STUDY NOTE: NCCI DATA COLLECTION CALLS AND STATISTICAL PLANS

Richard B. Moncher, FCAS, MAAA

Currently, there are five major data collection programs at NCCI.

Annual Financial Call Data - Aggregate premium and loss data (experience by state) primarily used to calculate overall loss cost and rate level changes.

Workers Compensation Statistical Plan (WCSP) Data - Individual policy loss and exposure (payroll) information collected with detail by classification, primarily used to calculate loss cost relativities and experience rating modifications.

Detailed Claim Information (DCI) Data - Sample of indemnity (mostly permanent partial disability) claims consisting of 85 data elements reflecting areas such as paid and incurred losses/claims, demographic, litigation and recovery information, used for special analyses and research.

Policy Issue Capture System (PICS) Data - Policy documents submitted by insurers. PICS is used to confirm proof of workers compensation coverage (and supply other information) to state accident boards and commissions. In most states, NCCI is designated as the commission's authorized agent to collect coverage information, so there is no need for insurers to submit policy information to the state commission. PICS is also used to let NCCI know when to expect a unit report.

Residual Market Data - Submissions from servicing carriers, including policy and calendar year premiums, losses and expenses (by state). As part of NCCI's role and responsibilities as administrator of the National Pool and other residual market pools, NCCI serves as the central clearinghouse for information on pool transactions. This information is used for pool financial reporting procedures, quarterly distribution of operating results and the determination of pool IBNR reserves.

This note focuses on the first two of these programs, which are the primary data sources used for workers compensation ratemaking.

HISTORY OF CALLS

Over the years, the workers compensation ratemaking process has undergone many changes, and these changes have impacted the data needed by NCCI.

Early WCSP

Initially, the WCSP was designed to provide a unit report that contained detailed exposure, premium and loss data. This data was submitted at three different evaluations on reports (18, 30 and 42 months after the policy effective date) until the

early 1960s. At that time, it was felt there was development beyond 42 months. The reporting was therefore extended to five reports under the belief that most case development would be reflected by 66 months after the effective date.

Financial Calls

By the mid-1960s, there was a feeling that there were additional loss amounts (beyond five reports) that should be included in the experience used to calculate rate changes. These additional amounts were a result of adverse development on known claims and pure IBNR claims.

So, in 1967, the first annual financial call was completed (with data as of December 31, 1966). This financial call was on a policy year basis and included standard premium, net premium, paid, case and IBNR losses .

In 1975, a modification excluded experience for the twenty-seven "F" classifications from the Policy Year (Financial) Call. "F" classifications apply to operations subject to exposure under the United States Longshore and Harbor Workers' Compensation Act. Because these classifications might distort the indicated rate change for classes covered under a state's own workers compensation act (due to the difference in benefits), their experience is reported on the "F" Classification Policy Year Call. The layout and content of this financial call is the same as the call for non-"F" classification experience.

Due to the need for more responsive information, in 1977 the Accident Year (Financial) Call was completed for the first time with data as of December 31, 1976. This allowed NCCI actuaries to examine the latest accident year and compare it to the latest policy year.

In the early-1980s, incurred indemnity claim counts became mandatory for policy years 1981 and subsequent and accident years 1980 and subsequent. Separate reporting of open and closed claim counts (and payments on closed claims) became a requirement for policy and accident years 1993 and subsequent.

In the late-1980s, severe inadequacy in assigned risk rates and huge growth in the residual market led to the need for two "supplementary" calls. These calls are the Policy Year Call for Assigned Risk Experience and the Accident Year Call for Assigned Risk Experience. The data from these calls was (and is) used to determine, support and justify the need for and the necessary magnitude of assigned risk pricing programs, such as differentials, surcharges, removal of premium discounts, etc. These calls were also needed to meet the statutory requirements in several states that voluntary rates / loss costs be based on voluntary business only (VBO). So, to meet these requirements, VBO data is derived by subtracting the appropriate assigned risk call data from the corresponding statewide financial call data.

