The Michigan Workers’ Compensation Statistical Plan contains instructions for the preparation and filing of experience for the State of Michigan. These instructions supersede all previous instructions issued by the Compensation Advisory Organization of Michigan (“CAOM”) or by the National Council on Compensation Insurance (“NCCI”).

Compensation Advisory Organization Of Michigan
17197 N. Laurel Park Drive, Suite 311
Livonia, Michigan 48152-2686
(734) 462-9600
www.caom.com
# MICHIGAN WORKERS’ COMPENSATION STATISTICAL PLAN

## Table of Contents

**SCOPE OF THE PLAN** ........................................................................................................................................ 1

**PART I – GENERAL RULES** .............................................................................................................................. 2

1. RECORDING OF STATISTICS .............................................................................................................. 2
2. FILING OF STATISTICAL DATA ........................................................................................................... 2
3. AUDITING OF STATISTICS PRIOR TO SUBMISSION ............................................................................ 2
4. CORRECTION OF ERRORS .................................................................................................................. 2
5. FILING REQUIREMENTS .................................................................................................................... 2
6. FILINGS FOR MULTISTATE POLICIES ................................................................................................. 3
7. UNCOLLECTIBLE PREMIUMS ............................................................................................................. 3
8. REINSURANCE ................................................................................................................................... 3
9. RADIATION EXPOSURE - OTHER THAN NUCLEAR REGULATORY COMMISSION PROJECTS ............ 3
10. DATE OF VALUATION AND FILING .................................................................................................... 3
11. FINE SYSTEM FOR UNIT REPORTS .................................................................................................... 4
12. RETROSPECTIVELY RATED POLICIES ............................................................................................... 4
13. MULTIPLE YEAR POLICIES OTHER THAN THREE-YEAR FIXED RATE ................................................... 4
14. THREE-YEAR FIXED RATE POLICIES ............................................................................................... 4

**PART II – DATA COMMON TO PREMIUM AND LOSSES** ................................................................................. 5

1. REPORT LEVEL CODE/REPORT NUMBER ........................................................................................... 5
2. CORRECTION SEQUENCE NUMBER ................................................................................................... 5
3. CORRECTION TYPE CODE .................................................................................................................. 5
4. CARRIER CODE .................................................................................................................................. 5
5. POLICY NUMBER IDENTIFIER ............................................................................................................ 5
6. POLICY EFFECTIVE DATE ................................................................................................................... 5
7. POLICY EXPIRATION OR CANCELLATION DATE ................................................................................. 6
8. EXPOSURE STATE CODE .................................................................................................................... 6
9. RISK ID NUMBER .................................................................................................................................. 6
10. NAME OF INSURED ........................................................................................................................... 6
11. ADDRESS OF INSURED – “O” OPTIONAL ........................................................................................... 6
12. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN) “O” OPTIONAL ........................................... 7
13. EXPERIENCE MODIFICATION EFFECTIVE DATE (IF APPLICABLE) ....................................................... 7
14. RATE EFFECTIVE DATE (IF APPLICABLE) ............................................................................................ 7
15. SPLIT PERIOD CODE .......................................................................................................................... 7
16. POLICY CONDITION INDICATORS ....................................................................................................... 7
17. POLICY TYPE ID CODES ....................................................................................................................... 7
PART III – EXPOSURE AND PREMIUM DATA ............................................................................................................ 9
1. UPDATE TYPE CODE .............................................................................................................................................. 9
2. EXPOSURE ACT/EXPOSURE COVERAGE CODE .................................................................................................................. 9
3. CLASSIFICATION CODE .............................................................................................................................................. 9
4. EXPOSURE AMOUNT .................................................................................................................................................. 9
5. MANUAL CHARGED RATE ......................................................................................................................................... 12
6. PREMIUM AMOUNT .................................................................................................................................................. 12
7. SUBJECT PREMIUM TOTAL ....................................................................................................................................... 13
8. EXPERIENCE MODIFICATION FACTOR ......................................................................................................................... 13
9. EXPOSURE – PAYROLL TOTAL ....................................................................................................................................... 13
10. STANDARD PREMIUM TOTAL ................................................................................................................................. 13
11. PREMIUM DISCOUNT AMOUNT .................................................................................................................................. 13
12. EXPENSE CONSTANT AMOUNT .................................................................................................................................. 13
13. TERRORISM PREMIUM AMOUNT .................................................................................................................................. 14

PART IV – LOSS DATA ....................................................................................................................................................... 15
1. UPDATE TYPE CODE .................................................................................................................................................. 17
2. CLAIM NUMBER ...................................................................................................................................................... 17
3. ACCIDENT DATE ...................................................................................................................................................... 17
4. CLAIM COUNT ....................................................................................................................................................... 17
5. INCURRED INDEMNITY AMOUNT ................................................................................................................................. 17
6. INCURRED MEDICAL AMOUNT .................................................................................................................................... 17
7. CLASSIFICATION CODE ............................................................................................................................................... 17
8. INJURY CODE (INJURY TYPE) ........................................................................................................................................... 17
9. CLAIM STATUS CODE .................................................................................................................................................. 17
10. LOSS CONDITION CODES .......................................................................................................................................... 17
11. JURISDICTION STATE CODE – “O” (OPTIONAL) ........................................................................................................... 17
12. CATASTROPHE NUMBER (IF APPLICABLE) .................................................................................................................. 17
13. MANAGED CARE ORGANIZATION TYPE CODE ........................................................................................................ 17
14. INJURY DESCRIPTION CODE (Part, Nature, Cause) ..................................................................................................... 17
15. VOCATIONAL REHABILITATION INDICATOR ................................................................................................................ 17
16. LUMP SUM INDICATOR ........................................................................................................................................... 17
17. FRAUDULENT CLAIM CODE ....................................................................................................................................... 17
18. CLAIM COUNT TOTAL ................................................................................................................................................ 17
19. INCURRED INDEMNITY TOTAL .................................................................................................................................... 17
20. INCURRED MEDICAL TOTAL ......................................................................................................................................... 17
MICHIGAN WORKERS’ COMPENSATION STATISTICAL PLAN

PART V – SUBSEQUENT AND CORRECTION REPORTS

1. SUBSEQUENT REPORTS
2. CORRECTION REPORTS
3. METHOD OF REPORTING
4. PROCEDURE FOR CORRECTION OF REPORTS AFTER SUBSEQUENT REPORTS HAVE BEEN FILED

PART VI – CALLS FOR AGGREGATE FINANCIAL DATA AND SPECIAL CALLS

1. ANNUAL CALL FOR POLICY YEAR EXPERIENCE
2. ANNUAL CALL FOR CALENDAR – ACCIDENT YEAR EXPERIENCE
3. ANNUAL CALL FOR DATA RECONCILING THE CALENDAR – ACCIDENT YEAR CALL TO PUBLISHED FINANCIAL DATA
4. ANNUAL CALL FOR COUNTRYWIDE LOSS ADJUSTMENT EXPENSE DATA
5. ANNUAL CALL FOR LARGE LOSS AND CATASTROPHE CLAIMS
6. SPECIAL CALLS FOR EXPERIENCE

PART VII – STATISTICAL CODES

CLASSIFICATION CODES – refer to the Compensation Advisory Organization of Michigan and Michigan Workers’ Compensation Placement Facility Classification Definitions Manual

INDEX

Ed. 06/20
SCOPE OF THE PLAN

The Michigan Workers’ Compensation Statistical Plan is applicable to direct Workers’ Compensation, Voluntary Compensation, and Employers’ Liability business written and/or submitted by insurance carriers in the state of Michigan. This Plan contains the necessary rules for reporting statistics for all policies to the Compensation Advisory Organization of Michigan (CAOM).

CAOM shall limit the disclosure and distribution of information obtained from insurers, whether through regular unit statistical reports, special data calls, or otherwise, as required by Chapter 23 of the Michigan Insurance Code, as written and as may be amended, and consistent with the requirements of any applicable federal, state or local privacy laws or regulations. Personally identifiable financial and/or health information of insureds or claimants shall be distributed only to the extent required by law.

THIS PLAN CONSISTS OF THE FOLLOWING THREE DATA REPORTING PROGRAMS.

1. THE REPORTING OF INDIVIDUAL RISK EXPERIENCE
   For each policy issued, carriers shall provide CAOM with an electronic version of policy Information Pages for new & renewal policies, change endorsements, cancellations and reinstatements. Such data is due at CAOM within 30 days of their issuance to the insured. In addition, carriers shall file individual risk experience data with CAOM according to the instructions set forth in this Plan.

2. THE REPORTING OF AGGREGATE FINANCIAL ACCOUNTING DATA
   Carriers shall also file summary financial experience with CAOM and/or a designated organization in accordance with the contractual agreement for specified services to be performed by the designated organization for CAOM. This summary data will be collected by the issuance of a series of periodic calls for experience as outlined in PART VI of this Plan.

3. THE REPORTING OF DATA UNDER SPECIAL CALLS
   Carriers may, from time to time, be required to submit supplemental experience (either detailed or summary) to meet special situations. The data reporting requirements are discussed in PART VI of this Plan.

