	40.243	39.545
9	46.138	46.770	47.425	44.135	43.434	42.733	42.034	41.337	40.642	39.948	39.252
10	45.820	46.441	47.084	43.814	43.115	42.418	41.724	41.032	40.340	39.646	38.948
11	45.492	46.102	46.736	43.486	42.792	42.100	41.411	40.722	40.031	39.336	38.636
12	45.155	45.755	46.381	43.155	42.466	41.779	41.093	40.405	39.712	39.015	38.314
13	44.810	45.402	46.022	42.822	42.137	41.453	40.768	40.077	39.383	38.684	37.981
14	44.458	45.045	45.660	42.485	41.803	41.120	40.432	39.740	39.044	38.344	37.639
15	44.103	44.684	45.294	42.142	41.461	40.776	40.086	39.393	38.695	37.993	37.288
16	43.744	44.320	44.923	41.791	41.108	40.421	39.730	39.035	38.335	37.632	36.926
17	43.381	43.950	44.543	41.430	40.745	40.056	39.363	38.666	37.966	37.262	36.555
18	43.013	43.571	44.151	41.058	40.371	39.680	38.986	38.287	37.586	36.882	36.175
19	42.636	43.181	43.747	40.675	39.986	39.294	38.597	37.898	37.196	36.492	35.784
20	42.248	42.780	43.332	40.280	39.590	38.896	38.199	37.499	36.797	36.092	35.384
21	41.848	42.366	42.905	39.875	39.183	38.488	37.790	37.090	36.387	35.682	34.975
22	41.436	41.941	42.465	39.458	38.765	38.069	37.371	36.670	35.967	35.262	34.556
23	41.014	41.504	42.014	39.030	38.337	37.640	36.941	36.241	35.538	34.833	34.128
24	40.579	41.055	41.551	38.592	37.897	37.201	36.502	35.801	35.098	34.395	33.689
25	40.133	40.595	41.076	38.143	37.448	36.751	36.052	35.351	34.649	33.946	33.241
26	39.675	40.123	40.590	37.683	36.987	36.290	35.592	34.892	34.190	33.487	32.782
27	39.206	39.640	40.092	37.212	36.517	35.820	35.122	34.422	33.721	33.018	32.313
28	38.727	39.145	39.583	36.731	36.036	35.339	34.642	33.942	33.241	32.538	31.835
29	38.236	38.640	39.063	36.240	35.545	34.849	34.151	33.451	32.750	32.049	31.347
30	37.734	38.124	38.532	35.738	35.043	34.347	33.649	32.950	32.250	31.550	30.851
31	37.222	37.597	37.990	35.226	34.532	33.835	33.137	32.439	31.741	31.043	30.344

Source: based on the 2004 United States Life Table for the Female Population (adjusted for the life expectancy of injured workers)
Annual Rate of Interest = 3.5%
Annual Rate of Escalation after year 2 = 2.9%
Annuity Values reduced by 2.4% to reflect the expected offset of Massachusetts benefits by Social Security benefits.

Table IIIEF-398-Female
Pension Table – Permanent Total Claimants
(for Claims after December 23, 1991 Excluding Claims Incurred Under U.S.L. & H. W. Act, with Escalation)

Age at Accident Date	- a (x)	- a (x) + 1	- a (x) + 2	- a (x) + 3	- a (x) + 4	- a (x) + 5	- a (x) + 6	- a (x) + 7	- a (x) + 8	- a (x) + 9	- a (x)+10
32	36.699	37.059	37.437	34.704	34.009	33.312	32.615	31.919	31.222	30.525	29.827
33	36.166	36.511	36.872	34.170	33.475	32.780	32.084	31.389	30.694	29.997	29.299
34	35.623	35.952	36.297	33.626	32.932	32.238	31.544	30.851	30.155	29.458	28.760
35	35.069	35.381	35.710	33.072	32.380	31.687	30.995	30.301	29.605	28.908	28.211
36	34.505	34.800	35.113	32.510	31.819	31.127	30.434	29.740	29.045	28.349	27.653
37	33.930	34.210	34.507	31.939	31.249	30.557	29.863	29.169	28.474	27.780	27.084
38	33.346	33.611	33.892	31.358	30.668	29.976	29.282	28.589	27.895	27.200	26.505
39	32.754	33.003	33.267	30.768	30.077	29.384	28.692	27.999	27.306	26.611	25.914
40	32.154	32.386	32.632	30.167	29.476	28.784	28.092	27.400	26.706	26.011	25.312
41	31.546	31.759	31.987	29.557	28.866	28.175	27.484	26.791	26.096	25.399	24.699
42	30.928	31.123	31.332	28.939	28.249	27.558	26.866	26.172	25.475	24.776	24.076
43	30.301	30.478	30.668	28.313	27.622	26.931	26.238	25.542	24.843	24.144	23.445
44	29.666	29.825	29.997	27.678	26.988	26.295	25.599	24.902	24.203	23.505	22.807
45	29.024	29.165	29.318	27.036	26.344	25.649	24.952	24.254	23.556	22.859	22.163
46	28.376	28.498	28.631	26.385	25.691	24.994	24.297	23.599	22.902	22.207	21.514
47	27.721	27.823	27.935	25.726	25.030	24.333	23.636	22.939	22.244	21.552	20.861
48	27.060	27.141	27.231	25.059	24.362	23.665	22.969	22.275	21.583	20.893	20.206
49	26.392	26.451	26.519	24.386	23.690	22.994	22.300	21.608	20.918	20.232	19.549
50	25.717	25.755	25.802	23.709	23.013	22.319	21.628	20.939	20.252	19.570	18.893
51	25.036	25.054	25.082	23.029	22.335	21.643	20.954	20.268	19.587	18.910	18.240
52	24.352	24.350	24.358	22.347	21.655	20.967	20.281	19.599	18.923	18.253	17.591
53	23.665	23.644	23.633	21.665	20.976	20.290	19.609	18.932	18.263	17.601	16.945
54	22.976	22.938	22.909	20.983	20.297	19.616	18.939	18.270	17.608	16.953	16.304
55	22.288	22.232	22.185	20.302	19.621	18.944	18.275	17.613	16.958	16.309	15.665
56	21.600	21.527	21.463	19.624	18.948	18.279	17.617	16.962	16.313	15.669	15.031
57	20.914	20.824	20.745	18.950	18.281	17.619	16.964	16.315	15.672	15.034	14.404
58	20.230	20.125	20.031	18.283	17.621	16.966	16.317	15.674	15.035	14.405	13.784
59	19.550	19.430	19.323	17.622	16.967	16.318	15.675	15.036	14.406	13.785	13.173
60	18.875	18.742	18.624	16.968	16.319	15.675	15.037	14.407	13.786	13.174	12.572
61	18.206	18.062	17.931	16.319	15.676	15.037	14.408	13.786	13.174	12.573	11.981
62	17.544	17.389	17.244	15.676	15.038	14.408	13.786	13.175	12.573	11.981	11.398
63	16.890	16.721	16.564	15.038	14.408	13.787	13.175	12.573	11.981	11.398	10.828

Source: based on the 2004 United States Life Table for the Female Population (adjusted for the life expectancy of injured workers)
Annual Rate of Interest = 3.5%
Annual Rate of Escalation after year 2 = 2.9%
Annuity Values reduced by 2.4% to reflect the expected offset of Massachusetts benefits by Social Security benefits.

Table IIIEF-398-Female
Pension Table – Permanent Total Claimants
(for Claims after December 23, 1991 Excluding Claims Incurred Under U.S.L. & H. W. Act, with Escalation)

Age at Accident Date	- a (x)	- a (x) + 1	- a (x) + 2	- a (x) + 3	- a (x) + 4	- a (x) + 5	- a (x) + 6	- a (x) + 7	- a (x) + 8	- a (x) + 9	- a (x)+10
64	16.241	16.059	15.888	14.408	13.787	13.175	12.573	11.981	11.399	10.828	10.271
65	15.598	15.403	15.221	13.787	13.175	12.573	11.981	11.399	10.828	10.271	9.727
66	14.960	14.755	14.564	13.175	12.573	11.981	11.399	10.828	10.271	9.727	9.194
67	14.330	14.116	13.916	12.573	11.981	11.399	10.828	10.271	9.727	9.194	8.673
68	13.709	13.486	13.279	11.981	11.399	10.828	10.271	9.727	9.194	8.673	8.164
69	13.098	12.868	12.653	11.399	10.828	10.271	9.727	9.194	8.673	8.164	7.672
70	12.496	12.258	12.036	10.828	10.271	9.727	9.194	8.673	8.164	7.672	7.201
71	11.904	11.659	11.432	10.271	9.727	9.194	8.673	8.164	7.672	7.201	6.751
72	11.322	11.073	10.842	9.727	9.194	8.673	8.164	7.672	7.201	6.751	6.319
73	10.752	10.499	10.267	9.194	8.673	8.164	7.672	7.201	6.751	6.319	5.902
74	10.195	9.940	9.703	8.673	8.164	7.672	7.201	6.751	6.319	5.902	5.506
75	9.652	9.392	9.151	8.164	7.672	7.201	6.751	6.319	5.902	5.506	5.132
76	9.120	8.856	8.612	7.672	7.201	6.751	6.319	5.902	5.506	5.132	4.779
77	8.599	8.333	8.092	7.201	6.751	6.319	5.902	5.506	5.132	4.779	4.445
78	8.091	7.827	7.594	6.751	6.319	5.902	5.506	5.132	4.779	4.445	4.131
79	7.600	7.343	7.117	6.319	5.902	5.506	5.132	4.779	4.445	4.131	3.840
80	7.130	6.881	6.659	5.902	5.506	5.132	4.779	4.445	4.131	3.840	3.565
81	6.681	6.436	6.218	5.506	5.132	4.779	4.445	4.131	3.840	3.565	3.307
82	6.249	6.008	5.799	5.132	4.779	4.445	4.131	3.840	3.565	3.307	3.065
83	5.834	5.601	5.403	4.779	4.445	4.131	3.840	3.565	3.307	3.065	2.839
84	5.439	5.217	5.030	4.445	4.131	3.840	3.565	3.307	3.065	2.839	2.628
85	5.067	4.854	4.676	4.131	3.840	3.565	3.307	3.065	2.839	2.628	2.432
86	4.715	4.511	4.344	3.840	3.565	3.307	3.065	2.839	2.628	2.432	2.250
87	4.382	4.190	4.036	3.565	3.307	3.065	2.839	2.628	2.432	2.250	2.084
88	4.071	3.890	3.745	3.307	3.065	2.839	2.628	2.432	2.250	2.084	1.932
89	3.781	3.609	3.471	3.065	2.839	2.628	2.432	2.250	2.084	1.932	1.798
90	3.508	3.344	3.215	2.839	2.628	2.432	2.250	2.084	1.932	1.798	1.684
91	3.252	3.096	2.976	2.628	2.432	2.250	2.084	1.932	1.798	1.684	1.575
92	3.012	2.864	2.753	2.432	2.250	2.084	1.932	1.798	1.684	1.575	1.470
93	2.788	2.649	2.545	2.250	2.084	1.932	1.798	1.684	1.575	1.470	1.371
94	2.580	2.448	2.353	2.084	1.932	1.798	1.684	1.575	1.470	1.371	1.276
95	2.386	2.263	2.177	1.932	1.798	1.684	1.575	1.470	1.371	1.276	1.186

Source: based on the 2004 United States Life Table for the Female Population (adjusted for the life expectancy of injured workers)
Annual Rate of Interest = 3.5%
Annual Rate of Escalation after year 2 = 2.9%
Annuity Values reduced by 2.4% to reflect the expected offset of Massachusetts benefits by Social Security benefits.

Table IIIEF-398-Female
Pension Table – Permanent Total Claimants
(for Claims after December 23, 1991 Excluding Claims Incurred Under U.S.L. & H. W. Act, with Escalation)

Age at Accident Date	- a (x)	- a (x) + 1	- a (x) + 2	- a (x) + 3	- a (x) + 4	- a (x) + 5	- a (x) + 6	- a (x) + 7	- a (x) + 8	- a (x) + 9	- a (x)+10
96	2.207	2.093	2.017	1.798	1.684	1.575	1.470	1.371	1.276	1.186	1.100
97	2.043	1.939	1.874	1.684	1.575	1.470	1.371	1.276	1.186	1.100	1.020
98	1.895	1.802	1.753	1.575	1.470	1.371	1.276	1.186	1.100	1.020	0.946
99	1.762	1.686	1.638	1.470	1.371	1.276	1.186	1.100	1.020	0.946	0.884
100	1.650	1.575	1.528	1.371	1.276	1.186	1.100	1.020	0.946	0.884	0.858
101	1.544	1.469	1.423	1.276	1.186	1.100	1.020	0.946	0.884	0.858	0.831
102	1.442	1.369	1.322	1.186	1.100	1.020	0.946	0.884	0.858	0.831	0.804
103	1.345	1.273	1.227	1.100	1.020	0.946	0.884	0.858	0.831	0.804	0.776
104	1.252	1.182	1.136	1.020	0.946	0.884	0.858	0.831	0.804	0.776	0.748

Source: based on the 2004 United States Life Table for the Female Population (adjusted for the life expectancy of injured workers)
Annual Rate of Interest = 3.5%
Annual Rate of Escalation after year 2 = 2.9%
Annuity Values reduced by 2.4% to reflect the expected offset of Massachusetts benefits by Social Security benefits.

Example - Fatal Claim - Spouse & One Child
Usage of: Surviving Spouse's Pension Table (Table IE-398)

Calculation of incurred loss to be reported when benefits are payable to a surviving spouse until death or remarriage, due to a fatal injury occurring after December 23, 1991.

Accident Date	2/5/2007	Policy Effective Date:	1/1/2007
Date of Death:	2/5/2007	Spouse's Birthdate:	2/18/1967
Weekly Wages:	$300	Child's Birthdate:	10/15/1996

Calculation		**1st Report**	**2nd Report**	**3rd Report**
1.	Valuation Date	7/2008	7/2009	7/2010
2.	Spouse's attained age at death date	39	39	39
3.	Duration since death date (to nearest year), t.	1	2	3
4.	Weekly Benefit Payable = (66 2/3%) x Wkly Wages	$200.00	$200.00	$218.11
5.	Annual Benefit Payable =(4) x 52	$10,400	$10,400	$11,342
Benefits for Spouse beyond the Valuation Date				
6.	Factor from Table IE-398	30.579	31.594	29.710
7.	Present Value of Future Payment=(5) x (6)	$318,022	$328,578	$336,963
Others				
8.	Payment since 2/05/07	$15,200	$25,600	$36,743
9.	Funeral Allowance, Maximum of $4,000	$4,000	$4,000	$4,000
10.	Total Incurred Indemnity Loss = (7) + (8) + (9)	$337,222	$358,178	$377,705

In no instance shall said widow/widower, receive less than $110 per week. Additional compensation is paid in the amount of $6 a week for each child of the deceased employee under the age of eighteen or over said age and physically or mentally incapiciated from earning, or over said age and a full time student qualified for exemption as a dependent, except that no additional compensation for the benefits of the children of the employee shall be payable when combined with the compensation due the spouse that would allow the window(er) an amount in excess of $150 per week. –MGL c. 152, Sec 31.

Note:
(6): 1st Report factor is from the 9/1/2006 Pension Table, 2nd Report factor is from the 9/1/2008 Pension Table, 3rd Report is from the 9/1/2009 Pension Table

Cost of Living Adjustments (COLA):
Weekly Benefit Payments are subjected to "Cost of Living Adjustments" (COLA):

1 Increase each October 1, the first escalated benefit starts at the next October 1st following 24 months after the accident date.
2 The supplemental benefit increase shall not exceed the minimum of:
   a. The increase in the State Average Weekly Wage (SAWW)
   b. The increase in the Northeastern region CPI for all urban consumers
   c. 5%.
3 The adjusted benefit is not greater than "three times the base benefit."

			Benefit Reevaluation Date		
	2/5/2007	10/1/2007	10/1/2008	10/1/2009	10/1/2010
SAWW	$1,000.43	$1,043.54	$1,093.27	$1,145.37	$1,199.95
a. Increase in SAWW		4.3%	4.8%	4.8%	4.8%
b. Increase in Northeastern CPI		3.6%	2.6%	2.6%	2.6%
c. 5%		5.0%	5.0%	5.0%	5.0%
Weekly Benefit =	$200.00	$200.00	$200.00	$218.11	$223.79
	Base Benefit			*1st escalated benefit*	

ex. $218.11= $200 x 1.036 x 1.026 x 1.026, to a maximum of $600 (3 times the $200 base benefit)
Note: the increase in the SAWW and Northeastern CPI for the 10/01/2009 and 10/01/2010 benefit reevaluations have been set equal to the values for 10/01/2008.

Example - Fatal Claim - Other than Spouse
Usage of: Other than Surviving Spouse's Pension Table (Table IIE-398)

Calculation of incurred loss to be reported when benefits are payable to another then surviving spouse due to a fatal injury occurring after December 23, 1991.

Accident Date	2/5/2007	Policy Effective Date:	1/1/2007
Date of Death:	2/5/2007	Dependent's Birthdate:	2/18/1967
Weekly Wages:	$300		

Calculation		**1st Report**	**2nd Report**	**3rd Report**
1.	Valuation Date	7/2008	7/2009	7/2010
2.	Spouse's attained age at death date	39	39	39
3.	Duration since death date (to nearest year), t.	1	2	3
4.	Weekly Benefit Payable = (66 2/3%) x Wkly Wages	$80.00	$80.00	$87.25
5.	Annual Benefit Payable =(4) x 52	$4,160	$4,160	$4,537
Benefits for Spouse beyond the Valuation Date				
6.	Factor from Table IIE-398	34.701	35.370	32.730
7.	Present Value of Future Payment=(5) x (6)	$144,356	$147,139	$148,496
Others				
8.	Payment since 2/05/07	$6,080	$10,240	$14,697
9.	Funeral Allowance, Maximum of $4000	$1,500	$1,500	$1,500
10.	Total Incurred Indemnity Loss = (7) + (8) + (9)	$151,936	$158,879	$164,693

The weekly benefit payment should not be more than two-thirds of the average weekly wage of the deceased employee or more than $80 a week; provided, however, that if there is more than one such dependent, the total amount payable shall not exceed the weekly amount which is, or would be payable to a surviving spouse of the deceased employee.
- M.G.L c.152, Sec 31

Note:
(6): 1st Report factor is from the 9/1/2006 Pension Table, 2nd Report factor is from the 9/1/2008 Pension Table, 3rd Report is from the 9/1/2009 Pension Table.

Cost of Living Adjustments (COLA):
Weekly Benefit Payments are subjected to "Cost of Living Adjustments" (COLA):

1. Increase each October 1, the first escalated benefit starts at the next October 1st following 24 months after the accident date.
2. The supplemental benefit increase shall not exceed the minimum of:
   a. The increase in the State Average Weekly Wage (SAWW)
   b. The increase in the Northeastern region CPI for all urban consumers
   c. 5%.
3. The adjusted benefit is not greater than "three times the base benefit."

		Benefit Reevaluation Date			
	2/5/2007	10/1/2007	10/1/2008	10/1/2009	10/1/2010
SAWW	$1,000.43	$1,043.54	$1,093.27	$1,145.37	$1,199.95
a. Increase in SAWW		4.3%	4.8%	4.8%	4.8%
b. Increase in Northeastern CPI		3.6%	2.6%	2.6%	2.6%
c. 5%		5.0%	5.0%	5.0%	5.0%
Weekly Benefit =	$80.00	$80.00	$80.00	$87.25	$89.51
	Base Benefit			*1st escalated benefit*	

ex. $87.25 = $80 x 1.036 x 1.026 x 1.026, capped at the weekly amount available to surviving spouse
Note: the increase in the SAWW and Northeastern CPI for the 10/01/2009 and 10/01/2010 benefit reevaluations have been set equal to the values for 10/01/2008.

Example - Permanent Total Claim - Female Worker
Usage of: Permanent Total Claimant's Pension Table (Table IIIEF-398)

Calculation of incurred loss to be reported when benefits are payable to an injured female worker for life, due to a permanent total injury occurring after December 23, 1991.

Accident Date:	2/5/2007	Policy Effective Date:	1/1/2007
Weekly Wages:	$300	Injured Worker's Birthdate:	2/18/1967
		Spouse's Birthdate:	10/15/1960

Calculation		**1st Report**	**2nd Report**	**3rd Report**
1.	Valuation Date	7/2008	7/2009	7/2010
2.	Injured worker's attained age at accident date	39	39	39
3.	Spouse's attained age at accident date	46	46	46
4.	Duration since death date (to nearest year), t.	1	2	3
5.	Weekly Benefit Payable = (66 2/3%) x Wkly Wages	$200.00	$200.00	$218.11
6.	Annual Benefit Payable =(5) x 52	$10,400	$10,400	$11,342
Benefits for Injured Worker beyond the Valuation Date				
7.	Factor from Table IIIEF-398	32.644	33.269	30.768
8.	Factor from Table IE-398	28.964	29.676	27.656
9.	Maximum of {(7),[2 x (7) + (8)]/3}, if (8) is n/a then (9) = (7)	32.644	33.269	30.768
10.	Present Value of Future Payment=(6) x (9)	$339,498	$345,998	$348,962
Others				
11.	Payment since 2/05/07	$15,200	$25,600	$35,801
12.	Total Incurred Indemnity Loss = (10) + (11)	$354,698	$371,598	$384,763

Note:
(7), (8): 1st Report factor is from the 9/1/2006 Pension Table, 2nd Report factor is from the 9/1/2008 Pension Table, 3rd Report is from the 9/1/2009 Pension Table.

Cost of Living Adjustments (COLA):
Weekly Benefit Payments are subjected to "Cost of Living Adjustments" (COLA):

1 Increase each October 1, the first escalated benefit starts at the next October 1st following 24 months after the accident date.
2 The supplemental benefit increase shall not exceed the minimum of:
   a. The increase in the State Average Weekly Wage (SAWW)
   b. The increase in the Northeastern region CPI for all urban consumers
   c. 5%.
3 The adjusted benefit is not greater than "three times the base benefit."

		Benefit Reevaluation Date			
	2/5/2007	10/1/2007	10/1/2008	10/1/2009	10/1/2010
SAWW	$1,000.43	$1,043.54	$1,093.27	$1,145.37	$1,199.95
a. Increase in SAWW		4.3%	4.8%	4.8%	4.8%
b. Increase in Northeastern CPI		3.6%	2.6%	2.6%	2.6%
c. 5%		5.0%	5.0%	5.0%	5.0%
Weekly Benefit =	$200.00	$200.00	$200.00	$218.11	$223.79
	Base Benefit			*1st escalated benefit*	

ex. $218.11= $200 x 1.036 x 1.026 x 1.026, to a maximum of $600 (3 times the $200 base benefit)
Note: the increase in the SAWW and Northeastern CPI for the 10/01/2009 and 10/01/2010 benefit reevaluations have been set equal to the values for 10/01/2008.

United States Longshore and Harbor Workers' Act Pension Tables

These tables are used to estimate the present value of pension related indemnity benefits for death and permanent total injuries payable in accordance with the United States Longshore and Harbor Workers' Act ("USL&HW Act"). The values contained in the pension tables are to be used to calculate estimated case reserves for indemnity benefits for death and permanent total injuries for purposes of reporting unit statistical reports (USRs) to the WCRIB

These pension tables are based on USL&HW Act, life expectancies from 1999 United States Life Tables, and the remarriage probabilities from the 1980 United States of America Railroad Retirement Board Remarriage Table. All of the tables assume a 3.5% discount rate and a 4% rate of benefit escalation.

Table Descriptions

UI - USLH: Surviving Spouse
Apply this table for all death claims incurred under the USL&HW Act to estimate the present value of the surviving spouse's benefits, exclusive of any remarriage dowry. This table is derived using female life expectancies and reflects the probability that the surviving spouse remarries.

UII - USLH: Present Value of the Remarriage Dowry
Apply this table to all death claims incurred under the USL&HW Act to estimate the present value of the surviving spouse's remarriage dowry. This table is derived using female life expectancies.

UIIIM – USLH: Male Other than Surviving Spouse
Apply this table to all permanent total claims incurred under the USL&HW Act to estimate the present value of wage losses benefits payable for the balance of a male claimant's life. This table is derived using male life expectancies.

UIIIF – USLH: Female Other than Surviving Spouse
Apply this table to all permanent total claims incurred under the USL&HW Act to estimate the present value of wage losses benefits payable for the balance of a female claimant's life. This table is derived using female life expectancies.

UIV – USLH: Present Value of Survivorship Benefits

Apply this table to all permanent total claims incurred under the USL&HW Act to estimate the present value of survivorship benefits. Note this table applies to surviving spouses of a permanent total disability claimant. This table is derived using female life expectancies and reflects the probability that the surviving spouse remarries.

This table should also be used to estimate the present value of survivorship benefits related to death claims which are payable to someone other than a spouse.

Application of the Tables

Death Claims with a Surviving Spouse
Estimate the present value of survivorship benefits, excluding the remarriage dowry, by using Table UI – USLH (Surviving Spouse). Additionally, estimate the present value of the remarriage dowry using Table UII – USLH (Present Value of Remarriage Dowry).

Death Claims without a Surviving Spouse
Estimate the present value of survivorship benefits by using Table UIV – USLH (Present Value of Survivorship Benefits).

Permanent Total Disability of a Male Claimant
Estimate the present value of wage losses benefits payable for the balance of a male claimant's life by using Table UIIIM – USLH (Male Other than Surviving Spouse). Additionally, upon the death of the employee, survivorship benefits are payable to a survivor and these should be estimated using Table UIV – USLH (Present Value of Survivorship Benefits).

Permanent Total Disability of a Female Claimant
Estimate the present value of wage losses benefits payable for the balance of a female claimant's life by using Table UIIIM – USLH (Female Other than Surviving Spouse). Additionally, upon the death of the employee, survivorship benefits are payable to a survivor and these should be estimated using Table UIV – USLH (Present Value of Survivorship Benefits).

Table UI - USLH
Pension Table - Surviving Spouse
(for Claims Incurred Under U.S.L. & H. W. Act)

Age at Widowhood (x)	- a (x)	- a (x) + 1	- a (x) + 2	- a (x) + 3	- a (x) + 4	- a (x) + 5	Attained Age (x + 5)
16	26.047	27.027	29.921	31.560	32.873	34.031	**21**
17	26.221	27.215	30.137	31.796	33.127	34.302	**22**
18	26.402	27.411	30.362	32.041	33.390	34.584	**23**
19	26.591	27.615	30.596	32.296	33.664	34.876	**24**
20	26.787	27.826	30.838	32.561	33.949	35.180	**25**
21	27.222	28.214	31.192	32.880	34.263	35.496	**26**
22	27.697	28.611	31.531	33.175	34.553	35.791	**27**
23	28.196	29.012	31.855	33.437	34.813	36.059	**28**
24	28.701	29.435	32.202	33.749	35.087	36.296	**29**
25	29.193	29.847	32.534	34.060	35.350	36.507	**30**
26	29.659	30.227	32.827	34.337	35.588	36.700	**31**
27	30.098	30.567	33.074	34.567	35.796	36.883	**32**
28	30.516	30.875	33.282	34.753	35.978	37.059	**33**
29	30.929	31.171	33.477	34.919	36.146	37.232	**34**
30	31.360	31.487	33.692	35.100	36.319	37.400	**35**
31	31.834	31.861	33.968	35.340	36.517	37.556	**36**
32	32.372	32.323	34.341	35.674	36.751	37.688	**37**
33	33.021	32.926	34.814	36.106	37.016	37.779	**38**
34	33.732	33.615	35.355	36.598	37.281	37.809	**39**
35	34.440	34.312	35.886	37.063	37.491	37.761	**40**
36	35.063	34.909	36.301	37.386	37.580	37.621	**41**
37	35.541	35.329	36.528	37.490	37.508	37.385	**42**
38	35.819	35.510	36.511	37.316	37.228	37.053	**43**
39	35.957	35.520	36.323	36.949	36.815	36.630	**44**
40	35.974	35.404	36.012	36.450	36.311	36.120	**45**
41	35.902	35.208	35.624	35.881	35.730	35.529	**46**
42	35.740	34.974	35.204	35.299	35.107	34.865	**47**
43	35.525	34.737	34.785	34.743	34.474	34.140	**48**
44	35.274	34.480	34.354	34.193	33.826	33.363	**49**
45	34.976	34.173	33.887	33.626	33.149	32.545	**50**
46	34.593	33.779	33.354	33.000	32.424	31.696	**51**
47	34.098	33.272	32.732	32.293	31.639	30.826	**52**

1999 United States Life Table for the Female Population

Table UI - USLH
Pension Table - Surviving Spouse
(for Claims Incurred Under U.S.L. & H. W. Act)

Age at Widowhood (x)	- a (x)	- a (x) + 1	- a (x) + 2	- a (x) + 3	- a (x) + 4	- a (x) + 5	Attained Age (x + 5)
48	33.467	32.625	31.997	31.478	30.769	29.943	**53**
49	32.781	31.915	31.225	30.633	29.889	29.054	**54**
50	32.048	31.157	30.424	29.771	29.005	28.167	**55**
51	31.272	30.365	29.604	28.902	28.125	27.287	**56**
52	30.458	29.549	28.771	28.034	27.250	26.418	**57**
53	29.615	28.708	27.928	27.171	26.385	25.559	**58**
54	28.761	27.859	27.080	26.314	25.531	24.711	**59**
55	27.901	27.007	26.232	25.464	24.685	23.872	**60**
56	27.043	26.157	25.387	24.621	23.848	23.044	**61**
57	26.191	25.314	24.550	23.787	23.022	22.227	**62**
58	25.346	24.478	23.719	22.962	22.205	21.420	**63**
59	24.507	23.648	22.897	22.147	21.398	20.625	**64**
60	23.676	22.827	22.086	21.342	20.602	19.839	**65**
61	22.856	22.019	21.286	20.548	19.815	19.063	**66**
62	22.049	21.223	20.498	19.767	19.038	18.295	**67**
63	21.261	20.443	19.723	18.997	18.272	17.537	**68**
64	20.488	19.676	18.959	18.237	17.516	16.788	**69**
65	19.722	18.918	18.203	17.486	16.770	16.049	**70**
66	18.956	18.161	17.454	16.743	16.033	15.319	**71**
67	18.204	17.421	16.713	16.009	15.304	14.598	**72**
68	17.453	16.683	15.981	15.283	14.584	13.887	**73**
69	16.711	15.957	15.259	14.567	13.876	13.191	**74**
70	15.980	15.240	14.547	13.861	13.181	12.511	**75**
71	15.259	14.532	13.846	13.170	12.503	11.847	**76**
72	14.547	13.833	13.157	12.494	11.841	11.199	**77**
73	13.844	13.147	12.484	11.834	11.194	10.567	**78**
74	13.155	12.475	11.826	11.189	10.563	9.954	**79**
75	12.480	11.817	11.181	10.559	9.950	9.362	**80**
76	11.821	11.173	10.552	9.947	9.359	8.792	**81**
77	11.177	10.545	9.941	9.356	8.791	8.247	**82**
78	10.548	9.935	9.351	8.788	8.246	7.728	**83**
79	9.937	9.346	8.784	8.243	7.727	7.240	**84**

1999 United States Life Table for the Female Population

Table UI - USLH
Pension Table - Surviving Spouse
(for Claims Incurred Under U.S.L. & H. W. Act)

Age at Widowhood (x)	- a (x)	- a (x) + 1	- a (x) + 2	- a (x) + 3	- a (x) + 4	- a (x) + 5	Attained Age (x + 5)
80	9.349	8.780	8.240	7.725	7.239	6.784	**85**
81	8.783	8.238	7.723	7.237	6.783	6.354	**86**
82	8.241	7.723	7.236	6.782	6.354	5.951	**87**
83	7.725	7.236	6.782	6.353	5.951	5.573	**88**
84	7.238	6.782	6.353	5.950	5.573	5.219	**89**
85	6.782	6.353	5.950	5.573	5.219	4.889	**90**
86	6.353	5.950	5.572	5.219	4.889	4.580	**91**
87	5.950	5.572	5.219	4.889	4.580	4.293	**92**
88	5.572	5.218	4.888	4.580	4.293	4.025	**93**
89	5.218	4.888	4.580	4.292	4.025	3.775	**94**
90	4.888	4.580	4.292	4.024	3.774	3.541	**95**
91	4.580	4.292	4.024	3.774	3.541	3.322	**96**
92	4.292	4.024	3.774	3.541	3.322	3.116	**97**
93	4.024	3.774	3.540	3.322	3.116	2.920	**98**
94	3.774	3.540	3.322	3.116	2.919	2.730	**99**
95	3.540	3.322	3.116	2.919	2.730	2.542	**100**
96	3.322	3.116	2.919	2.729	2.542	2.387	**101**
97	3.116	2.919	2.729	2.541	2.387	2.240	**102**
98	2.919	2.729	2.541	2.387	2.240	2.093	**103**
99	2.729	2.541	2.387	2.240	2.093	1.951	**104**
100	2.541	2.387	2.239	2.093	1.951	1.812	**105**
101	2.387	2.240	2.093	1.951	1.812	1.662	**106**
102	2.240	2.093	1.951	1.812	1.662	1.487	**107**
103	2.093	1.951	1.812	1.662	1.487	1.275	**108**
104	1.951	1.812	1.662	1.487	1.275	0.964	**109**
105	1.812	1.662	1.487	1.275	0.964	0.500	**110**
106	1.662	1.487	1.275	0.964	0.500	0.000	**111**
107	1.487	1.275	0.964	0.500	0.000	0.000	**112**
108	1.275	0.964	0.500	0.000	0.000	0.000	**113**
109	0.964	0.500	0.000	0.000	0.000	0.000	**114**
110	0.500	0.000	0.000	0.000	0.000	0.000	**115**

1999 United States Life Table for the Female Population
1980 United States of America Railroad Retirement Board Remarriage Table
Annual Rate of Interest = 3.5%
Annual Rate of Escalation = 4.0%

For durations beyond 5 years from death of claimant, use the annuity value in the column for age (x + 5) corresponding to the beneficiary's attained age.