Historically, financial calls contained the latest evaluation of each of the last eight (policy / accident) years of data, with "all prior" years grouped together. Starting in 1988 (with data valued as of December 31, 1987), both the Policy Year and Accident

Year Calls were expanded. At each year-end since (and up until 2000), both calls included an additional year of data, so that for data valued as of December 31, 1999, there will be twenty individual years of data on each call. This will allow loss development to be based on actual (historical) loss experience out until a twentieth report, beyond which time a tail factor will be applied, primarily utilizing data from the "all prior" line.

Starting in 1995 (with data valued as of December 31, 1994), allocated loss adjustment expense (ALAE) became mandatory for policy and accident years 1994 and subsequent. The paid, case and Bulk+IBNR ALAE for these years are reported according to the definition of ALAE filed by NCCI. After several years of collecting ALAE data, NCCI will be able to project each state's ALAE to an ultimate basis.

Expanded WCSP - Unit Report Expansion

In the early-1990s, the WCSP was redesigned through the efforts of the Advisory Statistical Working Group (ASWG). Each current unit report data element was thoroughly reviewed for its business need and frequency of use. The ASWG redefined current data elements, eliminated obsolete data elements, and defined new data elements to be collected. This expanded unit report will create a common reporting process for data providers and statistical organizations, and provide additional data elements with consistent definitions for improved data quality.

The expanded unit report is categorized into four primary components: policy information, exposure information, loss information, and loss totals. The reporting of the expanded unit is mandatory for policies effective January 1, 1996 and after. This means that all "first report" units valued on or after July 1, 1997 are in the expanded format.

Detailed Claim Information

The DCI Call started in 1979 with data being collected in thirteen states, primarily with unusual benefit structures and/or claim characteristics. Initially, DCI captured 54 data elements. During the 1980s, claim costs were increasing dramatically in almost all states, leading NCCI to realize the need to collect additional data in all of its states. In 1989, the NAIC developed a model regulation of workers compensation data to be collected in all states. NCCI addressed this model regulation with an expanded DCI format. The expanded DCI format, which contains 85 data elements, was optional in 1991 and became mandatory in 1992. DCI is now captured in all NCCI states (except Maine) and several independent bureau states.

Currently, the following are several of the data elements collected by NCCI only through the DCI Data Call: Marital status, gender, injury site zip code, hospital payments, physician payments, date of hire, and date of first indemnity payment. All of the DCI data elements can be seen in the DCI record layout included as Appendix C.

Participation in the DCI Call is limited to only those carriers contributing at least 0.1% of the total statewide net direct written premium, and the number of claims reported is

determined by a random sample percentage set for each state. The sampling methodology is meant to assure randomness, thus making it a representative and accurate reflection of reality.

DCI has been used in such areas as measuring the cost of system reforms, updating the Standard Wage Distribution Tables, and creating a medical cost index specific to workers compensation medical costs.

FINANCIAL CALLS - DATA REPORTING

There are over twenty financial aggregate calls that are submitted to NCCI. All of these calls can be separated into three categories, of which only the first is addressed in this study note. The first category contains calls used directly for ratemaking either in determining the overall rate/loss cost level for a state or in confirming the accuracy of the ratemaking data. The second category contains calls used to supplement ratemaking data, and the third category contains calls that are state-specific in which data is collected and summarized at the directive of a state insurance department.

Applicability

NCCI (Policy Year and Accident Year) Financial Calls are collected in thirty seven states and the District of Columbia; they are not collected in seven of the "independent bureau" states and six monopolistic state fund states. Beginning in 1998, NCCI will be collecting Financial Calls for Nevada. A copy of the actual "Policy Year Call for Experience By State Valued As Of December 31, 1996" is contained as Appendix A.

The statewide and assigned risk data reported on the policy year and accident year financial calls includes direct business only, excludes experience developed under large deductible policies ($100,000 or greater per accident or claim) and includes small deductible experience. Other experience also excluded from financial calls are: "F" classifications, underground coal mine, excess policies and National Defense Projects. These are excluded because the benefit provisions that apply to these types of policies or coverages usually differ from workers compensation statutes or other state laws.