THIS PLAN IS ORGANIZED IN THE FOLLOWING MAJOR PARTS:
I. General Rules
II. Data Common to Premium and Losses
III. Exposure and Premium Data
IV. Loss Data
V. Subsequent and Correction Reports
VI. Calls for Aggregate Financial Data and Special Calls
VII. Statistical Codes
PART I – GENERAL RULES

1. RECORDING OF STATISTICS
Under Michigan law, carriers shall file with the Commissioner of Insurance all rates and rating plans. If an insurer files a rating plan with the Commissioner of Insurance that is incompatible with the approved statistical plans of CAOM, the insurer must also propose a plan to the Commissioner of Insurance for reporting data which will conform with the data reporting requirements of the statistical plans of CAOM, as approved by the Commissioner of Insurance (MCL 500.2407(5)).

The standard reporting procedures contained in this Plan may be modified by a carrier to conform to its own recording methods, provided that such alternative reporting procedures: (a) yield all of the information required under the standard procedures of this Plan; and (b) have received prior approval by CAOM as an acceptable alternative reporting procedure.

2. FILING OF STATISTICAL DATA
Exposure, premium, and loss data for each Workers’ Compensation policy is required by law. Electronically file all unit statistical report data directly with CAOM through CDX (Compensation Data Exchange), found on the acacct.org website.

3. AUDITING OF STATISTICS PRIOR TO SUBMISSION
The carrier must audit the statistics being reported prior to submission to detect any errors, e.g., errors in the assignment of statistical codes or in the assignment of claims to their corresponding policies. If audited information is not available prior to the submission of statistics, the carrier should identify and report the estimated premium until the audited information becomes available.

4. CORRECTION OF ERRORS
Carriers are expected to correct all errors found in their data. All errors that impact the accuracy of rate making and experience rating must be corrected.

5. FILING REQUIREMENTS
Exposure, premium, and loss data must be filed for every Workers’ Compensation and Employers’ Liability policy including experience under any Voluntary Compensation Endorsements.

EXCEPTIONS: Policies providing coverage under the National Defense Projects Rating Plan or on Nuclear Regulatory Commission projects are not required. Employers’ Liability Insurance on residence and farm employees as may be provided in conjunction with other Liability Insurance, Workers’ Compensation on domestics provided in conjunction with homeowners insurance, and Excess Insurance are not required.
6. FILINGS FOR MULTISTATE POLICIES
Data must be filed for each policy providing coverage for Michigan. If a policy was filed with CAOM, a statistical report must be filed unless the policy is cancelled flat.

7. UNCOLLECTIBLE PREMIUMS
A. Audited Policies
Report all earned premiums on those policies on which an audit has been conducted and the earned premium is known, but uncollectible. Likewise, report the corresponding exposure and loss data.

B. Policies on Which a Final Audit is Not Possible
Report the estimated earned premium and exposure corresponding to the term of coverage for those policies on which a final audit is not possible and the audited earned premium and exposure is not known. Likewise, report the loss data for the corresponding term of coverage.

8. REINSURANCE
Statistics are only reported for direct business. Exclude premiums received from or losses paid to other carriers on account of reinsurance assumed by the carrier. Deductions should not be made by the carrier for premiums ceded to or for losses recovered from other carriers due to ceded reinsurance.

9. RADIATION EXPOSURE - OTHER THAN NUCLEAR REGULATORY COMMISSION PROJECTS
A supplemental rate may be applied to operations involving research, manufacturing, handling, transportation, use of, or exposure to radioactive materials, where such operations are not performed for or under the direction of any government agency. The additional premium resulting from this supplemental rate must be reported separately from the class code premiums under the designated classification code (9985).

Radiation losses on risks where this supplemental rate has been applied must also be reported under the designated classification code (9985).

10. DATE OF VALUATION AND FILING
Losses included in the first reporting of a given policy must be valued as of 18 months after the month in which the policy became effective, and the report must be filed no later than 20 months after the effective month of the policy. Subsequent reporting of loss data must be valued 12, 24, 36, 48, 60, 72, 84, 96 and 108 months, respectively, after the valuation date of the first report.
11. FINE SYSTEM FOR UNIT REPORTS
A. Fines are assessed to carriers with more than 20 overdue reports, or if the number of overdue reports is equal to or greater than 5% of their monthly policy count. Reports for experience rated risks not received by CAOM by the 20th month after the effective date shall be subject to the following fine system:

B. Fines will also be assessed for any outstanding WCCRIT’s at 60 days and shall be subject to the following fine system:

    SCHEDULE OF STATISTICAL PLAN FINES

    Overdue by           Fine
    30-60 days           $  0
    60-90 days           $ 50
    3 months             $100

12. RETROSPECTIVELY RATED POLICIES
Advance special reports are sometimes required by the Retrospective rating Plans due to short-term policies, cancellations, or in cases of bankruptcy, liquidation, reorganization, etc. These special reports include losses valued as of the date exactly six months after the termination date except in cases of bankruptcy, liquidation, reorganization, etc., where an earlier valuation is permissible.

These advance reportings are entirely independent of, and in addition to, the normal reportings that include losses valued as of a later date.

13. MULTIPLE YEAR POLICIES OTHER THAN THREE-YEAR FIXED RATE
Multiple year policies other than three-year fixed rate must be considered separate annual policies for reporting purposes and must be filed at the time all reports on policies with the same effective date are being filed. Losses must be valued 18 months after the policy effective month and at annual periods thereafter. Note that a policy issued for a period not longer than one year and 16 days is treated as a one-year policy.

14. THREE-YEAR FIXED RATE POLICIES
The complete three-year experience incurred under each policy must be reported as one complete policy. Cancellation penalty premium must be reported.

A. Date of Valuation and Filing
Losses included in the reporting of a given policy must be valued 42 months after the inception date of the policy, and the reports must be filed not later than 44 months after the effective month of the policy. These reportings must be specifically identified as three-year fixed rate policy experience, segregated, and reported separately from the one-year policies.

B. Subsequent Valuations - Subsequent valuations are not required.
PART II – DATA COMMON TO PREMIUM AND LOSSES

Data elements required for Michigan, those marked “O” are optional for Michigan. Refer to the WCIO Workers Compensation Data Specifications Manual (www.wcio.org) for additional information.

1. REPORT LEVEL CODE/REPORT NUMBER
Report the numeric or alpha code corresponding to the policy valuation date. This code indicates whether the report is a first or subsequent report.

2. CORRECTION SEQUENCE NUMBER
Report the sequential number or alpha that corresponds with the number of correction reports submitted within a particular report level.

3. CORRECTION TYPE CODE
Identify the type of correction report being submitted. Corrections to header, exposures, losses and totals, or all four, may be provided in a submission.

4. CARRIER CODE
Report the five-digit numeric code assigned to the reporting company by National Council on Compensation Insurance. This code must be reported consistently for the payroll, premium, and loss data submitted for a given policy, unless a correction has been submitted to revise the carrier code previously reported.

5. POLICY NUMBER IDENTIFIER
Report the alphanumeric code (up to 18 positions) that uniquely identifies the policy under which the experience occurred, excluding blanks, punctuation marks, and special characters. This number must be identical to the number as set forth on the policy Information Page. The complete policy number, including prefixes or suffixes, if used, must remain the same throughout the life of the policy and for all experience reporting, unless a correction report has been submitted to revise the policy number.

6. POLICY EFFECTIVE DATE
Report the month, day, and year the policy became effective.

Report the effective date that corresponds exactly to the date shown on the policy Information Page or endorsements attached thereto. In cases where an interstate policy was endorsed after the effective date to provide coverage for Michigan, report the effective date of the policy.
MICHIGAN WORKERS’ COMPENSATION STATISICAL PLAN

Note that the policy effective date reported for the second and third years of a three-year variable rate policy should NOT be the date given on the policy Information Page. The report corresponding to the second year of the policy must have an effective date one year subsequent to the original effective date. Likewise, the report corresponding to the third year of the policy must have an effective date equal to two years subsequent to the original policy effective date.

For the second and the third period of extended term policies (if applicable), the effective date must equal the date that the second or third period began, as shown on the policy period endorsement.

7. POLICY EXPIRATION OR CANCELLATION DATE
Report the month, day, and year on which the policy expired. If the policy was canceled, report the cancellation date.

A policy issued for no longer than one year and 16 days is treated as a one-year policy, and the expiration date shown on the policy Information Page is reported.

Note that the policy expiration date reported for the first and second year of a three-year variable rate policy should NOT be the date given on the policy Information Page but should be the date one year or two years later than the original policy effective date depending upon whether the report is for the first or the second year of the policy.

For extended-term policies, report the associated expiration date for each term shown on the Policy Period Endorsement, with the last period always being the policy expiration date as shown on the policy Information Page, or as so endorsed for extended term policies.

8. EXPOSURE STATE CODE
Report the state in which coverage has been provided for the classifications and corresponding exposure, if any, and to which the payrolls of injured workers have been assigned. The exposure state code for Michigan is 21.