Table UII - USLH
Present Value of Remarriage Dowry
(for Claims Incurred Under U.S.L. & H. W. Act)

Age at Widowhood (x)	- a (x)	- a (x) + 1	- a (x) + 2	- a (x) + 3	- a (x) + 4	- a (x) + 5	Attained Age (x + 5)
16	0.7847	0.7634	0.7240	0.6947	0.6675	0.6408	**21**
17	0.7729	0.7508	0.7096	0.6790	0.6506	0.6228	**22**
18	0.7608	0.7377	0.6946	0.6626	0.6330	0.6041	**23**
19	0.7482	0.7241	0.6790	0.6457	0.6148	0.5847	**24**
20	0.7351	0.7101	0.6629	0.6281	0.5959	0.5645	**25**
21	0.7189	0.6935	0.6449	0.6093	0.5761	0.5436	**26**
22	0.7017	0.6763	0.6265	0.5902	0.5560	0.5224	**27**
23	0.6836	0.6584	0.6078	0.5710	0.5357	0.5009	**28**
24	0.6646	0.6396	0.5881	0.5506	0.5146	0.4792	**29**
25	0.6451	0.6202	0.5680	0.5295	0.4930	0.4574	**30**
26	0.6252	0.6006	0.5478	0.5083	0.4713	0.4351	**31**
27	0.6049	0.5809	0.5276	0.4871	0.4493	0.4125	**32**
28	0.5843	0.5611	0.5075	0.4661	0.4272	0.3894	**33**
29	0.5630	0.5409	0.4870	0.4448	0.4047	0.3658	**34**
30	0.5406	0.5196	0.4656	0.4227	0.3816	0.3416	**35**
31	0.5167	0.4967	0.4426	0.3990	0.3574	0.3171	**36**
32	0.4907	0.4714	0.4171	0.3729	0.3320	0.2924	**37**
33	0.4617	0.4427	0.3890	0.3443	0.3053	0.2680	**38**
34	0.4304	0.4113	0.3586	0.3135	0.2778	0.2442	**39**
35	0.3979	0.3786	0.3274	0.2823	0.2506	0.2214	**40**
36	0.3659	0.3466	0.2974	0.2529	0.2252	0.2000	**41**
37	0.3358	0.3171	0.2704	0.2271	0.2025	0.1803	**42**
38	0.3089	0.2918	0.2478	0.2067	0.1838	0.1623	**43**
39	0.2843	0.2695	0.2284	0.1901	0.1678	0.1460	**44**
40	0.2616	0.2493	0.2114	0.1763	0.1536	0.1316	**45**
41	0.2402	0.2304	0.1958	0.1640	0.1411	0.1190	**46**
42	0.2201	0.2118	0.1807	0.1519	0.1296	0.1080	**47**
43	0.2005	0.1926	0.1650	0.1390	0.1181	0.0985	**48**
44	0.1810	0.1732	0.1493	0.1257	0.1070	0.0905	**49**
45	0.1619	0.1544	0.1340	0.1125	0.0964	0.0836	**50**
46	0.1444	0.1372	0.1200	0.1006	0.0870	0.0777	**51**
47	0.1294	0.1226	0.1082	0.0908	0.0794	0.0725	**52**

1999 United States Life Table for the Female Population

Table UII - USLH
Present Value of Remarriage Dowry
(for Claims Incurred Under U.S.L. & H. W. Act)

Age at Widowhood (x)	- a (x)	- a (x) + 1	- a (x) + 2	- a (x) + 3	- a (x) + 4	- a (x) + 5	Attained Age (x + 5)
48	0.1180	0.1117	0.0995	0.0842	0.0743	0.0680	**53**
49	0.1078	0.1023	0.0918	0.0785	0.0697	0.0638	**54**
50	0.0989	0.0942	0.0850	0.0734	0.0654	0.0599	**55**
51	0.0912	0.0872	0.0789	0.0688	0.0613	0.0561	**56**
52	0.0847	0.0809	0.0733	0.0644	0.0574	0.0523	**57**
53	0.0792	0.0756	0.0682	0.0602	0.0535	0.0485	**58**
54	0.0742	0.0708	0.0635	0.0561	0.0496	0.0448	**59**
55	0.0697	0.0664	0.0593	0.0522	0.0458	0.0411	**60**
56	0.0654	0.0622	0.0552	0.0483	0.0420	0.0374	**61**
57	0.0613	0.0582	0.0513	0.0446	0.0383	0.0338	**62**
58	0.0574	0.0544	0.0475	0.0409	0.0347	0.0302	**63**
59	0.0536	0.0506	0.0438	0.0373	0.0312	0.0267	**64**
60	0.0499	0.0470	0.0402	0.0339	0.0279	0.0234	**65**
61	0.0462	0.0434	0.0366	0.0305	0.0246	0.0202	**66**
62	0.0424	0.0398	0.0331	0.0271	0.0215	0.0172	**67**
63	0.0384	0.0359	0.0294	0.0237	0.0185	0.0145	**68**
64	0.0341	0.0320	0.0259	0.0205	0.0156	0.0120	**69**
65	0.0300	0.0282	0.0225	0.0174	0.0131	0.0099	**70**
66	0.0265	0.0250	0.0194	0.0147	0.0109	0.0081	**71**
67	0.0229	0.0215	0.0167	0.0125	0.0091	0.0067	**72**
68	0.0200	0.0187	0.0144	0.0106	0.0077	0.0056	**73**
69	0.0173	0.0161	0.0123	0.0090	0.0065	0.0047	**74**
70	0.0149	0.0138	0.0105	0.0076	0.0055	0.0039	**75**
71	0.0127	0.0117	0.0088	0.0064	0.0045	0.0032	**76**
72	0.0108	0.0099	0.0074	0.0053	0.0038	0.0027	**77**
73	0.0092	0.0083	0.0062	0.0044	0.0031	0.0022	**78**
74	0.0078	0.0071	0.0052	0.0037	0.0026	0.0018	**79**
75	0.0068	0.0061	0.0044	0.0030	0.0021	0.0014	**80**
76	0.0058	0.0052	0.0037	0.0025	0.0017	0.0011	**81**
77	0.0050	0.0045	0.0031	0.0020	0.0013	0.0009	**82**
78	0.0043	0.0039	0.0026	0.0017	0.0011	0.0008	**83**
79	0.0037	0.0033	0.0022	0.0014	0.0009	0.0006	**84**

1999 United States Life Table for the Female Population

Table UII - USLH
Present Value of Remarriage Dowry
(for Claims Incurred Under U.S.L. & H. W. Act)

Age at Widowhood (x)	- a (x)	- a (x) + 1	- a (x) + 2	- a (x) + 3	- a (x) + 4	- a (x) + 5	Attained Age (x + 5)
80	0.0030	0.0027	0.0018	0.0012	0.0008	0.0005	**85**
81	0.0024	0.0022	0.0015	0.0010	0.0007	0.0004	**86**
82	0.0018	0.0016	0.0011	0.0008	0.0005	0.0004	**87**
83	0.0013	0.0012	0.0008	0.0006	0.0004	0.0003	**88**
84	0.0009	0.0008	0.0006	0.0004	0.0003	0.0003	**89**
85	0.0008	0.0007	0.0005	0.0004	0.0003	0.0002	**90**
86	0.0007	0.0006	0.0005	0.0003	0.0002	0.0002	**91**
87	0.0006	0.0006	0.0004	0.0003	0.0002	0.0002	**92**
88	0.0005	0.0005	0.0004	0.0003	0.0002	0.0001	**93**
89	0.0005	0.0005	0.0003	0.0002	0.0002	0.0001	**94**
90	0.0004	0.0004	0.0003	0.0002	0.0002	0.0001	**95**
91	0.0004	0.0004	0.0003	0.0002	0.0001	0.0001	**96**
92	0.0004	0.0003	0.0002	0.0002	0.0001	0.0001	**97**
93	0.0003	0.0003	0.0002	0.0002	0.0001	0.0001	**98**
94	0.0003	0.0003	0.0002	0.0002	0.0001	0.0000	**99**
95	0.0003	0.0003	0.0002	0.0002	0.0001	0.0000	**100**
96	0.0002	0.0002	0.0002	0.0002	0.0001	0.0000	**101**
97	0.0002	0.0002	0.0002	0.0002	0.0001	0.0000	**102**
98	0.0002	0.0002	0.0002	0.0001	0.0001	0.0000	**103**
99	0.0002	0.0002	0.0002	0.0001	0.0001	0.0000	**104**
100	0.0002	0.0002	0.0002	0.0001	0.0001	0.0000	**105**
101	0.0001	0.0002	0.0002	0.0001	0.0001	0.0000	**106**
102	0.0001	0.0002	0.0002	0.0001	0.0001	0.0000	**107**
103	0.0001	0.0001	0.0002	0.0001	0.0001	0.0000	**108**
104	0.0001	0.0001	0.0001	0.0001	0.0001	0.0000	**109**
105	0.0001	0.0001	0.0001	0.0001	0.0001	0.0000	**110**

1999 United States Life Table for the Female Population
1980 United States of America Railroad Retirement Board Remarriage Table
Annual Rate of Interest = 3.5%
Annual Rate of Escalation = 4.0%

For durations beyond 5 years from death of claimant, use the annuity value in the column for age (x + 5) corresponding to the beneficiary's attained age.

Table UIIIM - USLH
Male – Pension Table Other than Surviving Spouse
(for Claims Incurred Under U.S.L. & H. W. Act)

Age	- a	Age	- A	Age	- a	Age	- a
11	75.314	**40**	40.351	**69**	14.047	**98**	2.568
12	73.964	**41**	39.262	**70**	13.387	**99**	2.419
13	72.624	**42**	38.184	**71**	12.747	**100**	2.268
14	71.301	**43**	37.115	**72**	12.123		
15	69.995	**44**	36.059	**73**	11.516		
16	68.708	**45**	35.013	**74**	10.926		
17	67.438	**46**	33.981	**75**	10.353		
18	66.183	**47**	32.961	**76**	9.796		
19	64.940	**48**	31.954	**77**	9.253		
20	63.706	**49**	30.957	**78**	8.724		
21	62.482	**50**	29.971	**79**	8.211		
22	61.268	**51**	28.995	**80**	7.718		
23	60.061	**52**	28.030	**81**	7.249		
24	58.860	**53**	27.076	**82**	6.806		
25	57.661	**54**	26.136	**83**	6.392		
26	56.465	**55**	25.211	**84**	6.003		
27	55.273	**56**	24.303	**85**	5.635		
28	54.083	**57**	23.412	**86**	5.290		
29	52.900	**58**	22.538	**87**	4.968		
30	51.722	**59**	21.681	**88**	4.666		
31	50.551	**60**	20.840	**89**	4.385		
32	49.387	**61**	20.014	**90**	4.122		
33	48.229	**62**	19.205	**91**	3.878		
34	47.080	**63**	18.414	**92**	3.651		
35	45.937	**64**	17.641	**93**	3.439		
36	44.803	**65**	16.887	**94**	3.242		
37	43.677	**66**	16.150	**95**	3.058		
38	42.559	**67**	15.430	**96**	2.885		
39	41.450	**68**	14.728	**97**	2.723		

1999 United States Life Table for the Male Population
Annual Rate of Interest = 3.5%
Annual Rate of Escalation = 4.0%

Table UIIIF - USLH
Female – Pension Table Other than Surviving Spouse
(for Claims Incurred Under U.S.L. & H. W. Act)

Age	- a	Age	- A	Age	- a	Age	- a
11	82.580	**40**	45.719	**69**	16.950	**98**	2.916
12	81.196	**41**	44.566	**70**	16.176	**99**	2.725
13	79.819	**42**	43.423	**71**	15.418	**100**	2.535
14	78.453	**43**	42.289	**72**	14.675		
15	77.098	**44**	41.164	**73**	13.948		
16	75.755	**45**	40.048	**74**	13.239		
17	74.422	**46**	38.942	**75**	12.549		
18	73.099	**47**	37.845	**76**	11.877		
19	71.783	**48**	36.760	**77**	11.222		
20	70.474	**49**	35.684	**78**	10.585		
21	69.170	**50**	34.619	**79**	9.967		
22	67.871	**51**	33.564	**80**	9.372		
23	66.580	**52**	32.521	**81**	8.800		
24	65.294	**53**	31.490	**82**	8.252		
25	64.015	**54**	30.470	**83**	7.733		
26	62.742	**55**	29.464	**84**	7.243		
27	61.476	**56**	28.472	**85**	6.786		
28	60.217	**57**	27.495	**86**	6.356		
29	58.965	**58**	26.533	**87**	5.952		
30	57.720	**59**	25.585	**88**	5.574		
31	56.482	**60**	24.651	**89**	5.220		
32	55.251	**61**	23.732	**90**	4.889		
33	54.029	**62**	22.829	**91**	4.580		
34	52.815	**63**	21.942	**92**	4.292		
35	51.611	**64**	21.071	**93**	4.024		
36	50.415	**65**	20.216	**94**	3.774		
37	49.228	**66**	19.376	**95**	3.539		
38	48.049	**67**	18.551	**96**	3.320		
39	46.880	**68**	17.742	**97**	3.113		

1999 United States Life Table for the Female Population
Annual Rate of Interest = 3.5%
Annual Rate of Escalation = 4.0%

Table UIV - USLH
Present Value of Survivorship Benefits
(for Claims Incurred Under U.S.L. & H. W. Act)
Age Difference (Spouse's Age minus Claimant's Age)

Claimant's Age	-5	-4	-3	-2	-1	-0
16						10.877
17					11.497	10.819
18				12.138	11.436	10.761
19			12.798	12.073	11.374	10.701
20		13.477	12.730	12.008	11.312	10.641
21	14.172	13.406	12.663	11.943	11.249	10.581
22	14.098	13.336	12.595	11.878	11.186	10.519
23	14.025	13.265	12.527	11.812	11.122	10.457
24	13.952	13.195	12.458	11.745	11.057	10.395
25	13.879	13.124	12.390	11.679	10.993	10.332
26	13.806	13.053	12.321	11.612	10.928	10.269
27	13.733	12.983	12.253	11.546	10.864	10.207
28	13.660	12.912	12.184	11.479	10.799	10.144
29	13.587	12.840	12.115	11.412	10.734	10.081
30	13.512	12.768	12.045	11.344	10.669	10.018
31	13.438	12.696	11.974	11.276	10.602	9.953
32	13.362	12.622	11.903	11.207	10.535	9.888
33	13.285	12.548	11.831	11.136	10.466	9.821
34	13.208	12.472	11.757	11.064	10.396	9.752
35	13.128	12.395	11.682	10.991	10.324	9.682
36	13.048	12.316	11.604	10.915	10.250	9.609
37	12.965	12.235	11.525	10.837	10.174	9.534
38	12.881	12.152	11.444	10.757	10.095	9.457
39	12.794	12.066	11.359	10.674	10.014	9.378
40	12.704	11.978	11.272	10.589	9.930	9.296
41	12.611	11.886	11.181	10.500	9.843	9.211
42	12.514	11.791	11.088	10.408	9.753	9.123
43	12.414	11.692	10.991	10.313	9.660	9.032
44	12.310	11.590	10.891	10.215	9.564	8.938
45	12.202	11.484	10.787	10.113	9.465	8.841
46	12.090	11.374	10.679	10.007	9.361	8.740
47	11.974	11.259	10.566	9.897	9.253	8.634

1999 United States Life Table for the Total Population and the Female Population

Table UIV - USLH
Present Value of Survivorship Benefits
(for Claims Incurred Under U.S.L. & H. W. Act)
Age Difference (Spouse's Age minus Claimant's Age)

Claimant's Age	-5	-4	-3	-2	-1	-0
48	11.852	11.140	10.449	9.782	9.141	8.525
49	11.727	11.017	10.329	9.664	9.026	8.414
50	11.598	10.890	10.204	9.543	8.908	8.300
51	11.465	10.759	10.077	9.419	8.788	8.184
52	11.327	10.625	9.946	9.292	8.665	8.065
53	11.186	10.487	9.812	9.163	8.540	7.944
54	11.039	10.345	9.674	9.029	8.411	7.820
55	10.888	10.198	9.532	8.891	8.278	7.693
56	10.730	10.045	9.383	8.748	8.141	7.561
57	10.565	9.886	9.230	8.600	7.999	7.425
58	10.395	9.720	9.070	8.447	7.852	7.284
59	10.219	9.551	8.907	8.291	7.702	7.140
60	10.039	9.378	8.741	8.131	7.548	6.992
61	9.856	9.201	8.571	7.967	7.391	6.841
62	9.668	9.020	8.397	7.800	7.230	6.687
63	9.475	8.834	8.218	7.628	7.065	6.529
64	9.277	8.643	8.034	7.451	6.896	6.367
65	9.074	8.448	7.847	7.271	6.723	6.200
66	8.868	8.250	7.656	7.088	6.546	6.031
67	8.659	8.048	7.462	6.901	6.367	5.859
68	8.445	7.842	7.263	6.710	6.183	5.683
69	8.226	7.631	7.060	6.514	5.996	5.504
70	8.001	7.414	6.851	6.314	5.804	5.321
71	7.771	7.193	6.638	6.110	5.609	5.135
72	7.538	6.969	6.424	5.905	5.413	5.013
73	7.303	6.743	6.207	5.698	5.291	4.906
74	7.064	6.514	5.988	5.577	5.186	4.724
75	6.822	6.282	5.868	5.473	4.994	4.542
76	6.577	6.164	5.768	5.271	4.802	4.361
77	6.464	6.071	5.558	5.072	4.614	4.183
78	6.381	5.851	5.349	4.875	4.427	4.007
79	6.150	5.633	5.142	4.679	4.242	3.834

1999 United States Life Table for the Total Population and the Female Population

Table UIV - USLH
Present Value of Survivorship Benefits
(for Claims Incurred Under U.S.L. & H. W. Act)
Age Difference (Spouse's Age minus Claimant's Age)

Claimant's Age	-5	-4	-3	-2	-1	-0
80	5.919	5.414	4.934	4.482	4.059	3.664
81	5.686	5.192	4.725	4.286	3.876	3.496
82	5.448	4.967	4.514	4.090	3.695	3.330
83	5.206	4.740	4.302	3.894	3.515	3.167
84	4.962	4.511	4.090	3.699	3.338	3.007
85	4.716	4.283	3.879	3.506	3.164	2.853
86	4.472	4.057	3.673	3.320	2.998	2.704
87	4.232	3.838	3.474	3.142	2.838	2.560
88	3.999	3.626	3.285	2.971	2.684	2.423
89	3.775	3.425	3.102	2.807	2.537	2.291
90	3.562	3.232	2.928	2.650	2.396	2.165
91	3.358	3.047	2.761	2.500	2.262	2.045
92	3.163	2.871	2.603	2.358	2.135	1.931
93	2.978	2.703	2.452	2.223	2.014	1.824
94	2.802	2.545	2.310	2.095	1.899	1.721
95	2.635	2.395	2.175	1.974	1.791	1.623
96	2.479	2.254	2.048	1.860	1.688	1.530
97	2.332	2.122	1.929	1.752	1.590	1.440
98	2.196	1.999	1.818	1.652	1.498	1.354
99	2.071	1.886	1.716	1.558	1.411	1.273
100	1.960	1.786	1.624	1.473	1.331	1.197
101	1.842	1.677	1.523	1.378	1.241	1.127
102	1.730	1.573	1.425	1.285	1.168	1.058
103	1.624	1.473	1.329	1.210	1.097	0.988
104	1.520	1.373	1.252	1.136	1.025	0.918
105	1.420	1.295	1.178	1.063	0.953	0.845

1999 United States Life Table for the Total Population and the Female Population
Remarriage rates based on the 1980 United States of America Railroad Retirement Board Remarriage Table
Annual Rate of Interest = 3.5%
Annual Rate of Escalation = 4.0%

For durations beyond 5 years from death of claimant, use the annuity value in the column for age (x + 5) corresponding to the beneficiary's attained age.

Example - Fatal Claim - USL&H
Usage of: Surviving Spouse's Pension Table (Table UI-USLH) & Remarriage Dowry (Table UII-USLH)

Calculation of incurred loss to be reported when benefits are payable to a surviving spouse until death or remarriage, due to a fatal injury occurring after December 23, 1991.

Accident Date	9/16/1997	Policy Effective Date:	1/1/1997
Date of Death:	9/16/1997	Spouse's Birthdate:	2/18/1965
Weekly Wages:	$500		

Calculation		**1st Report**	**2nd Report**	**3rd Report**
1.	Valuation Date	7/1998	7/1999	7/2000
2.	Spouse's age nearest accident date	33	33	33
3.	Duration since death date (to nearest year), t.	0	1	2
4.	Weekly Benefit Payable = (50%) x Wkly Wages x Escalation	$260	$270	$281
5.	Annual Benefit Payable =(4) x 52	$13,520	$14,040	$14,612
6.	Factor from Table UI-USLH	33.021	32.926	34.814
7.	Present Value of Future Payment=(5) x (6)	$446,444	$462,281	$508,702
	…….			
Others				
8.	Two Year Remarriage Payment = (5) x 2	$27,040	$28,080	$29,224
9.	Factor from Table UII-USLH	0.4617	0.4427	0.3890
10.	Present Value of Future Remarriage Payments=(8) x (9)	$12,484	$12,431	$11,368
11.	Payment since 9/17/1997 …….	$10,510	$24,290	$38,632
12.	Funeral Allowance	$2,000	$2,000	$2,000
13.	Total Incurred Indemnity Loss = (7) + (10) + (11) + (12)	$471,438	$501,002	$560,702
	…….			

Escalation Rate 0.04

Example - USL&H
Other than Surviving Spouse Pension Table (Table UIIIM-USLH) & Survivorship Benefits (Table UIV-USLH)

Calculation of incurred loss to be reported when benefits are escalated annually payable for life to an injured employee due to a permanent total disability and when, upon death of the employee, benefits are payable to the surviving spouse.

Accident Date	5/30/1997	Policy Effective Date:	1/1/1997
Weekly Wages:	$300	Injured worker's Birthdate:	10/21/1963
		Spouse's Birthdate:	7/16/1965

Calculation		**1st Report**	**2nd Report**	**3rd Report**
1.	Valuation Date	7/1998	7/1999	7/2000
2.	Injured worker's age nearest valuation date	35	36	38
3.	Difference in ages (Spouse - employee)	-2	-2	-2
4.	Weekly Benefit Payable = (66 2/3%) x WW x Escalation	$208	$216	$225
5.	Annual Benefit Payable =(4) x 52	$10,816	$11,232	$11,700
6.	Factor from Table UIIIM-USLH	45.937	44.803	43.677
7.	Present Value of Future Payment=(5) x (6)	$496,855	$503,227	$511,021
	…….			
Others				
8.	Initial annual survivorship benefit (WW x 50% x 52 weeks)	$7,800	$7,800	$7,800
9.	Factor from Table UIV-USLH	10.991	10.915	10.837
10.	Present Value of Future Remarriage Payments=(8) x (9)	$85,730	$85,137	$84,529
11.	Payment since 5/30/1997 …….	$11,408	$22,432	$33,916
12.	Total Incurred Indemnity Loss = (7) + (10) + (11) …….	$593,992	$610,796	$629,466

Escalation Rate 0.04

RESERVED FOR FUTURE USE

PART I

UNIT STATISTICAL REPORTING

SECTION X

ELECTRONIC REPORTING INSTRUCTIONS

SECTION X – ELECTRONIC REPORTING INSTRUCTIONS

A. General Submission Requirements

1. ***The required data, valid codes, and reporting requirements are contained within Part I of this Statistical Plan. The Massachusetts Workers' Compensation Statistical Plan must always be followed for reporting requirements and code values.***

2. ***Data file formats are found in the WCIO Data Specifications Manual, at www.wcio.org.***
    a. ***The Workers' Compensation Insurance Organization (WCIO) consists of several workers' compensation data collection and rating organizations. The Electronic Data Interchange (EDI) Committee, a subcommittee of the WCIO which includes insurance company representatives, is responsible for the maintenance of the Data Specifications Manual. The committee meets twice a year to maintain and improve the record formats and manual.***
    b. ***Revisions necessary for Massachusetts reporting are brought before the committee for manual updates to reflect such changes.***

3. ***Data may be submitted to the WCRIB via various electronic media. The acceptable media can be found in the Data Reporting Area of the WCRIB's web site, www.wcribma.org .***

B. Carrier Transmittal Record

1. General

A Record of Transmittal is completed by the carrier and is submitted along with each submission. Data Providers must report transmittal information as an electronic record within the submission file. Should the transmittal record not be included in the submission, all material will be returned to the carrier.

The transmittal record provides the Bureau with general information on the unit report data being submitted as well as the data processing specifications.

The carrier's transmittal record is also used as a control device to acknowledge the receipt of the submission.

Refer to the WCIO Data Specification Manual for the transmittal record.

PART I

UNIT STATISTICAL REPORTING

SECTION XI

DATA QUALITY INCENTIVE PROGRAM

A. Introduction

The Data Quality Incentive Program was developed in response to an order of the Commissioner of Insurance to ensure that unit statistical data is reported promptly and accurately as required by this Plan. A committee of Bureau staff and several carrier representatives worked to modify other jurisdictions' existing plans to suit the needs of Massachusetts.

The Data Quality Incentive Program does not apply to workers' compensation self-insurance groups. Please note that separate Data Quality ***Compliance Programs*** ***apply*** to aggregate financial reporting, Part II Section V of this Plan.

B. Accuracy of Unit Statistical Data

Edit failures that are sufficient to prevent accurate experience rating or inclusion in the unit statistical data summary will not be accepted by the Bureau. Notification that data has failed edits and reason for failure is available the day following the processing of the submission. The rejected data will be subject to timeliness fines if applicable. (See Timeliness of Unit Statistical Data below)

The data submitting carrier must provide documentation and a written explanation to the Statistical Data Services Supervisor if the Bureau has indicated a unit correction is needed, but the carrier records support the unit data as filed.

The Bureau will advise carriers annually by circular letter of those edits that will cause unit statistical reports to be rejected.

C. Timeliness of Coverage Data

Units without Corresponding Policy Reports

Unit statistical data, for which there is no corresponding, previously submitted policy in the Bureau's Policy Database will be rejected by the Bureau. A data provider's failure to submit the appropriate policy and coverage data prior to submission of the unit statistical report (USR) will delay promulgation of the experience rating modification.

Unit reports that are rejected due to missing policy information are subject to fine if the policy information is not successfully submitted and the unit report is not accepted, or not otherwise resolved, before the 21st month from the policy effective date.

The fines will be $100 per month, for 6 consecutive months. The fines then increase to $200 per month thereafter.

Only missing policy and coverage data that prevents the acceptance of unit statistical reports will be subject to fines through the Unit Statistical Data Quality Incentive Program.

Timeliness Example: A unit report corresponding to a policy effective any day during January, 2007, is rejected due to missing policy information. If the policy is not successfully submitted and the unit report is not accepted or not otherwise resolved by the end of the 20th month following the policy effective date, the carrier will incur the first fine in the 21st month, October, 2008, and will be fined each subsequent month until resolution.

D. Timeliness of Unit Statistical Data

The timeliness of unit statistical reporting is measured in relation to the corresponding policy's effective date, so reporting and penalty determinations will be based on the number of months past the policy effective date of the unit. "Postings" as used in this section may be made through web-based postings or electronic files. The posting shall include policy data corresponding to the unit report. Posted information includes policy number, policy effective date, end of coverage date, carrier code, and exposure state.

1. Unit Reports -- Pre-delinquent

A "pre-delinquent" unit report is a unit report that is less than 18 months past the end of the month in which the corresponding policy became effective. The report is called "pre-delinquent" because it is an expected report that is not yet due. The Bureau will notify the carriers by posting corresponding policy data for pre-delinquent unit reports upon receipt of the policy data. Carriers have the option to review the pre-delinquent postings at any time during the period from policy issuance to first valuation of the losses. Carriers can minimize the risk of fines by reviewing their pre-delinquent unit reports to ensure that the policy number, policy effective date, end of coverage date, and carrier codes are accurate. If a policy or coverage transaction corresponding to a pre-delinquent unit report is absent from the Bureau's Policy Database the carrier may submit the corresponding policy or coverage information to the Bureau.

There will be no obligation for carriers to respond to the pre-delinquent unit report status. However, the appropriate response and corrective action may prevent an overdue unit report and fines. Coverage verification issues can be corrected only with the appropriate coverage transactions.

The Bureau will notify the carrier if the corrective action did not resolve the unit report issue.

Timeliness Example: If a policy in the Bureau's policy database has an effective date of any day in January ***2007***, then the Bureau posts the corresponding pre-delinquent unit report data as the policy data is processed by the Bureau.

2. Unit Reports -- Due

A "due" unit report is a unit report that is between 18 and 20 months past the end of the month in which the corresponding policy became effective. The report is called "due" because it is valued and reported during this 18 to 20 month period past the end of the month in which the corresponding policy became effective.

Timeliness Example: If a policy in the Bureau's policy database has an effective date of any day in January 2007, then the Bureau posts the corresponding due unit report data in July 2008.

3. Unit Reports –Delinquent and Subject to Fine

A "delinquent and subject to fine" unit report is a unit report that has not been successfully submitted to the Bureau and is more than 20 months past the end of the month in which the corresponding policy became effective. Delinquent USRs will be fined in the 21st month and each month thereafter, until the unit report is successfully submitted or the delinquent and subject to fine status is otherwise resolved.

The fines will be $100 per month, for 6 consecutive months. The fines then increase to $200 per month thereafter.

It is possible for a unit report to make its initial posting under delinquent status, with no prior posting under pre-delinquent or due status. The unit report status for policies received after the 20th month will appear as delinquent.

Please note that corrective action following notification that the unit report is subject to a fine may prevent additional penalties but will not eliminate the penalty charge already incurred.

If corrective action was taken based on a prior fine or overdue notification and the carrier was not notified of a problem with the correction, the carrier should contact the Bureau in accordance with the appeals process outlined in Section E.

Timeliness Example (effective for data due September, 2009): A unit report corresponding to a policy effective any day during January, 2007, but that has not been successfully submitted to the Bureau, is posted with due status in July, 2008. If the USR is not successfully submitted or other resolution reached, or corrective action is not received by the end of the 20th month, the carrier will incur the first fine in the 21st month, October, 2008, and will be fined each subsequent month until resolution.

4. Correction Reports – Rejected and Subject to Fine (data due September, 2009)

Correction reports which remain in rejected status for three (3) months, following the last day of the month in which the unit was rejected, will be fined at a rate of $100 per month, for 6 consecutive months. The fines then increase to $200 per month, thereafter.

Timeliness Example (effective for data due September, 2009): A USR correction report is received at the Bureau on any day in January, 2010 and is rejected by the Bureau. If the rejected correction is not resolved by the reporting carrier, within the 3 months following the month in which the unit was rejected, (February, March, April) the carrier will incur the first fine on May 1, 2010 and will be fined each subsequent month until resolution.

5. Disciplinary Fines

A series of disciplinary fines will be issued in correlation to the Annual Summary review Any data which is missing, rejected, or filtered from the Summary will be excluded from the data reconciliation process. Carrier groups will be subject to fines on data that remains missing, rejected, or filtered as of ***October 1st*** of that review year and each month thereafter until the acceptable threshold is met.

Any data which remains missing, rejected, or filtered will count against the overall data expected to be included in ***the summary*** for that carrier group. Carrier groups, who have more than 10 unit reports and more than 1% of their overall data excluded from ***the summary***, will be fined each month until they reach the 1% or ***the*** less than 10 unit report threshold. A carrier group will be subject to a disciplinary fine of $500 per unit report with a maximum cap of $50,000 fined each month.

Example: If a carrier group has 10,000 units expected to be included in ***the summary***, and 200 units, or 2%, are either missing, rejected or filtered, the

carrier would be fined each month until 100 or fewer units are missing, rejected or filtered.

[redacted]

[redacted]

E. Appeal of Penalties Levied under the Data Quality Incentive Program (effective immediately)

If the carrier or carrier group is subject to a fine, which in the opinion of the carrier is inappropriate, the carrier group is encouraged to work with the staff of the Statistical Data Services Department to address such issues. Carrier groups may also submit a written appeal to the Statistical Data Services Department at the following address:

Statistical Data Services Department
WCRIBMA
101 Arch Street, 5th Floor
Boston, MA 02110

The written appeal must be submitted by an officer or senior manager of the carrier group within twenty (20) business days of the Invoice Date on the invoice for the particular fine(s) at issue. The appeal should include copies of the relevant invoice(s), all pertinent written communications and detailed statements that describe why the carrier thinks the fine(s) is inappropriate. The Bureau will provide the carrier with its written decision on the carrier's appeal within twenty (20) business days of its receipt of the appeal.

If the carrier group is not satisfied with the Bureau's decision, it may appeal to the Commissioner of Insurance. Such an appeal shall be filed within thirty (30) days of the carrier group's receipt of the Bureau's written decision. The carrier should provide the Bureau with a copy of any appeal submitted to the Commissioner of Insurance.

The Honorable [redacted] ***Joseph Murphy***
Commissioner of Insurance
Commonwealth of Massachusetts
Division of Insurance
[redacted]
1000 Washington Street, #810
Boston, MA 02118-4082

PART I

UNIT STATISTICAL REPORTING

SECTION XII

DATA RECONCILIATION

SECTION XII- Data Reconciliation

A. Reconciliation of Manual Rates

1. Rationale

Manual rates reported in accordance with the instructions herein should not reflect any deviations or discounts from the Bureau's filed and approved rates. The manual rates reported on unit statistical data should equal the Bureau's filed and approved rates.

2. Comparisons

Manual rates for non statistical classes submitted on unit statistical reports are compared to the Bureau's filed and approved rates based on the USR reported rate effective, modification effective and policy effective dates.

Manual premiums for non statistical classes submitted on unit statistical reports are compared to a "calculated manual premium" which is based on the exposure reported on the USR and the Bureau's filed and approved rate based on the USR reported rate effective, modification effective and policy effective dates.

3. Data Tested

The latest five composite policy years reported to the Division of Insurance in Schedule Z will be reconciled by carrier group. For this report, a composite policy year is the aggregation of all policies with effective dates between July 1 of one year and June 30 of the next year. For example, composite policy year 2003 at report level one includes all policies with effective dates from July 1, 2003 to June 30, 2004. The first valuation of the data for this composite year will be available for testing in mid 2006.

Composite policy years where a carrier group has less than $100,000 in calculated manual premium will not be tested.

4. Tolerances

For this report, records where the reported manual rate is not the same as the Bureau's filed and approved rate are referred to as unmatched records. Similarly, records where the reported manual rate is the same as the Bureau's filed and approved rate are referred to as matched records.

Manual Rates - If 5% or more of USR non statistical records for a given composite policy year are unmatched, the carrier group is outside of tolerance.

Manual Premiums – If the percentage difference between the reported manual premiums and the calculated manual premiums is not within +/- 5%, the carrier group is outside of tolerance.

The percentage difference for manual premiums will be calculated as:

Percentage Difference = [(Reported Value - Calculated Value) / Calculated Value] x 100

5. Sample Report Format

The report to the Division of Insurance will include all tested carrier groups.

August 31, 2006

USR Manual Rates and Manual Premium Reconciliation

Summary by Carrier Group

Composite Policy Years 1999 to 2003

			Manual Rates			Manual Premiums			
Carrier Group Code	Composite Policy Year	Total Number of USR Exposure Records	Number of Exposure Records Matching	Number of Exposure Records Not Matching (3) - (4)	Percent of Exposure Records Not Matching (5) / (3)	Manual Premium Reported	Calculated Manual Premium (Using Approved Rates)	Manual Premium Percent Difference [(8) – (7)] / (8)	Within Tolerance Or Indicator
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
11111	1999	50,000	49,500	500	1.00%	5,800,000	6,300,000	7.9%	N
11111	2000	40,000	39,900	100	0.25%	5,000,000	4,975,000	-0.5%	Y
11111	2001	30,000	29,400	600	2.00%	4,500,000	4,522,500	0.5%	Y
11111	2002	20,000	16,800	3,200	16.00%	4,000,000	3,964,000	-0.9%	N
11111	2003	10,000	9,800	200	2.00%	3,800,000	3,800,000	0.0%	Y
22222	1999	25,000	24,500	500	2.00%	3,000,000	3,129,000	4.1%	Y
22222	2000	22,000	21,800	200	0.91%	2,800,000	2,702,000	-3.6%	Y
22222	2001	26,000	25,500	500	1.92%	3,200,000	3,643,380	12.2%	N
22222	2002	23,000	18,500	4,500	19.57%	3,200,000	3,139,520	-1.9%	N
22222	2003	18,000	17,900	100	0.56%	2,400,000	2,400,000	0.0%	Y

6. ***Carrier Notification***

Each tested carrier will receive their results prior to reporting to the Division of Insurance.

B. USR to Aggregate Financial Reconciliations

Both USR and Aggregate Financial Data as detailed in Part I and Part II respectively, call for the reporting of premium and loss information. Despite timing and definitional differences between the submission and valuation of unit statistical and Aggregate Financial Data, meaningful comparisons can be made between these two sources of data as a test for consistency. The rationale, test and tolerances for this comparison are detailed in Part II Section V of this plan.

THE WORKERS' COMPENSATION
RATING AND INSPECTION BUREAU

MASSACHUSETTS WORKERS' COMPENSATION STATISTICAL PLAN

PART II: AGGREGATE FINANCIAL REPORTING

The Workers' Compensation Rating and
Inspection Bureau of Massachusetts
101 Arch Street, Boston, MA 02110

PREFACE

A. *The Commissioner of Insurance first issued general instructions, known as the Massachusetts Workers' Compensation Statistical Plan, on January 2, 1929, for the preparation and filing of experience with The Workers' Compensation Rating and Inspection Bureau of Massachusetts on all policies effective in Massachusetts on and after January 1, 1929. The plan has been reprinted in amended form and supplemented by circular letters from time to time.*

On June 30, 2000 the Massachusetts Commissioner of Insurance ordered that effective immediately the Commissioner's Statistical Plan shall consist of two components, first the unit statistical data and second the aggregate financial data.