Premiums

Accumulated earned premiums are reported as Standard at NCCI DSR (Designated Statistical Reporting) Level, Standard at Company Level and Net Earned. DSR level may be at the full-rate premium for administered pricing states, or at the level of published loss costs in open competition states. Standard Premium at DSR Level is prior to the effect of any individual company competitive pricing activity (deviations, retrospective rating, schedule rating, premium discounts, dividends), while Standard Pure Premium at DSR Level is also prior to the application of loss cost (expense) multipliers. So, Standard (Pure) Premium at DSR Level is used in ratemaking to evaluate NCCI's rate (loss cost) level. In all states where NCCI files loss costs for the voluntary market, assigned risk premiums are reported at a separate DSR level (the same assigned risk rate level for all carriers). Standard at Company Level is used to

confirm the accuracy of the ratemaking premium given individual company deviation and loss cost multiplier filings. Net direct earned premium (net of premium discounts, individual company deviations and pricing programs) is used to reconcile the company's annual statement (Statutory Page 14) to information reported on the call.

Losses

Indemnity and medical losses as of the valuation date (December 31) are reported by their separate component parts, with the following definitions:

Paid losses - Cumulative aggregate paid losses net of subrogation recoveries.

Case Reserves - Outstanding reserves established for specific known cases, reported in an aggregate amount.

Bulk Reserves - Outstanding reserves for general case reserve inadequacy, supplemental case reserves, cases that may be reopened, or other reserves not associated to specific claims.

IBNR Reserves - Outstanding reserves not reported as either case or bulk reserves. So, IBNR reserves may or may not include bulk reserves (and this must be indicated).

Claim Counts

Claim count information can be used to examine the level and the change in claim frequency, severity, and the level of reserve adequacy.

The incurred indemnity claim count represents the accumulated number of claims for which an indemnity payment has been made and/or an outstanding indemnity reserve exists. This claim count excludes medical only claims as well as those claims closed without payment.

The closed (paid) indemnity claim count includes those claims which are paid in full with no existing reserves.

The open (outstanding) indemnity claim count includes those claims for which outstanding case reserves exist (at the valuation date) regardless of whether or not any payments have been made on those claims, as well as any reopened claims that remain open at the valuation date.

Reconciliation Report

The Reconciliation Report is an example of a call that is used to review the data used in the state rate/loss cost filings.

Both the Accident Year Call and Policy Year Call for the current year-end should, in total, be different from the total from the prior year-end by an amount reconcilable to the current calendar year experience. The Reconciliation Report helps with this balancing process. The first part (of the Reconciliation Report) provides a place to indicate the net premiums and incurred losses reported. The second part, which is needed to reconcile the data reported to NCCI with NAIC data, provides for those items that are not considered a part of the experience to be reported to NCCI (e.g., large deductible policies). If the sum of these two parts is not within a stated tolerance of column 3 (for premiums) and column 7 (for losses) of Statutory Page 14, line 16 of the Annual Statement, the Reconciliation Report will require an explanation. This step addresses the concern of NCCI and the regulators that reportable and verifiable experience be used in the ratemaking process.

WCSP - DATA REPORTING

Applicability

The NCCI WCSP has been filed and approved in forty states, while the other ten states promulgate their own statistical plans. The NCCI WCSP is applicable only to Voluntary Compensation, Employers Liability, and United States Longshore and Harbor Workers' Coverage in jurisdictions which have monopolistic state funds. An actual copy of the "unit statistical report" is included as Appendix B.

All statistics for units are reported for direct business only, and a separate (WCSP) unit report is filed for each state of a multistate policy, including those states in which no exposure was developed.

Premiums

Premium details are included as part of the WCSP. The insured's exposure and the carrier's authorized rate (and not the DSR rate/loss cost) are reported for each class. Also, the insured's experience modification, premium discount, expense constant and any premium adjustment resulting from the application of an individual risk rating plan are reported.

For policies on which the earned premium is known (and an audit has been conducted), but uncollectible, all earned premium is reported. For policies on which a final audit is not possible (and the audited earned premium and exposure is not known), the estimated earned premium and exposure is reported.

Losses

Losses included in the first (unit) report of a given policy are valued as of eighteen months after the month in which the policy became effective, and the report is filed (with NCCI) not more than twenty months after the effective date of the policy. The expanded unit reports include paid and case losses separately, whereas the old unit reports (policies prior to 1/1/96) only had paid plus case losses in total.

For losses, the classification code under which the injured employee's payroll and premium is assigned is reported, even if, at the time of injury, the employee was involved in an activity that would have been classified differently. This is because the workers compensation classification and ratemaking systems are based on the business of the employer (not the occupation of each employee).