9. RISK ID NUMBER
Report the intrastate risk identification number assigned by CAOM.

10. NAME OF INSURED
Report the name of the insured as shown on the policy Information Page.

11. ADDRESS OF INSURED – “O” OPTIONAL
Report the address of the insured as shown in Item 1 of the policy Information Page or as endorsed.
12. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN) “O” OPTIONAL
Report the FEIN of the insured as shown on the policy Information Page. The primary FEIN is used when multiple FEIN numbers are on the policy.

13. EXPERIENCE MODIFICATION EFFECTIVE DATE (IF APPLICABLE)
The Experience Modification Effective Date is required on all exposure records. The Experience Modification Effective Date may be the policy effective date or a different date. For the first period of a split audit this must be equal to the policy effective date.

14. RATE EFFECTIVE DATE (IF APPLICABLE)
The Rate Effective Date is required on all exposure records. For the first period of a split audit this must be equal to the policy effective date.

15. SPLIT PERIOD CODE
This code is used to indicate a change in manual/charged rates or modification factors during the life of the policy. For policies with no change in manual/charged rates or modification factors zero fill.

16. POLICY CONDITION INDICATORS
Indicate the policy conditions that apply for the statistical data being reported:

- Code: Y = Yes  N = No
- Three Year Fixed Rate
- Multi-state Policy
- Interstate Rated
- Retrospective Rated
- Canceled Mid-Term
- Managed Care Organization

- Code: Y = Yes  N = No  U = Uncooperative
- Estimated Audit Code

17. POLICY TYPE ID CODES
Report the type of coverage and plan indicator for the policy.

A. Type of Coverage

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Standard Workers’ Compensation Policy</td>
</tr>
<tr>
<td></td>
<td>Coverage determined by the manual rate and classification to which exposure has been assigned under the provisions of the Workers’ Compensation and Employers’ Liability policy. No other “type of coverage” codes are available for Michigan.</td>
</tr>
</tbody>
</table>
B. Plan Indicator

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Voluntary</td>
</tr>
<tr>
<td></td>
<td>The policy was written voluntarily by the carrier.</td>
</tr>
<tr>
<td>2</td>
<td>Normal Assigned Risk Policy</td>
</tr>
<tr>
<td></td>
<td>The insured was unable to secure workers’ compensation insurance in the voluntary market and obtained coverage through the Michigan Workers’ Compensation Placement Facility or a state Workers’ Compensation Insurance Plan which extended coverage to Michigan. The Facility or Plan assigned the policy to a servicing carrier that issued the policy and administers the claims. The policy is reinsured by the member companies which comprise the Facility.</td>
</tr>
</tbody>
</table>

C. Non-Standard Type

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Non-Standard code does not apply.</td>
</tr>
<tr>
<td></td>
<td>This is the only “non-standard type” available for Michigan.</td>
</tr>
</tbody>
</table>
MICHIGAN WORKERS’ COMPENSATION STATISTICAL PLAN

PART III – EXPOSURE AND PREMIUM DATA

All of the information listed in this section is required for Michigan.

1. UPDATE TYPE CODE
Report the code that identifies the activity of an exposure record.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>Previously Reported</td>
</tr>
<tr>
<td>R</td>
<td>Revised</td>
</tr>
</tbody>
</table>

2. EXPOSURE ACT/EXPOSURE COVERAGE CODE
Report the code that identifies the type of exposure coverage.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>State Act or Federal Act excluding USL&amp;H and Federal Coal Mine</td>
</tr>
<tr>
<td>2</td>
<td>USL&amp;H “F” or USL&amp;H Coverage on Non-F-Classes</td>
</tr>
</tbody>
</table>

3. CLASSIFICATION CODE
Report the numeric code corresponding to the classifications established for the insured’s operation as defined in the Compensation Advisory Organization of Michigan and Michigan Workers Compensation Placement Facility Definitions Manual.

4. EXPOSURE AMOUNT
Report the entire whole dollar amount for each payroll classification used. This exposure information is to be audited exposure. When a final audit has not been made at the time of filing a report, submit the estimated exposures and identify them as estimated. Without further request, replace estimated exposures as soon as audited exposures are available.

Carriers shall report exposure data according to the rules and definitions outlined below. If the carrier’s own rating program provides for different rules and definitions, the rules stated here shall still apply for experience reporting purposes.

A. Payroll means money or substitutes for money.

B. Payroll includes:
   1. Wages or salaries including retroactive wages or salaries
   2. Total payments received by employees for commissions and draws against commissions
   3. Bonuses including stock bonus plans
   4. Extra pay for overtime work except as provided below
   5. Pay for holidays, vacations, or periods of sickness
   6. Payment by an employer of amounts otherwise required by law to be paid by employees to statutory insurance or pension plans, such as the Federal Social
Security Act
7. Payment to employees on any basis other than time worked, such as piece work, profit sharing, or incentive plans
8. Payment or allowance for hand or power tools used by hand provided by employees either directly or through a third party and used in their work or operations for the insured, except as provided under the Logging classification
9. The rental value of an apartment or a house provided for an employee based on comparable accommodations
10. The value of lodging, other than an apartment or house, received by employees as part of their pay, to the extent shown in the insured's records
11. The value of meals received by employees as part of their pay, to the extent shown in the insured's records
12. The value of store certificates, merchandise, credits or any other substitutes for money received by employees as part of their pay (refer to Exclusions below for certain fringe benefits [substitutes for money] not considered to be renumeration)
13. Payments for salary reduction, retirement, or cafeteria plans (IRC125) that are made through deductions from employee's gross pay
14. Davis-Bacon wages paid to employees
15. Annuity plans
16. Expense reimbursements to employees to the extent that an employer's records do not substantiate that the expense was incurred as a valid business expense
17. Payment for filming of commercials excluding subsequent residuals that are earned by the commercial's participant(s) each time the commercial appears in print or is broadcast

C. Payroll excludes:
1. Tips and other gratuities received by employees
2. Payments by an employer to group insurance or group pension plans for employees, other than payments covered in The Basic Manual Rule 5 B-2 F & M
3. The value of special rewards for individual invention or discovery
4. Dismissal or severance payments except for time worked or accrued vacation
5. Payments for active military duty
6. Employee discounts on goods purchased from the employee's employer
7. Expense reimbursements to employees to the extent that an employer's records substantiate that the expense was incurred as a valid business expense

Note: Reimbursed expenses and flat expense allowances, except for hand or power tools, paid to employees may be excluded from the audit, provided that all three of the following conditions are met:
   a. The reimbursed expenses or expenses for which allowances were paid were incurred upon the business of the employer, and
   b. the amount of each employee's expense payments or allowances is shown separately in the records of the employer, and
c. the amount of each expense reimbursement or allowance payment approximates the actual expenses incurred by the employee in the conduct of his or her work

8. Meal money for late work
9. Work uniform allowances
10. Sick pay paid to an employee by a third party such as an insured’s group insurance carrier that is paying disability income benefits to a disabled employee
11. Employer provided perquisites (perks) such as:
   a. Use of an automobile
   b. An airplane flight
   c. An incentive vacation (e.g., contest winner)
   d. A discount on property or services
   e. Club memberships
   f. Tickets to entertainment events

D. Overtime:
1. Overtime means those hours worked for which there is an increase in the rate of pay:
   a. For work in any day or in any week in excess of the number of hours normally worked or
   b. For hours worked in excess of 8 hours in any day or 40 hours in any week or
   c. For work on Saturdays, Sundays or Holidays.

   In the case of guaranteed wage agreements, overtime means only those hours worked in excess of the number specified in such agreement.

2. The extra pay for overtime shall be excluded from the payroll on which premium is computed as indicated in a. or b. below provided the insured’s books and records are maintained to show overtime pay separately by employee and in summary by classification.

   a. If the records show separately the extra pay earned for overtime, the entire extra pay shall be excluded.

   b. If the records show the total pay earned for overtime (regular pay plus overtime pay) in one combined amount, 1/3 of this total pay shall be excluded. If double time is paid for overtime and the total pay for such overtime is recorded separately, 1/2 of the total pay for double time shall be excluded.

E. Payroll Limitation
1. Payroll limitation applies after any deductions of extra pay for overtime.
2. For executive officers, elected public officials, and classifications with notes which indicate payroll limitation, the payroll on which premium is based shall exclude that part of the employee’s average weekly pay in excess of the applicable weekly limitation, provided:

   a. Books and records are maintained to show separately the total payroll earned by each employee whose average weekly pay for the total time employed during the policy period exceeds the weekly payroll limitation, and

   b. Separate records are maintained in summary by classification for such employees.

3. A part of a week shall be treated as a full week in determining average weekly pay.

Where the exposure base is not payroll, report the exposure as follows:

a. Per Capita Classifications

   Each employee covered under a per capita classification for a period of one year must be reported as an exposure of 1.0. For coverage of less than one year, the exposure reported must be the decimal portion, rounded to the nearest tenth, of the year for which coverage was in effect. For example, an employee covered for four months should be reported as an exposure of 0.3. Exposure is governed by the duration of the coverage and not by the number of days worked.

b. Aircraft Operation - Passenger Seat Surcharge

   For Policies Effective January 1, 2015 and subsequent:
   Report all exposures by classification.