B. *The instructions and definitions for the reporting of unit statistical data are contained in the "Part I – Unit Statistical Reporting" portion of the Statistical Plan. The instructions, definitions, and sample forms for the reporting of aggregate financial data are contained in the "Part II – Aggregate Financial Reporting" portion of the Statistical Plan.*

C. *Any future changes in the instructions or amendments of the rules of this plan will be made by means of reprinted pages. Changes will be indicated by bold italic print with a Times New Roman font. Elimination of text will be indicated by a shaded area.*

D. *The Statistical Plan is reprinted and approved by the Massachusetts Commissioner of Insurance.*

E. *Self-Insured Groups report unit statistical data under part one of this plan, but are not required to report the aggregate financial data under Part II of this plan.*

PART II – AGGREGATE FINANCIAL REPORTING: **PAGE**

SECTION I – INTRODUCTION

SECTION II – GENERAL INSTRUCTIONS

SECTION III – DEFINITIONS

Form

SECTION VII– EDIT LISTING

PART II
AGGREGATE FINANCIAL REPORTING

SECTION I
INTRODUCTION

SECTION I – INTRODUCTION

A. The Workers' Compensation Rating and Inspection Bureau ("***WCRIBMA***") collects aggregate financial data to fulfill our role as the designated rating organization and statistical agent for the Massachusetts Commissioner of Insurance. The Aggregate Financial Calls provide information needed in the ***WCRIBMA's*** rate filings to develop the indicated overall workers' compensation rate change.

B. The Massachusetts Financial Data Reporting Application (MAFDRA) User Guide detailing how to submit calls via the internet it is included in the Financial Call Package. The Aggregate Financial Reporting Annual Call Package is intended to conform to the specifications contained in this Statistical Plan. Should any questions exist, Part II of this Statistical Plan contains the required reporting instructions.

C. Self Insured Groups who report unit statistical data under Part I of the Statistical Plan are not required to report aggregate financial data under Part II of the Statistical Plan.

D. Page 2 of this section contains a table that explains the need for each call and the due dates.

E. A timetable that identifies key dates is found on page 3 of this section.

AGGREGATE FINANCIAL CALL DATA USAGE / REPORTING SCHEDULE

Aggregate Financial Acknowledgment Form (*See Section II, page 6*) is to be completed by June 1

Call Number	Call Name	Purpose for Collecting Data	Due Date
1	MA Take Out ***Credit*** Program Call	Pool Participation Ratios	March 1
2	Policy Year Call	Ratemaking	March 15
2A	Policy Year Residual Market Call	Ratemaking	March 15
2C	Policy Year Large Deductible Call	Ratemaking and Pool Participation Ratios	March 15
2D	Policy Year "F" Classification Call	Analysis of Ratemaking Data	March 15
2E	Policy Year Maritime Call	Ratemaking	March 15
3	Accident Year Call	Ratemaking	April 1
3A	Accident Year Residual Market Call	Analysis of Ratemaking Data	April 1
3C	Accident Year Large Deductible Call	Analysis of Ratemaking Data	April 1
4	Reconciliation Report	Data Review / Reconciliation	April 1
5	***Residual Market Direct Written Premium***	***Pool Participation Ratios***	April 1
5A	Large Deductible ***Company Level*** Written ***Premiums***	Pool Participation Ratios	April 1
5B	***Direct Written Premium***	***Assessments and Pool Participation Ratios***	***April 1***
6	Calendar Year Expense Data	Ratemaking	May 15
6A	Insurance Expense Exhibit	Analysis of Ratemaking Data	***April 15***
7	Large Loss and Catastrophe Call	Ratemaking	April 15

TIMETABLE OF KEY DATES FOR DATA REPORTING

March 15 to June 30:
The ***WCRIBMA*** receives and reviews the most recent data submitted by each of the carrier groups, runs the tolerances, and works with carrier groups to obtain any needed corrections or explanations.

June 30:
The ***WCRIBMA*** notifies carrier groups of any observed tolerance variances.

The ***WCRIBMA*** provides the DOI with all carrier groups' reported data and will continue to provide the DOI with carrier group reported data, as it may be revised, on a monthly basis through November 30.

July 31:
The carrier groups' independent auditing firms submit to the Division of Insurance ("DOI") and the ***WCRIBMA*** the Agreed Upon Procedures (AUP) findings reports pursuant to Part II, Section VI subsection E.

June 30 to August 31:
The ***WCRIBMA*** continues to work with each of the carrier groups to resolve any observed tolerance variances.

August 31:
The ***WCRIBMA*** reports any carrier group's uncorrected or unexplained tolerance variances, and any other questions that are unresolved either to the ***WCRIBMA's*** or the DOI's satisfaction regarding the group's data to the DOI. Any carrier group with such unexplained variances or other unresolved issues will have an independent auditing firm conduct an AUP of the carrier group's data reporting activities relating to the specific data in question for any carrier group with such variances.

September 1 to October 31:
On-site AUPs are conducted by independent auditing firms and the independent auditing firms submit their findings reports to the DOI, the ***WCRIBMA*** and the carrier groups.

Carrier groups submit to the DOI and the ***WCRIBMA*** their responses to the independent auditing firms' findings reports no later than thirty (30) days following the carrier groups' receipt of the results of such findings report.

PART II
AGGREGATE FINANCIAL REPORTING

SECTION II
GENERAL INSTRUCTIONS

SECTION II - GENERAL INSTRUCTIONS

A. Call for Year End Aggregate Financial Data

Every insurance company authorized to transact the business of workers' compensation insurance within the Commonwealth of Massachusetts shall file with the ***WCRIBMA***, complete year end aggregate financial data in accordance with the instructions contained herein.

Instructions, definitions, and general forms are provided in this Statistical Plan.

B. Cease Writing

Insurance companies who cease writing workers' compensation insurance may request to be exempt from submitting aggregate financial data if their Massachusetts workers' compensation direct calendar year earned premium does not exceed $100,000 and their direct calendar year incurred losses do not exceed $100,000**.** A letter requesting exemption must be remitted by the carrier to the ***WCRIBMA*** at least 10 days prior to the first call due date. Within 5 days of receipt of both the exemption request and the company annual statement, the ***WCRIBMA*** will respond with a letter either accepting or denying the exemption.

If an insurance company that was previously granted exemption from reporting decides to write again in the future, they must resume submitting aggregate financial data. However they will have to choose whether or not they will report the historical data that was reported prior to the exemption.

C. Group Reporting

The data for companies controlling, controlled by, or under common control with other companies may be aggregated for purposes of reporting the data requested in Part II of the Statistical Plan. Grouping of companies should remain consistent across time. If a change in corporate structure results in a needed modification to the grouping of companies for the purpose of submitting aggregate financial data, a request must be made to the ***WCRIBMA*** detailing the circumstances of the transaction prior to submitting data using a new grouping of companies.

Any companies electing group reporting must specify all companies to be grouped on the Acknowledgement Form. Reported data grouped in a manner inconsistent with the submitted Acknowledgement Form will be rejected and consequently requires resubmission of a correction.

D. In Addition to Reports for NCCI or other Rating Bureaus

The requirements of Part II of the Massachusetts Statistical Plan are independent of any comparable requirements by any other rating bureaus, including NCCI (National Council on Compensation Insurance). The call requirements contained herein are in addition to any requirements imposed by any other rating bureau, including NCCI.

E. Report ID

The Report ID and Reporting Group Name of the company appear on every call and every sheet in MAFDRA.

F. Nil Reports

When completing the Call Package Acknowledgment Form contained in MAFDRA, companies with no experience to report for a particular call should inform the ***WCRIBMA*** by unchecking the box next to the call in Section III of the form. MAFDRA will automatically create these calls and insert zeros in all of the fields.

G. Accumulated Aggregate Totals

Calls requesting policy year or accident year data require the reporting of accumulated aggregate totals, also referred to as inception to date.

In the case of premiums, submit the summation of all premiums and any subsequent adjustments to premiums since the inception of each policy.

In the case of paid losses, submit the summation of all loss payments less recoveries since the first report of the claim.

H. Calendar Year Totals

Some calls require calendar year totals. Calendar year totals are the sum of changes in accounting balances for a particular year.

Calendar year premium and loss totals may be calculated by subtracting the prior year aggregate totals from the current year aggregate totals from policy year or accident year calls.

I. Current Plus Twenty

The policy year and accident year calls require (or are adding years annually to achieve) current plus twenty years of reporting. Data related to years before the current plus twenty is combined and reported on the prior line.

For example, given a policy year data call valued as of 12/31/2003 for a company that has workers' compensation experience dating back to 1975, the policy years would be labeled as follows:

Current Policy Year	2003
Plus Twenty Policy Years	1983 – 2002
Prior Policy Years	Summation of 1975 – 1982

Similarly, the same company's accident year call valued as of 12/31/2003 would classify the accident years as follows:

Current Accident Year	2003
Plus Twenty Accident Years	1983 – 2002
Prior Accident Years	Summation of 1975 – 1982

J. Electronic Reporting

All calls are to be submitted via the internet using the MAFDRA application accessible at

https://www.mafdra.org/carriergroup. Please contact the ***WCRIBMA*** if a user ID needs to be established for your company. Likewise, if a user ID currently exists for your company and you have forgotten either the user id or the password please contact the ***WCRIBMA***.

Two options are generally available for the electronic submission of aggregate financial data to the ***WCRIBMA***. One, data may be entered into an Excel template and uploaded to the MAFDRA application. Two, data may be entered directly into a table displayed in an internet browser window. However, some calls can only be submitted using one of the two options.

More specifics about electronic submission and the MAFDRA application can be found in the Massachusetts Financial Data Reporting Application User Guide (MAFDRA User Guide) which is included with the Financial Call Package distributed by the ***WCRIBMA*** in January of each year. Additionally, the MAFDRA User Guide may be accessed within the MAFDRA application.

K. Whole Dollar Reporting

All dollar amounts should be reported as whole numbers without decimal places. Values to the right of any decimal place that are greater than or equal to .50 should be rounded upward. Values to the right of the decimal place that are less than or equal to .49 are to be rounded downward.

L. Reporting Credits

Negative amounts should be reported using the negative sign. Do not report negative amounts inside parenthesis. For example:

-1,000	Correct
(1,000)	Incorrect

M. Direct Business

These calls require the reporting of direct business only. Do not report reinsurance assumed or make adjustments for business that has been reinsured.

N. Prior Totals

Line Y for a submitted policy year or accident year call should reconcile to Line X for the same call submitted as of the prior valuation date. The ***WCRIBMA*** relies on the calculated totals from the prior data calls in all compilations and reports of the aggregate data. Changes to Line Y prior year totals must be supported by revisions to previously submitted calls.

O. M.G.L. Chapter 152 Section 65

1. DIA Assessment

The DIA assessment is **not** to be considered premium and should **not** be included in premium totals.

2. Funds maintained by the Treasurer of the Commonwealth

Losses are reported net of recoveries from the Second Injury Fund and Trust Fund.

In other words, reported loss amounts are reduced by recoveries carriers companies received from the Second Injury Fund and/or Trust Fund.

3. Penalties

a) Sections 7, 8, 10, 13A, and 14 of Chapter 152 provide for penalties or fees to be paid by the insurer in specified situations.

Section 7 sets forth penalties in cases in which the insurer fails either to pay or deny a claim promptly after receiving either a claim form or a First Report of Injury.

Section 8 sets forth penalties (i) in cases in which the insurer fails to make prompt payments in accordance with an order, decision or agreement; and (ii) in cases in which the insurer unlawfully terminates, reduces, or fails to make required payments and is later ordered to do so.

Section 10 requires a penalty fee for referral to the Industrial Accident Board of 130% of the average weekly wage in cases in which the insurer failed to appear at a scheduled conciliation without good cause.

Section 13A (iii) provides for attorneys' fees to be paid to claimants in instances in which insurers have been found to owe late payment penalties under Section 7 or 8 (described above).

Section 14 provides for certain penalties where an Administrative Judge finds that the insurer has brought, prosecuted or defended a proceeding without reasonable grounds.

b) Any amounts paid as penalties or fees in accordance with these provisions of law must **not** be added to the losses reported on the data calls.

P. ***WCRIBMA*** Contact

All correspondence, including questions and requests for additional information on these calls, should be directed to:

Financial Data Service Department – ***WCRIBMA***
101 Arch Street, Fifth Floor
Boston, MA 02110

Phone: (617) 439-9030
Fax: (617) 439-6055
Email: financial@wcribma.org

Q. Data Provider Contact

Companies are required to complete two Acknowledgment Forms. The Financial Call Package is used for indicating the calls for which the ***WCRIBMA*** should expect data to be submitted. The Call Package Acknowledgment Form requires that a contact be identified for each call except those involving nil submissions. Any questions the ***WCRIBMA*** has relating to a given call

will initially be directed to the contact associated with that call. If initial ***WCRIBMA*** questions go without sufficient response, the ***WCRIBMA*** will contact the primary contact listed on the Call Package Acknowledgment Form or the carrier's management.

The second form titled the Aggregate Financial Call Acknowledgment Form identifies a corporate

officer or actuary who acknowledges that, to the best of their knowledge, certain of the Aggregate Financial calls have been completed accurately. The specific calls at issue are listed on the Aggregate Financial Call Acknowledgment Form.

R. Changes to Contacts

Companies are required to inform the ***WCRIBMA*** of any changes to contacts by updating the Call Package Acknowledgment Form. It is very important that staff no longer working with a company or staff no longer responsible for reporting financial data for a company are updated immediately. This action will help to ensure that important ***WCRIBMA*** correspondence is delivered to the correct person. See the Financial Data Call Package Acknowledgment Form section of the MAFDRA User's Guide for instructions on updating contacts.

Aggregate Financial Call Acknowledgment Form Description

This form is required from all companies reporting aggregate financial data to the ***WCRIBMA***. The Aggregate Financial Call Acknowledgment Form must be signed by a designated contact that will be responsible for verifying, to the best of his/her knowledge and belief, the completeness and accurate representation of the following calls:

Call Number	Call Name	Due Date
2, 2A, 2C, 2D, 2E	Policy Year Calls	March 15
3, 3A, 3C	Accident Year Calls	April 1
4	Reconciliation Report	April 1
5	***Residual Market*** Direct Written Premium Call	April 1
5A	***Large Deductible Company Level Written Premiums***	***April 1***
5B	***Direct Written Premium Call***	***April 1***
6	Calendar Year Expense Data	May 15
6A	***Insurance Expense Exhibit***	***April 15***
7	Large Loss and Catastrophe Call	April 15

The acknowledgment must be signed by a company officer or a company actuary who is a member of the Casualty Actuarial Society and/or a member in good standing of the American Academy of Actuaries.

If companies are grouped for purposes of aggregate financial data reporting, the Aggregate Financial Call Acknowledgment Form would apply to the data for all companies assigned to the group. An acknowledgement contact may sign for multiple reporting companies within their carrier group if the calls were reported individually.

Aggregate Financial Call Acknowledgment Form

Please provide the contact information for the company officer or company actuary responsible for completion of this form. A non-officer actuarial designee must be a member of the Casualty Actuarial Society and/or a member in good standing of the American Academy of Actuaries.

Acknowledgment Contact Information	
Carrier Group Code	
Carrier Group Name	
Contact Name	
Contact Title	
Contact Department	
Address Line 1	
Address Line 2	
City, State, Zip	
Phone Number	
E-Mail Address	

By signing below, we acknowledge the importance of timely and accurate submission of the aggregate financial data calls which are used for workers' compensation ratemaking in the Commonwealth of Massachusetts. To the best of our knowledge and belief, the Aggregate Financial data calls listed below accurately represent our premium, loss, and expense experience.

Call Number	Call Name	Due Date
2, 2A, 2C, 2D, 2E	Policy Year Calls	March 15
3, 3A, 3C	Accident Year Calls	April 1
4	Reconciliation Report	April 1
5	***Residual Market*** Direct Written Premium Call	April 1
5A	***Large Deductible Company Level Written Premiums***	***April 1***
5B	***Direct Written Premium Call***	***April 1***
6	Calendar Year Expense Data	May 15
6A	***Insurance Expense Exhibit***	***April 15***
7	Large Loss and Catastrophe Call	April 15

_____ _____
Signature Date

This completed form must be received by the ***WCRIBMA's*** Financial Data Services Department no later than **June 1,** _____.

PART II
AGGREGATE FINANCIAL REPORTING

SECTION III
DEFINITIONS

DEFINITIONS

A. PREMIUMS REPORTED IN FINANCIAL CALLS

No assumed reinsurance premiums or ceded reinsurance premiums should be reflected on any of the Aggregate Financial calls.

For *WCRIBMA* Aggregate Financial reporting purposes, premium and losses exclude Federal (F) Classification experience, *Maritime Experience*, Excess Workers' Compensation, and National Defense plans, except as noted on the Reconciliation Report call, *Policy Year Maritime call* and on the Policy Year "F" Classification call.

The DIA Assessment is not to be considered premium.

- **Policy Year Premium and Calendar Year Premium**

Policy year premium and calendar year premium include all premium transactions associated with a policy including:

- the original estimated policy premium
- additional or return premium due to audits
- accrued premium due to anticipated audits
- retrospective rating premium adjustments
- policy endorsements and similar transactions

Policy year premium is the premium associated with policies that have policy effective dates during a specific twelve-month period. Policy year premium can change from valuation to valuation as premium audits are performed or retrospective premium adjustments are made.

With the exception of Three-Year Fixed Rate policies, multiyear policies with effective dates on or after January 1, 2009 must be reported as separate policies with individual effective dates for each of the annual components, in order to maintain consistency with the ASWG *Unit Report Workers' Compensation Statistical Plan* reporting requirements. Three-Year Fixed Rate policies ***regardless of*** effective dates may be reported as one policy with a single policy effective date.

Calendar year premium is the aggregate total of the premiums recorded on the company books during a given calendar year, regardless of the policy effective date. Calendar year premium is fixed at the end of the calendar year, and is not subject to change from valuation to valuation.

- **Written and Earned Premium**

Written premium is the estimated premium ***recorded*** in the company system ***for*** the entire policy term including any estimates of premium audits and retrospective rating premium adjustments.

Statutory accounting allows for workers' compensation written premiums to be recorded using one of two methods.

1. Written premiums may be recorded on an installment basis to match the billing to the policyholder.

2. Written premiums may be recorded as of the effective date of the contract.

Written premium reported on the Aggregate Financial calls must be recorded using the same method for recognizing written premiums employed in preparing the Annual Statement.

Written premium does not include advance premiums received by the insurance company for policies yet to take effect.

Earned premium is the proportional share of the written premium applicable to the expired portion of the policy.

Earned premium reported on the Aggregate Financial calls should be recorded using the same method for prorating written premiums as was employed in preparing the Annual Statement.

Premium Levels

Four distinct levels of premium are submitted on the Aggregate Financial calls. The difference between levels is associated with the inclusion or exclusion of various credits and company specific rating mechanisms such as deviations and schedule rating.

1. **Standard Premium at Bureau Designated Statistical Reporting (DSR) Level**
   Standard Premium at DSR Level is the accumulated premium resulting from standard rating procedures as if all policies had been issued using ***WCRIBMA*** manual rates. For purposes of Aggregate Financial reporting, standard premium is the accumulated premium after the application of experience rating, but prior to all schedule rating credits, premium discounts, deductible premium credits, and retrospective and loss sensitive rating premium adjustments. The standard premium is usually not the net premium that the insured pays. Standard Premium at Bureau DSR Level should include premium for Waiver of Subrogation. ***Do not include Terrorism Insurance Program Premiums.***

2. **Standard Premium at Company Level**
   Standard Premium at Company Level is the accumulated premium calculated by adjusting the Standard Earned Premium at DSR level by application of the company deviation. It is the accumulated premium resulting from standard procedures at company rates using standard rating procedures. Standard Premium at Company Level should include premium for Waiver of Subrogation. ***Do not include Terrorism Insurance Program Premiums.***

3. **Net Premium Level**
   Net Premium is premium that has been adjusted for all schedule rating credits, premium discounts, deductible premium credits, and retrospective rating premium adjustments. Net premium is the premium that the carrier accumulated and is entitled to as of the valuation ***date. Net Premium Level should include premium for Waiver of Subrogation. Do not include Terrorism Insurance Program Premiums.***

4. **Direct Premium (Direct Premium at Annual Statement Basis) Level**
   Direct premiums are the aggregate amount of recorded originated premiums, excluding all reinsurance assumed without deducting any reinsurance ceded, whether collected or not, at the close of the year (plus retrospective premium collections), after deducting all return premiums. In financial statements, it is the premium income adjusted for additional or return premiums but excluding any additions for reinsurance assumed and any deductions for reinsurance ceded.

Premium Level Components

Components	Standard Premium at Bureau Designated Statistical Rate Level	Standard Premium at Company Level	Net Premium	Direct Premium
1. Experience Rating	X	X	X	X
2. Merit Rating	X	X	X	X
3. Expense Constant	X	X	X	X
4. Loss Constant	X	X	X	X
5. Increased Limits of Employers Liability	X	X	X	X
6. Retrospective Rating Adjustments			X	X
7. Scheduled Rating Adjustments			X	X
8. Premium Discount			X	X
9. Massachusetts Benefits Deductible Premium Credit			X	X
10. Massachusetts Benefits Claim and Aggregate Deductible Premium Credit			X	X
11. Large Deductible Premium Credit			X	X
12. Rate Deviations		X	X	X
13. MCCPAP	X	X	X	X
14. ARAP Surcharge				X
15. QLMP Credit				X
16. Terrorism Insurance Program (Certified Acts of Terrorism) Premiums				X
17. ***Waiver of Subrogation***	***x***	***x***	***x***	***x***
18. ***Short Rate Penalty Premium***	***x***	***x***	***x***	***x***
19. ***Balance to Minimum Premium Adjustment***	***x***	***x***	***x***	***x***
20. Deductible Reimbursements	Do Not Report			
21. Policyholder Dividends	Do Not Report			
22. DIA Assessment	Do Not Report			

Notes:

- ***An "x" denotes that the component is included in the column.***
- Deductible Reimbursements, Policyholder Dividends, and DIA Assessments are not considered premium.
- ***The following components do not apply for Residual Market Policies: Retrospective Rating Adjustments, Scheduled Rating Adjustments, Premium Discount, Large Deductible Premium Credit and Rate Deviations.***
- ***The QLMP Credit program relates to residual market risks and is available for a period of four years for a given insured. However, if a carrier voluntarily insures a risk previously written in the residual market that was paying a reduced premium because of the application of a QLMP credit factor, the carrier must continue to apply the QLMP factor for the balance of the four year eligibility period for those policies written on a guaranteed cost basis.***

1. Experience Rating

Experience rating is a mandatory rating plan approved by the Massachusetts Division of Insurance for use by all insurance companies in Massachusetts. The ***WCRIBMA*** calculates experience modification rating factors or "mods" for eligible employers based on the employer's historical loss experience. The application of the experience modification factor results in either a premium credit or premium debit.

See the *Experience Rating Plan Manual for Workers' Compensation and Employers Liability Insurance*.

2. Merit Rating

The Massachusetts merit rating program is a mandatory rating plan approved by the Massachusetts Division of Insurance for eligible insureds that are too small to qualify for experience rating that results in premium credits or debits based on the number of lost time claims reported over a three year period.

See the *Experience Rating Plan Manual for Workers' Compensation and Employers Liability Insurance*.

3. Expense Constant

A premium charge, applicable to all policies, intended to cover expenses such as those for issuing, recording and auditing which are common to all workers' compensation policies. ***Include any additional premium required to balance to the minimum premium.***

4. Loss Constant

A flat charge added to the premium of small insureds to offset the higher loss ratios produced by such risks. The loss constant applies in addition to the expense constant

See ***the*** *Massachusetts Workers Compensation and Employers Liability Insurance Manual*.

5. Increased Limits of Employers Liability

An insured may elect employer's liability coverage limits other than the standard limits. If an insured selects limits higher than the standard limits a premium charge is applied. ***Include any additional premium required to balance to the minimum premium.***

6. Retrospective Rating Adjustments

The retrospective rating plan is an optional rating plan approved by the Massachusetts Division of Insurance for larger insureds. The premium for a retrospectively rated policy is a function of the loss experience of the insured during the term of the policy. The premium of a retrospectively rated policy is adjusted using losses valued eighteen months from policy inception and annually thereafter until the insured and the insurance company mutually decide to discontinue any further adjustment.

7. Scheduled Rating Adjustments

Insurance companies may independently file a schedule rating plan that allows the insurance company to modify an insured's premium based on the special characteristics of risk that are not reflected in the experience. In Massachusetts, schedule rating programs are only allowed to adjust premiums downward. Downward schedule rating adjustments are known as schedule rating credits.

Individual insurance companies must get approval from the Massachusetts Division of Insurance prior to offering schedule rating to their insureds. The ***WCRIBMA*** has **not** filed a schedule rating plan on behalf of its members. ***See the Massachusetts Department of Insurance website for scheduling rating guidelines.***

8. Premium Discounts

The relative expense of acquisition, issuing, and administering a policy, as a percentage of premiums, decreases as the size of the policy increases. Premium discounts, are applied to larger insureds to reflect the expense differential. The premium discount schedule to be used in Massachusetts may be found in the *Massachusetts Workers' Compensation and Employers Liability Insurance Manual*.

Note that residual market policies are not eligible for premium discounts.

9. Massachusetts Benefits Deductible Premium Credit (Small Deductible)

Every Massachusetts employer seeking a workers' compensation policy is to be offered a per claim deductible that applies to the sum of indemnity and medical ***losses***. Insureds electing to purchase coverage with a deductible will receive a premium credit. Deductible credit percentages for various deductible levels are filed by the ***WCRIBMA*** on behalf of its members.

This program is not available for insureds with retrospectively rated policies. Unlike the Massachusetts Benefits Claim and Aggregate Deductible Program, **no aggregate limit** applies to the potential liability of the insured for loss amounts below the deductible.

10. Massachusetts Benefits Claim and Aggregate Deductible Premium Credit (Small Deductible)

Insureds in Massachusetts that want a deductible but are concerned about the unlimited potential of their liability for loss amounts below the deductible may opt for the Massachusetts Benefits Claim and Aggregate Deductible Program. This program involves a per claim deductible and an aggregate limitation on the loss amounts the insured would be obligated to reimburse the insurance company. Insureds electing to purchase coverage with a deductible will receive a premium credit. The applicable deductible credit percentages are filed by the ***WCRIBMA*** on behalf of its members.

This program is not available for insureds with retrospectively rated policies.

11. Large Deductible Premium Credit

Massachusetts large deductible rating plans are optional and allow insurance companies to offer large insureds per claim deductibles of $75,000 or more (subject to an aggregate limitation of loss amounts below the deductible). The insured receives a large deductible premium credit for agreeing to reimburse the insurance companies for loss amounts below the deductible.

Individual insurance companies must get approval from the Massachusetts Division of Insurance prior to offering large deductibles to their insureds. The ***WCRIBMA*** has **not** filed a large deductible rating plan on behalf of its members.

12. Rate Deviations

In Massachusetts, companies are permitted to file **downward** deviations from the approved ***WCRIBMA*** manual rates. Deviations typically are applied uniformly across all class codes. The Commissioner must approve a deviation before it may be used in Massachusetts.

13. Massachusetts Construction Classification Premium Adjustment Program (MCCPAP)

The Massachusetts Construction Classification Premium Adjustment Program (MCCPAP), initially approved by the Massachusetts Commissioner in 1991, allows for a credit to be offered to experience-rated risks with construction class exposures if the hourly wage rate applicable to the construction class codes exceeds a specified threshold.

14. All Risk Adjustment Program (ARAP) Surcharge

The All Risk Adjustment Program (ARAP), initially approved by the Massachusetts Commissioner in 1990, is a mandatory extension of the experience rating program. All insureds subject to experience rating will be subject to the calculation of an ARAP surcharge.

Note that some ***other*** states have Assigned Risk Adjustment Programs, also referred to as ARAP, however these apply only to residual market insureds.

15. Qualified Loss Management Program (QLMP) Credit

The QLMP, approved by the Massachusetts Commissioner in 1990, affords residual market insureds the option to enroll in a loss management program approved by the ***WCRIBMA*** and the opportunity to receive a premium credit, for up to four years.

Note that if an insured becomes eligible for a QLMP credit while in the residual market and subsequently is written in the voluntary market, the QLMP credit will apply for the balance of the four years as long as the insured remains enrolled in the loss management program and is written on a guaranteed cost policy.

16. Terrorism Insurance Program (Certified Acts of Terrorism) Premiums

Premiums related to filed catastrophe provisions in response to the Terrorism Insurance Program (Certified Acts of Terrorism) of 2002 and successor acts.

17. Waiver of Subrogation

When a policy is endorsed to waive the right to subrogate, the carrier cannot pursue subrogation recoveries from a third party. Waiver of subrogation may apply to a policy in total or to a specific job covered by the policy.

18. Short Rate Penalty Premium

Premium applied when a policy is cancelled mid-term by the insured, except when retiring from business.

19. Balance to Minimum Premium Adjustments

Any additional premium required to balance to the minimum premium, as reported in Statistical Codes 0990 – Minimum Premium (Balanced to) and 9849 – Minimum Premium for Admiralty/FELA (Balanced to) should be included in Standard Premium at Bureau DSR Level, Standard Premium at Company Level, Net Premium and Direct Premium.

20. **Deductible Reimbursements**

In workers' compensation insurance, the insurance company is required to pay for all claims including those below any applicable deductible, large or small. If a deductible applies to a given policy, the insurance company ***will*** seek reimbursement from the insured for amounts below the deductible. The amounts **actually reimbursed** by the insured plus any amounts **expected to be reimbursed** by the insured are defined as deductible reimbursements.

Any amounts due from the insured that are determined to be uncollectible should not be reflected in deductible reimbursements because no offset to reserves is permitted where any amount due from the insured has been determined to be uncollectible.

21. **Policyholder Dividends**

Any amounts paid or credited to policyholders that are **not** fixed in the insurance contract but are dependent on either the experience of the insurance company or employer or the discretion of ***the*** insurance company management.

22. DIA Assessment

Chapter 152, Section 65 of the Massachusetts General Laws (as amended by Chapter 572 of the Acts of 1985), established a Workers Compensation Special Fund and a Workers Compensation Trust Fund. The

Department of Industrial Accidents is required to collect from each employer, through their insurer, an assessment charge and remit the appropriate amount to the Treasurer of the Commonwealth. The first DIA Assessment applied to policies with an effective date of July 1, 1986.

B. LOSSES AND LOSS ADJUSTMENT EXPENSES (LAE) REPORTED IN FINANCIAL CALLS

No assumed reinsurance losses or ceded reinsurance losses should be reflected on any of the Aggregate Financial calls.

Any amounts paid as penalties or fees in accordance with Sections 7, 8, 10, 13A, and 14 of Chapter 152 of the General Laws of Massachusetts should not be included in incurred losses reported on the data calls.

Additionally, with the exception of the incurred loss value from Statutory Page 14 used to complete the Reconciliation Report (Call #4), all loss amounts are to be reported before any offsets for deductibles. Likewise, all loss adjustment expense amounts are to be reported before any offsets for deductibles.

Losses reported on the Aggregate Financial calls should be recorded using the same methods employed in preparing the Annual Statement with respect to reserve discounting.

Do not classify a claim as Massachusetts if the jurisdiction state is Massachusetts but the associated exposures used to calculate the policy's premium are for a state other than Massachusetts. Conversely, if the jurisdiction state is not Massachusetts but the associated exposures used to calculate the policy's premium are for Massachusetts, classify such a claim as Massachusetts.

Jurisdiction state identifies which state's benefits to apply to a claim but this may not coincide with the exposure state used in the calculation of the policy's premium. For example, a Massachusetts employer may have an employee injured while on a business trip to New York. That Massachusetts employee could elect to receive either Massachusetts or New York workers' compensation benefits. In either event, the claims should be categorized as Massachusetts.

Direct Losses Net of Deductibles

In workers' compensation insurance, the insurance company pays all claims from the first-dollar. Eligible insureds may elect to purchase insurance above a specified threshold, using an approved deductible program ***requiring*** insureds to reimburse the insurance companies for loss amounts below the deductible. Direct losses net of deductibles are the loss amounts that the insurer incurred (first dollars) less ***deductible*** reimbursements.

Direct incurred loss amounts should reconcile with ***the*** Exhibit of Premiums and Losses (Statutory page 14 Data) of your Annual Statement.

- **Accident Year , Policy Year and Calendar Year Losses and Loss Adjustment Expenses**

  Accident year losses and loss adjustment expenses are the **inception to date** total dollar amounts associated with all claims having an accident date in a given year, regardless of when the loss and/or claim is reported or the policy is effective.

  Note that accident year losses and loss adjustment expense are subject to change over time as losses develop and/or additional claims are reported.

Policy year losses and loss adjustment expenses are the **inception to date** dollar amounts that arise for a group of policies having policy effective dates in a given year, regardless of when the loss and/or claim is reported.

Note that policy year losses and loss adjustment expense are subject to change over time as losses develop and/or additional claims are reported.

With the exception of Three-Year Fixed Rate policies, multiyear policies ***with effective dates on or after January 1, 2009 must be*** reported as separate policies with individual effective dates for each of the annual components. in order to maintain consistency with the ASWG *Unit Report Workers' Compensation Statistical Plan* reporting requirements. ***Three-Year Fixed Rate policies regardless of effective dates may be reported as one policy with a single policy effective date.***

Calendar year loss and loss adjustment expenses are the **year to date** total dollar amounts associated with all claims regardless of the accident date, the policy effective date, or date the loss and/or claim is reported.

Note that calendar year losses and loss adjustment expenses are not subject to change beyond December 31 because they are year to date summaries.

- **Indemnity Losses and Medical Losses**

Workers' compensation losses are classified as either indemnity losses or medical losses.

Indemnity
Indemnity losses are the losses incurred for benefits due to lost wages, vocational rehabilitation, claimant's attorney fees, burial expenses, sums designated for specific injuries, and employers liability losses, including all defense fees associated with employer's liability claims.

Medical
Medical losses are those incurred for the medical treatment of an employee injured due to a work related injury. Medical losses exclude costs associated with engaging medical experts to present medical opinions during the claim settlement process.

- **Incurred Loss and Loss Adjustment Expenses**

Incurred - A loss or loss adjustment expense is "incurred" when an event causes the loss and results in a claim under the terms of a policy, regardless of when the claim is filed. Incurred Losses should be reported at nominal (undiscounted) values with the single exception of pension cases.

For more information on pension cases, see the Massachusetts Workers' Compensation Statistical Plan, Part I, Section IX Pension Tables.

Note that companies may recover some losses as a result of subrogation, second injury fund recoveries, or reimbursements for supplemental benefits in accordance with Section 34B of Chapter 152 of the General Laws of Massachusetts. These types of recovery amounts less any associated recovery expenses should

be netted out of all indemnity loss amounts and all medical loss amounts reported on the Aggregate Financial calls, but under no circumstances should the reduction be more than the original paid loss or case reserve. When the allocation of a recovery (less applicable recovery expenses) to indemnity loss and medical loss is unknown, the recovery must be divided between indemnity loss and medical loss in proportion to indemnity loss and medical loss amounts gross of (before netting out) any recovery.

Incurred losses (or loss adjustment expenses) include paid losses, case loss reserves, and Incurred But Not Reported (IBNR) Reserves. Incurred losses should be reported **prior to** any reduction for deductibles (i.e. first-dollar). ***Case Incurred is the sum of paid losses and case reserves.***

1. **Paid Losses and Loss Adjustment Expenses** represent the amount of losses actually paid out by the insurance company and the paid cost of claim adjustment services including defense, litigation, and medical cost containment. In some instances, the carrier is able to recover some or all of the paid losses from a third party.

2. **Case Reserves** are amounts set aside for future expected payments on a specific claim. A case reserve represents the carrier's claims adjuster's best estimate of what the future payments on the claim will be.

3. **Incurred But Not Reported (IBNR) Reserves** are expected payments for losses relating to insured events that have occurred but have not been reported to the carrier as of the valuation date **plus** reserves to reflect deficiencies in known case reserves. Aggregate outstanding reserves established for general case reserve inadequacy, supplemental case reserves, cases that may reopen, or other reserves not associated with specific claims (bulk reserves) are included in IBNR.