Claim Counts

Currently, for most states, each claim which involves a total (indemnity and medical) incurred loss of greater than $2,000 must be listed individually with the appropriate claim number and accident date. Claims less than $2,000 need not be reported individually, as that level of detail is not needed for class ratemaking analysis or experience rating calculations. For claims reported under the grouping option, the number of claims is reported. Claims partially covered by contract or capitated medical must be listed separately.

The status (opened, closed, reopened) of each claim is also reported. This facilitates claim frequency, severity, loss and tail development analyses.

Injury Types

There are many different types of injuries in workers compensation, all of which will ultimately end up in one of the following categories: fatal, permanent total, permanent partial, temporary, or medical only. The type of injury reported corresponds to the carrier's estimate, as of the valuation date, of the ultimate injury type of the claim. The injury type does not have to correspond to the type of benefit being paid. For example, if temporary total benefit payments are being made on a claim with permanent partial reserves, the claim should be reported as a permanent partial claim.

For death claims, the amount reported as incurred indemnity includes all paid and outstanding benefits, including compensation paid to the deceased prior to death, burial expenses, payments to the state and (survivor) reserves calculated in accordance with the WCSP. Most reserves on death claims (not limited by duration or amount) are calculated from pension tables included in the WCSP.

A claim is reported as permanent total when it is defined as such under the law or expected by the carrier to result in permanent total disability. In general, permanent total disability includes the loss or loss of use of both hands, arms, feet, legs, eyes or any combination of such members. The disabled life portion of a reserve where benefits are payable for life is also calculated from WCSP pension tables.

A permanent partial claim is any permanent injury that does not involve permanent total disability. A permanent partial claim is also any temporary injury that meets any one of the following criteria: (1) The duration of disability benefits exceeds or is expected to exceed one year or; (2) A lump-sum settlement is made or, in the judgment of the carrier, will be made to settle future benefits or; (3) The extent of liability for future payments cannot be determined. The incurred indemnity includes specific benefits and compensation for temporary disability as well as loss of earning capacity. The reserves for lifetime permanent partial claims may (at the option of the carrier) be calculated from WCSP pension tables.

Death, permanent total or permanent partial claims calculated from pension tables are referred to as tabular claims (with tabular discounts). In states with Social Security offsets, the reserves calculated from these tables must be reduced to recognize the effects of these offsets.

During the 1990s, managed care contracts have become more common in workers compensation. These contracts (between the insurer and the medical provider) may be priced on a per employee or payroll basis, or some other way that generally does not reflect actual costs per claim. Today, there are many arrangements for paying medical care on an aggregate basis. These medical costs that cannot be allocated to individual claims should be reported in the aggregate as paid and incurred contract medical. The amount reported as contract medical must be the contract amount and the actual incurred costs to the carrier (if any) for these medical contracts, including payments to physicians and hospitals under contract. Bonus or return-to-work incentives paid by the carrier to the medical care provider must also be reported as medical loss by claim, if available; otherwise, the contract amount should be reported.

For amounts not reported by class, NCCI will allocate the costs based on the classes reported for the policy.

Deductible Reporting

Deductibles have begun to proliferate in workers compensation in recent years. However, as gross losses are more appropriate for class ratemaking (since loss costs are calculated on a full coverage basis), all losses are reported gross of the deductible. Deductible reimbursements are reported for states that require use of net losses for experience rating (and these reimbursements can then be deducted from the gross losses for experience rating purposes).

Assessments and Subrogation Reporting

Assessments and claims involving subrogation require special reporting procedures. Assessments specified by law that are levied on a specific injury type are reported as incurred indemnity losses. Examples are (1) second injury fund payments in no dependent death claims and; (2) payments that are a specified percent of a permanent partial award. By contrast, any special payments to a state that are assessed on total premiums or total losses, are not reported as incurred losses.

When a claim is eligible for reimbursement to the carrier from a special fund, the net incurred cost (gross incurred cost less the paid or anticipated recovery from the fund) is reported. Similarly, when there has been a recovery of loss due to subrogation, the amount of loss reported is the net incurred loss (gross incurred loss less the amount recovered plus the recovery expense). When the recovery expenses exceed the amount recovered, the gross incurred loss is reported.