   For policies Effective Prior to January 1, 2015:
   Report the number of seats as 1.0 per seat.

5. MANUAL CHARGED RATE

   Report the carrier’s manual rate which is the charge per unit of exposure for each classification.

6. PREMIUM AMOUNT

   Report the extension of exposure times manual rate for each classification. Where the exposure base is payroll, the rate applies per $100.00 of payroll. Other premium amounts are reported as defined by the classification/statistical code.
In the case where there are split rates, the exposures, manual rates, and corresponding premiums must be split. The period covered must be shown with the effective date of the rate change.

Premium must be reported under the appropriate classification or statistical codes as outlined in this Manual.

Carriers must use the appropriate statistical codes to report items such as schedule credits, deductible credits, increased limits charges, etc. as either subject to rating or not subject to rating according to their own filings. Approved statistical codes are listed in Part VII.

7. SUBJECT PREMIUM TOTAL
Report the sum of all premium amounts subject to modification.

8. EXPERIENCE MODIFICATION FACTOR
Report the rating modification factor used to develop the charged premium. If more than one modification applies, the exposure, rates, and premiums must be split and reported separately with the appropriate effective dates.

NOTE: rating modifications include all modifications that alter by factor the risk’s manual premium, where such alteration is due to the individual risk’s actual historical loss experience. This includes merit rating programs, based, for example, on the number of lost time claims, and traditional experience rating programs, based on past loss experience.

9. EXPOSURE – PAYROLL TOTAL
Report the sum of all payroll exposure.

10. STANDARD PREMIUM TOTAL
Report the sum of all premium dollars, both subject and not subject to modification, excluding the expense constant, premium discount, premium developed by the Terrorism Risk Insurance Act of 2002 as defined by this Statistical Plan, and premium developed by Domestic Terrorism, Earthquakes, and Catastrophic Industrial Accidents.

11. PREMIUM DISCOUNT AMOUNT
Report the premium adjustment resulting from the application of the premium discount plan under code 0063 (stock company) or 0064 (non-stock company). Do not include this amount in the standard premium.

12. EXPENSE CONSTANT AMOUNT
Report the expense constant separately from class code exposures and premiums under the designated statistical code (0900). The expense constant on multi state policies must be allocated to the state with the highest expense constant applicable. If
two or more states included on the policy have the same highest expense constant, the expense constant is to be allocated to the state developing the highest standard premium of the states with the highest expense constant.

13. TERRORISM PREMIUM AMOUNT
Premium surcharged to policies based on the Terrorism Risk Insurance Act of 2002.
MICHIGAN WORKERS’ COMPENSATION STATISTICAL PLAN

PART IV – LOSS DATA

REPORTING OF LOSSES
Losses must be reported with the applicable class codes of the corresponding exposure and premium. This includes medical only claims. Medical only claims must be coded to the classification where the payroll for the injured employee was reported. Losses must only be reported if the Incurred Indemnity plus the Incurred Medical is greater than $0.00.

EXPENSES INCLUDED IN LOSSES
Expenses must be excluded from losses except as noted below. Expenses included in losses:

Expenses incurred for the benefit of the claimant
Employers Liability Loss Adjustment Expenses
Impartial examinations ordered by the magistrate or appeals board
Physical rehabilitation expenses
Vocational rehabilitation evaluation/testing expenses

EXPENSES EXCLUDED FROM LOSSES
Expenses which are excluded from losses include those expenses incurred for the benefit of the carrier. They are divided into the following classifications:

Allocated Loss Adjustment Expenses
Allocated loss adjustment expenses encompass the following costs of a carrier which can be directly allocated to a particular claim.

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

B. Court, alternative dispute resolution and other specific items of expense such as:

   Medical examinations of a claimant to determine the extent of the carrier’s liability, degree of permanency or length of disability.
   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

C. 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 of services are
paid. The expenses include:

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, and medical or vocational rehabilitation vendor bills

Hospital and other treatment utilization reviews, including precertification/preadmission, concurrent or retrospective reviews;

Preferred provider network/organization expenses;

Medical fee review panel expenses.

D. 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.

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

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

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.

Report all losses on a gross basis, including losses that were reimbursed by a deductible payment by the insured.

Losses should not include payments made by or on behalf of special funds. Specifically, losses covered by the Second Injury Fund; Silicosis, Dust Diseases and Logging Industry Compensation Fund; or the Compensation Supplemental Fund are to be reported excluding such covered amounts. Assessments by any of the above-mentioned funds are not to be reported under this Plan. In all cases where a claim has been determined to be eligible for reimbursement to the carrier from a special fund, the gross incurred cost of the claim (i.e., prior to any reimbursement) shall be reduced by the amount of any paid or anticipated recovery from such Fund and the net incurred cost of the claim shall be reported. Anticipated recovery is defined, for this purpose, as the amount of recovery expected to be recovered from such Funds based on the rules governing such Funds or a binding agreement between such Funds and the carrier on
an amount, or percentage of the incurred cost, to be reimbursed to the carrier on a particular claim.

When such an anticipated recovery becomes known by the carrier, or when a recovery is paid to the carrier, subsequent to the first reporting of the claim, a correction report must be filed reducing the incurred cost on the claim by the amount of paid or anticipated recovery. If subsequent reports have been issued correct all report levels.

Penalties for which the carrier is liable for reasons beyond its control and which accrue as benefits to the injured worker or his dependents, such as for interest on awards or for penalties imposed upon the employer for improper controversion of awards, shall be chargeable to indemnity losses and so reported; other penalties such as daily charges for late payments of undisputed claims, shall be chargeable to claim expenses.

1. UPDATE TYPE CODE
Report the code that identifies the activity of a loss record. The coding is the same as for the Update Type under the Exposure Information Section.

2. CLAIM NUMBER
Report the alphanumeric code which uniquely identifies the specific claim and which will make it possible to locate the claim records in the company files. The complete claim number including suffixes and prefixes must remain the same throughout the life of the claim. If a claim number changes during the life of the claim, submit a correction report to revise the claim number as soon as the change is known. Each claim must be listed individually with the appropriate claim number and accident date.

3. ACCIDENT DATE
Report the month, day, and year on which the injury occurred.

4. CLAIM COUNT
All claims where contract medical covers only part of the claim must be reported separately.

A claim on which more than one payment is made must be counted only once.

An accident resulting in two or more reported claims must have each claim counted separately.

An accident resulting in an injury to one worker, but on which payments are made under different coverages of the policy (e.g., Workers’ Compensation and Employers’ Liability) must be reported as one claim and identified with the appropriate loss condition code.

5. INCURRED INDEMNITY AMOUNT
Report the whole dollar amount of incurred indemnity as of the loss valuation date.
These losses consist of all paid and outstanding reserve benefits due to an employee’s lost wages or inability to work, including compensation paid to the deceased prior to death, burial expenses, claimant’s attorney fees, vocational rehabilitation benefits, payments to the state and employer’s liability losses and expenses.

Note: Allocated Loss Adjustment Expenses for other than Employers Liability coverage must be excluded from indemnity losses.

6. INCURRED MEDICAL AMOUNT

Report the whole dollar amount of incurred medical, as of the loss valuation date. These losses consist of all paid and outstanding reserve benefits.

Incurred medical should include:

- Reserves for future payments
- All payments to doctors and hospitals
- Medical loss items, such as transportation expenses associated with medical treatment
- Physical rehabilitation costs
  - Physical rehabilitation concerns all medical activities performed and/or services rendered in the treatment of an industrial injury or disease to achieve maximum recovery, relief, and/or cure. Physical rehabilitation costs incurred due to the purchase of such services from outside vendors must be reported as part of medical incurred loss. The following physical rehabilitation activities must be reported as medical losses when performed by persons who are medically trained in the following fields:
    - Physicians
    - Licensed registered nurses
    - Licensed speech therapists
    - Registered physical therapists
    - Dentists and dental technicians
    - Occupational therapists
    - Chiropractors
    - Podiatrists
    - Licensed physician assistants
    - Licensed cardiopulmonary technicians
And when performed by outside vendors. Additionally, expenses associated with these activities performed by carrier personnel (other than claims supervisors’ or claims adjusters’ efforts to return an injured worker to gainful employment) who are similarly medically trained may also be reported as part of medical losses:

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

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

Necessary consultation(s) with physician(s)

Monitoring the treatment and progress of the claimant’s medical condition

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

Clinical Medical
If the carrier provides a medical clinic, the cost of each treatment given must be charged against the individual risk according to a fixed schedule of charges per treatment. These costs must be assigned to the proper manual classification. The schedule of charges, which may distinguish between types of treatment, must apply without exception to all risks with cases treated by the clinic. The schedule of charges must be frequently revised and adjusted if necessary to 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.

