Request to Use California Self-Insured Data for Experience Rating Purposes

Form 701 (Rev. 03/2022)

Instructions

Purpose of Form

This form is for use when requesting that self-insured data be used to promulgate an experience modification for an insured employer. Employer, as used in this form, means a single entity or two or more entities that are combinable for experience rating purposes in accordance with Section IV, Rule 2, of the *California Workers' Compensation Experience Rating Plan—1995* (ERP).

Use of Form

This form must be submitted by the insurer providing coverage for the period the proposed experience modification will be in effect. Only self-insured data pertaining to the employer's self-insured California operations is eligible for use in experience rating.

Requesting insurers submitting self-insured data electronically in WCSTAT format need only complete Sections A through E of this form.

Requesting insurers not submitting self-insured data electronically in WCSTAT format must complete Sections A through H of this form, with a separate Section G – Report of Payroll and Section H – Report of Losses completed for each reporting period.

Submission and Review of Self-Insured Data

All self-insured data developed during the applicable experience period must be submitted. *An experience modification will not be promulgated with partial self-insured data.* The requesting insurer is strongly encouraged to submit the self-insured data electronically in a WCSTAT format consistent with that used to submit unit statistical data on insured policies; otherwise, a $500 processing fee will be charged for each request.

The self-insured data will be subject to the same rigorous validation that applies to all unit statistical data reported in accordance with the rules set forth in Part 4, *Unit Statistical Reporting Requirements*, of the *California Workers' Compensation Uniform Statistical Reporting Plan—1995* (USRP). Self-insured data that is determined to be acceptable will be eligible for use in experience rating.

If the prior valuation of self-insured data contained open claims, or if previously reported closed claims were subsequently reopened and/or revalued with different incurred indemnity and/or incurred medical amounts, or if one or more new claims were subsequently reported, a separate request as well as the subsequent valuation of self-insured claims must be submitted by the insurer providing coverage for the period the proposed experience modification using this subsequent valuation of claims will be in effect. **The regulations and procedures concerning the submission and use of California self-insured data for experience rating purposes are found in Section III, Rule 5, of the ERP.** The ERP and USRP are available on the WCIRB's website (wcirb.com).

Additional Information Required to be Submitted with this Form

Applicable loss reports; subrogation, joint coverage, partially fraudulent and compromised death claims must be identified and the total gross incurred amount as defined in the USRP must be provided for each such claim.

Form Completion

- This form can be completed electronically; if completed manually, please print clearly.
- Authorized representatives from both the insurer and employer must sign this form to verify the completeness and accuracy of the information stated in the form and the self-insured data that will be submitted to the WCIRB. Insurance brokers/agents may not sign this form on behalf of the employer or insurer.
- Failure to complete all sections of the form and provide all required information may delay or prevent the request from being processed.

Form Submission

Mail, fax or e-mail this completed form, including the signatures of the authorized employer and insurer representative, to the WCIRB:

WCIRB Customer Service
WCIRB California
1901 Harrison Street, 17th Floor
Oakland, CA 94612

customerservice@wcirb.com

Questions

Call WCIRB Customer Service toll free
888.CA.WCIRB (229.2472)
7:30 AM – 4:45 PM PST

Section A — Employer Information

Name of Employer (List the primary insured business name) | Employer Bureau Number (If available)

List all other business names, including all DBAs.

Name of Insurer (For the policy covering the period during which the experience modification will be in effect)

Policy Number (For the period during which the experience modification will be in effect) | Policy Period

Proposed Rating Date (Set by the new policy inception date unless otherwise prescribed by the ERP)

Name of Insurer (For the policy covering the period immediately preceding the period of self-insurance)

Policy Number (For the period immediately preceding the period of self-insurance) | Policy Period

Section B — California Locations

List the address of each California location insured under the policy that covers the period during which the experience modification will be in effect and provide a description of the operations conducted at each location. Only self-insured data developed in connection with the employer's California operations can be used to compute an experience modification. Any change in operations resulting in a reclassification of operations during the five (5) years preceding the effective date of the requested experience modification must be explained in writing.

