**ERM-6 FORM**
**WORKERS COMPENSATION EXPERIENCE RATING**
**FOR SELF INSURANCE**

NAME OF RISK _____

ADDRESS OF RISK _____ CITY _____ STATE _____

ZIP _____ RISK IDENTIFICATION NO. _____ EFFECTIVE DATE OF RATING _____

FEDERAL IDENTIFICATION NUMBER _____ STATE OF COVERAGE _____

| Coverage Period | | | | | | | |
|---|---|---|---|---|---|---|---|
| (1) Effective Month/Day/ Year | (2) Expiration Month/Day/ Year | (3) Class Code | (4) Payroll | (5) Claim Identification Number Assigned | (6) Injury Type Code | (7) Open/Closed –Final (O/F) | (8) Incurred Losses (Paid plus Reserves) |
| | | | | | | | |

PLEASE FOLLOW THE INSTRUCTIONS ON THE BACK PAGE FOR COMPLETING THIS WORKSHEET

## INSTRUCTIONS FOR SUBMITTING EXPERIENCE RATING DATA

PAYROLL AND LOSSES MUST BE ROUNDED TO THE NEAREST WHOLE DOLLAR.

COLUMN 1 — Fill in the effective month, day, and year of the period for which information will be provided. In accordance with the Delaware Experience Rating Plan rules, a total of three (3) years of experience can be included in the rating, not including the year immediately prior to the effective date of the rating. Each year's payroll losses must be listed separately.

COLUMN 2 — Fill in the expiration month, day, and year of the period for which information will be provided.

COLUMN 3 — Fill in the appropriate workers' compensation classification code(s) which best describes the type of business. Questions regarding the classifications can be directed to the DCRB's Classification Department at 215-320-4488.

COLUMN 4 — Fill in the payroll amounts for classification code(s) for each year as reported in Column 3...

COLUMN 5 — Provide the claim number used for internal record keeping should you desire this information on the modification worksheet. If claim numbers are not used for internal record keeping, leave column blank.

COLUMN 6 — Fill in the appropriate injury type code (see following list). Only one injury type code is applicable per claim. Medical only claims should be listed as a "6," but claims that include both medical and disability or death benefits should be listed under the applicable disability or death code, such as "5" (Temporary Total or Temporary Partial Disability). Injury types must be noted for each entry.

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

COLUMN 7 — Indicate whether the claim is open or closed/final by placing an O or F in the column.

COLUMN 8 — In Column 8, fill in the sum of incurred (paid plus reserved) losses per row. If no claims occurred, place a 0 in that space. Claims must be reported individually regardless of claim amount.

The experience rating will be completed in accordance with the Delaware Experience Rating Plan.

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## AGREEMENT

We hereby certify that the information given in this report is correct to the best of our knowledge and belief. By submission of this information, we request the Delaware Compensation Rating Bureau produce an experience modification factor for each of the risk(s) listed.

The person signing this agreement certifies he/she has the authority to execute this agreement on behalf of the self-insured risk requesting the rating.

Signed _____ Date _____

Printed Name of Signer _____ Title _____