7. CLASSIFICATION CODE
Report the classification code under which the injured employee’s payroll or other exposure was reported. No claim may be assigned to any classification unless payroll or other exposure also has been reported for that class.

For policies effective 1-1-2015 and subsequent:
Losses incurred in connection with aircraft operation involving employees of the risk other than members of the flying crew shall be reported by classification.

For policies effective prior to 1-1-2015:
Losses incurred in connection with aircraft operation involving employees of the risk other than members of the flying crew shall not be reported by classification, but shall be assigned to Statistical Code 0088 or 9108, provided such losses arise out of the operation of the aircraft subject to a passenger seat surcharge.
8. INJURY CODE (INJURY TYPE)
The kind of injury is to be assigned based on the section of Michigan law under which
benefits are being claimed, by means of the following numbers:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
</table>
| 1    | Death Benefits claimed under the provisions of Section 418.345. Report each death claim. If there is compensation paid prior to the death of a claimant, and there is later found to be no liability on the death claim, the loss is to be reported on the basis of the injury for which payments have previously been made. The outstanding costs shall be the carrier’s individual claim estimates of future payments. Carriers may use either their own filed tables or the tables published by the Bureau of Workers’ Disability Compensation to calculate reserves for future benefits. The amount entered as indemnity incurred shall include all paid and outstanding benefits, including compensation paid under other sections of the statute to the deceased prior to death, burial expenses and payments to the State. Michigan statute provides that weekly compensation benefits shall be paid to the employee’s dependents for a period of 500 weeks from the date of death. Upon the remarriage of a dependent spouse, such weekly payments shall cease to be made to her. Instead the spouse shall receive, as a remarriage dowry, the balance of the compensation to which she would otherwise have been entitled, subject to the maximum payment amount. Benefits to dependent children may be extended beyond the 500-week period, until such a dependent child:
   a. Reaches the age of 16 and thereafter is self-supporting for 6 months
   b. Reaches the age of 18 and is neither physically nor mentally incapacitated from earning

1    | Permanent Total Disability Benefits claimed for permanent injury under the provision of Section 418.351. Report as permanent total each claim that constitutes permanent total disability as defined under the law. The outstanding costs shall be the carrier’s individual claim estimates of future payments using tables as stated in 1. above. The reserves must recognize the effects of the Social Security and other benefit coordination.
Michigan statute provides that weekly compensation benefits shall be paid to an employee who is permanently and totally disabled. Disability beneficiaries who are eligible for old age benefits under Social Security will have their benefits reduced 5% per year from age 65 until age 75. Benefits thereafter will be at 50% of the normal rate (Section 418.357). The reduction described above does not apply to beneficiaries whose benefits are coordinated with Social Security benefits under Section 418.354.

2 Scheduled Partial Disability Benefits claimed under the specific schedule of benefits provided in Section 418.361 (2). These include loss of thumb, finger(s), toe(s), hand, arm, foot, leg, or eye.

Report each claim for scheduled partial disability benefits. The law provides a specific schedule of benefits for various classes of injuries that are presumed to be partially disabling.

3 Other Partial Disability Benefits claimed under Section 418.361 (1), not specifically provided for in the schedule, but involving partial incapacity.

Report each claim for benefits of claimants who are partially disabled by injuries not contained in the specific schedule of injuries.

4 Temporary Total Disability Benefits claimed for temporary injury under the provisions of Section 418.351.

Report each claim for temporary total disability benefits.

Do not report as Temporary Total any claim where indemnity benefits have been paid or are payable under a previously enumerated section of the statute.

5 Medical Only Claims - no indemnity benefits.

Report claims involving medical losses only, having no indemnity benefits to be paid.

6 Contract Medical.

Contract medical refers to medical costs that have a predetermined total price and are not directly related to service rendered for medical services performed. This may occur when a medical care provider (MCP) and a carrier agree that the MCP will directly treat injured workers for a predetermined fee and amount of time. The contract price is the same regardless of the number of claims that actually occur. The contract price
may be on a per person or capitated basis, a percentage of premium, or on some other basis. If the medical contract covers more than one policy, report the contract amount allocated to each policyholder, deriving the contract amount in the same manner as the contract is priced.

Contract medical costs that cannot be allocated to individual claims should be reported in the aggregate as paid and incurred medical. These medical costs must be designated by the appropriate injury type. Medical costs allocated to individual claims must be reported in connection with these claims and must not be included in the amount reported as contract medical. The amount reported as contract medical must be the contract amount and the actual incurred cost to the carrier for these medical contracts, including payments to physicians and hospitals under contract. Bonus or return to work incentives paid by the carrier to the MCP must also be reported as medical loss by claim, if available; otherwise, report the contract amount.

9. CLAIM STATUS CODE
Indicate the status of the claim by means of the following codes:

<table>
<thead>
<tr>
<th>Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Closed Claim</td>
</tr>
<tr>
<td>0</td>
<td>Open Claims</td>
</tr>
<tr>
<td>4</td>
<td>Open Claim - payment not made or initiated</td>
</tr>
</tbody>
</table>

10. LOSS CONDITION CODES
Report the Act, Type of Loss, Type of Recovery, Type of Claim, and Type of Settlement for the claim. An accident resulting in an injury to one worker with payments made under different coverages of the policy must be reported as one claim with all of the incurred combined.

Loss Conditions (ACT)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>State Act or Federal Act (Excluding USL&amp;H Act)</td>
</tr>
<tr>
<td></td>
<td>A claim with benefits determined according to the Workers’ Compensation Law or Federal Compensation Law, excluding United States Longshore and Harbor Workers’ Compensation Act.</td>
</tr>
<tr>
<td>2</td>
<td>USL&amp;H Act (F Classifications and Non-F Classifications)</td>
</tr>
<tr>
<td></td>
<td>A claim with benefits determined according to the United States Longshore and Harbor Workers' Compensation Act.</td>
</tr>
</tbody>
</table>
## MICHIGAN WORKERS’ COMPENSATION STATISICAL PLAN

### Loss Conditions (TYPE OF LOSS)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Trauma</td>
</tr>
<tr>
<td></td>
<td>An injury resulting in disability, the need for medical treatment, or death that is caused by a work related accident. A traumatic injury cannot be classified as either a Cumulative Injury or an Occupational Disease Loss as defined below.</td>
</tr>
<tr>
<td>2</td>
<td>Occupational Disease</td>
</tr>
<tr>
<td></td>
<td>Any abnormal condition or disorder, other than a workplace injury, resulting in a disability, the need for medical treatment, or death, caused by extended exposure to environmental factors associated with employment, including acute and chronic illness or disease caused by inhalation, adsorption, ingestion, or direct contact. For example, a granite worker presents a claim for the occupational disease of silicosis due to exposure to the disease agent silica. In order for a claim to be coded as an occupational disease case, it must have resulted from repetitive exposure extending over a period of time. Do not code claims that arise from single identifiable incidents as occupational disease claims although they may have been caused by inhalation, absorption, ingestion, or other environmental factors.</td>
</tr>
<tr>
<td>3</td>
<td>Cumulative Injury Other Than Disease</td>
</tr>
<tr>
<td></td>
<td>An injury occurring from repetitive mental or physical traumatic activities extending over a period of time, the combined effect of which caused disability, need for medical treatment, or death. For example, a cement mason, carpet or tile installer presents a claim for injury to the knee caused by repetitive bending and kneeling on the job.</td>
</tr>
</tbody>
</table>

### Loss Conditions (TYPE OF RECOVERY)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No Recovery</td>
</tr>
<tr>
<td></td>
<td>The carrier has not received any reimbursement.</td>
</tr>
<tr>
<td>2</td>
<td>Special Funds Only</td>
</tr>
</tbody>
</table>
|      | The carrier has received reimbursements from one of the special funds (The Second Injury Fund; The Silicosis, Dust Disease, and Logging Industry Compensation Fund, or the Compensation Supplement Fund Etc.). These funds are trusts established to reimburse 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 or when an initial injury occurs in particular industries.

3 Subrogation Only (Third Party)
The carrier has received reimbursements from an entity, other than the employer, with legal liability for the injury due to the circumstances involved.

In all cases where there has been recovery of loss under subrogation rights, each claim shall be included at a figure equal to the net liability incurred. The net liability incurred shall be determined by deducting from the incurred cost prior to recovery, the amount recovered through subrogation less any expenses incurred in connection with such recovery. However, in cases where the expenses incurred in connection with such recovery exceed the amount recovered, the net amount of loss reported shall not exceed the gross amount of loss prior to recovery. Furthermore, the net liability incurred shall be apportioned to indemnity and medical in the same proportion as existed in the gross incurred cost.

4 Subrogation with Special Fund (Third Party)
The carrier has received reimbursements from both the special funds and a third party.