Physical Address (No P.O. Boxes)	Description of Operations

Section C — Ownership Information

If the employer's business has undergone a change in ownership, as defined in the ERP, during the last five (5) years, a notification of change in ownership and/or combinability of entities must be submitted to the WCIRB. Please go to WCIRB Connect® to submit ownership information, visit the WCIRB's website (wcirb.com), or contact WCIRB Customer Service to obtain more information.

Indicate by checking the appropriate box below whether there have been any changes in ownership during the last five (5) years.

☐ **Ownership changes have occurred during the last five (5) years. I have submitted a notification of change in ownership and/or combinability of entities for each ownership change that has occurred during the last five (5) years.**

☐ **No ownership changes have occurred during the last five (5) years.**

WCIRB Customer Service | 1901 Harrison Street, 17th Floor, Oakland, CA 94612 | Voice 888.229.2472 | customerservice@wcirb.com | wcirb.com

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Section D — Affidavit of the Employer

I certify under penalty of perjury under the laws of the State of California that the following statements are true and correct:
- I am authorized to complete this form on behalf of the employer identified in Section A of this form (The Employer);
- The information provided in this form is true and correct to the best of my knowledge; and
- All payroll and loss information provided to Insurer is an accurate and complete representation of the self-insured payroll and loss data developed in connection with the operations that are currently insured under the policy identified in Section A of this form.

Name of Employer

Name of Employer's Authorized Signatory (Please print or type)

Signature of Employer's Authorized Signatory (Brokers or agents cannot sign on behalf of the employer)

Title | Date

Section E — Insurer's Verification of Self-Insured Data

I verify that:
- I am authorized to complete this form on behalf of the Insurance Company submitting this request (Insurer);
- The information provided in this form is true and correct to the best of my knowledge; and
- I understand and agree that Insurer is responsible for accurately submitting all of The Employer's self-insured payroll and loss data developed during the experience period in accordance with the rules of the USRP.

Name of Insurer

Name of Insurer's Authorized Signatory (Please Print or Type)

Signature of Insurer's Authorized Signatory (Brokers or Agents cannot Sign on Behalf of the Insurer)

Title | Date

E-mail Address | Phone Number

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Sections F through H Must Be Completed If Not Submitting Self-Insured Data Electronically in WCSTAT Format.

Section F — Payment Method

WCIRB Member Insurer Billing

Authorized by (Print Name)	Signature
Title	Date
Member Company	
Address	
City	State Zip

Instructions and Notes for Section G — Report of Payroll and Section H — Report of Losses

There are three two-page sets (one page for Payroll and one page for Losses) in this form.

1. List the employer's name and Bureau Number at the top of each sheet.
2. Indicate the Reporting Period on each Section G and Section H sheet and the Loss Valuation Date on each Section H sheet.
3. If you have two or more Reporting Periods, always begin the next Reporting Period on a new set of pages, even if the previous sheets are not full.
4. If Report of Losses for a reporting period requires multiple sheets, please place required totals on the last sheet for that reporting period only.
5. If there is insufficient space for the data, download another copy of this form from the WCIRB website, wcirb.com, or copy the applicable pages.
6. **Please sequentially number all pages submitted.** Start numbering the Payroll and Losses pages from Page 4, the page after this one. There is a space at the bottom of each page for this purpose.

NOTES:

1. Payroll and loss data must be submitted as if the employer had been covered by policies incepting on the same month and day as the Rating Date. If the inception date (month and day) of the self-insured period does not coincide with the Rating Date, report the actual inception date. The expiration date of the first reporting period must coincide with the Rating Date. The inception date of each reporting period thereafter must coincide with the Rating Date. If the expiration date of the last reporting period does not coincide with the Rating Date, report the actual expiration date.
2. Subrogation, joint coverage, partially fraudulent and compromised death claims must be identified and the total gross incurred amount as defined in the USRP must be provided for each such claim.
3. Catastrophe claims must be identified and reported as defined in the USRP in the Cat. No. column.

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Name of Employer | Employer Bureau Number (If Available)

Section G — Report of Payroll

1. **Indicate the Reporting Period (Inception to Expiration Date)**

Reporting Period (Inception to Expiration Date) See NOTE 1 of Instructions and Notes for Section G – Report of Payroll and Section H – Report of Losses.