Loss adjustment expenses can be classified into two broad categories: Defense and Cost Containment (DCC) and Adjusting and Other (AO). **Loss adjustment expenses should be reported in accordance with the current NAIC definitions.**

1. **Defense and Cost Containment**
   DCC includes defense, litigation, and medical cost containment expenses, whether internal or external. DCC includes, but is not limited to, the following items:
   - Surveillance expenses;
   - Fixed amounts for medical cost containment expenses;
   - Litigation management expenses;
   - Loss adjustment expenses for participation in voluntary and involuntary market pools if reported by accident year;
   - Fees or salaries for appraisers, private investigators, hearing representatives, reinspectors and fraud investigators, **if working in defense of a claim**, and fees or salaries for rehabilitation nurses, if such cost is not included in losses;
   - Attorney fees incurred owing to a duty to defend, even when other coverage does not exist; and
   - The cost of engaging experts;

2. **Adjusting and Other**
   AO are claim settling expenses other than those included in DCC. AO includes, but is not limited to, the following items:
   - Fees and expenses of adjusters and settling agents;
   - Loss adjustment expenses for participation in voluntary and involuntary market pools if reported by calendar year;

- Attorney fees incurred in the determination of coverage, including litigation between the reporting entity and the policyholder; and
- Fees and salaries for appraisers, private investigators, hearing representatives, reinspectors and fraud investigators, **if working in the capacity of an adjuster**.

C. CLAIM CATEGORIES

1. An **indemnity claim** ***(i.e. lost time claim)*** is one that has either paid or expected indemnity losses. An indemnity claim usually has associated medical losses.

2. A **medical-only claim** is one that, by definition, has medical losses only. The injured worker was not eligible for wage replacement, either because the worker returned directly to work after the injury or was not out of work for more than the state-specified 'waiting period'. A medical-only claim does not have any associated indemnity losses.

The status of a claim can be either "Open" (i.e., still in process of settlement) or "Closed" (i.e., already settled):

- **Closed (*with payment*) Indemnity Claim Count**
  - This count includes those indemnity claims that are paid in full with no existing outstanding loss and DCC expense reserves. ***It does not include claims that involve medical benefits only, i.e., medical-only claims.***
  - Claims that started out as medical-only claims but were subsequently resolved as indemnity claims should be added.
  - Indemnity claims that were closed at the previous valuation, but later were reopened and remain open as of this valuation date, should be removed.
  - Claims that started out as indemnity claims but were subsequently resolved as either medical-only claims or claims closed without payment should be removed.

- **Open (Outstanding) Indemnity Claim Count**
  - This count includes those indemnity claims for which outstanding case ***or*** DCC expense reserves exist as of the valuation date, regardless of whether or not any payments have been made on those claims. ***It does not include claims that involve medical benefits only, i.e., medical-only claims.***
  - Indemnity claims that were closed at the previous valuation date but were reopened and remain open as of the current valuation date should be added.

D. EXPENSES REPORTED IN FINANCIAL CALLS

- ***Other*** **Acquisition, Field Supervision and Collection Expenses Incurred**
  Report acquisition, field supervision and collection expense***s other than commission and brokerage*** as defined in the Annual Statement instructions.

- **Boards and Bureau Expenses**
  Boards and Bureau expenses include dues, assessments, fees, and charges of:
  - Underwriting boards, rating organizations, statistical agencies, and audits bureaus;
  - Underwriters' advisory and service organizations;
  - Accident and loss prevention organizations;
  - Claims organizations; and
  - Specific payments to boards, bureaus, and associations for rate manuals, revisions, fillers, rating plans, and experience data.

- **General Expenses**
  Includes all general expenses***, including*** boards and bureaus expenses, expenses incurred for auditing, inspecting, and administrative expenses incurred in conducting an insurance operation. ***Note that this should include the Boards and Bureau Expenses which are also reported separately.***

- **Incidental Income**
  Any revenues received from finance charges, installment fees, check bouncing fees, reinstatement fees or similar charges, related to Massachusetts workers' compensation policies, imposed on a policyholder by their insurance company.

- **Unreported Expenses**
  Any expenses not reported on the ***WCRIBMA's*** Calendar Year Expense Data Call which are associated with the collection of incidental income for workers' compensation policies.

- **Uncollectible Premium Receivables**
  Any premium receivable that has been written off because the determination was made that it was uncollectible.

  Note that this does not impact earned premiums or written premiums because uncollectible premium receivables are written off against other income.

E. EXPERIENCE TYPES

- **Voluntary**

  - **Guaranteed Cost and Retrospectively Rated**
    - Guaranteed Cost
      A standard workers' compensation insurance policy that is not subject to premium adjustment due to losses that occur during the policy term. In a guaranteed cost policy, the only variable affecting premium that is expected to change between policy inception and audit is exposure. This is in contrast to retrospective rating, where premium adjustments are made based on losses incurred during the policy term.

    - Retrospective Rating
      A workers' compensation insurance policy that periodically makes adjustments to the premium, after policy expiration, based on the actual losses generated during the policy period. The premium adjustments are constrained by a maximum premium and a minimum premium. See the Retrospective Rating Manual.

  - **Large Deductible**
    Massachusetts large deductible rating plans are optional and allow insurance companies to offer large insureds per claim deductibles of $75,000 or more (subject to an aggregate limitation of loss amounts below the deductible). Insureds reimburse the insurer for losses below a specified threshold, the deductible, and in return, receive a premium credit.

  - **National Defense Rating Plan**
    The Defense Base Act was established in 1941. It provides workers' compensation coverage for workers engaged in employment on U.S. overseas defense bases or under a contract for public work overseas. This consists of coverage provided under the Special National Defense Comprehensive Rating or Special National Defense Premium Discount Plans.

Note: Previous Annual Statement reporting instructions allowed Excess Workers' Compensation, excess coverage purchased by a self-insured on a per-occurrence or per-claim basis above a self-insured retention, to be reported on the workers' compensation line (Line 16.0) of the Exhibit of Premium and Losses (Statutory Page 14). This is no longer the case. Excess Workers' Compensation should now be reported on the excess workers' compensation line (Line 17.3) of Statutory Page 14.

- **Residual Market**
  The Massachusetts workers' compensation Assigned Risk Pool was created by statute to provide a means for Massachusetts employers, who are unable to obtain workers compensation coverage from a licensed insurer in the voluntary market, to satisfy their obligations under M.G.L. Chapter 152. The Massachusetts workers' compensation Assigned Risk Pool must provide coverage to any employer who is entitled to workers compensation insurance.

- **Voluntary Direct Assignment Risk**
  The Pool Plan of Operation of the Massachusetts Workers' Compensation Assigned Risk Pool (the "Pool"), provides that any insurer may satisfy its assessment obligations as a Pool member by accepting voluntary direct assignments of risks. The voluntary direct assignment carrier issues the policies and provides service to assigned employers.

- **Servicing Carrier**
  A servicing carrier is a designated member company of the Pool that issues policies and provides services to assigned employers in return for a servicing carrier fee paid by the Pool.

  The loss and premium results generated by the servicing carrier are pooled and shared with all members of the Massachusetts Workers' Compensation Assigned Risk Pool via an assessment of Pool participants.

F. CLASS CATEGORIES

- **Federal "F" Classification vs. Non "F" Classification**

Note that the policy year and accident year calls make a distinction between Federal "F" Classification and Non "F" Classification, **not** USL&H versus Non USL&H. Even if the rate for a Non "F" Classification code has been modified by the USL&H premium multiplier, it should **not** be classified as "F" Classification.

However, for purposes of USL&H reporting include "F" Classification codes and Non "F" Classification codes that have been modified by the USL&H premium multiplier.

- **Maritime**

The Merchant Marine Act of 1920, also known as the Jones Act, is a compensation legislation intended to allow maritime workers with injuries recover money to help cover medical care and health ***related costs*** .

Beginning with policies effective January 1, 2006 and later, all maritime experience is reported separately, in the Maritime Classification call.

Prior to January 1, 2006, maritime experience is included in the policy and accident year calls.

PART II
AGGREGATE FINANCIAL REPORTING

SECTION IV
ANNUAL CALLS

CALL # 1: MA TAKE-OUT *CREDIT* PROGRAM

Due Date: March 1st

A. DESCRIPTION

A listing of voluntary written policies removed from the Assigned Risk Pool and therefore eligible for credit against the carrier's or carrier group's residual market pool assessment base.

B. GENERAL INSTRUCTIONS

1. Companies who wish to participate in the Take–Out ***Credit*** Program in the current calendar year, as well as all carriers who have adjustments to previously reported take out policies in the current calendar year must submit a take out report.

[redacted]

[redacted]

2. Take-Out Credits are optional. A Take-Out Credit is available to a carrier for a given risk for a period of up to 36 months beginning with the policy effective date of the voluntary policy that replaced the residual market policy.

3. If policies effective in the prior year are booked in the current calendar year, these policies may be reported for the current calendar year; otherwise, all policies must be reported in the calendar year that the policy was written.

[redacted]

[redacted]

[redacted]

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

4. Policy premiums may ***change*** due to audit or ***the use of*** the installment method to book written premiums.

5. ***For a policy to be eligible for a Take-Out Credit, the kinds and amounts of coverage offered to a risk removed from the residual market shall not be less than those afforded by the residual market policy being replaced unless such kinds and amounts of coverage are refused by the insured. In determining whether the kinds and amounts of coverage being offered are less than those afforded by the residual market policy, the introduction of retrospective rating will not be considered "less coverage." Therefore, a carrier can obtain a Take-Out Credit by removing a risk from the residual market with a retrospectively rated voluntary policy.***

6. ***Treatment of large deductible policies for purposes of the Program is unique in that large deductible policies are not eligible for Take-Out Credit regardless of whether or not the insured has initially refused a policy that offered kinds and amounts of coverage not less than those afforded by its residual market policy. For example, if an insured refused a guaranteed cost policy and opts instead for a large deductible policy, the large deductible policy would not be eligible for Take-Out Credit. In fact, no large deductible policies are eligible for Take-Out Credits.***

7. ***In no instance will a carrier receive a Take-Out Credit for a risk returned to the residual market within one year of having been removed from the residual market.***

8. ***If there is a gap in coverage of more than 30 days between the residual market policy and the first subsequent voluntary policy, a Take-Out Credit is not available to any carrier.***

9. ***If a risk has been insured within the residual market for a period of less than one year, Take-Out Credits would be available to any carrier except a carrier who provided voluntary coverage anytime during the last year prior to the risk entering the residual market, and its carriers' affiliates. Carrier affiliation for this purpose is determined by using the NAIC carrier groupings as of the policy effective date associated with the voluntary policy that resulted in the risk's removal from the residual market. Any carrier, other than carriers that provided voluntary coverage to the risk anytime during the last year, prior to the risk entering the residual market, may remove a policy without any restriction on the length of time the policy resided in the residual market. If a risk has been insured within the residual market for a period of at least one year, any carrier may qualify for a Take-Out Credit for writing voluntary coverage.***

10. ***For purposes of calculating the Take-Out Credit, the Take-Out Credit Period is segmented into three 12 month intervals; First Year of Credit, Second Year of Credit, and Third Year of Credit. The Take-Out Credit for a given Year of Credit is calculated as the premiums earned (or subject to be earned)***

multiplied by the appropriate credit factor in accordance with the following schedule:

Take – Out Credit Factors By Premium Range & Year of Credit			
Premiums Earned or Subject to be Earned during Year of Credit	***Year of Credit***		
	First	***Second***	***Third***
Premium < $5,500	***1.50***	***1.50***	***1.50***
$5,500 < = Premium < $150,000	***1.00***	***1.00***	***1.00***
$150,000 < = Premium	***0.75***	***0.62***	***0.50***

11. For more information refer to MA Take-Out Credit Program listed under Actuarial/Other Programs at the ***WCRIBMA's*** website at www.wcribma.org.

C. COLUMN INSTRUCTIONS:

Column 1: ***NCCI Carrier Code – A unique 5 digit numeric code assigned by the National Council on Compensation Insurance (NCCI) to an insurance company.***

Column *2*: Insured's Name

Column *3*: Policy Number – A unique number that identifies a specific policy must be reported consistently for all reporting years. ***The Policy Number should be reported in the same manner as it was reported on the WCPOLS and USR records.***

Column *4*: ***WCRIBMA*** File Number – A unique number that identifies a specific file used by the ***WCRIBMA***.

Column *5*: Policy Effective Date of First Year Take–Out – The date the risk first became eligible for take-out credit. The effective date of the first voluntary policy written by ***the*** carrier ***group***.

Column *6*: Policy Effective Date – The date when a policy becomes effective.

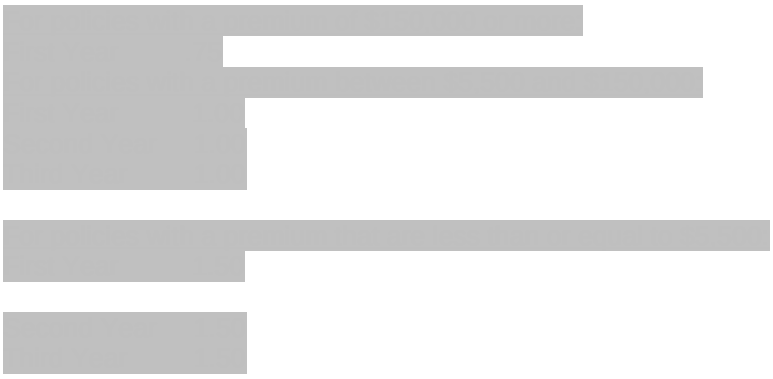
Column *7*: Policy Expiration Date – The ***first date when a*** policy ***no longer provides coverage.***

Column *8*: ***Written Premium***

Column *9*: ***Take-Out Credit***

Column *10*: ***First Year Take-Out Premium – The amount of premium earned or subject to be earned during the first year of credit.***

Column *11*: ***First Year Take-Out Credit Factor – The factor applied to the First Year Take-Out Premium to calculate the Take-Out Credit for the first year in the voluntary market.***



Column 12: ***Second Year Take-Out Premium - The amount of premium earned or subject to be earned during the second year of credit.***

Column 13**:** ***Second Year Take-Out Credit Factor - The factor applied to the Second Year Take-Out Premium to calculate the Take-Out Credit for the second year in the voluntary market.***

Column 14: ***Third Year Take-Out Premium – The amount of premium earned or subject to be earned during the third year of credit.***

Column 15: ***Third Year Take-Out Credit Factor – The factor applied to the Third Year Take-Out Premium to calculate the Take-Out Credit for the third year in the voluntary market.***

CALL # 1 – M A S S A C H U S E T T S T A K E O U T *CREDIT* P R O G R A M – Due March 1st

VALUED AS OF DECEMBER 31st _____

REPORTING GROUP NAME:_____ **REPORT ID:** _____

NCCI Carrier Code (1)	Insured's Name (2)	Policy Number (3)	*WCRIBMA* File Number (3)	Policy Eff. Date for 1st Yr. Take–Out (5)	Policy Eff. Date (6)	Policy Exp. Date (7)	Written Premium (8)	*Take-Out* Credit (9)	*First Year Take-Out Premium (10)*	*First Year Take-Out Credit Factor (11)*	*Second Year Take-Out Premium (12)*	*Second Year Take-Out Credit Factor (13)*	*Third Year Take-Out Premium (14)*	*Third Year Take-Out Credit Factor (15)*

DETAIL TAKE–OUT POLICIES AND ADJUSTMENTS

The Workers Compensation Rating and Inspection Bureau of Massachusetts
101 ARCH STREET • 5TH FLOOR • Boston, MA 02110
617-439-9030 • FAX 617-439-6055 • www.wcribma.org

POLICY YEAR CALLS - CALLS # 2, 2A, 2C, 2D, 2E

Data Period: Policy Year data valued as of December 31
Due Date: March 15

A. GENERAL DESCRIPTION

These are calls for Massachusetts workers' compensation experience summarized by policy year.

B. GENERAL INSTRUCTIONS (Applies to all Policy Year Calls)

1. Report aggregate totals (inception to date totals). Consequently, no premium, paid loss, or claim count values should be less than zero.

2. Massachusetts claims are those that relate to Massachusetts exposures used to calculate Massachusetts premiums. See the Definitions section for further details.

3. Report all loss amounts on a first dollar basis. In other words, for any policies having deductibles, report the loss amounts gross, before any deductible offset. This applies to:

   - Massachusetts Benefits Deductible Premium Credit
   - Massachusetts Benefits Claim and Aggregate Deductible Premium Credit
   - Independently filed large or small deductible ***programs***

4. The following experience should **not be included** in these calls:
   - Excess Workers' Compensation (written over a self-insured retention)
   - National Defense Projects Rating Plan
   - Terrorism Insurance Program (Certified Acts of Terrorism) Premium

5. The following fields must always be positive:
   - Earned Premium (Columns 1-3)
   - Indemnity Paid (Column 4)
   - Medical Paid (Column 5)
   - Indemnity Case Reserves (Column 8)
   - Medical Case Reserves (Column 9)
   - Incurred Indemnity Claim Count – ***Closed (with payment) (Column 11)***
   - ***Incurred Indemnity Claim Count – Open (Outstanding) (Column 12)***
   - Defense and Cost Containment Expense Paid (Column ***13***)
   - Defense and Cost Containment Expense Case (Column ***14***)
   - Premium Adjustment due to ARAP Surcharge (Column ***15***)

   The following fields must always be negative:
   - Premium Adjustments due to Construction Credit (Column ***16***)
   - Premium Adjustments due to QLMP Credit (Column ***17***)
   - Premium Adjustments due to Scheduled Rating Plans (Column ***18***)

6. Policy Year calls (columns 1, 2 and 3) should include Earned But Unbilled (EBUB) premium. If these amounts are not estimated at policy year level then make a reasonable allocation. Any future EBUB allocation should be consistent with prior allocations.

C. <u>ROW INSTRUCTIONS</u> (Applies to all Policy Year Calls):

- For each Row A-V, report the cumulative premium, paid losses, claim counts, and paid DCC from the date of policy inception to 12/31 of the current reporting year. Report loss reserves and DCC reserves as of December 31 of the current reporting year.
- For Line A, report all years prior to the twenty plus current.
- Line X is a calculated row; it is the sum of Rows A-V.
- For Line Y, report the prior year's call Line X.
- Line Z is a calculated row; it is the difference of Line X minus Line Y. This is the calendar year total for the current year.

D. <u>COLUMN INSTRUCTIONS</u> (Applies to all Policy Year Calls):

Column 1: Policy Year Accumulated Earned Premium – Standard at Bureau DSR Level

Column 2: Policy Year Accumulated Earned Premium – Standard at Company Level

Column 3: Policy Year Accumulated Earned Premium – Net

Column 4: Accumulated Policy Year – Paid Indemnity

Column 5: Accumulated Policy Year – Paid Medical

Column *6*: Accumulated Policy Year – Case Reserves Indemnity

Column *7*: Accumulated Policy Year – Case Reserves Medical

Column *8*: ***Indemnity and Medical Total Paid Losses*** - The MAFDRA and MAFDRA templates will automatically calculate Column ***8*** as Columns 4 and 5 are entered.

Column *9*: ***Indemnity and Medical Total Case Reserves*** calculate Column ***9*** as Columns 6 and 7 are entered.

Column *10*: ***Indemnity and Medical Total Case Incurred Losses*** - The MAFDRA and MAFDRA templates will automatically calculate Column 12 as Columns 8 and 9 are entered.

Column *11*: Policy Year Incurred Indemnity Claim Count – Accumulated Closed (***with payment***)

Column *12*: Policy Year Incurred Indemnity Claim Count – Open (Outstanding)

Column *13*: Accumulated Policy Year Defense and Cost Containment Expense – Paid

Column *14*: Accumulated Policy Year Defense and Cost Containment Expense – Case

Column *15*: Premium Adjustments Due to ARAP Surcharge

Column *16*: Premium Adjustments Due to Construction Credit Program (MCCPAP)

Column *17*: Premium Adjustments Due to QLMP Credit

Column *18*: Premium Adjustments Due to Scheduled Rating Plans

CALL # 2 – POLICY YEAR CALL

A. CALL SPECIFIC DESCRIPTION

This call ***contains*** Massachusetts workers' compensation experience ***excluding large deductible policies*** .

B. CALL SPECIFIC INSTRUCTIONS (Applies in addition to Policy Year Calls General Instructions)

1. Report premium and loss amounts for the current policy year and the twenty policy years prior to the current policy year. For earlier policy years, combine the data and report on the "All Prior Combined" line.

2. Reporting of the following elements is only required for policy years 1994 and subsequent:

   - Incurred Indemnity Claim Count - Accumulated Closed ***(with payment)*** (column ***11***)
   - Incurred Indemnity Claim Count - Open Outstanding (column ***12***)
   - Defense and Cost Containment Expenses Paid (column ***13***)
   - Defense and Cost Containment Expenses Case (column ***14***)
   - Premium Adjustments due to Scheduled Rating Plans (column ***18***)

3. Exclude the following experience when compiling the data for this call:

   - Excess Workers' Compensation (written over a self-insured retention)
   - National Defense Projects Rating Plan
   - Terrorism Insurance Program (Certified Acts of Terrorism) Premium
   - F Classification experience
   - Maritime experience for all policies effective January 1, 2006 and later
   - Large Deductible experience

CALL #2 – POLICY YEAR CALL

REPORTING GROUP NAME:_____ **REPORT ID:** _____

			(1)	(2)	(3)	(4)	(5)
			Policy Year Accumulated Earned Premium			Paid	
Line	Report Level	Policy Year Being Valued	Standard at Bureau Designated Statistical Reporting Level	Standard at Company Level	Net	Indemnity	Medical
A.	All Prior Combined	***Prior to 1990***					
B.	20th	***1990***					
C.	19th	***1991***					
D.	18th	***1992***					
E.	17th	***1993***					
F.	16th	***1994***					
G.	15th	***1995***					
H.	14th	***1996***					
I.	13th	***1997***					
J.	12th	***1998***					
K.	11th	***1999***					
L.	10th	***2000***					
M.	9th	***2001***					
N.	8th	***2002***					
O.	7th	***2003***					
P.	6th	***2004***					
Q.	5th	***2005***					
R.	4th	***2006***					
S.	3rd	***2007***					
T.	2nd	***2008***					
U.	1st	***2009***					
V.	Current	***2010***					
X.	Total to Current 12/31 Sum (A) to (V)						
Y.	Total to Prior 12/31 Sum (A) to (V)						
Z.	Calendar Year Experience (X-Y)						

CALL #2 – POLICY YEAR CALL

REPORTING GROUP NAME:_____ **REPORT ID:** _____

			(6)	(7)	(8)	(9)	(10)	(11)	(12)
		Policy	Case Reserves		Indemnity and Medical – Total Losses			Policy Year Incurred Indemnity Claim Count	
Line	Report Level	Year Being Valued	Indemnity	Medical	Paid (4)+(5)	Case Reserves (6)+(7)	Case Incurred Losses (8)+(9)	Accumulated Closed (with payment)	Open Outstanding
A.	All Prior Combined	*Prior to 1990*							
B.	20th	*1990*							
C.	19th	*1991*							
D.	18th	*1992*							
E.	17th	*1993*							
F.	16th	*1994*							
G.	15th	*1995*							
H.	14th	*1996*							
I.	13th	*1997*							
J.	12th	*1998*							
K.	11th	*1999*							
L.	10th	*2000*							
M.	9th	*2001*							
N.	8th	*2002*							
O.	7th	*2003*							
P.	6th	*2004*							
Q.	5th	*2005*							
R.	4th	*2006*							
S.	3rd	*2007*							
T.	2nd	*2008*							
U.	1st	*2009*							
V.	Current	*2010*							
X.	Total to Current 12/31 Sum (A) to (V)								
Y.	Total to Prior 12/31 Sum (A) to (V)								
Z.	Calendar Year Experience (X-Y)								

CALL #2 – POLICY YEAR CALL

REPORTING GROUP NAME:_____ **REPORT ID:** _____

			(13)	(14)	(15)	(16)	(17)	(18)
			Accumulated Policy Year Defense and Cost Containment Expense		Premium Adjustments			
Line	Report Level	Policy Year Being Valued	Paid	Case	Due to ARAP Surcharge	Due to Construction Credit Program	Due to QLMP Credit	Due to Scheduled Rating Plans
A.	All Prior Combined	***Prior to 1990***						
B.	20th	***1990***						
C.	19th	***1991***						
D.	18th	***1992***						
E.	17th	***1993***						
F.	16th	***1994***						
G.	15th	***1995***						
H.	14th	***1996***						
I.	13th	***1997***						
J.	12th	***1998***						
K.	11th	***1999***						
L.	10th	***2000***						
M.	9th	***2001***						
N.	8th	***2002***						
O.	7th	***2003***						
P.	6th	***2004***						
Q.	5th	***2005***						
R.	4th	***2006***						
S.	3rd	***2007***						
T.	2nd	***2008***						
U.	1st	***2009***						
V.	Current	***2010***						
X.	Total to Current 12/31 Sum (A) to (V)							
Y.	Total to Prior 12/31 Sum (A) to (V)							
Z.	Calendar Year Experience (X-Y)							

CALL #2A: POLICY YEAR RESIDUAL MARKET CALL

A. CALL SPECIFIC DESCRIPTION

Report all Massachusetts workers' compensation residual market experience .

The Massachusetts residual market is made up of the following:

- Massachusetts Assigned Risk Pool
- Voluntary Direct Assigned Risks

B. CALL SPECIFIC INSTRUCTIONS (Applies in addition to Policy Year Calls General Instructions)

1. The Massachusetts Assigned Risk Pool assigns residual market policies to either a servicing carrier or to a voluntary direct assignment carrier. Both types of policies are to be reported.

2. Report premium and loss amounts for the policy years 1989 and subsequent.

3. Reporting of the following elements is only required for policy years 1994 and subsequent:

   - Incurred Indemnity Claim Count – Accumulated Closed ***(with payment)*** (column ***11***)
   - Incurred Indemnity Claim Count – Open Outstanding (column ***12***)
   - Defense and Cost Containment Expenses Paid (column ***13***)
   - Defense and Cost Containment Expenses Case (column ***14***)

4. Exclude the following experience when compiling the data for this call:

   - Excess Workers' Compensation (written over a self-insured retention)
   - National Defense Projects Rating Plan
   - Terrorism Insurance Program (Certified Acts of Terrorism) Premium
   - F Classification experience
   - Maritime experience for all policies effective January 1, 2007 and later

CALL #2A – POLICY YEAR RESIDUAL MARKET CALL

REPORTING GROUP NAME:_____ **REPORT ID:** _____

			(1)	(2)	(3)	(4)	(5)
			Policy Year Accumulated Earned Premium			Paid	
Line	Report Level	Policy Year Being Valued	Standard at Bureau Designated Statistical Reporting Level	Standard at Company Level	Net	Indemnity	Medical
A.	All Prior Combined	***Prior to 1990***					
B.	20th	***1990***					
C.	19th	***1991***					
D.	18th	***1992***					
E.	17th	***1993***					
F.	16th	***1994***					
G.	15th	***1995***					
H.	14th	***1996***					
I.	13th	***1997***					
J.	12th	***1998***					
K.	11th	***1999***					
L.	10th	***2000***					
M.	9th	***2001***					
N.	8th	***2002***					
O.	7th	***2003***					
P.	6th	***2004***					
Q.	5th	***2005***					
R.	4th	***2006***					
S.	3rd	***2007***					
T.	2nd	***2008***					
U.	1st	***2009***					
V.	Current	***2010***					
X.	Total to Current 12/31 Sum (A) to (V)						
Y.	Total to Prior 12/31 Sum (A) to (V)						
Z.	Calendar Year Experience (X-Y)						

CALL #2A – POLICY YEAR RESIDUAL MARKET CALL

REPORTING GROUP NAME:_____ **REPORT ID:** _____

			(6)	(7)	(8)	(9)	(10)	(11)	(12)
			Case Reserves		Indemnity and Medical – Total Losses			Policy Year Incurred Indemnity Claim Count	
Line	Report Level	Policy Year Being Valued	Indemnity	Medical	Paid (4)+(5)	Case Reserves (6)+(7)	Incurred Losses Including IBNR (8)+(9)	Accumulated Closed (with payment)	Open Outstanding
A.	All Prior Combined	*Prior to 1990*							
B.	20th	*1990*							
C.	19th	*1991*							
D.	18th	*1992*							
E.	17th	*1993*							
F.	16th	*1994*							
G.	15th	*1995*							
H.	14th	*1996*							
I.	13th	*1997*							
J.	12th	*1998*							
K.	11th	*1999*							
L.	10th	*2000*							
M.	9th	*2001*							
N.	8th	*2002*							
O.	7th	*2003*							
P.	6th	*2004*							
Q.	5th	*2005*							
R.	4th	*2006*							
S.	3rd	*2007*							
T.	2nd	*2008*							
U.	1st	*2009*							
V.	Current	*2010*							
X.	Total to Current 12/31 Sum (A) to (V)								
Y.	Total to Prior 12/31 Sum (A) to (V)								
Z.	Calendar Year Experience (X-Y)								

CALL #2A – POLICY YEAR RESIDUAL MARKET CALL

REPORTING GROUP NAME:_____ **REPORT ID:** _____

			(13)	(14)	(15)	(16)	(17)	(18)
					Premium Adjustments			
Line	Report Level	Policy Year Being Valued	Accumulated Policy Year Defense and Cost Containment Expense		Due to ARAP Surcharge	Due to Construction Credit Program	Due to QLMP Credit	Due to Scheduled Rating Plans
			Paid	Case				
A.	All Prior Combined	***Prior to 1990***						
B.	20th	***1990***						
C.	19th	***1991***						
D.	18th	***1992***						
E.	17th	***1993***						
F.	16th	***1994***						
G.	15th	***1995***						
H.	14th	***1996***						
I.	13th	***1997***						
J.	12th	***1998***						
K.	11th	***1999***						
L.	10th	***2000***						
M.	9th	***2001***						
N.	8th	***2002***						
O.	7th	***2003***						
P.	6th	***2004***						
Q.	5th	***2005***						
R.	4th	***2006***						
S.	3rd	***2007***						
T.	2nd	***2008***						
U.	1st	***2009***						
V.	Current	***2010***						
X.	Total to Current 12/31 Sum (A) to (V)							
Y.	Total to Prior 12/31 Sum (A) to (V)							
Z.	Calendar Year Experience (X-Y)							

CALL #2C: POLICY YEAR LARGE DEDUCTIBLE CALL

A. CALL SPECIFIC DESCRIPTION

Report Massachusetts workers' compensation large deductible experience summarized by policy year. In Massachusetts, large deductibles are defined as policies with **per claim deductibles of at least $75,000**.

B. CALL SPECIFIC INSTRUCTIONS (Applies in addition to Policy Year Calls General Instructions)

1. Report premium and loss amounts for policy years 1990 and subsequent.

2. Reporting of the following elements is only required for policy years 1994 and subsequent:

   - Incurred Indemnity Claim Count – Accumulated Closed ***(with payment)*** (column ***11***)
   - Incurred Indemnity Claim Count – Open Outstanding (column ***12***)
   - Defense and Cost Containment Expenses Paid (column ***13***)
   - Defense and Cost Containment Expenses Case (column ***14***)

3. Effective January 1, 2007 report Premium Adjustments due to Schedule Rating Plans (column 22).

4. Policies with provisions for the MA Benefits Deductible Premium Credit or the MA Benefits Claim and Aggregate Deductible Premium Credit are not to be reported on this call.

5. Exclude the following experience when compiling the data for this call:

   - Excess Workers' Compensation (written over a self-insured retention)
   - National Defense Projects Rating Plan
   - Terrorism Insurance Program (Certified Acts of Terrorism) Premium
   - F Classification experience
   - Maritime experience for all policies effective January 1, 2006 and later

CALL #2C – POLICY YEAR LARGE DEDUCTIBLE CALL

REPORTING GROUP NAME:_____ **REPORT ID:** _____

			(1)	(2)	(3)	(4)	(5)
		Policy	**Policy Year Accumulated Earned Premium**			**Paid**	
Line	**Report Level**	**Year Being Valued**	**Standard at Bureau Designated Statistical Reporting Level**	**Standard at Company Level**	**Net**	**Indemnity**	**Medical**
A.	All Prior Combined	***Prior to 1990***					
B.	20th	***1990***					
C.	19th	***1991***					
D.	18th	***1992***					
E.	17th	***1993***					
F.	16th	***1994***					
G.	15th	***1995***					
H.	14th	***1996***					
I.	13th	***1997***					
J.	12th	***1998***					
K.	11th	***1999***					
L.	10th	***2000***					
M.	9th	***2001***					
N.	8th	***2002***					
O.	7th	***2003***					
P.	6th	***2004***					
Q.	5th	***2005***					
R.	4th	***2006***					
S.	3rd	***2007***					
T.	2nd	***2008***					
U.	1st	***2009***					
V.	Current	***2010***					
X.	Total to Current 12/31 Sum (A) to (V)						
Y.	Total to Prior 12/31 Sum (A) to (V)						
Z.	Calendar Year Experience (X-Y)						

CALL #2C – POLICY YEAR LARGE DEDUCTIBLE CALL

REPORTING GROUP NAME:_____ **REPORT ID:** _____

			(6)	(7)	(8)	(9)	(10)	(11)	(12)
		Policy	Case Reserves		Indemnity and Medical – Total Losses			Policy Year Incurred	
		Year					Case Incurred Losses	Indemnity Claim Count	
Line	Report Level	Being Valued	Indemnity	Medical	Paid (4)+(5)	Case Reserves (6)+(7)	(8)+(9)	Accumulated Closed (with payment)	Open Outstanding
A.	All Prior Combined	*Prior to 1990*							
B.	20th	*1990*							
C.	19th	*1991*							
D.	18th	*1992*							
E.	17th	*1993*							
F.	16th	*1994*							
G.	15th	*1995*							
H.	14th	*1996*							
I.	13th	*1997*							
J.	12th	*1998*							
K.	11th	*1999*							
L.	10th	*2000*							
M.	9th	*2001*							
N.	8th	*2002*							
O.	7th	*2003*							
P.	6th	*2004*							
Q.	5th	*2005*							
R.	4th	*2006*							
S.	3rd	*2007*							
T.	2nd	*2008*							
U.	1st	*2009*							
V.	Current	*2010*							
X.	Total to Current 12/31 Sum (A) to (V)								
Y.	Total to Prior 12/31 Sum (A) to (V)								
Z.	Calendar Year Experience (X-Y)								

CALL #2C – POLICY YEAR LARGE DEDUCTIBLE CALL

REPORTING GROUP NAME:_____ **REPORT ID:** _____

			(13)	(14)	(15)	(16)	(17)	(18)
			Accumulated Policy Year Defense And Cost Containment Expense		Premium Adjustments			
Line	Report Level	Policy Year Being Valued	Paid	Case	Due to ARAP Surcharge	Due to Construction Credit Program	Due to QLMP Credit	Due to Scheduled Rating Plans
A.	All Prior Combined	*Prior to 1990*						
B.	20th	*1990*						
C.	19th	*1991*						
D.	18th	*1992*						
E.	17th	*1993*						
F.	16th	*1994*						
G.	15th	*1995*						
H.	14th	*1996*						
I.	13th	*1997*						
J.	12th	*1998*						
K.	11th	*1999*						
L.	10th	*2000*						
M.	9th	*2001*						
N.	8th	*2002*						
O.	7th	*2003*						
P.	6th	*2004*						
Q.	5th	*2005*						
R.	4th	*2006*						
S.	3rd	*2007*						
T.	2nd	*2008*						
U.	1st	*2009*						
V.	Current	*2010*						
X.	Total to Current 12/31 Sum (A) to (V)							
Y.	Total to Prior 12/31 Sum (A) to (V)							
Z.	Calendar Year Experience (X-Y)							

CALL #2D: POLICY YEAR "F" CLASSIFICATION CALL

A. CALL SPECIFIC DESCRIPTION

Report Massachusetts workers' compensation "F" classification experience .

B. CALL SPECIFIC INSTRUCTIONS (Applies in addition to Policy Year Calls General Instructions)

1. Report premium and loss amounts for the current policy year and the twenty policy years prior to the current policy year. For earlier policy years, combine the data and report on the "All Prior Combined" line.

2. Effective January 1, 2007, "F" classification experience for policy years 2006 and subsequent is to be reported on an individual classification-by-classification basis.

   For policy years 2005 and prior, report "F" classification experience in the same manner as reported previously.