Loss Conditions (TYPE OF CLAIM)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Workers’ Compensation Only</td>
</tr>
<tr>
<td></td>
<td>The entire loss is incurred under the provisions of Part One of the Workers’</td>
</tr>
<tr>
<td></td>
<td>Compensation and Employers’ Liability insurance policy.</td>
</tr>
<tr>
<td>2</td>
<td>Employers’ Liability Only</td>
</tr>
<tr>
<td></td>
<td>The entire loss is incurred under the provisions of Part Two of the Workers’</td>
</tr>
<tr>
<td></td>
<td>Compensation and Employers’ Liability insurance policy.</td>
</tr>
<tr>
<td>3</td>
<td>Workers’ Compensation and Employers’ Liability</td>
</tr>
<tr>
<td></td>
<td>The loss is incurred under the provisions of Part One and Part Two of the</td>
</tr>
<tr>
<td></td>
<td>Workers’ Compensation and Employers’ Liability insurance policy.</td>
</tr>
<tr>
<td>4</td>
<td>Liability Over</td>
</tr>
<tr>
<td></td>
<td>This refers to a particular employers’ liability coverage situation where a</td>
</tr>
<tr>
<td></td>
<td>third party, who is being sued by an employee, in turn sues the employer.</td>
</tr>
<tr>
<td></td>
<td>Any damages incurred by the employer are classified as “liability over” IN</td>
</tr>
<tr>
<td></td>
<td>ADDITION to compensation payments made to the injured employee.</td>
</tr>
</tbody>
</table>
MICHIGAN WORKERS’ COMPENSATION STATISICAL PLAN

Loss Conditions (TYPE OF SETTLEMENT)
Where a claim involves a lump sum or redemption representing the discounted or
commuted value of a specific award or benefit, subdivide the amount according to
indemnity and medical. In instances where this cannot be readily determined, report the
amounts which the carrier believes to be the most likely breakdown.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>Claim Not Subject to Settlement</td>
</tr>
<tr>
<td></td>
<td>Carrier anticipates additional payments of losses or the claim does not involve a settlement.</td>
</tr>
<tr>
<td>3</td>
<td>Stipulated Award</td>
</tr>
<tr>
<td></td>
<td>An award which has been drawn up between the carrier and claimant and submitted to the Magistrate for approval.</td>
</tr>
<tr>
<td>4</td>
<td>Findings and Award</td>
</tr>
<tr>
<td></td>
<td>An award which has been issued by a Magistrate or the Appeals Board based on evidence presented in the process of litigation.</td>
</tr>
<tr>
<td>5</td>
<td>Dis dismissal or Take Nothing (Noncompensable)</td>
</tr>
<tr>
<td>6</td>
<td>Compromise Settlement</td>
</tr>
<tr>
<td></td>
<td>Compromise and Release: A settlement over the issues of applicability, extent of injury, or future benefits.</td>
</tr>
<tr>
<td>09</td>
<td>All Other Settlements</td>
</tr>
<tr>
<td></td>
<td>Final payment has been made on the claim and the settlement cannot be classified as any of the above.</td>
</tr>
</tbody>
</table>

11. JURISDICTION STATE CODE – “O” (OPTIONAL)
The state code of the governing jurisdiction who will administer the claim and whose statutes will apply to the claim adjustment process when that state is different from the exposure state.

12. CATASTROPHE NUMBER (IF APPLICABLE)
A “catastrophe” is defined as any accident (one occurrence) resulting in two or more reported claims where the total amount of the loss exceeds $20,000. All claims resulting from this accident must be identified with a catastrophe number. The first catastrophe would be numbered 01. If there are succeeding catastrophes under the same policy, the second would be numbered 02, the third 03, etc. A separate series of catastrophe numbers must be used for each policy under which a catastrophe occurred. Extra-ordinary Loss Event Catastrophe Numbers between 11 and 99 are assigned for each qualifying extraordinary loss event. This unique code provides the industry a standard for reporting associated losses and is used by the insurance industry to fulfill internal needs and bureau reporting purposes.
13. MANAGED CARE ORGANIZATION TYPE CODE
Report the type of organization which will administer the applicable medical losses of a claim.

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCO not applicable</td>
<td>00</td>
<td>The claim is not administered by an approved/certified MCO</td>
</tr>
</tbody>
</table>

Report the three 2-digit codes that represent the part of body, nature of injury, and cause of injury for a given claim.

Refer to the WCIO website for applicable codes.

15. VOCATIONAL REHABILITATION INDICATOR

- **Y** = Claim includes vocational rehabilitation.
- **N** = Claim does not include vocational rehabilitation.

16. LUMP SUM INDICATOR

- **Y** = Claim was settled by lump sum payment.
- **N** = Claim has not been settled by a lump sum settlement.

17. FRAUDULENT CLAIM CODE
Report the code that identifies involvement of fraud in the claim.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>Not Fraudulent</td>
</tr>
<tr>
<td>02</td>
<td>Fully Fraudulent</td>
</tr>
</tbody>
</table>

18. CLAIM COUNT TOTAL
Report the total number of claims for the state within the policy. In the case of corrections and subsequent reports, this must be the revised cumulative total.

19. INCURRED INDEMNITY TOTAL
Report the total of the incurred indemnity amounts for the state within the policy. In the case of corrections and subsequent reports, this must be the revised cumulative total.

20. INCURRED MEDICAL TOTAL
Report the total of the incurred medical amounts for the state within the policy. In the case of corrections and subsequent reports, this must be the revised cumulative total.
PART V – SUBSEQUENT AND CORRECTION REPORTS

1. SUBSEQUENT REPORTS
A. Subsequent Report Valuations
Subsequent reports must be filed and the loss valued 12, 24, 36, 48, 60, 72, 84, 96 or 108 months after the first reporting date, when:

1. There is an open claim on the previous report.
2. There are reopened claims reported closed on the previous report.
3. There are claims previously Unreported.
4. There are changes in the valuation of losses.

B. Revaluation of Losses
Report the values previously reported and the revalued amounts for each open, reopened, new or changed claims on the second, third, fourth, fifth, sixth, seventh, eighth, ninth or tenth report. The revised cumulative totals must be reported for the following fields:

1. Number of Claims.
2. Incurred Indemnity.
3. Incurred Medical.

2. CORRECTION REPORTS
Correction reports must be filed if an error of any kind was made on a report previously filed. Each correction report shall show for each claim the amounts previously reported and the revised values. A correction report must also be filed when any of the following occur between valuation dates:

A. Loss values are found to have been included or excluded through mistake other than error of judgement.

B. The claim, or any part thereof, is declared noncompensable. For the purposes of this rule the term “noncompensable” refers to:

1. An official ruling especially holding that a claimant is not entitled to benefits under the Workers’ Compensation Law.

2. A case where no claim was filed during the period of limitation provided by the Workers’ Compensation Law for the filing of such claim, and the carrier therefore closes the case.

3. A case where the carrier contends, prior to the valuation date, that a claimant is not entitled to benefits under the Workers’ Compensation Law, and the claim is closed because of the claimant’s failure to prosecute his claim.
C. The carrier or claimant has obtained a subrogation recovery in an action against a third party or has received, or anticipates to receive, reimbursement from one of the special funds.

D. Aggravated inequity occurs. This occurs when a claim closes between the valuation date and the next rating effective date with an amount less than the amount valued previously.

Correction reports are not permissible under the following conditions:

1. Any change in loss due to development from one report to the next.

2. Any change due to departmental or judicial decision, except in cases where the change in the loss value results in a revision to the modification under an “aggravated inequity rule”.

3. Any change in injury type of a claim due to development from one report to the next except for death claims.

Correction reports submitted in connection with 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, or 10th reports must be identified with a correction indicator and sequence number.

A revised experience modification will automatically be issued if the change or changes contained on a correction report affect the current modification. A company may request corrected modifications for the immediately preceding two experience periods.

3. METHOD OF REPORTING

A. Exposure and Premium.
Where the exposure previously reported has been changed by reason of an audit, a reaudit, or any other adjustment affecting classifications, exposure or premiums, a correction report must be filed showing the amounts reported previously as well as revised amounts for those classifications where there have been changes. Also Total Standard Premium, Experience Modification, and the Risk Totals - Exposure and Premium shall be shown with revised figures. Previous and revised premium discounts, if any, shall also be shown. The previous and revised premiums must be reported on all statistical codes to be applied to the manual and or standard premium regardless of whether or not a change occurred.
If the exposure does not change, but the total premium previously reported is revised due solely to a change in the modification, it shall be necessary to submit a revised report showing only each item affected by the modification change on a revised basis. Premiums by classification are not required. Previous premium discounts and revised discounts also shall be reported. The previous and revised premiums must be reported on all statistical codes to be applied to the standard premium regardless of whether or not a change occurred.

B. Classification Code (for claim), Type of Injury, or other Nonmonetary Items; where the classification code of the claim or type of injury requires revision, the revised report shall show all of the data previously reported for the classification in question as well as all of the data (including those items which do not change) on a revised basis.

Where none of the individual items are incorrect but the totals were reported incorrectly, report only the revised corrected totals. Do not report any individual item information.