For ratemaking, when actual allocation of recovery to indemnity and medical losses is unknown, the net incurred loss is divided between indemnity and medical in the same proportion as the original gross incurred indemnity and medical amounts.

Expenses Included in Losses

ALAE and ULAE are reported separately from losses, though there are various examples of certain expenses that are reported as part of the incurred losses. For example, medical (exams) or legal court expenses incurred for the benefit of the claimant, or that the carrier is required to incur for the benefit of the claimant, are reported as incurred losses.

Vocational rehabilitation evaluation expenses are reported as incurred indemnity losses if these services are purchased from an outside vendor, and physical rehabilitation expenses purchased from an outside vendor are reported as incurred medical losses. Carrier case adjusters engaged in efforts to return an injured worker to gainful employment are reported as unallocated loss adjustment expense (ULAE).

If a carrier is liable for penalties for reasons beyond its control that accrue as benefits to the claimant, the penalties must be reported as indemnity losses. Whenever the reason for a penalty is within a carrier's control, it should be reported as ULAE.

Miscellaneous WCSP Reporting Issues

A "catastrophe" is defined as any accident (one occurrence) resulting in two or more reported claims. This is used to limit the losses for any one occurrence that would enter the rate/loss cost calculation for any one particular classification.

The type of Medical Care Organization (MCO), if any, that will provide services for the applicable medical losses is reported. This allows analysis as to the utilization, costs, and effectiveness of (different types of) MCOs. If a claimant is receiving treatment from more than one physician, the MCO of the primary care physician is reported.

In order to identify certain cost drivers and determine preventative measures for potential accidents, the part of the body to which the injury occurred, the nature of the injury (sprain/strain), and the cause of the injury (slip/fall) is reported.

Other Data Elements

The following are some of the key data elements (not discussed above) that are coded on all unit reports (if applicable):

Policy Number
Exposure State
Carrier Code
Policy Effective Date
Policy Expiration Date
Insured's Name
Policy Conditions (Y/N)
    Three-year fixed rate
    Multistate policy
    Interstate rated
    Estimated or audited exposure
    Retrospective rated
    Canceled midterm
Managed Care Organization Indicator (Y/N)
Policy Type ID
    Type of Coverage
    --Standard WC Policy
    --Alternative WC Policy
    Plan Indicator
    --Voluntary
    --Assigned Risk

Deductible Type
    Type of Reimbursement
    --Medical Losses Only
    --Indemnity Losses Only
    --Medical and Indemnity Losses Only
    Type of Program
    --Per Claim
    --Per Accident
    --Per Policy (Aggregate)
    --Percent of Claim Cost
    --Other Deductible Programs
Deductible Percent (If applicable)
Deductible Amount Per Claim/Accident (If applicable)
Deductible Amount Aggregate (If applicable)

These data elements are collected for class ratemaking analyses, validation/editing procedures, and research. They allow policies and claims with common characteristics to be grouped together for further analyses. For example, all assigned risk policies with an exposure state of Georgia and a policy effective date in 1997 may be isolated for further study.

NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC.

POLICY YEAR CALL FOR COMPENSATION EXPERIENCE BY STATE VALUED AS OF DECEMBER 31, 1996

CARRIER(S)* ______________________________ CARRIER CODE NUMBER ______________

STATE NAME ______________________________ STATE CODE NUMBER ______________

SUBMITTED BY ______________ TITLE ______________ TELEPHONE NO. ______________ DATE SUBMITTED ______________

Policy Year	Policy Year Accumulated Earned Premium			Accumulated Policy Year Incurred Losses—Total			
	Standard at NCCI Designated Stat. Reporting Level (1)	Standard at Company Level (2)	Net (3)	Paid (9) + (10) (4)	Outstanding Excluding IBNR (11) + (12) (5)	IBNR (13) + (14) (6)	Incurred Losses Including IBNR (4) + (5) + (6) (7)
A. Prior to 1978							
B. 1978							
C. 1979							
D. 1980							
E. 1981							
F. 1982							
G. 1983							
H. 1984							
I. 1985							
J. 1986							
K. 1987							
L. 1988							
M. 1989							
N. 1990							
O. 1991							
P. 1992							
Q. 1993							
R. 1994							
S. 1995							
T. 1996							
U. 1997							
V. 1998							
X. Total to 12-31-96							
Y. Total to 12-31-95							
Z. Calendar Year 1996 (X-Y)							

* If this is a group report, list all carrier names or carrier codes for which any experience is reported

NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC.