3. For a complete listing of all classification codes, refer to the rate table in the Massachusetts Workers' Compensation and Employers Liability Insurance Manual.

4. Reporting of the following elements is only required for policy years 1994 and subsequent:

   - Incurred Indemnity Claim Count - Accumulated Closed ***(with payment)*** (column ***11***)
   - Incurred Indemnity Claim Count - Open Outstanding (column ***12***)
   - Defense and Cost Containment Expenses Paid (column ***13***)
   - Defense and Cost Containment Expenses Case (column ***14***)
   -

5. Effective January 1, 2007 report Premium Adjustments due to Schedule Rating Plans (column 22).

6. Exclude the following experience when compiling the data for this call:

   - Excess Workers' Compensation (written over a self-insured retention)
   - National Defense Projects Rating Plan
   - Terrorism Insurance Program (Certified Acts of Terrorism) Premium
   - Maritime experience

CALL #2D - POLICY YEAR "F" CLASSIFICATION CALL

REPORTING GROUP NAME:_____ **REPORT ID:** _____

			(1)	(2)	(3)	(4)	(5)
			Policy Year Accumulated Earned Premium			Paid	
Line	**Report Level**	**Policy Year Being Valued**	**Standard at Bureau Designated Statistical Reporting Level**	**Standard at Company Level**	**Net**	**Indemnity**	**Medical**
A.	All Prior Combined	***Prior to 1990***					
B.	20th	***1990***					
C.	19th	***1991***					
D.	18th	***1992***					
E.	17th	***1993***					
F.	16th	***1994***					
G.	15th	***1995***					
H.	14th	***1996***					
I.	13th	***1997***					
J.	12th	***1998***					
K.	11th	***1999***					
L.	10th	***2000***					
M.	9th	***2001***					
N.	8th	***2002***					
O.	7th	***2003***					
P.	6th	***2004***					
Q.	5th	***2005***					
R.	4th	***2006***					
S.	3rd	***2007***					
T.	2nd	***2008***					
U.	1st	***2009***					
V.	Current	***2010***					
X.	Total to Current 12/31 Sum (A) to (V)						
Y.	Total to Prior 12/31 Sum (A) to (V)						
Z.	Calendar Year Experience (X-Y)						

CALL #2D - POLICY YEAR "F" CLASSIFICATION CALL

REPORTING GROUP NAME:_____ **REPORT ID:** _____

			(6)	(7)	(8)	(9)	(10)	(11)	(12)
		Policy	Case Reserves		Indemnity and Medical– Total Losses			Policy Year Incurred	
		Year					Case Incurred Losses	Indemnity Claim Count	
Line	Report Level	Being Valued	Indemnity	Medical	Paid (4)+(5)	Case Reserves (6)+(7)	(8)+(9)	Accumulated Closed (with payment)	Open Outstanding
A.	All Prior Combined	*Prior to 1990*							
B.	20th	*1990*							
C.	19th	*1991*							
D.	18th	*1992*							
E.	17th	*1993*							
F.	16th	*1994*							
G.	15th	*1995*							
H.	14th	*1996*							
I.	13th	*1997*							
J.	12th	*1998*							
K.	11th	*1999*							
L.	10th	*2000*							
M.	9th	*2001*							
N.	8th	*2002*							
O.	7th	*2003*							
P.	6th	*2004*							
Q.	5th	*2005*							
R.	4th	*2006*							
S.	3rd	*2007*							
T.	2nd	*2008*							
U.	1st	*2009*							
V.	Current	*2010*							
X.	Total to Current 12/31 Sum (A) to (V)								
Y.	Total to Prior 12/31 Sum (A) to (V)								
Z.	Calendar Year Experience (X-Y)								

CALL #2D - POLICY YEAR "F" CLASSIFICATION CALL

REPORTING GROUP NAME:_____ **REPORT ID:** _____

			(13)	(14)	(15)	(16)	(17)	(18)
					Premium Adjustments			
Line	**Report Level**	**Policy Year Being Valued**	**Accumulated Policy Year Defense and Cost Containment Expense**		**Due to ARAP Surcharge**	**Due to Construction Credit Program**	**Due to QLMP Credit**	**Due to Scheduled Rating Plans**
			Paid	**Case**				
A.	All Prior Combined	***Prior to 1990***						
B.	20th	***1990***						
C.	19th	***1991***						
D.	18th	***1992***						
E.	17th	***1993***						
F.	16th	***1994***						
G.	15th	***1995***						
H.	14th	***1996***						
I.	13th	***1997***						
J.	12th	***1998***						
K.	11th	***1999***						
L.	10th	***2000***						
M.	9th	***2001***						
N.	8th	***2002***						
O.	7th	***2003***						
P.	6th	***2004***						
Q.	5th	***2005***						
R.	4th	***2006***						
S.	3rd	***2007***						
T.	2nd	***2008***						
U.	1st	***2009***						
V.	Current	***2010***						
X.	Total to Current 12/31 Sum (A) to (V)							
Y.	Total to Prior 12/31 Sum (A) to (V)							
Z.	Calendar Year Experience (X-Y)							

CALL #2E: POLICY YEAR MARITIME CLASSIFICATION CALL

A. CALL SPECIFIC DESCRIPTION

Report Massachusetts workers' compensation maritime experience summarized by policy year.
See the Definitions Section for further details about maritime experience.

B. CALL SPECIFIC INSTRUCTIONS (Applies in addition to Policy Year Calls General Instructions)

1. Report premium and loss amounts for the policy years 2006 and subsequent. Maritime experience for policy years prior to ***policy year*** 2006 is to be excluded from this call.

2. Exclude the following experience when compiling the data for this call:

   - Excess Workers' Compensation (written over a self-insured retention)
   - National Defense Projects Rating Plan
   - Terrorism Insurance Program (Certified Acts of Terrorism) Premium
   - F Classification experience

CALL #2E - POLICY YEAR MARITIME CLASSIFICATION CALL

REPORTING GROUP NAME:_____ **REPORT ID:** _____

			(1)	(2)	(3)	(4)	(5)
			Policy Year Accumulated Earned Premium			Paid	
Line	Report Level	Policy Year Being Valued	Standard at Bureau Designated Statistical Reporting Level	Standard at Company Level	Net	Indemnity	Medical
A.	All Prior Combined	***Prior to 1990***					
B.	20th	***1990***					
C.	19th	***1991***					
D.	18th	***1992***					
E.	17th	***1993***					
F.	16th	***1994***					
G.	15th	***1995***					
H.	14th	***1996***					
I.	13th	***1997***					
J.	12th	***1998***					
K.	11th	***1999***					
L.	10th	***2000***					
M.	9th	***2001***					
N.	8th	***2002***					
O.	7th	***2003***					
P.	6th	***2004***					
Q.	5th	***2005***					
R.	4th	***2006***					
S.	3rd	***2007***					
T.	2nd	***2008***					
U.	1st	***2009***					
V.	Current	***2010***					
X.	Total to Current 12/31 Sum (A) to (V)						
Y.	Total to Prior 12/31 Sum (A) to (V)						
Z.	Calendar Year Experience (X-Y)						

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CALL #2E - POLICY YEAR MARITIME CLASSIFICATION CALL

REPORTING GROUP NAME:_____ **REPORT ID:** _____

			(6)	(7)	(8)	(9)	(10)	(11)	(12)
			Case Reserves		Indemnity and Medical – Total Losses			Policy Year Incurred Indemnity Claim Count	
Line	Report Level	Policy Year Being Valued	Indemnity	Medical	Paid (4)+(5)	Case Reserves (6)+(7)	Case Incurred Losses (8)+(9)	Accumulated Closed (with payment)	Open Outstanding
A.	All Prior Combined	*Prior to 1990*							
B.	20th	*1990*							
C.	19th	*1991*							
D.	18th	*1992*							
E.	17th	*1993*							
F.	16th	*1994*							
G.	15th	*1995*							
H.	14th	*1996*							
I.	13th	*1997*							
J.	12th	*1998*							
K.	11th	*1999*							
L.	10th	*2000*							
M.	9th	*2001*							
N.	8th	*2002*							
O.	7th	*2003*							
P.	6th	*2004*							
Q.	5th	*2005*							
R.	4th	*2006*							
S.	3rd	*2007*							
T.	2nd	*2008*							
U.	1st	*2009*							
V.	Current	*2010*							
X.	Total to Current 12/31 Sum (A) to (V)								
Y.	Total to Prior 12/31 Sum (A) to (V)								
Z.	Calendar Year Experience (X-Y)								

CALL #2E - POLICY YEAR MARITIME CLASSIFICATION CALL

REPORTING GROUP NAME:_____ **REPORT ID:** _____

			(13)	(14)	(15)	(16)	(17)	(18)
			Accumulated Policy Year Defense and Cost Containment Expense		Premium Adjustments			
Line	Report Level	Policy Year Being Valued	Paid	Case	Due to ARAP Surcharge	Due to Construction Credit Program	Due to QLMP Credit	Due to Scheduled Rating Plans
A.	All Prior Combined	*Prior to 1990*						
B.	20th	*1990*						
C.	19th	*1991*						
D.	18th	*1992*						
E.	17th	*1993*						
F.	16th	*1994*						
G.	15th	*1995*						
H.	14th	*1996*						
I.	13th	*1997*						
J.	12th	*1998*						
K.	11th	*1999*						
L.	10th	*2000*						
M.	9th	*2001*						
N.	8th	*2002*						
O.	7th	*2003*						
P.	6th	*2004*						
Q.	5th	*2005*						
R.	4th	*2006*						
S.	3rd	*2007*						
T.	2nd	*2008*						
U.	1st	*2009*						
V.	Current	*2010*						
X.	Total to Current 12/31 Sum (A) to (V)							
Y.	Total to Prior 12/31 Sum (A) to (V)							
Z.	Calendar Year Experience (X-Y)							

ACCIDENT YEAR CALLS - CALLS # 3, 3A, 3C

Data Period: Accident Year data valued as of December 31
Due Date: April 1

A. GENERAL DESCRIPTION

These are calls for Massachusetts workers' compensation experience .

B. GENERAL INSTRUCTIONS (Applies to all Accident Year Calls)

1. Report aggregate totals (inception to date totals). Consequently, no paid loss, or claim count values should be less than zero.

2. Massachusetts claims are those that relate to Massachusetts exposures used to calculate Massachusetts premiums. ***See the Definitions section for further details.***

3. Report all loss amounts on a first dollar basis. In other words, for any policies having deductibles, report the loss amounts gross, before any deductible offset. This applies to:

   - Massachusetts Benefits Deductible Premium Credit
   - Massachusetts Benefits Claim and Aggregate Deductible Premium Credit
   - Independently filed large or small deductible ***programs***

4. The following experience should **not be included** in these calls:
   - Excess Workers' Compensation (written over a self-insured retention)
   - National Defense Projects Rating Plan
   - F Classification experience
   - Maritime experience for all policies effective January 1, 2006 and later

5. The following fields must always be positive:
   - Indemnity Paid (Column 1)
   - Medical Paid (Column 2)
   - Indemnity Case Reserves (Column ***3***)
   - Medical Case Reserves (Column ***4***)
   - Incurred Indemnity Claim Count: - ***Closed (with payment)*** (Column ***8***)
   - ***Incurred Indemnity Claim Count – Open (Outstanding) (Column 9)***
   - Defense and Cost Containment Expense Paid (Column ***10***)
   - Defense and Cost Containment Expense Case (Column ***11***)

C. <u>ROW INSTRUCTIONS</u> (Applies to all Accident Year Calls):

- For each Row A-V, report the cumulative paid losses from the date of accident through December 31 of the current reporting year. Report loss reserves or claim counts as of December 31 of the current reporting year.
- For Line A, report all years prior to the twenty plus current.
- Line X is a calculated row; it is the sum of Rows A-V.
- For Line Y, report the prior year's call Line X.
- Line Z is a calculated row; it is the difference of Line X minus Line Y. This is the calendar year total for the current year.

D. <u>COLUMN INSTRUCTIONS</u> (Applies to all Accident Year Calls):

Column 1: Accumulated Accident Year – Paid Indemnity

Column 2: Accumulated Accident Year – Paid Medical

Column *3*: Accumulated Accident Year – Case Reserves Indemnity

Column *4*: Accumulated Accident Year – Case Reserves Medical

Column *5*: ***Indemnity and Medical Total Paid Losses*** - The MAFDRA and MAFDRA templates will calculate Column ***5*** as Columns ***1*** and ***2*** are entered.

Column *6*: ***Indemnity and Medical Total Case Reserves*** - The MAFDRA and MAFDRA templates will calculate Column ***6*** as Columns ***3*** and ***4*** are entered.

Column *7*: ***Indemnity and Medical Total Case Incurred losses*** - The MAFDRA and MAFDRA templates will calculate Column ***3 7*** as Columns ***9 5*** and ***10 6*** are entered.

Column *8*: Accident Year Incurred Indemnity Claim Count – Accumulated Closed (***with payment***)

Column *9*: Accident Year Incurred Indemnity Claim Count – Open (Outstanding)

Column *10*: Accumulated Accident Year Defense and Cost Containment Expense – Paid

Column *11*: Accumulated Accident Year Defense and Cost Containment Expense – Case

CALL #3 – ACCIDENT YEAR CALL

A. CALL SPECIFIC DESCRIPTION

Report Massachusetts workers' compensation experience ***excluding large deductible***.

B. CALL SPECIFIC INSTRUCTIONS (Applies in addition to Accident Year Calls General Instructions)

1. Report loss amounts for the current accident year and the twenty accident years prior to the current accident year. For earlier accident years, combine the data and report on the "All Prior Combined" line.

2. Reporting of the following elements is only required for accident years 1994 and subsequent:

   - Incurred Indemnity Claim Count - Accumulated Closed ***(with payment)*** (column ***8***)
   - Incurred Indemnity Claim Count - Open ***(***Outstanding***)*** (column ***9***)
   - Defense and Cost Containment Expenses Paid (column ***10***)
   - Defense and Cost Containment Expenses Case (column ***11***)

3. Exclude the following experience when compiling the data for this call:

   - Excess Workers' Compensation (written over a self-insured retention)
   - National Defense Projects Rating Plan
   - F Classification experience
   - Maritime experience for all policies effective January 1, 2006 and later
   - Large Deductible experience

CALL #3 – ACCIDENT YEAR CALL

REPORTING GROUP NAME:_____ **REPORT ID:** _____

			(1)	(2)	(3)	(4)
			Paid		Case Reserves	
Line	Report Level	Accident Year Being Valued	Indemnity	Medical	Indemnity	Medical
A.	All Prior Combined	*Prior to 1990*				
B.	20th	*1990*				
C.	19th	*1991*				
D.	18th	*1992*				
E.	17th	*1993*				
F.	16th	*1994*				
G.	15th	*1995*				
H.	14th	*1996*				
I.	13th	*1997*				
J.	12th	*1998*				
K.	11th	*1999*				
L.	10th	*2000*				
M.	9th	*2001*				
N.	8th	*2002*				
O.	7th	*2003*				
P.	6th	*2004*				
Q.	5th	*2005*				
R.	4th	*2006*				
S.	3rd	*2007*				
T.	2nd	*2008*				
U.	1st	*2009*				
V.	Current	*2010*				
X.	Total to Current 12/31 Sum (A) to (V)					
Y.	Total to Prior 12/31 Sum (A) to (V)					
Z.	Calendar Year Experience (X-Y)					

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CALL #3 – ACCIDENT YEAR CALL

REPORTING GROUP NAME:_____ **REPORT ID:** _____

			(5)	(6)	(7)	(8)	(9)	(10)	(11)
		Accident Year	**Indemnity and Medical– Total Losses**			**Accident Year Incurred Indemnity Claim Count**		**Accumulated Accident Year Defense and**	
Line	**Report Level**	**Being Valued**	**Paid (1)+(2)**	**Case Reserves (3)+(4)**	**Case Incurred Losses (5)+(6)**	**Accumulated Closed (with payment)**	**Open Outstanding**	**Paid**	**Case**
A.	All Prior Combined	***Prior to 1990***							
B.	20th	***1990***							
C.	19th	***1991***							
D.	18th	***1992***							
E.	17th	***1993***							
F.	16th	***1994***							
G.	15th	***1995***							
H.	14th	***1996***							
I.	13th	***1997***							
J.	12th	***1998***							
K.	11th	***1999***							
L.	10th	***2000***							
M.	9th	***2001***							
N.	8th	***2002***							
O.	7th	***2003***							
P.	6th	***2004***							
Q.	5th	***2005***							
R.	4th	***2006***							
S.	3rd	***2007***							
T.	2nd	***2008***							
U.	1st	***2009***							
V.	Current	***2010***							
X.	Total to Current 12/31 Sum (A) to (V)								
Y.	Total to Prior 12/31 Sum (A) to (V)								
Z.	Calendar Year Experience (X-Y)								

CALL # 3A – ACCIDENT YEAR RESIDUAL MARKET CALL

A. CALL SPECIFIC DESCRIPTION

Report Massachusetts workers' compensation residual market experience summarized by accident year.

The Massachusetts residual market is made up of the following:

- Massachusetts Assigned Risk Pool
- Voluntary Direct Assigned Risks

B. CALL SPECIFIC INSTRUCTIONS (Applies in addition to Accident Year Calls General Instructions)

1. The Massachusetts Assigned Risk Pool assigns residual market policies to either a servicing carrier or to a voluntary direct assignment carrier. Both types of policies are to be reported.

2. Report loss amounts for the accident years 1989 and subsequent.

3. Reporting of the following elements is only required for accident years 1994 and subsequent:

   - Incurred Indemnity Claim Count – Accumulated Closed ***(with payment)*** (column ***8***)
   - Incurred Indemnity Claim Count – Open Outstanding (column ***9***)
   - Defense and Cost Containment Expenses Paid (column ***10***)
   - Defense and Cost Containment Expenses Case (column ***11***)

4. Exclude the following experience when compiling the data for this call:

   - Excess Workers' Compensation (written over a self-insured retention)
   - National Defense Projects Rating Plan
   - F Classification experience
   - Maritime experience for all policies effective January 1, 2006 and later

CALL #3A – ACCIDENT YEAR RESIDUAL MARKET CALL

REPORTING GROUP NAME:_____ **REPORT ID:** _____

			(1)	(2)	(3)	(4)
			Paid		Case Reserves	
Line	Report Level	Accident Year Being Valued	Indemnity	Medical	Indemnity	Medical
A.	All Prior Combined	*Prior to 1990*				
B.	20th	*1990*				
C.	19th	*1991*				
D.	18th	*1992*				
E.	17th	*1993*				
F.	16th	*1994*				
G.	15th	*1995*				
H.	14th	*1996*				
I.	13th	*1997*				
J.	12th	*1998*				
K.	11th	*1999*				
L.	10th	*2000*				
M.	9th	*2001*				
N.	8th	*2002*				
O.	7th	*2003*				
P.	6th	*2004*				
Q.	5th	*2005*				
R.	4th	*2006*				
S.	3rd	*2007*				
T.	2nd	*2008*				
U.	1st	*2009*				
V.	Current	*2010*				
X.	Total to Current 12/31 Sum (A) to (V)					
Y.	Total to Prior 12/31 Sum (A) to (V)					
Z.	Calendar Year Experience (X-Y)					

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CALL #3A – ACCIDENT YEAR RESIDUAL MARKET CALL

REPORTING GROUP NAME:_____ **REPORT ID:** _____

			(5)	(6)	(7)	(8)	(9)	(10)	(11)
		Accident Year	**Indemnity and Medical– Total Losses**			**Accident Year Incurred Indemnity Claim Count**		**Accumulated Accident Year Defense and Cost Containment Expense**	
Line	**Report Level**	**Being Valued**	**Paid (1)+(2)**	**Case Reserves (3)+(4)**	**Case Incurred Losses (5)+(6)**	**Accumulated Closed (with payment)**	**Open Outstanding**	**Paid**	**Case**
A.	All Prior Combined	***Prior to 1990***							
B.	20th	***1990***							
C.	19th	***1991***							
D.	18th	***1992***							
E.	17th	***1993***							
F.	16th	***1994***							
G.	15th	***1995***							
H.	14th	***1996***							
I.	13th	***1997***							
J.	12th	***1998***							
K.	11th	***1999***							
L.	10th	***2000***							
M.	9th	***2001***							
N.	8th	***2002***							
O.	7th	***2003***							
P.	6th	***2004***							
Q.	5th	***2005***							
R.	4th	***2006***							
S.	3rd	***2007***							
T.	2nd	***2008***							
U.	1st	***2009***							
V.	Current	***2010***							
X.	Total to Current 12/31 Sum (A) to (V)								
Y.	Total to Prior 12/31 Sum (A) to (V)								
Z.	Calendar Year Experience (X-Y)								

CALL # 3C– ACCIDENT YEAR LARGE DEDUCTIBLE CALL

A. CALL SPECIFIC DESCRIPTION

Report Massachusetts workers' compensation large deductible experience summarized by accident year. In Massachusetts, large deductibles are defined as policies with **per claim deductibles of at least $75,000**.

B. CALL SPECIFIC INSTRUCTIONS (Applies in addition to Accident Year Calls General Instructions)

1. Report loss amounts for accident years 1990 and subsequent.

2. Reporting of the following elements is only required for accident years 1994 and subsequent:

   - Incurred Indemnity Claim Count – Accumulated Closed ***(with payment)*** (column ***8***)
   - Incurred Indemnity Claim Count – Open Outstanding (column ***9***)
   - Defense and Cost Containment Expenses Paid (column ***10***)
   - Defense and Cost Containment Expenses Case (column ***11***)

3. Policies with provisions for the MA Benefits Deductible Premium Credit or the MA Benefits Claim and Aggregate Deductible Premium Credit are not to be reported on this call.

4. Exclude the following experience when compiling the data for this call:

   - Excess Workers' Compensation (written over a self-insured retention)
   - National Defense Projects Rating Plan
   - F Classification experience
   - Maritime experience for all policies effective January 1, 2006 and later

CALL #3C – ACCIDENT YEAR LARGE DEDUCTIBLE CALL

REPORTING GROUP NAME:_____ **REPORT ID:** _____

			(1)	(2)	(3)	(4)
			Paid		Case Reserves	
Line	Report Level	Accident Year Being Valued	Indemnity	Medical	Indemnity	Medical
A.	All Prior Combined	***Prior to 1990***				
B.	20th	***1990***				
C.	19th	***1991***				
D.	18th	***1992***				
E.	17th	***1993***				
F.	16th	***1994***				
G.	15th	***1995***				
H.	14th	***1996***				
I.	13th	***1997***				
J.	12th	***1998***				
K.	11th	***1999***				
L.	10th	***2000***				
M.	9th	***2001***				
N.	8th	***2002***				
O.	7th	***2003***				
P.	6th	***2004***				
Q.	5th	***2005***				
R.	4th	***2006***				
S.	3rd	***2007***				
T.	2nd	***2008***				
U.	1st	***2009***				
V.	Current	***2010***				
X.	Total to Current 12/31 Sum (A) to (V)					
Y.	Total to Prior 12/31 Sum (A) to (V)					
Z.	Calendar Year Experience (X-Y)					

CALL #3C – ACCIDENT YEAR LARGE DEDUCTIBLE CALL

REPORTING GROUP NAME:_____ **REPORT ID:** _____

			(5)	(6)	(7)	(8)	(9)	(10)	(11)
		Accident Year	Indemnity and Medical– Total Losses			Accident Year Incurred Indemnity Claim Count		Accumulated Accident Year Defense and Cost Containment Expense	
Line	Report Level	Being Valued	Paid (1)+(2)	Case Reserves (3)+(4)	Case Incurred Losses (5)+(6)	Accumulated Closed (with payment)	Open Outstanding	Paid	Case
A.	All Prior Combined	***Prior to 1990***							
B.	20th	***1990***							
C.	19th	***1991***							
D.	18th	***1992***							
E.	17th	***1993***							
F.	16th	***1994***							
G.	15th	***1995***							
H.	14th	***1996***							
I.	13th	***1997***							
J.	12th	***1998***							
K.	11th	***1999***							
L.	10th	***2000***							
M.	9th	***2001***							
N.	8th	***2002***							
O.	7th	***2003***							
P.	6th	***2004***							
Q.	5th	***2005***							
R.	4th	***2006***							
S.	3rd	***2007***							
T.	2nd	***2008***							
U.	1st	***2009***							
V.	Current	***2010***							
X.	Total to Current 12/31 Sum (A) to (V)								
Y.	Total to Prior 12/31 Sum (A) to (V)								
Z.	Calendar Year Experience (X-Y)								

CALL #4: RECONCILIATION REPORT

Data Period: Calendar Year data valued as of December 31
Due Date: April 1st

A. DESCRIPTION

The report compares the Net earned premium and incurred losses reported on ***the Policy Year and Accident Year*** calls to the Exhibit of Premium and Losses of the Annual Statement (Statutory Page 14).

B. REPORTING REQUIREMENTS

1. Page 1 reconciles the Net Earned Premium from the Policy Year Call to the Exhibit of Premium and Losses of the Annual Statement (Statutory Page 14 data, Line 16 column 2). All reconcilable items must be identified and explained.

2. Page 2 reconciles the Incurred Losses from the Policy Year and Accident Year Calls to the Exhibit of Premium and Losses of the Annual Statement (Statutory Page 14 data, Line 16 column 6). All reconcilable items must be identified and explained.

3. Page 3 reconciles the Standard Earned Premium at DSR Level to the Net Earned Premium from the ***Policy Year*** Calls. Differences exceeding $500 or 25% of the standard premium must be reconciled.

4. Submit the reconciliation report on same carrier or carrier group basis as the ***Policy Year and Accident Year*** calls.

Earned Premium Reconciliation Report (Page 1 of 3)

Line 1: Total Market Net Premium, Policy Year Call (Call #2), Line Z, column (3).

Line 2: Total Market Premium Adjustments due to ARAP Surcharge, Policy Year Call (Call #2), Line Z, column (***15***).

Line 3: Total Market Premium Adjustments due to QLMP Credit, Policy Year Call (Call #2), Line Z, column (***17***).

Line 4: Large Deductible Net Premium, Policy Year Large Deductible Call (Call #2C), Line Z, column (3).

Line 5: Large Deductible Premium Adjustments due to ARAP Surcharge, Policy Year Large Deductible (Call #2C), Line Z, column (1***5***).

Line 6: "F" Classification Net Premium, Policy Year "F" Classification Call (Call #2D), Line Z, column (3).

Line 7: "F" Classification Premium Adjustments due to ARAP Surcharge, Policy Year "F" Classification Call (Call #2D), Line Z, column (***15***).

Line 8: "F" Classification Premium Adjustments due to QLMP Credit, Policy Year "F" Classification Call (Call #2D), Line Z, column (***17***).

Line 9: Maritime Classification Net Premium, Policy Year Maritime Classification Call (Call #2E), Line Z, column (3).

Line 10: Maritime Classification Premium Adjustments due to ARAP Surcharge, Policy Year Maritime Classification Call (Call #2E), Line Z, column (***15***).

Line 11: Maritime Classification Premium Adjustments due to QLMP Credit, Policy Year Maritime Classification Call (Call #2E), Line Z, column (***17***).

Line 12: Sum of Lines 1 through 11.

Line 1*3*: National Defense Projects.

Line 1*4*: Terrorism Insurance Program (Certified Acts of Terrorism) Premium.

Line 1*5*: Subtotal of Lines 13 ***and 14.***

Line 1*6*: Annual Statement Earned Premium, Exhibit of Premium and Losses (Statutory Page 14 data), Line 16, Column 2.

Line 1*7*: Difference of (Line 17 – Line 16 – Line 12).

Line 18: : "Write-Ins" Reconciliation Item .

Line 19 "Write-Ins" Reconciliation Item.

Line 20: "Write-Ins" Reconciliation Item.

Line 21: "Write-Ins" Reconciliation Item.

Line 22: "Write-Ins" Reconciliation Item.

Line 2*3*: Sum of Lines ***18*** through ***22***.

Line 2*4*: Difference of (Line ***23*** – Line ***17***)

Incurred Loss Reconciliation Report (Page 2 of 3)

Line 1: Total Market Case Incurred Losses. In column (1) enter the amount from Line Z, column (1***0***) of Policy Year Call (Call #2). In column (2) enter the amount from Line Z, column (***7***) of Accident Year Call (Call #3).

Line 2: Large Deductible Case Incurred Losses. In column (1) enter the amount from Line Z, column (1***0***) of Policy Year Large Deductible Call (Call #2C). In column (2) enter the amount from Line Z, column (***7***) of Accident Year Large Deductible Call (Call #3C).

Line 3: "F" Classification Case Incurred Losses; Policy Year "F" Classification Call (Call #2D), Line Z, column (1***0***).

Line 4: Maritime Classification Case Incurred Losses; Policy Year Maritime Classification Call (Call #2E), Line Z, column (1***0***).

Line 5: Sum of Lines 1 through 4

Line 6: National Defense Projects

Line 7: Deductible Reimbursements (Large)

Line 8: Deductible Reimbursements (Small)

Line 9: Sections 7, 8, 10, 13A and 14 penalties

Line 10: Incurred But Not Reported (IBNR) Reserves

Line 11: DCC on Employers Liability Claims

Line ***12***: Sum of Lines 6 through ***11***

Line ***13***: Annual Statement Incurred Loss, Exhibit of Premium and Losses (Statutory Page 14 data), Line 16, Column 6.

Line ***14***: Difference of (Line ***13*** – Line ***12*** – Line 5)

Line ***15***: "Write-Ins" Reconciliation Item.

Line ***16***: "Write-Ins" Reconciliation Item.

Line ***17***: "Write-Ins" Reconciliation Item.

Line ***18***: "Write-Ins" Reconciliation Item.

Line ***19***: "Write-Ins" Reconciliation Item.

Line ***20***: Sum of Lines ***15*** through ***19***.

Line ***21***: Difference of (Line ***20*** – Line ***14***)

Net Premium Reconciliation Report (Page 3 of 3)

Line 1: Total Market Calendar Year Earned Premium; Standard at Bureau Designated Statistical Reporting Level. Policy Year Call (Call #2), Line Z column (1).

Line 2: Large Deductible Calendar Year Earned Premium; Standard at Bureau Designated Statistical Reporting Level. Policy Year Large Deductible Call (Call #2C), Line Z column (1).

Line 3: "F" Classification Calendar Year Earned Premium; Standard at Bureau Designated Statistical Reporting Level. Policy Year "F" Classification Call (Call #2D), Line Z column (1).

Line 4**:** Maritime Classification Calendar Year Earned Premium; Standard at Bureau Designated Statistical Reporting Level. Policy Year Maritime Classification Call (Call #2E), Line Z column (1).

Line 5: Sum of Lines 1 through 4

Line 6: Rate Deviations

Line 7: Premium discounts. Statistical Class Codes 0063 and 0064.

Line 8: Large Deductible Premium Credits. Statistical Classes 9663 and 9664.

Line 9: Massachusetts Benefits Deductible Premium Credit. Statistical Codes 9784 – 9788 or 9663 with deductible amounts less than $75,000.

Line 10: Massachusetts Benefits Claim and Aggregate Deductible Premium Credit. Statistical Codes 9784 – 9788 or 9663 with deductible amounts less than $75,000.

Line 11: Retrospective Rating Adjustments

Line 12: Scheduled Rating Adjustments

Line 13: Sum of Lines 6 through 12

Line 14: Sum of Lines 5 and 13

Line 15: Total Market Calendar Year Net Premium. Policy Year Call (Call #2), Line Z, column (3)

Line 16: Large Deductible Calendar Year Net Premium. Policy Year Large Deductible Call (Call #2C), Line Z, column (3)

Line 17: "F" Classification Calendar Year Net Premium. Policy Year "F" Classification Call (Call #2D), Line Z, column (3)

Line 18: Maritime Classification Calendar Year Net Premium. Policy Year Maritime Classification Call (Call #2E), Line Z, column (3)

Line 19: Sum of Lines 15 through 18

Line 20: Difference of (Line 19 – Line 14)

Line 21: "Write-Ins" Reconciliation Item.

Line 22: "Write-Ins" Reconciliation Item.

Line 23: "Write-Ins" Reconciliation Item.

Line 24: "Write-Ins" Reconciliation Item.

Line 25: "Write-Ins" Reconciliation Item.

Line 26: Sum of Lines 21 through 25

Line 27: Difference of (Line 26 – Line 20)

Call # 4 – RECONCILIATION REPORT – Due April 1st

VALUED DECEMBER 31st _____

REPORTING GROUP NAME:_____ **REPORT ID:** _____

This report shows the reconciliation of Earned Premium data reported to the WCRIBMA *in response to the current Calls for Experience and the Massachusetts Exhibit of Premiums & Losses data from the current Annual Statement. Enter amounts indicated below:*

Earned Premium Reconciliation

I. Indicated [ ] Calendar Year Results

A. Policy Year Call (Call #2)

1. Net Premium (Line Z, column (3)) _____
2. Premium Adjustments due to ARAP Surcharge (Line Z, column (15)) _____
3. Premium Adjustments due to QLMP Credit (Line Z, column (17)) _____

B. Policy Year Large Deductible Call (Call #2C)

4. Net Premium (Line Z, column (3)) _____
5. Premium Adjustments due to ARAP Surcharge (Line Z, column (15)) _____

C. Policy Year "F" Classification Call (Call #2D)

6. Net Premium (Line Z, column (3)) _____
7. Premium Adjustments due to ARAP Surcharge (Line Z, column (15)) _____
8. Premium Adjustments due to QLMP Credit (Line Z, column (17)) _____

D.Policy Year Maritime Classification Call (Call #2E)

9. Net Premium (Line Z, column (3)) _____
10. Premium Adjustments due to ARAP Surcharge (Line Z, column (15)) _____
11. Premium Adjustments due to QLMP Credit (Line Z, column (17)) _____

12. Subtotal (Lines 1 through 11) _____

II. Listed Reconciliation Items _____

13. National Defense Projects _____
14. Terrorism Insurance Program (Certified Acts of Terrorism) Premium _____
15. Subtotal (Lines 13 and 14) _____

III. Annual Statement

16. Exhibit of Premium and Losses (Statutory Page 14 Data), Line 16, Column 2 (Earned Premium) _____

IV. Difference

17. Calculate as indicated (Line 16 – Line 15 – Line 12) _____

V. "Write-Ins" Reconciliation Items (provide short description below)

18. _____ _____
19. _____ _____
20. _____ _____
21. _____ _____
22. _____ _____

23. Subtotal (Lines 18 through 22) _____

VI. Remaining Variance

25. Imbalance (Line 23 – Line 17) _____

Call # 4 – RECONCILIATION REPORT – Due April 1st

VALUED DECEMBER 31st _____

REPORTING GROUP NAME:_____ **REPORT ID:** _____

This report shows the reconciliation of Incurred Loss data reported to the WCRIBMA *in response to the current Calls for Experience and the Massachusetts Exhibit of Premiums & Losses data from the current Annual Statement. Enter amounts indicated below:*

Incurred Loss Reconciliation

	Policy Year (1)		Accident Year (2)
I. Indicated Calendar Year Results			
1. Total Market			
2. Large Deductible			
3. "F" Classification (from the Policy Year "F" Classification Call)			
4. Maritime Classification (from the Policy Year Maritime Call)			
5. Subtotal (Lines 1 through 4)			
II. Listed Reconciliation Items			
6. National Defense Projects			
7. Deductible Reimbursements (Large)			
8. Deductible Reimbursements (Small)			
9. Sections 7, 8, 10, 13A, and 14 penalties			
10. Incurred But Not Reported (IBNR) Reserves			
11. DCC on Employers Liability Claims			
12. Subtotal (Lines 6 through ***11***)			
III. Annual Statement			
13. Exhibit of Premium and Losses (Statutory Page 14 Data), Line 16, Column 6 (Incurred Loss)			
IV. Difference			
14. Calculate as indicated (Line ***13*** – Line ***12*** – Line 5)			
V. "Write-Ins" Reconciliation Items (provide short description below)			
15. _____			
16. _____			
17. _____			
18. _____			
19. _____			
20. Subtotal (Lines ***15*** through ***19***)			
VI. Remaining Variance			
21. Imbalance (Line ***20*** – Line ***14***)			

Call # 4 – RECONCILIATION REPORT – Due April 1st

VALUED DECEMBER 31st _____

REPORTING* GROUP NAME:_____** ***REPORT ID: _____ _____

This report shows the reconciliation of Standard Earned Premium data to the Net Earned Premium reported to the ***WCRIBMA*** *in response to the current Calls for Experience. Enter amounts indicated below:*

Calendar Year
Earned Premium

I. Calendar Year Standard Premium ***at Bureau Designated Statistical Reporting Level*** _____

1. Total Market, Policy Year Call – (Line Z, column (1)) _____
2. Policy Year Large Deductible Call – (Line Z, column (1)) _____
3. Policy Year "F" Classification Call – (Line Z, column (1)) _____
4. Policy Year Maritime Classification Call – (Line Z, column (1)) _____

5. Subtotal (Lines 1 through 4) _____

II. Premium Components: _____

6. Rate Deviations _____
7. Premium discounts. Statistical Class Codes 0063 & 0064 _____
8. Large Deductible Premium Credits. Statistical Classes 9663 and 9664 _____
9. Massachusetts Benefits Deductible Premium Credit. Statistical Codes 9784 – 9788 or 9663 with deductible amounts less than $75,000 _____
10. Massachusetts Benefits Claim and Aggregate Deductible Premium Credit. Statistical Codes 9784 – 9788 or 9663 with deductible amounts less than $75,000 _____
11. Retrospective Rating Adjustments _____
12. Scheduled Rating Adjustments _____

13. Subtotal (Lines 6 through 12) _____

III. Calculated Net Premium

14. Sum Lines 5 and 13 _____

IV. Calendar Year Net Earned Premium _____

15. Total Market, Policy Year Call – (Line Z, column (3)) _____
16. Policy Year Large Deductible Call – (Line Z, column (3)) _____
17. Policy Year "F" Classification Call – (Line Z, column (3)) _____
18. Policy Year Maritime Classification Call – (Line Z, column (3)) _____

19. Total Net Earned Premium (Sum Lines 15 through 18) _____

V. Difference

20. Calculate as indicated (Line 19 – Line 14) _____

VI. "Write-Ins" Reconciliation Items (provide short description below)

21. _____ _____
22. _____ _____
23. _____ _____
24. _____ _____
25. _____ _____

26. Subtotal (Lines 21 through 25) _____

VII. Remaining Variance

27. Imbalance (Line 26 – Line 20) _____

CALL #5*B* – DIRECT WRITTEN PREMIUM

Data Period: Calendar Year data valued as of December 31
Due Date: April 1

A. DESCRIPTION

This written premium reconciliation report records the annual calendar year workers compensation direct written premiums ***for market segments.*** The most recent calendar year data through December 31 should be reported.