4. PROCEDURE FOR CORRECTION OF REPORTS AFTER SUBSEQUENT REPORTS HAVE BEEN FILED.

In order to correct a report that has already had a subsequent report applied to it, it is necessary to use one or more correction reports for each report level previously filed. Correct the report level necessary with the individual claim information and adjust the totals. If these individual changes need to be reflected on subsequent reports, file the appropriate correction reports and adjust the totals. If the change only affects the totals on subsequent reports, file a totals only correction.
PART VI – CALLS FOR AGGREGATE FINANCIAL DATA AND SPECIAL CALLS

Carriers shall report aggregate financial accounting data as established in this plan.

1. ANNUAL CALL FOR POLICY YEAR EXPERIENCE

Carriers shall report the requested information annually. Experience shall be valued as of December 31, and reports shall be due on or before April 1st of the following calendar year.

Carriers must submit their calls electronically using the Michigan Financial Data Reporting Application (MIFDRA).

The carrier shall report for each policy year the following information on all policies directly written in the State of Michigan, EXCEPT those covering underground coalmines; those covering “F” classifications; those covering maritime and FELA classifications (for policies effective 1/1/2003 and subsequent); those written on reinsurance assumed policies; those written on policies with large deductibles ($100,000 or greater); those written on an excess coverage basis; and those written under the “National Defense Projects Rating Plan”. Also, catastrophe and terrorism provision premium [Stat Codes 9740, 9741 and 9752] should be excluded:

1. ACCUMULATED STANDARD EARNED PREMIUM AT DESIGNATED STATISTICAL REPORTING LEVEL (as determined by the Designated Advisory Organization) - This is designed to facilitate company-to-company experience comparisons, by placing all companies on a uniform premium basis. The details of this computation are provided in the MIFDRA Carrier User’s Guide and Reporting Instructions.

2. ACCUMULATED STANDARD EARNED PREMIUM AT COMPANY RATE LEVEL – This is earned premium on all risks after the application of deviations from the designated statistical reporting level premium, experience rating plan adjustments, expense constants and loss constants but prior to the application of schedule rating adjustments, premium discount, retrospective rating adjustments and the payments of policyholder dividends.

3. ACCUMULATED NET EARNED PREMIUM - This is the accumulated actual earned premium on all risks prior to the payment of policyholder dividends but after application of schedule rating, premium discount, and retrospective rating premium adjustments. This is the actual “collected” premium.

4. ACCUMULATED INDEMNITY PAID LOSSES

5. ACCUMULATED MEDICAL PAID LOSSES

6. INDEMNITY CASE RESERVES
MICHIGAN WORKERS’ COMPENSATION STATISTICAL PLAN

7. MEDICAL CASE RESERVES
8. INDEMNITY BULK RESERVE
9. MEDICAL BULK RESERVE
10. ACCUMULATED DEFENSE AND COST CONTAINMENT EXPENSE (DCCE) PAID
11. DCCE CASE RESERVES
12. CLOSED INDEMNITY CLAIM COUNT
13. OPEN INDEMNITY CLAIM COUNT

No deduction shall be made from premiums and losses for or on account of reinsurance ceded, nor shall premiums and losses on assumed business be included. Experience reported should be direct business only. Direct business of assigned risk policies should be included.

Bulk reserves should include an appropriate provision for reopened cases.

Assessments for the three Michigan special funds are to be excluded.

2. ANNUAL CALL FOR CALENDAR – ACCIDENT YEAR EXPERIENCE

Carriers shall report the information annually. Experience shall be valued as of December 31. Reports shall be due on or before April 1st of the following calendar year.

Carriers must submit their calls electronically using the Michigan Financial Data Reporting Application (MIFDRA).

The carrier shall report for each accident year the following information on all policies directly written in the State of Michigan, EXCEPT those covering underground coalmines; those covering “F” classifications; those covering maritime and FELA classifications (for policies effective 1/1/2003 and subsequent); those written on reinsurance assumed policies; those written on policies with large deductibles ($100,000 or greater); those written on an excess coverage basis; and those written under the “National Defense Projects Rating Plan”. Also, catastrophe and terrorism provision premium [Stat Codes 9740, 9741 and 9752] should be excluded:

1. CALENDAR YEAR STANDARD EARNED PREMIUM AT DESIGNATED STATISTICAL REPORTING LEVEL - This is designed to facilitate company-to-company experience comparisons, by placing all companies on a uniform premium
basis. The details for this computation are provided in the MIFDRA Carriers User’s Guide and Reporting Instructions.

2. CALENDAR YEAR STANDARD EARNED PREMIUM AT COMPANY RATE LEVEL – This is earned premium on all risks after the application of deviations from the designated statistical reporting level premium, experience rating plan adjustments, expense constants and loss constants but prior to the application of schedule rating adjustments, premium discount, retrospective rating adjustments and the payments of policyholder dividends.

3. CALENDAR YEAR NET EARNED PREMIUM - This is the actual earned premium on all risks prior to the payment of policyholder dividends, but after application of schedule rating, premium discount, and retrospective rating premium adjustments. This is the actual "collected" premium.

4. ACCUMULATED INDEMNITY PAID LOSSES

5. ACCUMULATED MEDICAL PAID LOSSES

6. INDEMNITY CASE RESERVES

7. MEDICAL CASE RESERVES

8. INDEMNITY BULK RESERVE

9. MEDICAL BULK RESERVE

10. ACCUMULATED DCCE PAID

11. DCCE CASE RESERVES

12. CLOSED INDEMNITY CLAIM COUNT

13. OPEN INDEMNITY CLAIM COUNT

No deduction shall be made from premiums and losses for or on account of reinsurance ceded, nor shall premiums and losses on assumed business be included. Experience reported should be direct business only. Direct business of assigned risk policies should be included.

The bulk reserve should include an appropriate provision for reopened cases.

Assessments for the three Michigan special funds are to be excluded.
3. ANNUAL CALL FOR DATA RECONCILING THE CALENDAR – ACCIDENT YEAR CALL TO PUBLISHED FINANCIAL DATA

Carriers shall report the information annually. Reports shall be due on or before April 1st of the following calendar year.

Carriers must submit their calls electronically using the Michigan Financial Data Reporting Application (MIFDRA).

The carrier shall report:

1. The direct earned premium, direct paid and incurred losses and direct paid and incurred DCCE in Michigan for the calendar year, subdivided as follows:
   a. Reported on the calendar year call.
   b. Unreported “F” class premium and losses.
   c. Unreported large deductible premium and losses.
   d. Unreported excess insurance premium and losses.
   e. Unreported National Defense Projects premium and losses.
   f. Unreported Underground Coal Mine premium and losses.
   g. Unreported Maritime and other FELA classifications premium and losses.
   h. Difference between gross losses for small deductible policies, as reported in the Call, and losses net of small deductibles, as reported in the Annual Statement.
   i. Catastrophe Provision Premium (TRIA/TRIPRA and DTEC)

2. The direct earned premium, direct paid and incurred losses, and direct paid and incurred DCCE as published on line 16 of the Exhibit of Premium and Losses of the Annual Statement.

3. An explanation of the differences between the sum of the items in 1) and 2).

4. ANNUAL CALL FOR COUNTRYWIDE LOSS ADJUSTMENT EXPENSE DATA

Carriers shall report the information annually. Reports shall be due on or before May 1 of the following calendar year.
MICHIGAN WORKERS’ COMPENSATION STATISTICAL PLAN

Carriers must submit their calls electronically using the Michigan Financial Data Reporting Application (MIFDRA).

The carrier shall report the following information:

1. ACCUMULATED DIRECT LOSSES PAID
2. DIRECT LOSSES UNPAID (OUTSTANDING AND IBNR)
3. ACCUMULATED DCCE PAID
4. DCCE UNPAID
5. ACCUMULATED ADJUSTING AND OTHER EXPENSES (AOE) PAID
6. AOE UNPAID
7. LARGE DEDUCTIBLE DIRECT NET (OF DEDUCTIBLE) ACCUMULATED LOSSES PAID
8. LARGE DEDUCTIBLE DIRECT NET LOSSES UNPAID
9. LARGE DEDUCTIBLE DIRECT NET ACCUMULATED DCCE PAID
10. LARGE DEDUCTIBLE DIRECT NET DCCE UNPAID

5. ANNUAL CALL FOR LARGE LOSS AND CATASTROPHE CLAIMS

Carriers shall report the information annually. Reports shall be due on or before April 1 of the following calendar year.

Carriers must submit their calls electronically using the Michigan Financial Data Reporting Application (MIFDRA).

The carrier shall report all claims where the total case incurred losses are $500,000 or greater, and all claims that have been assigned unique catastrophe numbers.

The carrier shall report the following information:

1. CLAIM NUMBER
2. POLICY NUMBER
3. INDUSTRY CATASTROPHE NUMBER – report the assigned catastrophe number. Otherwise, leave blank.