POLICY YEAR CALL FOR COMPENSATION EXPERIENCE BY STATE VALUED AS OF DECEMBER 31, 1996

CARRIER(S) ______________________ CARRIER CODE NUMBER __________

STATE NAME ______________________ STATE CODE NUMBER __________

ACCUMULATED POLICY YEAR INCURRED LOSSES

Policy Year	Incurred Indemnity Claim Count (8)	Paid		Outstanding Excluding IBNR		IBNR	
		Indemnity (9)	Medical (10)	Indemnity (11)	Medical (12)	Indemnity (13)	Medical (14)
A. Prior to 1978							
B. 1978							
C. 1979							
D. 1980							
E. 1981							
F. 1982							
G. 1983							
H. 1984							
I. 1985							
J. 1986							
K. 1987							
L. 1988							
M. 1989							
N. 1990							
O. 1991							
P. 1992							
Q. 1993							
R. 1994							
S. 1995							
T. 1996							
U. 1997							
V. 1998							
X. Total to 12-31-96							
Y. Total to 12-31-95							
Z. Calendar Year 1996 (X-Y)							

Appendix A

NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC.

POLICY YEAR CALL FOR COMPENSATION EXPERIENCE BY STATE VALUED AS OF DECEMBER 31, 1996

CARRIER(S) ____________ CARRIER CODE NUMBER ____________

STATE NAME ____________ STATE CODE NUMBER ____________

Policy Year	Outstanding Excluding IBNR Indemnity		Outstanding Excluding IBNR Medical	
	Case (15)	Bulk (16)	Case (17)	Bulk (18)
A. Prior to 1978				
B. 1978				
C. 1979				
D. 1980				
E. 1981				
F. 1982				
G. 1983				
H. 1984				
I. 1985				
J. 1986				
K. 1987				
L. 1988				
M. 1989				
N. 1990				
O. 1991				
P. 1992				
Q. 1993				
R. 1994				
S. 1995				
T. 1996				
U. 1997				
V. 1998				
X. Total to 12-31-96				
Y. Total to 12-31-95				
Z. Calendar Year 1996 (X–Y)				

NOTE:

A. Does your company currently report all bulk reserves for indemnity and medical under the IBNR columns on page 2? Indicate by placing an "x" in the appropriate space below.
____No ____Yes
If "No," data should be reported in Columns 15 through 18. If "Yes," Columns 15 through 18 should be left blank.

B. If your company currently reports any bulk reserves for indemnity and medical under the outstanding excluding IBNR columns on page 2 then:
1. Columns 15 + 16 on this page must equal Column 11 on page 2.
2. Columns 17 + 18 on this page must equal Column 12 on page 2.

Please indicate if the amounts shown on this page are actual or estimated by placing an "x" in the appropriate space provided below.
____Actual ____Estimated

C. If you have provided estimated amounts, will your company be able to provide NCCI with actual amounts in subsequent reports?
____No ____Yes

NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC.

POLICY YEAR CALL FOR COMPENSATION EXPERIENCE BY STATE VALUED AS OF DECEMBER 31, 1996

CARRIER(S) ______________________ CARRIER CODE NUMBER __________

STATE NAME ______________________ STATE CODE NUMBER __________

Policy Year	Policy Year Incurred Indemnity Claim Count		Accumulated Policy Year Losses Paid Losses on Closed Claims		Accumulated Policy Year Allocated Loss Adjustment Expense			
	Accumulated Closed (Paid) (19)	Open (Outstanding) (20)	Indemnity (21)	Medical (22)	Paid (23)	Case (24)	Bulk + IBNR (25)	Incurred (23) + (24) + (25) (26)
A. Prior to 1978								
B. 1978								
C. 1979								
D. 1980								
E. 1981								
F. 1982								
G. 1983								
H. 1984								
I. 1985								
J. 1986								
K. 1987								
L. 1988								
M. 1989								
N. 1990								
O. 1991								
P. 1992								
Q. 1993								
R. 1994								
S. 1995								
T. 1996								
U. 1997								
V. 1998								
X. Total to 12-31-96								
Y. Total to 12-31-95								
Z. Calendar Year 1996 (X–Y)								