B. REPORTING REQUIREMENTS

1. The Total reported in column (***4***) must reconcile to the direct written premium reported on the Exhibit of Premiums and Losses of the Annual Statement (Statutory Page 14).

2. Terrorism Insurance Program (Certified Acts of Terrorism) Premium should be included, consistent with the reporting of direct premium on the Annual Statement.

C. COLUMN INSTRUCTIONS

Column 1: Direct Written Premium
Direct written premium is the workers compensation and employers liability direct written premium as reported on Column 1, Line 16 of the Exhibit of Premiums and Losses of the Annual Statement (Statutory Page 14). This excludes all premiums for U.S. Longshore and Harborworkers' Act, and National Defense Plans.

Column 2: USL&H Premium
Report premiums written under the U.S. Longshore and Harborworkers' Act (USL&HW), in a manner consistent with the amounts reported in Column 1 for direct written premium ***and*** Line 16 of the Exhibit of Premiums and Losses of the Annual Statement (Statutory Page 14).

Column *3*: National Defense Plan Premium
Report premiums written under special National Defense Comprehensive Rating or specific National Defense Premium Discount plans, in a manner consistent with the amounts reported in Column 1 for direct written premium and Line 16 of the Exhibit of Premiums and Losses of the Annual Statement (Statutory Page 14).

Column *4*: The sum of Columns (1) thru (4)

Column *5*: Large Deductible Direct Written Premium
Massachusetts workers compensation and employers' liability direct written premiums as reported on Column 1, Line 16 Statutory Page 14 of the Annual Statement for large deductible policies.

Only report premiums for policies effective on or after January 1, 1994.

CALL #5B – DIRECT WRITTEN PREMIUM – DUE April 1st
VALUED AS OF DECEMBER 31st_____

REPORTING GROUP NAME:_____ **REPORT ID_____**

Calendar Year	Direct Written Premium (1)	USL&H Premium (2)	National Defense Plan Premium (3)	Total of Columns (1) through (3) Reconcilable to Exhibit of Premiums and Losses (4)	Large Deductible Direct Written Premium (5)
2010					

CALL #5A – LARGE DEDUCTIBLE WRITTEN CALENDAR YEAR EXPERIENCE

Data Period: Calendar Year data valued as of December 31
Due Date: April 1

A. DESCRIPTION

Report the current calendar year ***written standard premium at company level*** for large deductible ***policies***.

B. REPORTING REQUIREMENTS

1. Data is to be reported for all large deductible policies effective on or **after January 1, 1994**.

2. Consistent with the Policy Year ***Large Deductible*** Call, Terrorism Insurance Program (Certified Acts of Terrorism) Premium should **not** be included.

3. ***Unlike the Policy Year Large Deductible Call,*** do not exclude written premiums associated with "F" Classification and Maritime experience.

C. COLUMN INSTRUCTIONS

Column 1: Large Deductible[1] Written Standard Premium at Company Level
The Large Deductible Written Standard Premium at Company Level is analogous to the earned Standard at Company Level premium reported on Call # 2C – Policy Year Large Deductible Call **except** that this call is asking for written premium instead of earned premium ***and includes written premiums associated with "F" Classification and Maritime experience***.

Column 2: Large Deductible[1] Written ARAP Premium Surcharge
The Large Deductible Written ARAP Premium Surcharge is analogous to the earned ARAP premiums reported on Call # 2C – Policy Year Large Deductible Call **except** that this call is asking for written premium instead of earned premium ***and includes written premiums associated with "F" Classification and Maritime experience***.

[1] Prior to May 1, 2003 the per claim deductible for a large deductible policy had to be at least $100,000. Effective May 1, 2003, the minimum per claim deductible for a large deductible policy was reduced to $75,000.

THE WORKERS' COMPENSATION
RATING AND INSPECTION BUREAU

Call # 5A – LARGE DEDUCTIBLE COMPANY LEVEL WRITTEN PREMIUMS

Due April 1st

VALUED DECEMBER 31st _____

REPORTING GROUP NAME:_____ **REPORT ID: _____**

Calendar Year	Large Deductible Company Level Written Premiums	
	Standard Premium (1)	ARAP Premium (2)
2010		

CALL #5 RESIDUAL MARKET DIRECT WRITTEN PREMIUM

Data Period: Calendar Year data valued as of December 31
Due Date: April 1

A. DESCRIPTION

Report the current calendar year residual market direct written premium, consistent with the reporting on the Exhibit of Premiums and Losses of the Annual Statement (Statutory Page 14), by policy year.

B. REPORTING REQUIREMENTS

1. For policies effective prior to January 1, 2005, calendar year 2009 residual market direct written premiums are to be summarized and the total should be reported on Line (A) ("Prior to 2005").

2. For policies effective on or after January 1, 2005, calendar year 2009 residual market direct written premiums are to be summarized by policy year. Report the policy year written premium totals on the line having the corresponding policy year.

3. Calculate the calendar year 2009 total on Line (G) as the sum of Lines (A) through (F).

4. Terrorism Insurance Program (Certified Acts of Terrorism) Premium should be included, consistent with the reporting of direct premium on the Annual Statement.

C. COLUMN INSTRUCTIONS

Column 1: Residual Market ***(including "F" Classification and Maritime experience)*** Direct Written Premium

Massachusetts workers' compensation and employers' liability direct written premiums as reported on Column 1, Line 16 Statutory Page 14 of the Annual Statement for residual market policies (i.e., voluntary direct assigned risk policies and servicing carrier policies).

Column 2: VDAR (including "F" Classification and Maritime experience) Direct Written Premium

Massachusetts workers' compensation and employers' liability direct written premiums as reported on Column 1, Line 16 Statutory Page 14 of the Annual Statement for voluntary direct assigned risk policies.

Note that this item refers only to VDAR policy premium. It does not refer to assigned risk premium from policies serviced by servicing carriers.

Call # 5 – RESIDUAL MARKET DIRECT WRITTEN PREMIUM

Due April 1st

VALUED DECEMBER 31st _____

REPORTING GROUP NAME:_____ **REPORT ID:** _____

			Residual Market ***(including "F" Classification and Maritime experience)***	VDAR (including "F" Classification and Maritime experience)
Line	Calendar Year	Policy Year	(1)	(2)
A.	***2010***	***Prior to 2006***		
B.	***2010***	***2006***		
C.	***2010***	***2007***		
D.	***2010***	***2008***		
E.	***2010***	***2009***		
F.	***2010***	***2010***		
G.	Total to Current 12/31 Sum (A) to (F)			

CALL #6: CALENDAR YEAR EXPENSE DATA

Data Period: Calendar Year data valued as of December 31
Due Date: May 15

A. DESCRIPTION

Report the expenses associated with writing workers' compensation experience. The call requires **only** Massachusetts expense totals.

B. GENERAL INSTRUCTIONS

1. Adjusting and Other (AO) Expenses should be reported in accordance with the current NAIC definitions.

2. Expenses are reported on a calendar year basis.

3. Do not report expense amounts paid as penalties or fees in accordance with Sections 7, 8, 10, 13A, and 14 of Chapter 152 of the General Laws of Massachusetts.

4. Do not subtract from the expense totals the servicing carrier fees received for the expenses incurred due to servicing assigned risk business. Expense values are for all Workers' Compensation business, including "F" Classification experience, Large Deductible and Maritime experience as well as National Defense experience.

C. ROW INSTRUCTIONS:

Row 1: Other Acquisitions, Field Supervision, and Collection Expenses Incurred. Commission and Brokerage Expenses should be excluded.

Row 2: Adjusting and Other Expenses

Row 3: General Expenses. **Note that this should include the Boards and Bureau Expenses which are also reported separately.**

Row 3A: Boards and Bureau Expenses

Row 4: Incidental Income. A positive value indicates income for the calendar year.

Row 5: Unreported Expenses. A positive value indicates an expense for the calendar year.

Row 6: Uncollectible Premium Receivables. A positive value indicates an expense for the calendar year.

Call # 6 – C A L E N D A R Y E A R E X P E N S E D A T A
Due May 15th

VALUED DECEMBER 31st _____

REPORTING GROUP NAME:_____ **REPORT ID:** _____

		Incurred
(1)	Other Acquisitions, Field Supervision and Collection Expenses	
(2)	Adjusting and Other Expenses	
(3)	General Expenses	
(3A)	Boards and Bureau Expenses	
(4)	Incidental Income	
(5)	Unreported Expenses	
(6)	Uncollectible Premium Receivables	

CALL #6A: INSURANCE EXPENSE EXHIBIT

Data Period: Calendar Year data valued as of December 31
Due Date: April 15

A. DESCRIPTION

The Insurance Expense Exhibit (IEE) provide countrywide expense information.

B. GENERAL INSTRUCTIONS

1. You are not required to submit the Insurance Expense Exhibit (IEE) to ***WCRIBMA*** if your company has already submitted it to the National Association of Insurance Commissioners (NAIC).

2. If your company does not submit its IEE to the NAIC, you must send a ***pdf*** copy ***via MAFDRA*** to ***WCRIBMA***. This submission is due ***by*** April 15.

3. Please submit your IEE on an individual company basis rather than a group basis.

CALL # 7: LARGE LOSS & CATASTROPHE CALL

Data Period: Claims valued as of December 31
Due Date: April 15

A. DESCRIPTION

Report inception to date losses ***for***:

- ***L***arge loss claims where total case incurred losses are $500,000 or greater.
- Extraordinary loss event claims that are assigned ***one of the*** unique Catastrophe Numbers ***listed below***.

Extraordinary Loss Events			
Catastrophe Number	**Event**	**Description**	**Accident Dates**
48	World Trade Center Attacks	Events of September 11, 2001 attacks	9/11/2001 – 9/14/2001
87	World Trade Center Attacks	Rescue, recovery, and clean-up efforts related to September 11, 2001 at the World Trade Center site	9/11/2001 – 9/12/2002

B. GENERAL INSTRUCTIONS

1. The data reported in this Call should **exclude** the following experience:
   - Excess Workers' Compensation
   - National Defense Projects Rating Plan

2. Report **all** extraordinary loss event claims regardless of size***, including medical-only claims. The WCRIBMA will notify member companies of any new event that has been classified as an extraordinary loss event.***

3. Report claims individually. Claims cannot be grouped.

4. Report all claims for accident year 1984 and later where total case incurred losses are greater than or equal to $500,000 at the time of valuation.

5. Closed, as well as open and reopened claims are included.

6. Claim number is required to be reported for each claim ***in a manner consistent with Unit Statistical Reporting (USR).***

7. Loss amounts should be reported net of second injury fund and other recoveries such as subrogation, but gross of deductible reimbursements, consistent with the Policy and Accident Year Calls.

8. Case Outstanding may include or exclude statutorily allowable discounting, as long as the approach is consistent with the Policy and Accident Year Calls.

9. Unlike extraordinary loss event claims, if the case incurred for a large loss claim previously reported on this call drops below $500,000, do not report the claim.

C. COLUMN INSTRUCTIONS

Column 1: Claim Number - A unique number assigned by the insurance company to a claim for the life of that claim. Claim numbers must be reported in a manner consistent with Unit Statistical Reporting (USR).

Column 2: NCCI Carrier Code - A unique 5 digit numeric code assigned by the National Council on Compensation Insurance (NCCI) to an insurance company.

Column *3:* Policy Number – Policy number associated with the claim. Policy Numbers must be reported in a manner consistent with Unit Statistical Reporting (USR).

Column *4*: Catastrophe Number – Report Catastrophe Code for all extraordinary loss events assigned a unique catastrophe number (for example, report 48 for all Catastrophe Number 48 claims, regardless of claim size).

Column *5*: Market Type Code – Indicate the market type code for the policy associated with the claim:
0 – Involuntary
2 – Large Deductible
3 – Voluntary (Other than Large Deductible)

Column *6:* Policy Effective Date – The date of inception for the policy associated with the claim.

Column *7:* Accident Date – The date on which the large loss or catastrophe occurred.

Column *8:* Loss Condition Act Code – A code that identifies the basis of liability for the claim.
01 – State Act or Federal Excluding USL&H
02 – USL&H

Column *9:* Injury Type Code – A code that identifies under which provision(s) of the law benefits are paid or expected to be paid.
01 – Death
02 – Permanent Total Disability
05 – Temporary Injury
06 – Medical Only
09 – Permanent Partial Disability

Column *10:* Claim Status Code
0 – Open
1 – Closed
2 – Reopened

Column *11:* Paid Indemnity

Column *12:* Paid Medical

Column *13:* Case Reserves Indemnity

Column *14:* Case Reserves Medical

Column *15:* Defense and Cost Containment Expense – Paid

Column *16:* Defense and Cost Containment Expense – Case Reserves

CALL # 7: LARGE LOSS & CATASTROPHE CALL – Due April 15th

VALUED AS OF DECEMBER 31st _____

REPORTING GROUP NAME:_____ **REPORT ID:** _____

Claim Number (1)	NCCI Carrier Code (2)	Policy Number (3)	Catastrophe Number (4)	Market Type Code (5)	Policy Effective Date (6)	Accident Date (7)	Loss Condition Act Code (8)	Injury Type Code (9)	Claim Status Code (10)	Accumulated Paid Losses		Case Reserves		Accumulated Defense and Cost Containment Expense	
										Indemnity (11)	Medical (12)	Indemnity (13)	Medical (14)	Paid (15)	Case (16)

PART II
AGGREGATE FINANCIAL REPORTING

SECTION V
DATA QUALITY COMPLIANCE PROGRAMS

SECTION V - *DATA QUALITY COMPLIANCE PROGRAMS*

A. Overview

The timely collection of Aggregate Financial Call data is critical for providing the source data that is used in the development of workers' compensation rates. To ensure the inclusion of your data in the rate filing, it is necessary that the Bureau receives accurate data on or before the applicable due dates.

Three data quality programs apply to Aggregate Financial Call data. These are:

- ***Aggregate Financial Call Acknowledgment Process***
- ***Aggregate Financial Data Quality Incentive Program (AFDQIP)***
- ***Examinations and Reconciliations***

B. Aggregate Financial Call Acknowledgment Process

The Aggregate Financial Call Acknowledgment Process was established to emphasize the importance of timely and accurate data. The Aggregate Financial Call Acknowledgment Process requires the completion of the Aggregate Financial Call Acknowledgment Form by a company officer or a company actuary who is a member of the Casualty Actuarial Society and/or a member in good standing of the American Academy of Actuaries. This serves to confirm that the Aggregate Financial Call data that relates to ratemaking has been prepared to the best of your organization's professional abilities and are accurately represented.

More details, including a copy of the form, can be found in the General Instructions section of Part II of the Statistical Plan.

Fines for Tardiness - Forms that are submitted after the due date will accrue fines at a rate of $250 per business day for the first 30 business days overdue. Fines will accrue at the rate of $1,000 per business day for the next 30 business days after which fines will accrue at the rate of $2,500 per business day until such time as the form has been submitted.

Fines for Inappropriate Signatory - Forms that are submitted without the signature of a company officer or a company actuary who is a member of the Casualty Actuarial Society and/or a member in good standing of the American Academy of Actuaries will incur a fine of $1,000. If a carrier does not submit a corrected form to the Bureau within 5 business days of the Bureau's notification to the carrier, additional fines will begin to accrue at the rate of $250 per business day for the first 30 business days. Fines will accrue at the rate of $1,000 per business day for the next 30 business days after which fines will accrue at the rate of $2,500 per business day until such time that the form is submitted with the appropriate signatory in accordance with the Statistical Plan.

C. Aggregate Financial Data Quality Incentive Program (AFDQIP)

AFDQIP provides carriers with an incentive to submit aggregate financial data in a timely and accurate manner. Late and/or inaccurate reporting of data will subject carriers to timeliness and/or data quality fines. The fines under the AFDQIP will be assessed on either a carrier

group basis or an individual carrier basis, consistent with the manner in which the data is reported.

Please note that a separate Data Quality Incentive Program applies to unit statistical reporting, Part I, Section XI of this Plan.

1. Timeliness Fines

Carriers will be notified via email five business days before the call deadline for pending call submissions. Notification will be sent to the person designated as the primary contact for all calls and the person designated as the contact for a given call (if different than the primary contact).

A request to submit overdue calls will be emailed to delinquent data reporters five business days after the call due date. This request will be sent to the person designated as the primary contact for all calls and the person designated as the contact for a given call (if different than the primary contact). Daily fines will begin to accrue at a rate of $250 per business day per call for the first 30 business days beyond the date of the second email. Beyond 30 business days, fines will accrue at the rate of $1,000 per business day per call for the next 30 business days after which fines will accrue at the rate of $2,500 per business day per call.

Timeliness fines will continue to accrue until a complete call is submitted.

2. Data Quality Fines

All submitted data is subjected to a number of edits designed to help the Bureau identify data anomalies. Some data anomalies may be the result of errors in data submission while other data anomalies reflect accurately reported data resulting from atypical circumstances. The edits used by the Bureau are categorized into two groups, Basic Edits and Actuarial Edits.

i. Basic Edits

Basic Edits are intended to identify incorrect data. For example, reported policy year standard premiums should always be non-negative values. A carrier submitting a negative value for policy year standard premium has made a mistake. In addition to sign conventions, Basic Edits also check to see that premiums have been reported for any policy year for which losses have been reported.

Basic Edit failures result in per occurrence fines. Additionally, Basic Edit failures will result in timeliness fines if not corrected within 10 business days. There are no acceptable explanations for Basic Edits failures. All Basic Edit failures must be corrected.

<u>Per Occurrence Fines</u> - Each finable Basic Edit failure results in a fine of $250. Note that a single error condition can generate multiple errors within and across calls, with the generated errors resulting in fines of $250 each. For example, assume that a

carrier submits a policy year call where the standard premium at designated statistical rate is reported as a negative value for six separate policy years. This would result in a fine of $1,500 (6 x $250).

<u>Timeliness Fines</u> – Carriers will have 10 business days to correct Basic Edit failures. Beyond the 10 business day grace period, fines will accrue at the rate of $250 per business day per call for the first 30 business days. Fines will accrue at the rate of $1,000 per business day per call for the next 30 business days after which fines will accrue at the rate of $2,500 per business day per call.

<u>Basic Edit Testing</u> - Before submitting data to the Bureau, member carriers may utilize Bureau provided tools to test data against Basic Edits. These tools may be used repeatedly before making any initial call submission or any correction submission.

For example, assume that a carrier is working on their reporting of the Policy Year call. The Policy Year call data may be uploaded to the Bureau's website. At this point the data is termed "saved" and not "submitted." The "saved" data may then be tested by running the Basic Edits against the data. Based on the results of the Basic Edit testing, the carrier may make any necessary corrections.

- ***Assuming no changes are warranted, the carrier can proceed to "submit" the data. The Bureau will review the Basic Edits report for the submitted call.***

- ***Assuming, for example, the Basic Edits flag a number of records because negative policy year premium amounts were reported, the "saved" data may be corrected and subsequently retested. This process may be repeated as often as necessary. Once the carrier has resolved all data issues flagged by the Basic Edits, the carrier can proceed to "submit" the data. The Bureau will review the Basic Edits report for the submitted call.***

Note that only "submitted" data that fails Basic Edits will be subject to fines. Also, once a call is submitted it is subject to fines. Data quality fines apply if a correction is required for a submitted call, even if corrected prior to the call due date.

ii. Actuarial Edits

Actuarial Edits are intended to ensure:

- ***consistency of Aggregate Financial data within a call***
- ***consistency of Aggregate Financial data between Aggregate Financial calls***
- ***consistency of Aggregate Financial data with Unit Statistical Reports***
- ***reasonableness of changes between valuations***

Data flagged as a result of the Actuarial Edit process is atypical but not necessarily incorrect data. Consequently, to resolve issues with data flagged by Actuarial Edits carriers must supply an acceptable explanation for the data anomaly or the data must be corrected.

Acceptable explanations must describe, to the satisfaction of the Bureau's actuarial staff, the circumstances that caused the anomaly.

The following would be deemed unacceptable explanations by the Bureau:

- ***explanations that simply identify the source of the error***
- ***explanations that simply state that the reported data is correct as filed without sufficient documentation to allow for the Bureau's evaluation***

For each Actuarial Edit that flags a data anomaly, carriers must provide the Bureau either an acceptable explanation or corrected data within 10 business days of being notified of the data anomaly. Please note that each response must be reviewed and accepted by the Bureau's actuarial staff within the allotted 10 business day time frame. Therefore, data reporters should reply in a timely manner to allow sufficient time for the Bureau to request further clarifying information. Business days will not be counted during the time that the Bureau's actuarial staff is reviewing an explanation or a correction.

For example, assume that a carrier submits a call which results in an actuarial edit. The carrier will be notified via email of any flagged actuarial edits that have not been resolved. The carrier reviews the data and sends an explanation or a correction after 3 business days. Bureau's actuarial staff will review carrier's response. The time that the actuarial staff reviews the response is not counted in the time frame of 10 business days. If the Bureau requests further clarifying information the carrier has 7 business days remaining to provide an acceptable explanation or corrected data.

Acceptable responses not received within 10 business days are deemed late and will result in fines. For each applicable Actuarial Edit, fines will accrue at a rate of $250 per business day for the first 30 business days overdue. Beyond 30 business days, fines will accrue at the rate of $1,000 per business day for the next 30 business days after which fines will accrue at the rate of $2,500 per business day until an acceptable explanation has been submitted.

In addition, revisions to data may generate further errors and result in additional fines. Data Reporters should take this into consideration because revisions that trigger other edit failures do not warrant an additional 10 business days to resolve. Fines will be levied for each business day until an acceptable explanation or correction is submitted.

3. Caps Applicable to Fines Relating to Timeliness and Data Quality

Fines associated with Timeliness and Data Quality Edits are subject to a cap which is a function of calendar year earned premium. The calendar year earned premium used to calculate the caps is derived by taking the difference of policy year standard earned premiums at the designated statistical reporting level for successive valuation dates. The applicable policy year premiums are the totals for all policy years taken from the following calls:

- CALL # 2 : POLICY YEAR CALL
- CALL #2C: POLICY YEAR LARGE DEDUCTIBLE CALL
- CALL #2D: POLICY YEAR "F" CLASSIFICATION CALL
- CALL #2E: POLICY YEAR MARITIME CLASSIFICATION CALL

For calls due in a year XXXX the calendar year earned premium applied in capping will be for year XXXX – 2. For example, calls due to be submitted in 2007 will be subject to a cap based on calendar year 2005 earned premiums at the designated statistical reporting level.

The maximum total fine for all calls due is a given year is limited to the greater of $15,000 or 0.5% of the applicable earned premium at the designated statistical reporting level.

D. Examinations and Reconciliations

The Bureau will annually perform certain reconciliations as mandated by the Massachusetts Commissioner of Insurance.

If the mandated reconciliations identify unexplained data anomalies which are not resolved in accordance with the established timeline, the insurance group to which the carrier belongs is subject to an on-site targeted examination by an auditing firm charged with preparing a Findings Report relative to the data in question. See Section VI for complete details.

Additionally, insurance groups with market shares exceeding a given threshold are subject to a triennial examination requirement. See Section VI for complete details.

Findings Reports related to either an on-site targeted examination ***(Section VI, Part C)*** or a triennial examination ***(Section VI, Part E)*** that are submitted after the due date will accrue fines at a rate of $250 per business day for the first 30 business days. Fines will accrue at the rate of $1,000 per business day for the next 30 business days after which fines will accrue at the rate of $2,500 per business day until such time as the Findings Report has been submitted.

E. Disciplinary Fine

In addition to the fines described above, the Bureau may impose a Disciplinary Fine for any of the following reasons:

1. If, in any filing the Bureau makes with the Division of Insurance, it becomes necessary for the Bureau to adjust, correct, or make allowances for inaccuracies in the data supplied by a carrier or carrier group.

2. If the Bureau deems the data unsuitable for use in any Bureau filing.

3. A carrier or carrier group is not responsive to the Bureau's request to submit overdue calls.

4. A carrier or carrier group is not responsive or does not satisfactorily respond to the Bureau's attempts to resolve data anomalies.

5. If the Bureau, in its sole discretion, determines that a carrier group is uncooperative with the Bureau and/or the auditing firm designated to prepare the findings report in accordance with Part II Section VI.

6. A carrier group does not comply with the triennial examination requirement as outlined in Part II Section VI.

The Disciplinary Fine is designed so that it is a function of calendar year earned premium. The calendar year earned premium used to calculate the Disciplinary Fine is derived by taking the difference of policy year standard earned premiums at the designated statistical reporting level for successive valuation dates. For calls due in a year XXXX the calendar year earned premium applied in capping will be for year XXXX – 2. For example, calls due to be submitted in 2007 will be subject to a cap based on calendar year 2005 earned premiums at the designated statistical reporting level. The Disciplinary Fine shall be the greater of $25,000 or 2.0% of the applicable earned premium at the designated statistical reporting level.

For reasons one, two, three and four listed above, the premium used in the calculation will correspond to the basis at which the data in question was reported. If the data in question was reported on a grouped basis, the premiums used in the calculation will be for the carriers that were included in the grouping. Conversely, if the data in question was reported on an individual company basis, the premiums used in the calculation will be those of the individual company.

For reasons five and six above, the premium used in the calculation will be the total premium for all carriers within the NAIC insurance group.

The Bureau will send a written warning letter via email at least 10 business days prior to levying a Disciplinary Fine for any of the above listed reasons. On the same date, the Bureau will also send a hard copy of the written warning letter via certified mail return receipt
In addition to any authority the Commissioner of Insurance already has, the Commissioner may, at his or her discretion, require the Workers Compensation Rating and Inspection Bureau of Massachusetts to impose a fine upon a reporting carrier or carrier group in the amount set forth above if, after written notice and a hearing, the Commissioner finds that any reporting entity's aggregate financial data is unreliable, incomplete, untimely or otherwise defective and that such defect has materially impacted a filing submitted to the Commissioner. Such fine will be calculated in the same manner as Disciplinary Fines stemming from reasons one, two, three, or four listed above and such fines will not require a written warning letter.

F. Reporting of Fines to the Massachusetts Division of Insurance

By September 15th of each year, the Bureau shall provide the Massachusetts Division of Insurance a listing by carrier or carrier group of all Timeliness Fines and Data Quality Fines levied during the course of the year as a result of the Aggregate Financial Data Quality Incentive Program. If additional Timeliness Fines or Data Quality Fines are levied during the balance of the year, the Bureau shall provide an updated report.

Additionally, all Disciplinary Fines will be reported to the Division of Insurance by November 15th of each year. If additional Disciplinary Fines are levied during the balance of the year, the Bureau shall provide an updated report.

G. Appeal of Penalties Levied under the Data Quality Program

If the carrier or carrier group ("carrier") is subject to a fine, which in the opinion of the carrier is inappropriate, the carrier may submit a written appeal to the Financial Data Services Department at the following address:

Financial Data Services Department
WCRIBMA
101 Arch Street, 5th Floor
Boston, MA 02110

The written appeal must be submitted by an officer or senior manager of the carrier within twenty (20) business days of the Invoice Date on the invoice for the particular fine(s) at issue. The appeal should include copies of the relevant invoice(s), all pertinent written communications and detailed statements that describe why the carrier thinks the fine(s) is inappropriate. The Bureau will provide the carrier with its written decision on the carrier's appeal within twenty (20) business days of its receipt of the appeal.

If the carrier is not satisfied with the Bureau's decision, it may appeal to the Commissioner of Insurance. Such an appeal shall be filed within thirty (30) days of the carrier's receipt of the Bureau's written decision. The carrier should provide the Bureau with a copy of any appeal submitted to the Commissioner of Insurance.

PART II
AGGREGATE FINANCIAL REPORTING

SECTION VI
EXAMINATIONS AND RECONCILIATIONS

SECTION VI – EXAMINATIONS AND RECONCILIATIONS

A. UNIT STATISTICAL REPORTS AND AGGREGATE FINANCIAL DATA RECONCILIATIONS

The Bureau will routinely work with its member carriers to attempt to reconcile the Unit Statistical Data to the Aggregate Financial Data that is submitted to the Bureau for each policy year at the latest evaluation. The Bureau will also attempt to reconcile the Aggregate Financial Data to the Annual Statements each carrier group submits to the Division of Insurance ("DOI"). During this process, the carrier group may be subject to fines under the provisions of the Statistical Plan's Data Quality ***Compliance*** Programs.

The data submitted by each carrier group to the Bureau will be tested for compliance with the tolerances set forth in Part II, Section VI. In accordance with the timetable prescribed in Part II, Section I, each carrier group will have an opportunity to work with the Bureau to provide corrections or explanations for any data falling outside the established tolerances. At the end of this prescribed time period, the Bureau will report to the DOI all carrier group data falling outside allowable tolerances ("tolerance variances").

If a carrier group provides what the Bureau deems to be an acceptable explanation for its tolerance variances, the Bureau will report the tolerance variances to the DOI with an explanation as to why it believes the carrier group's data reporting activities do not need to be examined on-site by an independent auditing firm. Any carrier group's uncorrected or unexplained tolerance variances that are reported to the DOI, and any carrier group whose explanations are deemed insufficient by the DOI will, at the carrier group's expense, have an independent auditing firm perform an Agreed-Upon Procedures Engagement. The Agreed Upon Procedures ("AUP") with regard to the data reporting activities relating to the specific data in question for any carrier group with such variances will be determined by the Bureau in consultation with the DOI. [1]

In accordance with the timetable prescribed in Part II, Section I, the independent auditing firm will conduct the AUP and submit to the DOI and the Bureau a findings report which describes the procedures performed by the firm and its findings. For each carrier group, any applicable work papers, including any applicable tables showing the reported and reconciled data together with a CD containing the data examined will be submitted by the auditing firm to the Bureau and the DOI. The independent auditing firm's findings report will also be provided to the carrier group. Upon receipt of the findings report, the carrier group will be given not more than thirty (30) days to make a written submission to the DOI and the Bureau responding to the findings report prior to any final determination by the Bureau or the DOI regarding the appropriateness of the carrier group's data submissions.

B. RECONCILIATION TOLERANCES AND REPORT FORMATS

1. USR and Aggregate Financial Data Reconciliation

    - Rationale

[1] An Agreed-Upon Procedures Engagement is one in which a practitioner is engaged to issue a report of findings based on specific procedures performed on the designated subject matter. The application of agreed-upon procedures engagements is discussed in AICPA Statements on Standards for Agreed-Upon Procedures Engagements ("AT 201").

Both Unit Statistical Reports ("USR") and Aggregate Financial Data as detailed in Part I and Part II of the Statistical Plan respectively, call for the reporting of premium and loss information. Despite timing and definitional differences between the submission and valuation of USR and Aggregate Financial Data, meaningful comparisons can be made between these two sources of data as a test for consistency.

- Comparisons
  Policy year premium and policy year loss data submitted on USRs will be compared to comparable policy year Aggregate Financial Data by carrier group.

  - USRs at first report, 18 months, will be compared to Aggregate Financial policy year data valued at 24 months.
  - USRs at second report, 30 months, will be compared to Aggregate Financial policy year data valued at 36 months.
  - USRs at third report, 42 months, will be compared to Aggregate Financial policy year data valued at 48 months.
  - USRs at fourth report, 54 months, will be compared to Aggregate Financial policy year data valued at 60 months.
  - USRs at fifth report, 66 months, will be compared to Aggregate Financial policy year data valued at 72 months.

  The specific data elements to be reviewed are:

    - Standard Premium
    - Indemnity Paid Loss
    - Medical Paid Loss
    - Indemnity Paid & Case Loss
    - Medical Paid & Case Loss

  The "difference" between values submitted on USRs and those submitted on Aggregate Financial Data calls will be calculated and compared.

  Also, for each reviewed data element, the "percentage difference" between USR and Aggregate Financial Data will be calculated.

  Note that standard premium is defined differently in Part I and Part II of the Statistical Plan. Consequently, adjustments will be made to the USR standard premium to facilitate the reconciliation to the Aggregate Financial Data. Specifically, the USR standard premium used in the comparison will include the expense constant reported under statistical code 0900 and it will exclude schedule rating credits, deviations, and deductible credits reported under statistical codes 0887, 9034, 9037, and 9664.

- Data Tested
  Data for five policy years will be tested.

  For a policy effective in December, the first USR report is not due for 20 months. For example, the first USR report for a policy with an effective date in December, 2002 is due in August 2004.

Consequently, a lag in the policy years contained in the report is required. For instance, the report prepared in 2006 will compare premiums and losses for policy years 1999, 2000, 2001, 2002, and 2003.

- Tolerances
  The reconciliation will calculate differences and percentage differences which will be compared against the applicable tolerances.