4. EXPO STATE CODE

5. MARKET TYPE CODE

6. POLICY EFFECTIVE DATE

7. ACCIDENT DATE

8. CLAIM STATUS CODE

9. ACCUMULATED PAID LOSSES – INDEMNITY

10. ACCUMULATED PAID LOSSES – MEDICAL

11. CASE OUTSTANDING – INDEMNITY

12. CASE OUTSTANDING – MEDICAL

13. ACCUMULATED PAID DEFENSE AND COST CONTAINMENT EXPENSE

14. CASE OUTSTANDING DEFENSE AND COST CONTAINMENT EXPENSE

6. SPECIAL CALLS FOR EXPERIENCE

Special circumstances may require the reporting of additional information, either to the CAOM or to a designated subcontractor. An example for such circumstance might be a benefit change affecting only certain categories of insureds or classes of injuries. To respond to this kind of circumstance, it may be necessary to obtain additional information relative to it.

In response to the potential for this kind of circumstance, the NCCI has established an ongoing Call of Detail Claim Information. The CAOM has contracted with the NCCI to continue this Call. Participating carriers are instructed to continue reporting experience to the NCCI.

The Detail Claim Call is a continuous random sampling of Indemnity Claims, which began in April of 1979. There are 54 items of information that are asked for on each claim.
MICHIGAN WORKERS’ COMPENSATION STATISICAL PLAN

Sampled claims are evaluated six months after their arising, and then are evaluated at 18, 30, and 42 months, unless closes beforehand. Claims are due at the NCCI two months after evaluation.

Other special calls may be forthcoming as necessary including special calls requested by the Commissioner of Insurance.

Additional information and reporting instructions can be found in the MIFDRA Carrier User's Guide.
### MICHIGAN WORKERS’ COMPENSATION STATISTICAL PLAN

#### PART VII – STATISTICAL CODES

<table>
<thead>
<tr>
<th>Class Code</th>
<th>Subject to Mod</th>
<th>Class Description</th>
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<tbody>
<tr>
<td>0012</td>
<td>No</td>
<td>Paid Furloughed Workers During a Governmental Emergency</td>
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<tr>
<td>0020</td>
<td>No</td>
<td>Expense Constant charged to small risks only</td>
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<td>0032</td>
<td>No</td>
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<td>0046</td>
<td>No</td>
<td>For transactions involving retrospective surcharge</td>
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<tr>
<td>0056</td>
<td>No</td>
<td>Difference between Standard Premium and Final Premium under Comprehensive Rating Plan</td>
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<td>0057</td>
<td>No</td>
<td>Waiver of charges of the Retrospective Rating Plan</td>
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<tr>
<td>0063</td>
<td>No</td>
<td>Premium Discount - Stock Carrier Discount Plan</td>
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<td>0064</td>
<td>No</td>
<td>Premium Discount - Non-Stock Carrier Discount Plan</td>
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<td>0071</td>
<td>Yes</td>
<td>Employers’ Liability coverage for coverage up to and including $100,000/$100,000</td>
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<td>0072</td>
<td>Yes</td>
<td>Employers' Liability coverage for any coverage in excess of a limitation of $100,000/$100,000</td>
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<td>0077</td>
<td>No</td>
<td>Premium Surcharge - Assigned risk (Plan A)</td>
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<td>0088</td>
<td>Yes</td>
<td>Aircraft Operation - Passenger Seat Surcharge <strong>Code discontinued 1-1-2015</strong></td>
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<td>0098</td>
<td>No</td>
<td>Exclusive State or Federal coverage</td>
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<td>Premium for Increased Limits: $500,000</td>
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<td>0122</td>
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<td>Premium for Increased Limits: $1,000,000</td>
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<td>0123</td>
<td>Yes</td>
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<td>0133</td>
<td>No</td>
<td>Asbestos Disease Experience</td>
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<td>0164</td>
<td>No</td>
<td>For reporting disease experience in connection with any classification other than coal mining where there is liability under the Federal Mine Safety &amp; Health Act</td>
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<tr>
<td>0179</td>
<td>No</td>
<td>For reporting any other supplemental disease experience</td>
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<td>0388</td>
<td>No</td>
<td>Excess Insurance</td>
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<td>0900</td>
<td>No</td>
<td>Policy Fee charged to all risks (Expense Constant)</td>
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<td>0930</td>
<td>Yes</td>
<td>Waiver of Our Right to Recover from Others Premium</td>
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<td>0931</td>
<td>Yes</td>
<td>Short Rate Penalty Premium</td>
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<tr>
<td>0990</td>
<td>No</td>
<td>Required to balance to Risk Minimum Premium. Do not include loss and/or expense constants.</td>
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<td>0993</td>
<td>No</td>
<td>Flat charge or Minimum Premium for USL&amp;HW Act coverage for non-F classes.</td>
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<td>0994</td>
<td>Yes</td>
<td>Premium credit resulting from a flat decrease on outstanding policies</td>
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<td>0998</td>
<td>Yes</td>
<td>Additional premium resulting from flat increase on outstanding policies</td>
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<td>1111</td>
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<td>No Exposure Unit Reports</td>
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<td>7445</td>
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<td>Non-ratable catastrophe loading Code 7405</td>
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<td>9034</td>
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<td>9036</td>
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<td>Rate deviation premium debit</td>
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<table>
<thead>
<tr>
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<tbody>
<tr>
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<td>Yes</td>
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<td>9039</td>
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<td>Risk Loss Fund relative to former self-insurers (Plan B)</td>
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<td>Loss Constant charged to small risks only</td>
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<td>Employers' Liability coverage for coverage up to and including $100,000/$100,000</td>
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<td>Yes</td>
<td>Miscellaneous debit premium which does not fall under any other code</td>
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<td>9136</td>
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<td>Group Loss Fund relative to former self-insurers (Plan B)</td>
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<td>No</td>
<td>Stop-Gap coverage for Employers' Liability/Workers' Compensation where a monopolistic state is involved</td>
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<td>Terrorism Risk Insurance Act of 2002 Premium</td>
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<td>9741</td>
<td>No</td>
<td>Domestic Terrorism, Earthquakes, and Catastrophic Industrial Accidents</td>
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<td>Audit Non-Compliance Charge (effective 1/1/2017)</td>
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<td>Drug Free Workplace Premium Credit</td>
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<td>Managed Care Premium Credit</td>
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<td>No</td>
<td>Drug Free Workplace Premium Credit</td>
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<td>Required to balance to Increased Limits Minimum Premium</td>
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<td>Credit under individual risk rating plan - other than experience rating</td>
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<tr>
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<td>No</td>
<td>Debit under individual risk rating plan - other than experience rating</td>
</tr>
</tbody>
</table>
INDEX

Accident Date, 17
ACT (Loss Conditions), 22
Address of Insured, 6
Aggregate Financial Data and Special Calls, 30
Aircraft Operation, 12
Aircraft Operation Losses, 19
Allocated Loss Adjustment Expense (ALAE), 15
Assessments, 16
Cancellation Date, 6
Carrier Code, 5
Catastrophe Number, 25
Claim Count, 17
Claim Count Total, 26
Claim Number, 17
Claim Status Code, 22
Classification Code (Losses), 19
Classification Code (Payroll/Exposure), 9
Closed Claim, 22
Contract Medical, 21
Correction of Errors, 2
Correction Reports, 27
Correction Sequence Number, 5
Correction Type Code, 5
Cumulative Injury, 23
Death, 20
Deductibles, 13, 16, 30, 31, 33, 34
Disease Loss, 23
Effective Date
  of Experience Modification, 7
  of Policy, 5
  of Rate, 7
Electronic Submissions, 2
Employers’ Liability Loss, 24
Excess Policies, 30, 31
Expense Constant Amount, 13
Expenses Excluded From Losses, 15
Expenses Included in Losses, 15
Experience Modification Effective Date, 7
Experience Modification Factor, 13
Expiration Date, 6
Exposure
  Aircraft Passenger Seats, 12
  Other than Payroll, 12
  Per Capita, 12
Exposure Act, 9
Exposure Amount, 9
Exposure Coverage Code, 9
Exposure Payroll Total, 13
Exposure State Code, 6
Federal Employer Identification Number (FEIN), 7
Filing Date, 3
Fine System for Unit Reports, 4
Fraudulent Claim Code, 26
General Rules, 2
Incurred Indemnity Amount, 17
Incurred Indemnity Total, 26
Incurred Medical Amount, 18
Incurred Medical Total, 26
Injury Code, 20
Injury Description Code, 26
Jurisdiction State Code, 25
Loss Condition Codes, 22
Loss Totals, 26
Losses, 15
Lump Sum Indicator, 26
Lump Sum Settlements, 25
Managed Care Organization Type Code, 26
Manual Charged Rate, 12
Medical
  Clinical Medical, 19
  Contract Medical, 21
  Medical Expense, 15
  Medical Only Claims, 21
Multiple Year Policies Other Than Three Year Fixed Rate, 4
Multistate Policies, 3
Name of Insured, 6
National Defense Projects, 2, 30, 31
Occupational Disease Loss, 23
Penalties, 17
Per Capita, 12
Permanent Total, 20
Physical Rehabilitation, 15, 18
Policy Condition Indicators, 7
Policy Effective Date, 5
Policy Expiration or Cancellation Date, 6
Policy Number Identifier, 5
Policy Type ID Codes, 7
Premium
  Not Subject to Experience Modification, 13

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