CALL3N-2

Appendix A

UNIT STATISTICAL REPORT

POLICY INFORMATION

Report No.	Corr. No.	Corr. Type	Replace. Rpt. Ind.	Carrier Code	Policy Number	Policy Effective Date	Policy Expiration Date	Expos. State	State Effective Date	Certificate Number	Card Serial No.	Risk ID Number	Page No.	Last Page No.

Insured's Name:	F.E.I.N.	Pending File No.
Insured's Address:		

Mod Effective Date	Rate Effective Date	Policy Conditions							Policy Type ID			Deduct. Type	Deduct. Percent	Deductible Amount Per Claim/Accident	Deductible Amount Aggregate	Reserved	For Carrier Use	For Bureau Use
		3 Yr. F/R Policy	Multistate Policy	Interstate Rating	Estimated Exposures	Retro Policy	Canceled Mid-Term	MCO Indicator	Type Cov.	Plan Ind.	Non-Std.							

EXPOSURE INFORMATION

	Upd Type	Exp. Cov.	Class Code	Exposure Amount	Manual Rate	Premium Amount
CODES SUBJECT						
		A. Total Subject Premium				
		B. Experience Mod. (XX.XXX)				
		C. Total Modified Premium				
NOT SUBJ		D.				
		E.				
		F.				
G.			Total Standard Exposure		Total Standard Premium	
AFTER STD		H.	006_	Premium Discount Amount		
		I.	0900	Expense Constant Amount		
		J.				
		K.				
		L.				

LOSS INFORMATION

(The following block is repeated five times.)

Upd Type	Claim Number	Acc. Date/No. Claims	Incurred Indemnity	Incurred Medical	Class Code	Injury	Status	Loss Conditions: Act	Type	Recov.	Cov.	Settl.	Jurisdic. State	Cat. No.	MCO Type
	Social Security Number	Part / Nature / Cause	Occupation Description		Voc.	Lump	Fraud	Deduct.	Paid Indemnity				Paid Medical		
	Claimant's Attorney Fees	Employer's Attorney Fees	Deductible Reimbursement	Reserved for Future Use					ALAE Paid				ALAE Incurred		

LOSS TOTALS

Reserved for Future Use	Total No. Claims	Total Incurred Indemnity	Total Incurred Medical	Reserved for Future Use	Total Paid Indemnity	Total Paid Medical
Tot. Claimant's Attorney Fees	Tot. Employer's Attorney Fees	Reserved for Future Use			Total ALAE Paid	Total ALAE Incurred

NATIONAL COUNCIL ON COMPENSATION INSURANCE
CALL FOR DETAILED CLAIM INFORMATION

ADM. NO.

COMMON INFORMATION

INSURER NAME | 1. CARRIER CODE | 2. POLICY NUMBER

3. POLICY EFFECTIVE DATE | 4. CLAIM NUMBER | 5. REPORT TYPE | 6. TRANSACTION CODE
1 - Original Report
2 - Revised Report

7. STATE OF JURSIDICTION | 8. STATE OF ACCIDENT | 9. DATE REPORTED TO INSURER | 10. EMPLOYEE SOCIAL SECURITY NUMBER

CLAIMANT AND EMPLOYER INFORMATION

11. EMPLOYER FEDERAL TAX NUMBER | 12. EMPLOYER SIC CODE | 13. EMPLOYER PAYROLL
1 - $0
2 - $1 – $100,000
3 - $100,001 – $1,000,000
4 - $1,000,001 – $10,000,000
5 - OVER $10,000,000

14. ZIP CODE OF INJURY SITE | 15. EMPLOYEE NAME — LAST, FIRST

16. SEX: 1 - Male, 2 - Female, 3 - Unknown
17. MARITAL STATUS: 1 - Single, 2 - Married, 3 - Separated, 4 - Unknown
18. DATE OF BIRTH
19. DATE OF HIRE
20. OCC. CODE
21. EMPLOYMENT STATUS: 1 - Regular Employee, 2 - Part Time Employee, 3 - Unemployed, 4 - On Strike, 5 - Disabled, 6 - Retired, 7 - Other