  The difference and percentage difference for a given data element will be calculated as:

  Difference = USR Value – Aggregate Financial Value

  Percentage Difference = [(USR Value – Aggregate Financial Value) / USR Value] x 100

  To be considered within tolerance, the reviewed data elements must meet either condition A or condition B:

Condition A - Dollar differences must be within the range specified below. Acceptable Range for Differences (in thousands of dollars)						
Data Element	Range	FA_24 / USR_18	FA_36 / USR_30	FA_48 / USR_42	FA_60 / USR_54	FA_72 / USR_66
Standard Premium	Low	-100	-50	-50	-50	-50
	High	100	50	50	50	50
Paid - Indemnity, Medical	Low	-300	-200	-100	-100	-100
	High	300	200	100	100	100
Paid & Case - Indemnity, Medical	Low	-300	-200	-100	-100	-100
	High	300	200	100	100	100

Condition B – Dollar differences must be within the ranges specified below AND percentage differences must be within the ranges specified below.						
Acceptable Range for Percentage Differences						
Standard Premium	Low	-20%	-10%	-10%	-10%	-10%
	High	20%	10%	10%	10%	10%
Paid - Indemnity, Medical	Low	-20%	-15%	-10%	-10%	-10%
	High	20%	15%	10%	10%	10%
Paid & Case - Indemnity, Medical	Low	-20%	-15%	-10%	-10%	-10%
	High	20%	15%	10%	10%	10%
Acceptable Range for Differences (in thousands of dollars)						
Standard Premium	Low	-2,000	-1,000	-1,000	-1,000	-1,000
	High	2,000	1,000	1,000	1,000	1,000
Paid - Indemnity, Medical	Low	-2,000	-1,500	-1,000	-1,000	-1,000
	High	2,000	1,500	1,000	1,000	1,000
Paid & Case - Indemnity, Medical	Low	-2,000	-1,500	-1,000	-1,000	-1,000
	High	2,000	1,500	1,000	1,000	1,000

- USR and Aggregate Financial Reconciliation Report Format

August 31, 2006

USR and Aggregate Financial Reconciliation

NAIC Carrier Group Code: **99999** NAIC Carrier Group Name: **ABC Insurance Group**
Data Element: **Standard Premium (in $000)**

Policy Year	Aggregate Financial		USR		Percentage Difference	Difference	Within Tolerance
	Age in Months	Amount	Unit Number	Amount			
(1)	(2)	(3)	(4)	(5)	[(5) – (3)] / (5) (6)	(5) - (3) (7)	(8)
1999	72	18,262	5	20,557	11.2%	2,295	N
2000	60	22,415	4	22,804	1.7%	389	Y
2001	48	20,572	3	21,501	4.3%	929	Y
2002	36	21,927	2	22,556	2.8%	629	Y
2003	24	20,034	1	22,224	9.9%	2,190	N

2. Aggregate Financial Standard Earned at Designated Statistical Reporting Level and Aggregate Financial Net Premium Reconciliation

   - Rationale
     Comparisons made between Aggregate Financial Data and data submitted on Annual Statements help to monitor consistency in reporting. Calendar year premium and loss information can be calculated using the policy year data submitted on the Aggregate Financial Data calls which can then be compared to Statutory Page 14 of the Annual Statement.

   - Comparisons
     This report compares earned premium at designated statistical reporting level (DSR) to net earned premium. This is the first step in reconciling the Aggregate Financial earned premium at DSR to the Annual Statement.

   - Data Tested
     The Aggregate Financial Reconciliation Call as of the prior year end will be the basis for the report.

   - Tolerances
     Only carrier groups with an imbalance falling within the range of +/- $100,000 are considered to be within tolerance. Note that the calculated imbalance is equal to line 24 from page 3 of the Reconciliation Report call.

In addition to carrier groups falling outside of the tolerances, any carrier group utilizing a "write-in" adjustment as part of the reconciliation will be included on the report made to the DOI.

- Aggregate Financial Standard Earned at DSR Level Premium and Aggregate Financial Net Premium Reconciliation Report Format

August 31, 2006

Aggregate Financial Standard Earned at Designated Statistical Rate Level Premium and Aggregate Financial Net Premium Reconciliation

By NAIC Group for Calendar Year 2005
Amount in Thousands

NAIC Group Number	Aggregate Financial Std EP @ DSR			Aggregate Financial Net Earned Premium			Reconciliation Items		
	All Policy Years Total As of		Calendar Year	All Policy Years Total As of		Calendar Year			
	Year End 2005	Year End 2004	2005	Year End 2005	Year End 2004	2005	Listed	Write In	Imbalance
(1)	(2)	(3)	(2) - (3) (4)	(5)	(6)	(5) - (6) (7)	(8)	(9)	(7) - (4) - (8) - (9) (10)
88888	225,000	205,000	20,000	189,000	172,000	17,000	(2,500)	(500)	0
77777	45,000	38,000	7,000	35,000	30,000	5,000	(1,500)	(250)	(250)
66666	93,750	90,500	3,250	87,500	85,000	2,500	(500)	(250)	0

3. Aggregate Financial and Annual Statement Reconciliation

- Rationale
  Comparisons made between Aggregate Financial Data and data submitted on Annual Statements help to monitor consistency in reporting. Calendar year premium and loss information can be calculated using the policy year data submitted on the Aggregate Financial Data calls which can then be compared to Statutory Page 14 of the Annual Statement.

- Comparisons
  For the prior calendar year, this report compares Aggregate Financial Data to Annual Statement data.

  The specific data elements to be reviewed are:

  - Direct Earned Premium
  - Incurred Losses

- Data Tested
  The Aggregate Financial Reconciliation Call as of the prior year end will be the basis for the report.

- Tolerances
  Only carrier groups with an imbalance falling within the range of +/- $100,000 are considered to be within tolerance. Note that the calculated imbalance for direct earned premium is equal to line 22 from page 1 of the Reconciliation Report call and that the calculated imbalance for incurred losses is equal to line 19 from page 2 of the Reconciliation Report call.

  In addition to carrier groups falling outside of the tolerances, any carrier group utilizing a "write-in" adjustment as part of the reconciliation will be included on the report made to the DOI.

- Aggregate Financial and Annual Statement Reconciliation Report Format

August 31, 2006

Aggregate Financial and Annual Statement Reconciliation
By NAIC Group for Calendar Year 2005
Amounts in Thousands

Data Element: **Direct Earned Premium**

NAIC Group Number	Aggregate Financial			Annual Statement	Reconciliation Items		Imbalance
	All Policy Years Total As of		Calendar Year 2005	Calendar Year 2005			
	Year End 2005	Year End 2004	(2) - (3)		Listed	Write In	(5) - (4) - (6) - (7)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
88888	144,000	142,200	1,800	1,500	(200)	(100)	0
77777	35,000	30,000	5,000	7,500	2,250	0	250
66666	87,500	85,000	2,500	2,500	500	(500)	0

C. ROUTINE REVIEWS BY THE BUREAU

The Bureau will review the data submitted by each of the carrier groups. If the Bureau identifies any anomalies or questionable patterns in the data submitted, Bureau staff will work with the carrier group to obtain corrections or valid explanations of the anomalous or questionable data. During this process, the carrier group may be subject to fines under the provisions of the Statistical Plan's Data Quality ***Compliance*** Programs. A carrier group's questionable data must be resolved to the Bureau's satisfaction within the timetable prescribed in Part II, Section I. Any questionable patterns that might reasonably be expected to affect the suitability of the data for use in ratemaking will be reported to the DOI in accordance with the timetable prescribed in Part II, Section I.

Whenever issues relating to a carrier group's questionable data, that are deemed to be of material significance to the DOI or the Bureau, are not resolved to the Bureau's or DOI's satisfaction, the Bureau shall engage an independent auditing firm, at the carrier group's expense, to perform on–site AUP, responsive to the unresolved issues. Such AUP shall be determined by the Bureau in consultation with the DOI. Such AUP Engagements shall not be required to occur under the timetable prescribed in Part II, Section I. The independent auditing firm will conduct the AUP and submit to the DOI and the Bureau a findings report which describes the procedures performed by the firm and its findings. For each carrier group, any applicable work papers, including any applicable tables showing the reported and reconciled data together with a CD containing the data examined will be submitted by the auditing firm to the DOI and the Bureau. The independent auditing firm's findings report will also be provided to the carrier group. Upon receipt of the findings report, the carrier group will be given not more than thirty (30) days to make a written submission to the DOI and the Bureau responding to the findings report. The 30 day response period provided to the carrier group shall not prohibit the Bureau from making any determination regarding the appropriateness of the carrier group's data submissions. The DOI will, however, withhold any findings regarding the appropriateness of the carrier group's data submissions for 30 days after the conclusion of the AUP Engagement.

D. AGREED UPON PROCEDURES BY INDEPENDENT AUDITING FIRMS

The Bureau will seek to ensure that the above referenced AUP will be conducted by an independent auditing firm that does not have a current audit relationship with the carrier subject to the on-site exam. The Bureau will provide the DOI with the names of the independent auditing firms it intends to engage to conduct the AUPs. The carrier group will be obligated to provide the independent auditing firm with an adequate work space during normal business hours and to reimburse the firm for associated travel expenses incurred during the course of any on-site visit.

Applicable AUP costs are initially subject to a calendar year presumptive billing limit equal to the greater of $50,000 or .5% of the carrier group's direct workers' compensation earned premium for the state of Massachusetts as reported on Statutory Page 14 of the Annual Statement for the prior calendar year. Therefore, the Bureau shall engage only such auditing firms as agree to a presumptive billing limit for the costs associated with performance of their contract. If a carrier group did not file an Annual Statement for the prior calendar year, the Annual Statement most recently filed prior to the current year is to be used in the calculation of the above-described presumptive billing limit. If no annual statements have been filed prior to the current year, an independent AUP presumptive billing limit of $50,000 will apply. A presumptive billing limit may be increased by the Bureau only following a detailed written submission from the independent auditing firm which establishes to the satisfaction of the Bureau that the firm cannot complete the AUP and submit a findings report within such limit.

The independent auditing firm's periodic invoices for the on-site AUP shall be submitted to the carrier group, through the Bureau, and will be payable upon receipt by the carrier group. Any carrier group that fails to timely pay any invoice for an on-site AUP pursuant to the Statistical Plan shall be reported to the DOI for appropriate action.

E. ROUTINE ENGAGEMENTS BY INDEPENDENT AUDITING FIRMS

Any carrier group with at least a one percent (1%) market share in any of the three calendar years immediately preceding the latest calendar year for which Annual Statements have been filed, will be required to engage its independent auditing firm (the auditing firm used by the carrier group to audit their most recent year end financial statements) or another independent auditing firm of its choice to perform an on-site AUP Engagement. Carrier group market shares will be based on calendar year earned premiums for the Massachusetts workers' compensation line as reported on Statutory Page 14. The Bureau will notify those carrier groups that will be subject to an AUP for any given year. The carrier groups selected for an AUP Engagement in any given year shall be determined by the Bureau in consultation with the DOI. The routine AUP is to be performed at the carrier group's expense. Carrier groups will not be required to perform a routine on-site AUP Engagement more frequently than once every three years.

The AUP with regard to the underlying internal control environment (premiums and claims systems) governing Aggregate Financial data will be proposed by the Bureau for approval by the DOI and will result in a findings report that will be submitted to the DOI, the Bureau and the carrier group in accordance with the timetable prescribed in Part II, Section I, page 3.

Upon receipt of the findings report, the carrier group will be given not more than thirty (30) days to make a written submission to the DOI and the Bureau responding to the findings report. The 30 day response period provided to the carrier group shall not prohibit the Bureau from making any determination regarding the appropriateness of the carrier group's data submissions. The DOI will, however, withhold any findings regarding the appropriateness of the carrier group's data submissions for 30 days after the conclusion of the AUP Engagement.

PART II
AGGREGATE FINANCIAL REPORTING

SECTION VII
EDIT LISTING

SECTION VII - EDIT LISTING

EDITS EXCLUSIVE TO CALL #1		
Edit #	**Edit Description**	**Edit Type**
1.1	Duplicate records should not be reported.	Actuarial
1.3	Invalid First Effective Date.	Actuarial
1.4	Invalid Effective Date.	Actuarial
1.5	Invalid Expiration Date.	Actuarial
1.6	Incorrect year of credit.	Actuarial
1.7	Incorrect 1st, 2nd, 3rd or 4th year credit factor.	Actuarial

EDITS EXCLUSIVE TO CALL #2 – Policy Year Call		
Edit #	**Edit Description**	**Edit Type**
2.1	Total (Line (X)) Indemnity Paid Losses (Column (4)) on the Current call decreased more than 200,000 from the Prior call.	Actuarial
2.2	Total (Line (X)) Medical Paid Losses (Column (5)) on the Current call decreased more than 200,000 from the Prior call.	Actuarial
2.4	For Lines (A) through (U), Indemnity Paid Losses (Column (4)) on the Current call decreased more than 10,000 from the Prior call.	Actuarial
2.5	For Lines (A) through (U), Medical Paid Losses (Column (5)) on the Current call decreased more than 10,000 from the Prior call.	Actuarial
2.6	For Lines (A) through (U), the ratio of the Indemnity Paid Losses + Indemnity Case Reserves (Column (4) + Column (8)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 200,000. .80 to 1.25 6th & prior .80 to 1.40 5th .80 to 1.40 4th .80 to 1.40 3rd .75 to 1.70 2nd 1.00 to 5.00 1st	Actuarial

Edit Type Description:
Basic identifies errors or omissions in data.
Actuarial checks for consistency between calls and related data, also reasonableness in the change between valuations.

EDITS EXCLUSIVE TO CALL #2 – Policy Year Call		
Edit #	**Edit Description**	**Edit Type**
2.7	For Lines (A) through (U), the ratio of the Medical Paid Losses + Medical Case Reserves (Column (5) + Column (9)) on the Current to the Prior call should fall within the ranges listed if the change exceeds 200,000. .80 to 1.25 6th & prior .80 to 1.40 5th .80 to 1.40 4th .80 to 1.40 3rd .75 to 1.70 2nd 1.00 to 5.00 1st	Actuarial
2.8	For Lines (A) through (T), the ratio of the Accumulated Closed (Paid) + Open Outstanding (Column (14) + Column (15)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 20. .99 to 1.01 6th & prior .98 to 1.05 5th .98 to 1.05 4th .94 to 1.20 3rd .90 to 1.30 2nd	Actuarial
2.9	Line (V) Accident Year Losses (Columns (1) through (6), Columns (13) through (15)) should be >= to Line (V) Policy Year Losses (Columns (4) through (9), Columns (16) through (18)). (Threshold of 10)	Actuarial
2.10	Within the same calendar year, for Lines (A) through (V), Accident Year Losses (Columns (1) through (6), Columns (13) through (15)) should be less than or equal to the corresponding Policy Year Losses (Columns (4) through (9), Columns (16) through (18)) + the Prior Policy Year Losses. (Threshold of 10)	Actuarial
2.11	Line (A) Policy Year Losses (Columns (4) through (9), Columns (16) through (18)) should be greater than Line (A) Accident Year Losses (Columns (1) through (6), Columns (13) through (15)). (Threshold of 10)	Actuarial
2.12	For Policy Year 1994 through Line (V), if Indemnity Paid Losses + Indemnity Case Reserves (Column (4) + Column (8)) are > 0 then Incurred Accumulated Closed (Paid) + Open Outstanding (Column (14) + Column (15)) must be > 0.	Basic
2.13	For Policy Year 1994 through Line (V)), if Accumulated Closed (Paid) + Open Outstanding (Column (14) + Column (15)) is > 0, then Indemnity Paid Losses + Indemnity Case Reserves (Column (4) + Column (8)) must be > 0.	Basic
2.14	For Policy Year 1994 through Line (V), if the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (4) + Column (5) + Column (8) + Column (9)) are greater than $100,000, then the sum of DCC expenses (Column (16) through Column (18)) should be greater than 0.	Actuarial
2.15	For Lines (X) and (Z) Accident Year Losses (Columns (1) through (6), Columns (13) through (15)) must equal Policy Year Losses (Columns (4) through (9), Columns (16) through (18)). (Threshold of 10)	Actuarial
2.16	For Lines (A) through (V), if Standard at Bureau Designated Stat. Reporting Level (Column (1)) is greater than $250,000, then the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (4) + Column (5) + Column (8) + Column (9)) should be greater than 0.	Actuarial
2.17	For Lines (A) through (V), if the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (4) + Column (5) + Column (8) + Column (9)) is greater than 0, then Standard at Bureau Designated Stat. Reporting Level (Column (1)) must not be 0.	Basic

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EDITS EXCLUSIVE TO CALL #2 – Policy Year Call		
Edit #	**Edit Description**	**Edit Type**
2.18	For Lines (X) and (Z) Accident Year Accumulated Closed (Paid) and Open Outstanding (Column (11), Column (12)) must equal Policy Year Accumulated Closed (Paid) and Open Outstanding (Column (14), Column (15)).	Actuarial
2.19	Line (V) Accident Year Accumulated Closed (Paid), Open Outstanding (Column (11), Column (12)) should be >= to Line (V) Policy Year Accumulated Closed (Paid), Open Outstanding (Column (14), Column (15)).	Basic
2.20	Within the same calendar year, for Lines (A) through (V), Accident Year Accumulated Closed (Paid), Open Outstanding (Column (11), Column (12)) should be less than or equal to the corresponding Policy Year Accumulated Closed (Paid), Open Outstanding (Column (14), Column (15)) + the Prior Policy Year Accumulated Closed (Paid), Open Outstanding (Column (14), Column (15)).	Actuarial
2.30	For Lines (A) through (V), Standard at Bureau Designated Stat. Reporting Level (Column (1)) should not equal Net Premium (Column (3)), unless the value equals 0.	Actuarial
2.31	For Lines (A) through (V), Standard at Company Level (Column (2)) should not equal Net Premium (Column (3)) unless the value equals 0.	Actuarial
2.32	For Lines (B) through (V), the ratio of the Standard at Company Level (Column (2)) to Net Premium (Column (3)) should fall between .500 and 2.00.	Actuarial
2.34	For Lines (B) through (V), the ratio of the Standard at Bureau Designated Stat. Reporting Level (Column (1)) to Net Premium (Column (3)) should fall between .500 and 2.00.	Actuarial
2.36	For Lines (A) through (U), the ratio of the Standard at Bureau Designated Stat. Reporting Level (Column (1)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 200,000. .93 to 1.07 5th & prior .80 to 1.25 4th .80 to 1.25 3rd .75 to 1.33 2nd 1.00 to 4.00 1st	Actuarial
2.37	For Lines (A) through (U), the ratio of the Standard at Company Level (Column (2)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 200,000. .93 to 1.07 5th & prior .80 to 1.25 4th .80 to 1.25 3rd .75 to 1.33 2nd 1.00 to 4.00 1st	Actuarial
2.38	For Lines (A) through (U), the ratio of the Net Premium (Column (3)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 200,000. .93 to 1.07 5th & prior .80 to 1.25 4th .80 to 1.25 3rd .75 to 1.33 2nd 1.00 to 4.00 1st	Actuarial
2.39	For Lines (A) through (V), Standard at Company Level (Column (2)) must be less than or equal to Standard at Bureau Designated Stat. Reporting Level (Column (1)).	Basic
2.40	Premium Adjustments Due to ARAP Surcharge (Column (19)) should not be reported prior to 1990.	Basic

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EDITS EXCLUSIVE TO CALL #2 – Policy Year Call		
Edit #	**Edit Description**	**Edit Type**
2.41	For Lines (F) through (V), if Standard at Bureau Designated Stat Reporting Level (Column (1)) is >=2,500,000, then Premium Adjustments Due to ARAP Surcharge (Column (19)) should be reported.	Actuarial
2.42	Premium Adjustments Due to Construction Credit Program (Column (20)) should not be reported prior to 1991.	Basic
2.43	Premium Adjustments Due to QLMP Credit (Column (21)) should not be reported prior to 1990.	Basic
4.14	***Columns 3, 15 and 17, Line Z should equal Call #4, Page 1, Lines 1, 2 and 3 respectively.*** ***Column 10, Line Z should equal Call #4, Page 2, Line 1, Column 1.***	***Actuarial***

EDITS EXCLUSIVE TO CALL #2A – Policy Year Residual Market Call		
Edit #	**Edit Description**	**Edit Type**
2.1	Total (Line (X)) Indemnity Paid Losses (Column (4)) on the Current call decreased more than 200,000 from the Prior call.	Actuarial
2.2	Total (Line (X)) Medical Paid Losses (Column (5)) on the Current call decreased more than 200,000 from the Prior call.	Actuarial
2.4	For Policy Year 1989 through Line (U), Indemnity Paid Losses (Column (4)) on the Current call decreased more than 10,000 from the Prior call.	Actuarial
2.5	For Policy Year 1989 through Line (U), Medical Paid Losses (Column (5)) on the Current call decreased more than 10,000 from the Prior call.	Actuarial
2.6	For Policy Year 1989 through Line (U), the ratio of the Indemnity Paid Losses + Indemnity Case Reserves (Column (4) + Column (8)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 200,000. .80 to 1.25 6th & prior .80 to 1.40 5th .80 to 1.40 4th .80 to 1.40 3rd .75 to 1.70 2nd 1.00 to 5.00 1st	Actuarial
2.7	For Policy Year 1989 through Line (U), the ratio of the Medical Paid Losses + Medical Case Reserves (Column (5) + Column (9)) on the Current to the Prior call should fall within the ranges listed if the change exceeds 200,000. .80 to 1.25 6th & prior .80 to 1.40 5th .80 to 1.40 4th .80 to 1.40 3rd .75 to 1.70 2nd 1.00 to 5.00 1st	Actuarial

Edit Type Description:
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EDITS EXCLUSIVE TO CALL #2A – Policy Year Residual Market Call		
Edit #	**Edit Description**	**Edit Type**
2.8	For Policy Year 1989 through Line (T), the ratio of the Accumulated Closed (Paid) + Open Outstanding (Column (14) + Column (15)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 20. .99 to 1.01 6th & prior .98 to 1.05 5th .98 to 1.05 4th .94 to 1.20 3rd .90 to 1.30 2nd	Actuarial
2.9	Line (V) Accident Year Losses (Columns (1) through (6), Columns (13) through (15)) should be >= to Line (V) Policy Year Losses (Columns (4) through (9), Columns (16) through (18)). (Threshold of 10)	Actuarial
2.10	Within the same calendar year, for Policy or Accident Year 1990 through Line (V), Accident Year Losses (Columns (1) through (6), Columns (13) through (15)) should be less than or equal to the corresponding Policy Year Losses (Columns (4) through (9), Columns (16) through (18)) + the Prior Policy Year Losses. (Threshold of 10)	Actuarial
2.12	For Policy Year 1994 through Line (V), if Indemnity Paid Losses + Indemnity Case Reserves (Column (4) + Column (8)) are > 0 then Incurred Accumulated Closed (Paid) + Open Outstanding (Column (14) + Column (15)) must be > 0.	Basic
2.13	For Policy Year 1994 through Line (V), if Accumulated Closed (Paid) + Open Outstanding (Column (14) + Column (15)) is > 0, then Indemnity Paid Losses + Indemnity Case Reserves (Column (4) + Column (8)) must be > 0.	Basic
2.14	For Policy Year 1994 through Line (V), if the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (4) + Column (5) + Column (8) + Column (9)) are greater than $100,000, then the sum of DCC expenses (Column (16) through Column (18)) should be greater than 0.	Actuarial
2.15	For Lines (X) and (Z) Accident Year Losses (Columns (1) through (6), Columns (13) through (15)) must equal Policy Year Losses (Columns (4) through (9), Columns (16) through (18)). (Threshold of 10)	Actuarial
2.16	For Policy Year 1989 through Line (V), if Standard at Bureau Designated Stat. Reporting Level (Column (1)) is greater than $250,000, then the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (4) + Column (5) + Column (8) + Column (9)) should be greater than 0.	Actuarial
2.17	For Policy Year 1989 through Line (V), if the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (4) + Column (5) + Column (8) + Column (9)) is greater than 0, then Standard at Bureau Designated Stat. Reporting Level (Column (1)) must not be 0.	Basic
2.18	For Lines (X) and (Z) Accident Year Accumulated Closed (Paid) and Open Outstanding (Column (11), Column (12)) must equal Policy Year Accumulated Closed (Paid) and Open Outstanding (Column (14), Column (15)).	Actuarial
2.19	Line (V) Accident Year Accumulated Closed (Paid), Open Outstanding (Column (11), Column (12)) should be >= to Line (V) Policy Year Accumulated Closed (Paid), Open Outstanding (Column (14), Column (15)).	Basic
2.20	Within the same calendar year, for Policy or Accident Year 1990 through Line (V), Accident Year Accumulated Closed (Paid), Open Outstanding (Column (11), Column (12)) should be less than or equal to the corresponding Policy Year Accumulated Closed (Paid), Open Outstanding (Column (14), Column (15)) + the Prior Policy Year Accumulated Closed (Paid), Open Outstanding (Column (14), Column (15)).	Actuarial
2.32	For Policy Year 1989 through Line (V), the ratio of the Standard at Company Level (Column (2)) to Net Premium (Column (3)) should fall between .500 and 2.00.	Actuarial
2.34	For Policy Year 1989 through Line (V), the ratio of the Standard at Bureau Designated Stat. Reporting Level (Column (1)) to Net Premium (Column (3)) should fall between .500 and 2.00.	Actuarial

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EDITS EXCLUSIVE TO CALL #2A – Policy Year Residual Market Call		
Edit #	**Edit Description**	**Edit Type**
2.36	For Policy Year 1989 through Line (U), the ratio of the Standard at Bureau Designated Stat. Reporting Level (Column (1)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 200,000. .93 to 1.07 5th & prior .80 to 1.25 4th .80 to 1.25 3rd .75 to 1.33 2nd 1.00 to 4.00 1st	Actuarial
2.37	For Policy Year 1989 through Line (U), the ratio of the Standard at Company Level (Column (2)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 200,000. .93 to 1.07 5th & prior .80 to 1.25 4th .80 to 1.25 3rd .75 to 1.33 2nd 1.00 to 4.00 1st	Actuarial
2.38	For Policy Year 1989 through Line (U), the ratio of the Net Premium (Column (3)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 200,000. .93 to 1.07 5th & prior .80 to 1.25 4th .80 to 1.25 3rd .75 to 1.33 2nd 1.00 to 4.00 1st	Actuarial
2.40	Premium Adjustments Due to ARAP Surcharge (Column (19)) should not be reported prior to 1990.	Basic
2.41	For Policy Year 1990 through Line (V), if Standard at Bureau Designated Stat Reporting Level (Column (1)) is >=2,500,000, then Premium Adjustments Due to ARAP Surcharge (Column (19)) should be reported.	Actuarial
2.42	Premium Adjustments Due to Construction Credit Program (Column (20)) should not be reported prior to 1991.	Basic
2.43	Premium Adjustments Due to QLMP Credit (Column (21)) should not be reported prior to 1990.	Basic
2.44	For Policy Year 2006 through Line (V), Standard at Bureau Designated Stat. Reporting Level (Column (1)) should equal Net Premium (Column (3)).	Actuarial
2.45	For Policy Year 2006 through Line (V), Standard at Company Level (Column (2)) should equal Net Premium (Column (3)).	Actuarial
2.46	For Policy Year 2006 through Line (V), Standard at Company Level (Column (2)) must be equal to Standard at Bureau Designated Stat. Reporting Level (Column (1)).	Basic
5.2	***For Call #5, Line (G), if Residual Market Written (Column (1)) is <> 0 then Call # 2A should not be NIL***	***Basic***
5.3	***For Call #5, Line (G), if Residual Market Written (Column (1)) <> 0 then Call # 2A Net Premium, Column (3), Line Z should not = 0.***	***Actuarial***
5.34	***For Call #5, Line (G), if Residual Market Written (Column (1)) = 0, then Call # 2A Net Premium, Column (3), Line Z should = 0.***	***Actuarial***

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Actuarial checks for consistency between calls and related data, also reasonableness in the change between valuations.

EDITS EXCLUSIVE TO CALL #2C – Policy Year Large Deductible Call		
Edit #	**Edit Description**	**Edit Type**
2.1	Total (Line (X)) Indemnity Paid Losses (Column (4)) on the Current call decreased more than 200,000 from the Prior call.	Actuarial
2.2	Total (Line (X)) Medical Paid Losses (Column (5)) on the Current call decreased more than 200,000 from the Prior call.	Actuarial
2.4	For Policy Year 1990 through Line (U), Indemnity Paid Losses (Column (4)) on the Current call decreased more than 10,000 from the Prior call.	Actuarial
2.5	For Policy Year 1990 through Line (U), Medical Paid Losses (Column (5)) on the Current call decreased more than 10,000 from the Prior call.	Actuarial
2.6	For Policy Year 1990 through Line (U), the ratio of the Indemnity Paid Losses + Indemnity Case Reserves (Column (4) + Column (8)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 200,000. .80 to 1.25 6th & prior .80 to 1.40 5th .80 to 1.40 4th .80 to 1.40 3rd .75 to 1.70 2nd 1.00 to 5.00 1st	Actuarial
2.7	For Policy Year 1990 through Line (U), the ratio of the Medical Paid Losses + Medical Case Reserves (Column (5) + Column (9)) on the Current to the Prior call should fall within the ranges listed if the change exceeds 200,000. .80 to 1.25 6th & prior .80 to 1.40 5th .80 to 1.40 4th .80 to 1.40 3rd .75 to 1.70 2nd 1.00 to 5.00 1st	Actuarial

Edit Type Description:
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Actuarial checks for consistency between calls and related data, also reasonableness in the change between valuations.

EDITS EXCLUSIVE TO CALL #2C – Policy Year Large Deductible Call		
Edit #	**Edit Description**	**Edit Type**
2.8	For Policy Year 1990 through Line (T), the ratio of the Accumulated Closed (Paid) + Open Outstanding (Column (14) + Column (15)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 20. .99 to 1.01 6th & prior .98 to 1.05 5th .98 to 1.05 4th .94 to 1.20 3rd .90 to 1.30 2nd	Actuarial
2.9	Line (V) Accident Year Losses (Columns (1) through (6), Columns (13) through (15)) should be >= to Line (V) Policy Year Losses (Columns (4) through (9), Columns (16) through (18)). (Threshold of 10)	Actuarial
2.10	Within the same calendar year, for Policy or Accident Year 1990 through Line (V), Accident Year Losses (Columns (1) through (6), Columns (13) through (15)) should be less than or equal to the corresponding Policy Year Losses (Columns (4) through (9), Columns (16) through (18)) + the Prior Policy Year Losses. (Threshold of 10)	Actuarial
2.12	For Policy Year 1994 through Line (V), if Indemnity Paid Losses + Indemnity Case Reserves (Column (4) + Column (8)) are > 0 then Incurred Accumulated Closed (Paid) + Open Outstanding (Column (14) + Column (15)) must be > 0.	Basic
2.13	For Policy Year 1994 through Line (V), if Accumulated Closed (Paid) + Open Outstanding (Column (14) + Column (15)) is > 0, then Indemnity Paid Losses + Indemnity Case Reserves (Column (4) + Column (8)) must be > 0.	Basic
2.14	For Policy Year 1994 through Line (V), if the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (4) + Column (5) + Column (8) + Column (9)) are greater than $100,000, then the sum of DCC expenses (Column (16) through Column (18)) should be greater than 0.	Actuarial
2.15	For Lines (X) and (Z) Accident Year Losses (Columns (1) through (6), Columns (13) through (15)) must equal Policy Year Losses (Columns (4) through (9), Columns (16) through (18)). (Threshold of 10)	Actuarial
2.16	For Policy Year 1990 through Line (V), if Standard at Bureau Designated Stat. Reporting Level (Column (1)) is greater than $250,000, then the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (4) + Column (5) + Column (8) + Column (9)) should be greater than 0.	Actuarial
2.17	For Policy Year 1990 through Line (V), if the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (4) + Column (5) + Column (8) + Column (9)) is greater than 0, then Standard at Bureau Designated Stat. Reporting Level (Column (1)) must not be 0.	Basic
2.18	For Lines (X) and (Z) Accident Year Accumulated Closed (Paid) and Open Outstanding (Column (11), Column (12)) must equal Policy Year Accumulated Closed (Paid) and Open Outstanding (Column (14), Column (15)).	Actuarial
2.19	Line (V) Accident Year Accumulated Closed (Paid), Open Outstanding (Column (11), Column (12)) should be >= to Line (V) Policy Year Accumulated Closed (Paid), Open Outstanding (Column (14), Column (15)).	Basic
2.20	Within the same calendar year, for Policy or Accident Year 1990 through Line (V), Accident Year Accumulated Closed (Paid), Open Outstanding (Column (11), Column (12)) should be less than or equal to the corresponding Policy Year Accumulated Closed (Paid), Open Outstanding (Column (14), Column (15)) + the Prior Policy Year Accumulated Closed (Paid), Open Outstanding (Column (14), Column (15)).	Actuarial
2.30	For Policy Year 1990 through Line (V), Standard at Bureau Designated Stat. Reporting Level (Column (1)) should not equal Net Premium (Column (3)), unless the value equals 0.	Actuarial
2.31	For Policy Year 1990 through Line (V), Standard at Company Level (Column (2)) should not equal Net Premium (Column (3)) unless the value equals 0.	Actuarial
2.33	For Policy Year 1990 through Line (V), the ratio of the Standard at Company Level (Column (2)) to Net Premium (Column (3)) should be greater than 1.25.	Actuarial

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EDITS EXCLUSIVE TO CALL #2C – Policy Year Large Deductible Call		
Edit #	**Edit Description**	**Edit Type**
2.35	For Policy Year 1990 through Line (V),the ratio of the Standard at Bureau Designated Stat. Reporting Level (Column (1)) to Net Premium (Column (3)) should be greater than 1.25.	Actuarial
2.36	For Policy Year 1990 through Line (U), the ratio of the Standard at Bureau Designated Stat. Reporting Level (Column (1)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 200,000. .93 to 1.07 5th & prior .80 to 1.25 4th .80 to 1.25 3rd .75 to 1.33 2nd 1.00 to 4.00 1st	Actuarial
2.37	For Policy Year 1990 through Line (U), the ratio of the Standard at Company Level (Column (2)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 200,000. .93 to 1.07 5th & prior .80 to 1.25 4th .80 to 1.25 3rd .75 to 1.33 2nd 1.00 to 4.00 1st	Actuarial
2.38	For Policy Year 1990 through Line (U), the ratio of the Net Premium (Column (3)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 200,000. .93 to 1.07 5th & prior .80 to 1.25 4th .80 to 1.25 3rd .75 to 1.33 2nd 1.00 to 4.00 1st	Actuarial
2.39	For Policy Year 1990 through Line (V), Standard at Company Level (Column (2)) must be less than or equal to Standard at Bureau Designated Stat. Reporting Level (Column (1)).	Basic
2.41	For Policy Year 1990 through Line (V), if Standard at Bureau Designated Stat Reporting Level (Column (1)) is >=2,500,000, then Premium Adjustments Due to ARAP Surcharge (Column (19)) should be reported.	Actuarial
2.42	Premium Adjustments Due to Construction Credit Program (Column (*16*)) should not be reported prior to 1991.	Basic
2.47	The sum of Net Premium (Column (3)) and Premium Adjustments Due to ARAP Surcharge (Column (*15*)) cannot be negative.	Basic
2.48	***For lines (A) through (V), Net Premium (Column (3)) should not be less than zero.***	***Actuarial***
4.9	***Call #4, Page 2, Line 7. If Deductible Reimbursements (Large) equal 0, then Standard at DSR Level (Column (1)) on Call #2C should equal 0.***	***Actuarial***
4.10	***Call #4, Page 2, Line 7. If Deductible Reimbursements (Large) is <> 0, then Standard at DSR Level (Column (1)) on Call #2C should not equal 0.***	***Actuarial***
4.11	***Call #4, Page 2, Line 7. If Deductible Reimbursements (Large) <> 0, then Call #2C should not be NIL.***	***Actuarial***
5B.1	***For Call #5, if Large Deductible Written (Column (5)) is <> 0 Call #2C should not be NIL.***	***Basic***
5B.2	***For Call #5, if Large Deductible Written (Column (5)) <> 0 then Call #2C Net Premium, Column (3), Line Z should not = 0.***	***Actuarial***
5B.3	***For Call #5, if Large Deductible Written (Column (5)) = 0, then Call #2C Net Premium, Column (3), Line Z should =0.***	***Actuarial***
5A.1	***For Call #5A, Column (1), if Standard Written Premium at Company Level is equal 0, then Standard Earned Premium at Company Level in Call #2C, Column (2), Line Z should equal 0.***	***Actuarial***
5A.2	***For Call #5A, Column (2), if ARAP Premium is equal 0, then ARAP Surcharge in Call #2C, Column (15), Line Z should equal 0.***	***Actuarial***

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EDITS EXCLUSIVE TO CALL #2C – Policy Year Large Deductible Call		
Edit #	**Edit Description**	**Edit Type**
5A.3	For Call #5A, Column (1), if Standard Written Premium at Company Level is not equal to 0, then Standard Earned Premium at Company Level in Call #2C, Column (2), Line Z should not equal 0.	Actuarial
5A.4	For Call #5A, Column (2), if ARAP Premium is not equal to 0, then ARAP Surcharge in Call #2C, Column (15), Line Z should not equal 0.	Actuarial
4.14	***Columns 3 and 15, Line Z should equal Call #4, Page 1, Lines 4 and 5 respectively. Column 10, Line Z should equal Call #4, Page 2, Line 2, Column 1.***	***Actuarial***

EDITS EXCLUSIVE TO CALL #2D – Policy Year "F" Classification Call		
Edit #	**Edit Description**	**Edit Type**
2.1	Total (Line (X)) Indemnity Paid Losses (Column (4)) on the Current call decreased more than 200,000 from the Prior call.	Actuarial
2.2	Total (Line (X)) Medical Paid Losses (Column (5)) on the Current call decreased more than 200,000 from the Prior call.	Actuarial
2.4	For Lines (A) through (U), Indemnity Paid Losses (Column (4)) on the Current call decreased more than 10,000 from the Prior call.	Actuarial
2.5	For Lines (A) through (U), Medical Paid Losses (Column (5)) on the Current call decreased more than 10,000 from the Prior call.	Actuarial
2.6	For Lines (A) through (U), the ratio of the Indemnity Paid Losses + Indemnity Case Reserves (Column (4) + Column (8)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 200,000. .80 to 1.25 6th & prior .80 to 1.40 5th .80 to 1.40 4th .80 to 1.40 3rd .75 to 1.70 2nd 1.00 to 5.00 1st	Actuarial
2.7	For Lines (A) through (U), the ratio of the Medical Paid Losses + Medical Case Reserves (Column (5) + Column (9)) on the Current to the Prior call should fall within the ranges listed if the change exceeds 200,000. .80 to 1.25 6th & prior .80 to 1.40 5th .80 to 1.40 4th .80 to 1.40 3rd .75 to 1.70 2nd 1.00 to 5.00 1st	Actuarial
2.8	For Lines (A) through (T), the ratio of the Accumulated Closed (Paid) + Open Outstanding (Column (14) + Column (15)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 20. .99 to 1.01 6th & prior .98 to 1.05 5th .98 to 1.05 4th .94 to 1.20 3rd .90 to 1.30 2nd	Actuarial
2.12	For Policy Year 1994 through Line (V), if Indemnity Paid Losses + Indemnity Case Reserves (Column (4) + Column (8)) are > 0 then Incurred Accumulated Closed (Paid) + Open Outstanding (Column (14) + Column (15)) must be > 0.	Basic

Edit Type Description:
Basic identifies errors or omissions in data.
Actuarial checks for consistency between calls and related data, also reasonableness in the change between valuations.

