Reset Form

CERTIFICATION OF INSURANCE CARRIER AS TO NUMBER OF WORKERS' COMPENSATION POLICIES WRITTEN OR RENEWED

State Form 55310 (R / 6-13)
Approved by State Board of Accounts, 2013
WORKERS' COMPENSATION BOARD

(PLEASE TYPE OR PRINT LEGIBLY.)

Please remit payment to:
Worker's Compensation Board of Indiana
402 W. Washington St., Room W196
Indianapolis, IN 46204
Tax ID: 35-6000158

STATE OF _____

COUNTY OF _____

I, _____, hereby CERTIFY that I am_____
(Official Title)
of_____ and that I have knowledge of the
(Carrier)
worker compensation policy records of Carrier. I further CERTIFY that the number of workers compensation policies written and/or renewed by Carrier for Indiana coverage for the calendar year _____ is _____. This number, multiplied by 2 totals $_____; Carrier's responsibility under IC 22-3-5-2 for the calendar year _____.

This Calendar Year Policy Count was calculated according to the following requirements:

- Include any policy (new, renewal, or annual rerate) (single state or multistate)
- Include Indiana listed in item 3.A of the policy
- Include those policies with an effective date of policy falling within the listed Calendar Year
- Include exposure and premium generated in Indiana (earned exposure/developed premium)
- Exclude policies cancelled flat
- Exclude Multistate policies where Indiana is deleted from policy (removed from item 3.A)
- Exclude policies where Indiana was written on "if any" basis and no exposure/premium developed.

I further CERTIFY that the enclosed sum of $_____ represents full payment of Carrier's calculated filing fee assessment for _____ , payable to the Worker's Compensation Board of Indiana for the Board's Supplemental Administrative Fund.

I hereby verify, subject to penalties of perjury, that the facts contained herein are true.

_____ _____
Signature Date *(month, day, year)*

_____ _____
Carrier Federal Identification Number

_____ _____
Telephone Number E-mail Address

_____
Mailing Address