22. DATE OF INJURY | 23. CLASS CODE | 24. PART OF BODY | 25. NATURE OF INJURY | 26. CAUSE OF INJURY | 27. LOSS COVERAGE CODE | 28. NO. OF DEPENDENTS

29. PRE-INJURY WEEKLY WAGE
30. METHOD OF DETERMINING PRE-INJURY WAGE: 1 - Actual, 2 - Estimated, 3 - Min Wkly Ben, 4 - Max Wkly Ben.
31. OTHER WEEKLY PAYMENTS
32. DATE REPORTED TO EMPLOYER
33. SURGERY: 1 - YES, 2 - NO
34. CLAIM STATUS: 1 - Open, 2 - Open (Med. Only), 3 - Reopened, 4 - Closed, 5 - Became Med. Only, 6 - Reopened, Closed

35. DATE OF CLOSING | 36. DATE OF FIRST PAYMENT | 37. DATE DISABILITY BEGAN | 38. DATE OF RETURN TO WORK

BENEFITS AND PAYMENTS

INDEMNITY BENEFITS

39. TOTAL INCURRED (INCL. VOC. REH.)

BENEFIT TYPE	BENEFITS PAID TO DATE	WEEKLY BENEFIT
40. BENEFIT TYPE	41. BENEFITS PAID TO DATE	42. WEEKLY BENEFIT
43. BENEFIT TYPE	44. BENEFITS PAID TO DATE	45. WEEKLY BENEFIT
46. BENEFIT TYPE	47. BENEFITS PAID TO DATE	48. WEEKLY BENEFIT
49. BENEFIT TYPE	50. BENEFITS PAID TO DATE	51. WEEKLY BENEFIT
52. BENEFIT TYPE	53. BENEFITS PAID TO DATE	54. WEEKLY BENEFIT

VOCATIONAL REHABILITATION

55. TOTAL INCURRED VOC. REH.
56. VOC. REH. EVALUATION EXPENSE PAID TO DATE
57. VOC. REH. MAINTENANCE BENEFIT PAID TO DATE
58. VOC. REH. EDUCATION EXPENSE PAID TO DATE
59. OTHER VOC. REH. EXPENSES PAID TO DATE

MEDICAL BENEFITS

60. TOTAL INCURRED MEDICAL
61. HOSPITAL COSTS PAID TO DATE
62. TOTAL PAYMENTS TO PHYSICIANS
63. OTHER MEDICAL PAID TO DATE

MISCELLANEOUS INFORMATION

64. POST INJURY WEEKLY WAGE | 65. PERCENTAGE IMPAIRMENT | 66. DATE OF MAXIMUM MEDICAL IMPROVEMENT

OTHER BENEFITS AND PAYMENTS

67. FUNERAL EXPENSES PAID TO DATE | 68. LUMP SUM SETTLEMENT AMOUNT | 69. EMPLOYERS LIABILITY PAID TO DATE

CLAIM ADMINISTRATION DETAILS

70. ATTORNEY OR AUTHOR. REP.: 1 - YES, 2 - NO
71. CONTROVERTED CASE: 1 - YES, 2 - NO
72. DEDUCTIBLE: 1 - YES, 2 - NO

SUBROGATION

73. PRODUCT LIABILITY | 74. AUTO LIABILITY | 75. OTHER

OTHER AMOUNTS PAID TO DATE

76. EMPLOYER LEGAL EXPENSE PAID TO DATE | 77. CLAIMANT LEGAL EXPENSE PAID TO DATE | 78. EXPERT WITNESS FEES PAID TO DATE | 79. PENALTIES PAID TO DATE | 80. ALLOCATED LOSS ADJUST. EXPENSE PAID TO DATE

BENEFIT OFFSETS

81. SOCIAL SECURITY: 1 - YES 2 - NO
82. UNEMPLOYMENT: 1 - YES 2 - NO
83. PENSION PLAN: 1 - YES 2 - NO
84. SPECIAL FUND: 1 - YES 2 - NO
85. OTHER: 1 - YES 2 - NO