2. **Payroll** (Not required for subsequent reports)

Classification Code	Payroll	Classification Code	Payroll

Please number Section G — Report of Payroll and Section H — Report of Losses Pages

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Sections F through H Must Be Completed If Not Submitting Self-Insured Data Electronically in WCSTAT Format.

Name of Employer

Employer Bureau Number (If Available)

Section H — Report of Losses (Value claims in accordance with USRP, Part 4, and attach loss reports.)

1. **Indicate the Reporting Period (Inception to Expiration Date)** **Indicate the Loss Valuation Date (Month/Year)**

Reporting Period (Inception to Expiration Date)

Month/Year

☐ If there are no losses for this period, check this box to confirm that no losses were incurred during this reporting period and provide the corresponding loss report.

2. **Losses** (See NOTE 2 of Instructions and Notes for Section G – Report of Payroll and Section H – Report of Losses.)

Claim Number	Accident Date MM/DD/YYYY	Injury Type (USRP, Part 4)	Classification Code	Incurred Losses		Type of Recovery (USRP, Part 4)	Total Gross Incurred Amt (USRP, Part 4)	Type of Settlement (USRP, Part 4)	Fraudulent Claim Code (USRP, Part 4)	Open (O)/ Closed (F)	Cat. No.
				Indemnity	Medical						
Fill in totals on the last page of each reporting period.			Totals								

Please number Section G — Report of Payroll and Section H — Report of Losses Pages

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Name of Employer ________________________ Employer Bureau Number (If Available) ________________________

Section G — Report of Payroll

1. **Indicate the Reporting Period (Inception to Expiration Date)**

   ____

   Reporting Period (Inception to Expiration Date) See NOTE 1 of Instructions and Notes for Section G – Report of Payroll and Section H – Report of Losses.

2. **Payroll** (Not required for subsequent reports)

Classification Code	Payroll	Classification Code	Payroll

Please number Section G — Report of Payroll and Section H — Report of Losses Pages

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Employer Bureau Number (If Available)

Section H — Report of Losses (Value claims in accordance with USRP, Part 4, and attach loss reports.)

1. **Indicate the Reporting Period (Inception to Expiration Date)** **Indicate the Loss Valuation Date (Month/Year)**

Reporting Period (Inception to Expiration Date)

Month/Year

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				Indemnity	Medical						
Fill in totals on the last page of each reporting period.			Totals								

Please number Section G — Report of Payroll and Section H — Report of Losses Pages

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Name of Employer ______________________ Employer Bureau Number (If Available) ______________________

Section G — Report of Payroll

1. **Indicate the Reporting Period (Inception to Expiration Date)**

   ____

   Reporting Period (Inception to Expiration Date) See NOTE 1 of Instructions and Notes for Section G – Report of Payroll and Section H – Report of Losses.

2. **Payroll** (Not required for subsequent reports)

Classification Code	Payroll	Classification Code	Payroll

Please number Section G — Report of Payroll and Section H — Report of Losses Pages

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Name of Employer ____________________ Employer Bureau Number (If Available) ____________________

Section H — Report of Losses (Value claims in accordance with USRP, Part 4, and attach loss reports.)

1. **Indicate the Reporting Period (Inception to Expiration Date)** **Indicate the Loss Valuation Date (Month/Year)**

Reporting Period (Inception to Expiration Date) ____________________ Month/Year ____________________

☐ If there are no losses for this period, check this box to confirm that no losses were incurred during this reporting period and provide the corresponding loss report.

2. **Losses** (See NOTE 2 of Instructions and Notes for Section G – Report of Payroll and Section H – Report of Losses.)

Claim Number	Accident Date MM/DD/YYYY	Injury Type (USRP, Part 4)	Classification Code	Incurred Losses		Type of Recovery (USRP, Part 4)	Total Gross Incurred Amt (USRP, Part 4)	Type of Settlement (USRP, Part 4)	Fraudulent Claim Code (USRP, Part 4)	Open (O)/ Closed (F)	Cat. No.
				Indemnity	Medical						
Fill in totals on the last page of each reporting period.			Totals								

Please number Section G — Report of Payroll and Section H — Report of Losses Pages

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