EDITS EXCLUSIVE TO CALL #2D – Policy Year "F" Classification Call		
Edit #	**Edit Description**	**Edit Type**
2.13	For Policy Year 1994 through Line (V), if Accumulated Closed (Paid) + Open Outstanding (Column (14) + Column (15)) is > 0, then Indemnity Paid Losses + Indemnity Case Reserves (Column (4) + Column (8)) must be > 0.	Basic
2.14	For Policy Year 1994 through Line (V), if the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (4) + Column (5) + Column (8) + Column (9)) are greater than $100,000, then the sum of DCC expenses (Column (16) through Column (18)) should be greater than 0.	Actuarial
2.16	For Lines (A) through (V), if Standard at Bureau Designated Stat. Reporting Level (Column (1)) is greater than $250,000, then the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (4) + Column (5) + Column (8) + Column (9)) should be greater than 0.	Actuarial
2.17	For Lines (A) through (V), if the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (4) + Column (5) + Column (8) + Column (9)) is greater than 0, then Standard at Bureau Designated Stat. Reporting Level (Column (1)) must not be 0.	Basic
2.30	For Lines (A) through (V), Standard at Bureau Designated Stat. Reporting Level (Column (1)) should not equal Net Premium (Column (3)), unless the value equals 0.	Actuarial
2.31	For Lines (A) through (V), Standard at Company Level (Column (2)) should not equal Net Premium (Column (3)) unless the value equals 0.	Actuarial
2.32	For Lines (B) through (V), the ratio of the Standard at Company Level (Column (2)) to Net Premium (Column (3)) should fall between .500 and 2.00.	Actuarial
2.34	For Lines (B) through (V), the ratio of the Standard at Bureau Designated Stat. Reporting Level (Column (1)) to Net Premium (Column (3)) should fall between .500 and 2.00.	Actuarial
2.36	For Lines (A) through (U), the ratio of the Standard at Bureau Designated Stat. Reporting Level (Column (1)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 200,000. .93 to 1.07 5th & prior .80 to 1.25 4th .80 to 1.25 3rd .75 to 1.33 2nd 1.00 to 4.00 1st	Actuarial
2.37	For Lines (A) through (U), the ratio of the Standard at Company Level (Column (2)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 200,000. .93 to 1.07 5th & prior .80 to 1.25 4th .80 to 1.25 3rd .75 to 1.33 2nd 1.00 to 4.00 1st	Actuarial
2.38	For Lines (A) through (U), the ratio of the Net Premium (Column (3)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 200,000. .93 to 1.07 5th & prior .80 to 1.25 4th .80 to 1.25 3rd .75 to 1.33 2nd 1.00 to 4.00 1st	Actuarial
2.39	For Lines (A) through (V), Standard at Company Level (Column (2)) must be less than or equal to Standard at Bureau Designated Stat. Reporting Level (Column (1)).	Basic
2.40	Premium Adjustments Due to ARAP Surcharge (Column (19)) should not be reported prior to 1990.	Basic

Edit Type Description:
Basic identifies errors or omissions in data.
Actuarial checks for consistency between calls and related data, also reasonableness in the change between valuations.

EDITS EXCLUSIVE TO CALL #2D – Policy Year "F" Classification Call		
Edit #	**Edit Description**	**Edit Type**
2.41	For Policy Year 1990 through Line (V), if Standard at Bureau Designated Stat Reporting Level (Column (1)) is >=2,500,000, then Premium Adjustments Due to ARAP Surcharge (Column (19)) should be reported.	Actuarial
2.42	Premium Adjustments Due to Construction Credit Program (Column (20)) should not be reported prior to 1991.	Basic
2.43	Premium Adjustments Due to QLMP Credit (Column (21)) should not be reported prior to 1990.	Basic
4.14	***Columns 3, 15 and 17, Line Z should equal Call #4, Page 1, Lines 6, 7 and 8 respectively.*** ***Column 10, Line Z should equal Call #4, Page 2, Line 3, Column 1.***	***Actuarial***

EDITS EXCLUSIVE TO CALL #2E – Policy Year Maritime Classification Call		
Edit #	**Edit Description**	**Edit Type**
2.1	Total (Line (X)) Indemnity Paid Losses (Column (4)) on the Current call decreased more than 200,000 from the Prior call.	Actuarial
2.2	Total (Line (X)) Medical Paid Losses (Column (5)) on the Current call decreased more than 200,000 from the Prior call.	Actuarial
2.4	For Policy Year 2006 through Line (U), Indemnity Paid Losses (Column (4)) on the Current call decreased more than 10,000 from the Prior call.	Actuarial
2.5	For Policy Year 2006 through Line (U), Medical Paid Losses (Column (5)) on the Current call decreased more than 10,000 from the Prior call.	Actuarial
2.6	For Policy Year 2006 through Line (U), the ratio of the Indemnity Paid Losses + Indemnity Case Reserves (Column (4) + Column (8)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 200,000. .80 to 1.25 6th & prior .80 to 1.40 5th .80 to 1.40 4th .80 to 1.40 3rd .75 to 1.70 2nd 1.00 to 5.00 1st	Actuarial
2.7	For Policy Year 2006 through Line (U), the ratio of the Medical Paid Losses + Medical Case Reserves (Column (5) + Column (9)) on the Current to the Prior call should fall within the ranges listed if the change exceeds 200,000. .80 to 1.25 6th & prior .80 to 1.40 5th .80 to 1.40 4th .80 to 1.40 3rd .75 to 1.70 2nd 1.00 to 5.00 1st	Actuarial

Edit Type Description:
Basic identifies errors or omissions in data.
Actuarial checks for consistency between calls and related data, also reasonableness in the change between valuations.

EDITS EXCLUSIVE TO CALL #2E – Policy Year Maritime Classification Call		
Edit #	**Edit Description**	**Edit Type**
2.8	For Policy Year 2006 through Line (T), the ratio of the Accumulated Closed (Paid) + Open Outstanding (Column (14) + Column (15)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 20. .99 to 1.01 6th & prior .98 to 1.05 5th .98 to 1.05 4th .94 to 1.20 3rd .90 to 1.30 2nd	Actuarial
2.12	For Policy Year 2006 through Line (V), if Indemnity Paid Losses + Indemnity Case Reserves (Column (4) + Column (8)) are > 0 then Incurred Accumulated Closed (Paid) + Open Outstanding (Column (14) + Column (15)) must be > 0.	Basic
2.13	For Policy Year 2006 through Line (V), if Accumulated Closed (Paid) + Open Outstanding (Column (14) + Column (15)) is > 0, then Indemnity Paid Losses + Indemnity Case Reserves (Column (4) + Column (8)) must be > 0.	Basic
2.14	For Policy Year 2006 through Line (V), if the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (4) + Column (5) + Column (8) + Column (9)) are greater than $100,000, then the sum of DCC expenses (Column (16) through Column (18)) should be greater than 0.	Actuarial
2.16	For Policy Year 2006 through Line (V), if Standard at Bureau Designated Stat. Reporting Level (Column (1)) is greater than $250,000, then the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (4) + Column (5) + Column (8) + Column (9)) should be greater than 0.	Actuarial
2.17	For Policy Year 2006 through Line (V), if the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (4) + Column (5) + Column (8) + Column (9)) is greater than 0, then Standard at Bureau Designated Stat. Reporting Level (Column (1)) must not be 0.	Basic
2.30	For Policy Year 2006 through Line (V), Standard at Bureau Designated Stat. Reporting Level (Column (1)) should not equal Net Premium (Column (3)), unless the value equals 0.	Actuarial
2.31	For Policy Year 2006 through Line (V), Standard at Company Level (Column (2)) should not equal Net Premium (Column (3)) unless the value equals 0.	Actuarial
2.32	For Policy Year 2006 through Line (V), the ratio of the Standard at Company Level (Column (2)) to Net Premium (Column (3)) should fall between .500 and 2.00.	Actuarial
2.34	For Policy Year 2006 through Line (V), the ratio of the Standard at Bureau Designated Stat. Reporting Level (Column (1)) to Net Premium (Column (3)) should fall between .500 and 2.00.	Actuarial
2.36	For Policy Year 2006 through Line (U), the ratio of the Standard at Bureau Designated Stat. Reporting Level (Column (1)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 200,000. .93 to 1.07 5th & prior .80 to 1.25 4th .80 to 1.25 3rd .75 to 1.33 2nd 1.00 to 4.00 1st	Actuarial

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EDITS EXCLUSIVE TO CALL #2E – Policy Year Maritime Classification Call		
Edit #	**Edit Description**	**Edit Type**
2.37	For Policy Year 2006 through Line (U), the ratio of the Standard at Company Level (Column (2)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 200,000. .93 to 1.07 5th & prior .80 to 1.25 4th .80 to 1.25 3rd .75 to 1.33 2nd 1.00 to 4.00 1st	Actuarial
2.38	For Policy Year 2006 through Line (U), the ratio of the Net Premium (Column (3)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 200,000. .93 to 1.07 5th & prior .80 to 1.25 4th .80 to 1.25 3rd .75 to 1.33 2nd 1.00 to 4.00 1st	Actuarial
2.39	For Policy Year 2006 through Line (V), Standard at Company Level (Column (2)) must be less than or equal to Standard at Bureau Designated Stat. Reporting Level (Column (1)).	Basic
2.41	For Policy Year 2006 through Line (V), if Standard at Bureau Designated Stat Reporting Level (Column (1)) is >=2,500,000, then Premium Adjustments Due to ARAP Surcharge (Column (19)) should be reported.	Actuarial
4.14	***Columns 3, 15 and 17, Line Z should equal Call #4, Page 1, Lines 9, 10 and 11 respectively. Column 10, Line Z should equal Call #4, Page 2, Line 4, Column 1.***	***Actuarial***

EDITS EXCLUSIVE TO CALL # 3 - Accident Year Call		
Edit #	**Edit Description**	**Edit Type**
3.1	Total (Line (X)) Indemnity Paid Losses (Column (1)) on the Current call decreased more than 200,000 from the Prior call.	Actuarial
3.2	Total (Line (X)) Medical Paid Losses (Column (2)) on the Current call decreased more than 200,000 from the Prior call.	Actuarial
3.4	For Accident Year Lines (A) through (U), Indemnity Paid Losses (Column (1)) on the Current call decreased more than 10,000 from the Prior call.	Actuarial
3.5	For Lines (A) through (U), Medical Paid Losses (Column (2)) on the Current call decreased more than 10,000 from the Prior call.	Actuarial
3.6	For Lines (A) through (U), the ratio of the Indemnity Paid Losses + Indemnity Case Reserves (Column (1) + Column (5)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 200,000. .75 to 1.33 5th & prior .75 to 1.40 4th .75 to 1.40 3rd .80 to 1.50 2nd .90 to 2.30 1st	Actuarial

Edit Type Description:
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EDITS EXCLUSIVE TO CALL # 3 - Accident Year Call		
Edit #	**Edit Description**	**Edit Type**
3.7	For Lines (A) through (U), the ratio of the Medical Paid Losses + Medical Case Reserves (Column (2) + Column (6)) on the Current to the Prior call should fall within the ranges listed if the change exceeds 200,000. .75 to 1.33 5th & prior .75 to 1.40 4th .75 to 1.40 3rd .80 to 1.50 2nd .90 to 2.30 1st	Actuarial
3.8	For Lines (A) through (T), the ratio of the Accumulated Closed (Paid) + Open Outstanding (Column (11) + Column (12)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 20. .99 to 1.02 5th & prior .98 to 1.05 4th .94 to 1.20 3rd .88 to 1.40 2nd .88 to 2.50 1st	Actuarial
3.9	Line (V) Accident Year Losses (Columns (1) through (6), Columns (13) through (15)) should be >= to Line (V) Policy Year Losses (Columns (4) through (9), Columns (16) through (18)). (Threshold of 10)	Actuarial
3.10	Within the same calendar year, for Lines (A) through (V), Accident Year Losses (Columns (1) through (6), Columns (13) through (15)) should be less than or equal to the corresponding Policy Year Losses (Columns (4) through (9), Columns (16) through (18)) + the Prior Policy Year Losses. (Threshold of 10)	Actuarial
3.11	Line (A) Policy Year Losses (Columns (4) through (9), Columns (16) through (18)) should be greater than Line (A) Accident Year Losses (Columns (1) through (6), Columns (13) through (15)). (Threshold of 10)	Actuarial
3.12	For Accident Year 1994 through Line (V), if Indemnity Paid Losses + Indemnity Case Reserves (Column (1) + Column (5)) are > 0 then Incurred Accumulated Closed (Paid) + Open Outstanding (Column (11) + Column (12)) must be > 0.	Basic
3.13	For Accident Year 1994 through Line (V), if Accumulated Closed (Paid) + Open Outstanding (Column (11) + Column (12)) is > 0, then Indemnity Paid Losses + Indemnity Case Reserves (Column (1) + Column (5)) must be > 0.	Basic
3.14	For Accident Year 1994 through Line (V), if the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (1) + Column (2) + Column (5) + Column (6)) are greater than $100,000, then the sum of DCC expenses (Column (13) through Column (15)) should be greater than 0.	Actuarial
3.15	For Lines (X) and (Z) Accident Year Losses (Columns (1) through (6), Columns (13) through (15)) must equal Policy Year Losses (Columns (4) through (9), Columns (16) through (18)). (Threshold of 10)	Actuarial
3.16	For Lines (A) through (V), if Standard at Bureau Designated Stat. Reporting Level (Column (1) of Policy Year Call) is greater than $250,000, then the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (1) + Column (2) + Column (5) + Column (6)) should be greater than 0.	Actuarial
3.17	For Lines (A) through (V), if the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (1) + Column (2) + Column (5) + Column (6)) is greater than 0, then Standard at Bureau Designated Stat. Reporting Level (Column (1) of Policy Year Call) must not be 0.	Actuarial

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EDITS EXCLUSIVE TO CALL # 3 - Accident Year Call		
Edit #	**Edit Description**	**Edit Type**
3.18	For Lines (X) and (Z) Accident Year Accumulated Closed (Paid) and Open Outstanding (Column (11), Column (12)) must equal Policy Year Accumulated Closed (Paid) and Open Outstanding (Column (14), Column (15)).	Actuarial
3.19	Line (V) Accident Year Accumulated Closed (Paid), Open Outstanding (Column (11), Column (12)) should be >= to Line (V) Policy Year Accumulated Closed (Paid), Open Outstanding (Column (14), Column (15)).	Basic
3.20	Within the same calendar year, for Lines (A) through (V), Accident Year Accumulated Closed (Paid), Open Outstanding (Column (11), Column (12)) should be less than or equal to the corresponding Policy Year Accumulated Closed (Paid), Open Outstanding (Column (14), Column (15)) + the Prior Policy Year Accumulated Closed (Paid), Open Outstanding (Column (14), Column (15)).	Actuarial
4.14	***Column 7, Line Z should equal Call #4, Page 2, Line 1, Column 2.***	***Actuarial***

EDITS EXCLUSIVE TO CALL # 3A - Accident Year Residual Market Call		
Edit #	**Edit Description**	**Edit Type**
3.1	Total (Line (X)) Indemnity Paid Losses (Column (1)) on the Current call decreased more than 200,000 from the Prior call.	Actuarial
3.2	Total (Line (X)) Medical Paid Losses (Column (2)) on the Current call decreased more than 200,000 from the Prior call.	Actuarial
3.4	For Accident Year 1989 through Line (U), Indemnity Paid Losses (Column (1)) on the Current call decreased more than 10,000 from the Prior call.	Actuarial
3.5	For Accident Year 1989 through Line (U), Medical Paid Losses (Column (2)) on the Current call decreased more than 10,000 from the Prior call.	Actuarial
3.6	For Accident Year 1989 through Line (U), the ratio of the Indemnity Paid Losses + Indemnity Case Reserves (Column (1) + Column (5)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 200,000. .75 to 1.33 5th & prior .75 to 1.40 4th .75 to 1.40 3rd .80 to 1.50 2nd .90 to 2.30 1st	Actuarial
3.7	For Accident Year 1989 through Line (U), the ratio of the Medical Paid Losses + Medical Case Reserves (Column (2) + Column (6)) on the Current to the Prior call should fall within the ranges listed if the change exceeds 200,000. .75 to 1.33 5th & prior .75 to 1.40 4th .75 to 1.40 3rd .80 to 1.50 2nd .90 to 2.30 1st	Actuarial

Edit Type Description:
Basic identifies errors or omissions in data.
Actuarial checks for consistency between calls and related data, also reasonableness in the change between valuations.

EDITS EXCLUSIVE TO CALL # 3A - Accident Year Residual Market Call		
Edit #	**Edit Description**	**Edit Type**
3.8	For Accident Year 1989 through Line (T), the ratio of the Accumulated Closed (Paid) + Open Outstanding (Column (11) + Column (12)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 20. .99 to 1.02 5th & prior .98 to 1.05 4th .94 to 1.20 3rd .88 to 1.40 2nd .88 to 2.50 1st	Actuarial
3.9	Line (V) Accident Year Losses (Columns (1) through (6), Columns (13) through (15)) should be >= to Line (V) Policy Year Losses (Columns (4) through (9), Columns (16) through (18)). (Threshold of 10)	Actuarial
3.10	Within the same calendar year, for Policy or Accident Year 1990 through Line (V), Accident Year Losses (Columns (1) through (6), Columns (13) through (15)) should be less than or equal to the corresponding Policy Year Losses (Columns (4) through (9), Columns (16) through (18)) + the Prior Policy Year Losses. (Threshold of 10)	Actuarial
3.12	For Accident Year 1994 through Line (V), if Indemnity Paid Losses + Indemnity Case Reserves (Column (1) + Column (5)) are > 0 then Incurred Accumulated Closed (Paid) + Open Outstanding (Column (11) + Column (12)) must be > 0.	Basic
3.13	For Accident Year 1994 through Line (V), if Accumulated Closed (Paid) + Open Outstanding (Column (11) + Column (12)) is > 0, then Indemnity Paid Losses + Indemnity Case Reserves (Column (1) + Column (5)) must be > 0.	Basic
3.14	For Accident Year 1994 through Line (V), if the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (1) + Column (2) + Column (5) + Column (6)) are greater than $100,000, then the sum of DCC expenses (Column (13) through Column (15)) should be greater than 0.	Actuarial
3.15	For Lines (X) and (Z) Accident Year Losses (Columns (1) through (6), Columns (13) through (15)) must equal Policy Year Losses (Columns (4) through (9), Columns (16) through (18)). (Threshold of 10)	Actuarial
3.16	For Accident Year 1989 through Line (V), if Standard at Bureau Designated Stat. Reporting Level (Column (1) of Policy Year Residual Market Call) is greater than $250,000, then the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (1) + Column (2) + Column (5) + Column (6)) should be greater than 0.	Actuarial
3.17	For Accident Year 1989 through Line (V), if the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (1) + Column (2) + Column (5) + Column (6)) is greater than 0, then Standard at Bureau Designated Stat. Reporting Level (Column (1) of Policy Year Residual Market Call) must not be 0.	Actuarial
3.18	For Lines (X) and (Z) Accident Year Accumulated Closed (Paid) and Open Outstanding (Column (11), Column (12)) must equal Policy Year Accumulated Closed (Paid) and Open Outstanding (Column (14), Column (15)).	Actuarial
3.19	Line (V) Accident Year Accumulated Closed (Paid), Open Outstanding (Column (11), Column (12)) should be >= to Line (V) Policy Year Accumulated Closed (Paid), Open Outstanding (Column (14), Column (15)).	Basic
3.20	Within the same calendar year, for Policy or Accident Year 1990 through Line (V), Accident Year Accumulated Closed (Paid), Open Outstanding (Column (11), Column (12)) should be less than or equal to the corresponding Policy Year Accumulated Closed (Paid), Open Outstanding (Column (14), Column (15)) + the Prior Policy Year Accumulated Closed (Paid), Open Outstanding (Column (14), Column (15)).	Actuarial

Edit Type Description:
Basic identifies errors or omissions in data.
Actuarial checks for consistency between calls and related data, also reasonableness in the change between valuations.

EDITS EXCLUSIVE TO CALL # 3C - Accident Year Large Deductible Call		
Edit #	**Edit Description**	**Edit Type**
3.1	Total (Line (X)) Indemnity Paid Losses (Column (1)) on the Current call decreased more than 200,000 from the Prior call.	Actuarial
3.2	Total (Line (X)) Medical Paid Losses (Column (2)) on the Current call decreased more than 200,000 from the Prior call.	Actuarial
3.4	For Accident Year 1990 through Line (U), Indemnity Paid Losses (Column (1)) on the Current call decreased more than 10,000 from the Prior call.	Actuarial
3.5	For Accident Year 1990 through Line (U), Medical Paid Losses (Column (2)) on the Current call decreased more than 10,000 from the Prior call.	Actuarial
3.6	For Accident Year 1990 through Line (U), the ratio of the Indemnity Paid Losses + Indemnity Case Reserves (Column (1) + Column (5)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 200,000. .75 to 1.33 5th & prior .75 to 1.40 4th .75 to 1.40 3rd .80 to 1.50 2nd .90 to 2.30 1st	Actuarial
3.7	For Accident Year 1990 through Line (U), the ratio of the Medical Paid Losses + Medical Case Reserves (Column (2) + Column (6)) on the Current to the Prior call should fall within the ranges listed if the change exceeds 200,000. .75 to 1.33 5th & prior .75 to 1.40 4th .75 to 1.40 3rd .80 to 1.50 2nd .90 to 2.30 1st	Actuarial

Edit Type Description:
Basic identifies errors or omissions in data.
Actuarial checks for consistency between calls and related data, also reasonableness in the change between valuations.

EDITS EXCLUSIVE TO CALL # 3C - Accident Year Large Deductible Call		
Edit #	**Edit Description**	**Edit Type**
3.8	For Accident Year 1990 through Line (T), the ratio of the Accumulated Closed (Paid) + Open Outstanding (Column (11) + Column (12)) on the Current call to the Prior call should fall within the ranges listed if the change exceeds 20. .99 to 1.02 5th & prior .98 to 1.05 4th .94 to 1.20 3rd .88 to 1.40 2nd .88 to 2.50 1st	Actuarial
3.9	Line (V) Accident Year Losses (Columns (1) through (6), Columns (13) through (15)) should be >= to Line (V) Policy Year Losses (Columns (4) through (9), Columns (16) through (18)). (Threshold of 10)	Actuarial
3.10	Within the same calendar year, for Policy or Accident Year 1990 through Line (V), Accident Year Losses (Columns (1) through (6), Columns (13) through (15)) should be less than or equal to the corresponding Policy Year Losses (Columns (4) through (9), Columns (16) through (18)) + the Prior Policy Year Losses. (Threshold of 10)	Actuarial
3.12	For Accident Year 1994 through Line (V), if Indemnity Paid Losses + Indemnity Case Reserves (Column (1) + Column (5)) are > 0 then Incurred Accumulated Closed (Paid) + Open Outstanding (Column (11) + Column (12)) must be > 0.	Basic
3.13	For Accident Year 1994 through Line (V), if Accumulated Closed (Paid) + Open Outstanding (Column (11) + Column (12)) is > 0, then Indemnity Paid Losses + Indemnity Case Reserves (Column (1) + Column (5)) must be > 0.	Basic
3.14	For Accident Year 1994 through Line (V), if the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (1) + Column (2) + Column (5) + Column (6)) are greater than $100,000, then the sum of DCC expenses (Column (13) through Column (15)) should be greater than 0.	Actuarial
3.15	For Lines (X) and (Z) Accident Year Losses (Columns (1) through (6), Columns (13) through (15)) must equal Policy Year Losses (Columns (4) through (9), Columns (16) through (18)). (Threshold of 10)	Actuarial
3.16	For Accident Year 1990 through Line (V), if Standard at Bureau Designated Stat. Reporting Level (Column (1) of Policy Year Large Deductible Call) is greater than $250,000, then the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (1) + Column (2) + Column (5) + Column (6)) should be greater than 0.	Actuarial
3.17	For Accident Year 1990 through Line (V), if the sum of Indemnity Paid, Medical Paid, Indemnity Case Reserves and Medical Case Reserves (Column (1) + Column (2) + Column (5) + Column (6)) is greater than 0, then Standard at Bureau Designated Stat. Reporting Level (Column (1) of Policy Year Large Deductible Call) must not be 0.	Actuarial
3.18	For Lines (X) and (Z) Accident Year Accumulated Closed (Paid) and Open Outstanding (Column (11), Column (12)) must equal Policy Year Accumulated Closed (Paid) and Open Outstanding (Column (14), Column (15)).	Actuarial
3.19	Line (V) Accident Year Accumulated Closed (Paid), Open Outstanding (Column (11), Column (12)) should be >= to Line (V) Policy Year Accumulated Closed (Paid), Open Outstanding (Column (14), Column (15)).	Basic
3.20	Within the same calendar year, for Policy or Accident Year 1990 through Line (V), Accident Year Accumulated Closed (Paid), Open Outstanding (Column (11), Column (12)) should be less than or equal to the corresponding Policy Year Accumulated Closed (Paid), Open Outstanding (Column (14), Column (15)).	Actuarial

Edit Type Description:
Basic identifies errors or omissions in data.
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EDITS EXCLUSIVE TO CALL # 3C - Accident Year Large Deductible Call		
Edit #	**Edit Description**	**Edit Type**
4.14	***Column 7, Line Z should equal Call #4, Page 2, Line 2, Column 2.***	***Actuarial***

EDITS EXCLUSIVE TO CALL #4 - Reconciliation Report		
Edit #	**Edit Description**	**Edit Type**
4.1	Page 1. If a Write-in value is entered on Lines 19, 20, 21, 22, 23 there should be a note added on the same line.	Basic
4.2	Page 1. The Imbalance on Line 25 should not be greater than or less than zero.	Actuarial
4.3	Page 2. If a Write-in value is entered on Lines ***15***, ***16***, ***17***, ***18***, ***19*** there should be a note added on the same line.	Basic
4.4	Page 2. The Imbalance on Line ***21*** should not be greater than or less than zero.	Actuarial
4.5	Page 2. (Line 1) Total Market Policy Year Incurred Losses must equal (Line 1) Total Market Accident Year Incurred Losses.	Actuarial
4.6	Page 2. (Line 2) Large Deductible Policy Year Incurred Losses must equal (Line 2) Large Deductible Accident Year Incurred Losses.	Actuarial
4.7	Page 3. If a Write-in value is entered on Lines 21, 22, 23, 24, 25 there should be a note added on the same line.	Basic
4.8	Page 3. If the Imbalance reported on Line 27 is > the absolute value of 500, then an adequate explanation must be included within the Call Notes.	Actuarial
4.9	Page 2, Line 7. If Deductible Reimbursements (Large) equal 0, then Standard at DSR Level (Column (1)) on Call #2C should equal 0.	Actuarial
4.10	Page 2, Line 7. If Deductible Reimbursements (Large) is <>), then Standard at DSR Level (Column (1)) on Call #2C should not equal 0.	Actuarial
4.11	Page 2, Line 7. If Deductible Reimbursements (Large) <> 0, then Call #2C should not be NIL.	Actuarial
4.12	Page 3, Line 6. Rate Deviations should not be positive.	Actuarial
4.13	Page 3, Line 12. Scheduled rating Adjustments should not be positive.	Actuarial

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EDITS EXCLUSIVE TO CALL #4 - Reconciliation Report		
Edit #	**Edit Description**	**Edit Type**
4.14	***Page 1, Lines 1, 2 and 3 should equal Call #2 Columns 3, 15 and 17, Line Z respectively.*** ***Page 1, Lines 4 and 5 should equal Call #2C Columns 3 and 15, Line Z respectively.*** ***Page 1, Lines 6, 7 and 8 should equal Call #2D Columns 3, 15 and 17, Line Z respectively.*** ***Page 1, Lines 9, 10 and 11 should equal Call #2E Columns 3, 15 and 17, Line Z respectively.*** ***Page 2, Line 1, Column 1 should equal Call #2 Column 10, Line Z.*** ***Page 2, Line 1, Column 2 should equal Call #3 Column 7, Line Z.*** ***Page 2, Line 2, Column 1 should equal Call #2C Column 10, Line Z.*** ***Page 2, Line 2, Column 2 should equal Call #3C Column 7, Line Z.*** ***Page 2, Line 3 should equal Call #2D Column 10, Line Z.*** ***Page 2, Line 4 should equal Call #2E Column 10, Line Z.***	***Actuarial***

EDITS EXCLUSIVE TO CALL # 5B – Direct Written Premium		
Edit #	**Edit Description**	**Edit Type**
5B.1	If Large Deductible Written (Column (5)) is <> 0 Call #2C should not be NIL.	Basic
5B.2	If Large Deductible Written (Column (5)) <> 0 then Call #2C Net Premium, Column (3), Line Z should not = 0.	Actuarial
5B.3	If Large Deductible Written (Column (5)) = 0, then Call #2C Net Premium, Column (3), Line Z should =0.	Actuarial
5A.5	For Call #5A, if Standard Written Premium at Company Level, Column (1) + ARAP Premium, Column (2) is not equal to zero then Large Deductible Written in Call #5B, Column (5), should not equal zero.	Actuarial
5A.6	For Call #5A, if Standard Written Premium at Company Level, Column (1) + ARAP Premium, Column (2) is equal to zero then Large Deductible Written in Call #5B, Column (5), should equal zero.	Actuarial

EDITS EXCLUSIVE TO CALL # 5A – Large Deductible Company Level Written Premiums		
Edit #	Edit Description	Edit Type
5A.1	For Column (1), if Standard Written Premium at Company Level is equal to 0, then Standard Earned Premium at Company Level in Call 2C, Column (2), Line Z should equal zero.	Actuarial
5A.2	For Column (2), if ARAP Premium is not equal to 0, then ARAP Surcharge in Call 2C, Column (15), Line Z should not equal zero.	Actuarial
5A.3	For Column (1), if Standard Written Premium at Company Level is not equal to 0, then Standard Earned premium at Company Level in Call #2C, Column (2), Line Z should not equal zero.	Actuarial

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EDITS EXCLUSIVE TO CALL # 5A – Large Deductible Company Level Written Premiums		
Edit #	***Edit Description***	***Edit Type***
5A.4	***For Column (2), if ARAP Premium is not equal to 0, then ARAP Surcharge in Call #2C, Column (15), Line Z should not equal zero.***	***Actuarial***
5A.5	***If Standard Written Premium at Company Level, Column (1) , + ARAP Premium, Column (2) is not equal to zero then Large Deductible Written in Call #5B, Column (5), should not equal zero.***	***Actuarial***
5A.6	***If Standard Written Premium at Company Level, Column (1) + ARAP Premium, Column (2) is equal to zero then Large Deductible Written in Call #5B, Column (5) should equal zero.***	***Actuarial***

EDITS EXCLUSIVE TO CALL # 5 – Residual Market Direct Written Premiums		
Edit #	***Edit Description***	***Edit Type***
5.1	***For Line (A) through (G), if VDAR Written (Column (2)) is reported it should be less than or equal to Residual Market Written (Column (1)).***	***Actuarial***
5.2	***For Line (G), if Residual Market Written (Column (1)) is <> 0 then Call #2A should not be NIL.***	***Basic***
5.3	***For Line (G), if Residual Market Written (Column (1)) <> 0 then Call #2A Net Premium, Column (3), Line Z should not = 0.***	***Actuarial***
5.4	***For Line (G), if Residual Market Written (Column (1)) = 0, then Call #2A Net Premium, Column (3), Line Z should = 0.***	***Actuarial***

EDITS EXCLUSIVE TO CALL # 6 - Calendar Year Expense Data		
Edit #	**Edit Description**	**Edit Type**
6.1	MA Data (Call # 6) should be less than or equal to Country Wide Data (Call # 6A) for the following fields: Other Acquisitions, Field Supervisions and Collection Expenses (Line (1)), Adjusting and Other Expenses (Line (2)) and General Expenses (Lines (3)).	Actuarial
6.2	Other Acquisitions, Field Supervision, and Collection Expenses Incurred (Line (1)) should not be zero ***if there is Written Premium reported on the Exhibit of Premium and Losses.***	Actuarial

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EDITS EXCLUSIVE TO CALL # 6A – Insurance Expense Exhibit		
Edit #	**Edit Description**	**Edit Type**
6.1	MA Data (Call # 6) should be less than or equal to Country Wide Data (Call # 6A) for the following fields: Other Acquisitions, Field Supervisions and Collection Expenses, Adjusting and Other Expenses and General Expenses.	Actuarial

EDITS EXCLUSIVE TO CALL # 7 - Large Loss and Catastrophe Call		
Edit #	**Edit Description**	**Edit Type**
7.1	Duplicate records should not be reported.	Basic
7.2	Extraordinary Loss Event claim that reported on previous call must be reported on current call.	Basic
7.3	Claim reported on current call but not reported on previous call.	Actuarial
7.4	If a Policy is reported then a Claim Number must be reported.	Basic
7.5	If a Claim Number is reported then a Policy must be reported.	Basic
7.6	Incurred Losses must be >= 500,000 if the claim is not an Extraordinary Loss Event claim.	Actuarial
7.7	Catastrophe Number should be a number that has been classified as an Extraordinary Loss Event.	Basic
7.8	Market type code (Column (*5*)) must be 0, 2 ***or*** 3.	Basic
7.9	Loss Condition Act Code (Column (*8*)) must be 01 or 02.	Basic
7.10	Injury Type Code (Column (*9*)) must be 01, 02, 05, 06 or 09.	Basic
7.11	Claim *S*tatus *Code (Column (10)* must be 0, 1, or 2.	Basic
7.12	Columns *(13), (14)* and *(16)* – Indemnity Case, Medical Case and DCC Case Respectively – should not be less than zero.	***Actuarial***

Edit Type Description:
Basic identifies errors or omissions in data.
Actuarial checks for consistency between calls and related data, also reasonableness in the change between valuations.