WCIO WORKERS COMPENSATION

DATA REPORTING HANDBOOK

TABLE OF CONTENTS

Change Tracking Guide ***CHGTRK-1***

Introduction ***INTRO-1***

Introduction to the WCIO Data Reporting Handbook

Workers Compensation Insurance Organizations (WCIO)

Overview of Workers Compensation

Stakeholders ***STKHOL-1***

Information Common to Multiple Data Types ***COMM-1***

Naming and Coding Conventions Criteria

Specifications Manual Definitions

Link and Key Field Data Elements

Policy Data Reporting ***POL-1***

Policy Data Reporting Overview

Policy Data Reporting Stakeholders

Use of Policy Data

Electronic Policy Data Reporting

Policy State and Reporting DCO

Policy Forms

Policy Transaction Code Notes/Instructions

Policy Name Coding Examples

Policy Name/Address/Exposure/Link Coding Examples

Policy Independent DCO Risk ID Number/File Number/Account Number Reporting

Example of Experience Modification/Anniversary Rating Date Application

Policy Change Effective/Expiration Dates

Proof of Coverage (POC)

Policy Reports

Unit Statistical Data Reporting ***UNIT-1***

Unit Statistical Data Reporting Overview

Unit Statistical Reporting Stakeholders

Use of Unit Statistical Data

Electronic Unit Statistical Data Reporting

Electronic Submission Unit Report Record Set Matrix

Unit Statistical State and Reporting DCO

Statistical Plans - Overview

Unit Statistical Loss Valuation and Reporting Dates

Unit Statistical Listings/Reports

Detailed Claim Information Data Reporting *DCI-1*

Detailed Claim Information Data Reporting Overview

Detailed Claim Information Reporting Stakeholders

Use of Detailed Claim Information Data

Detailed Claim Information Participation Process

Electronic Detailed Claim Information Data Reporting

Detailed Claim Information State and Reporting DCO

Detailed Claim Reports

Aggregate/Financial Data Reporting *FIN-1*

Aggregate/Financial Data Reporting Overview

Aggregate/Financial Data Reporting Stakeholders

Use of Aggregate/Financial Data

Electronic Aggregate/Financial Data Reporting

Aggregate/Financial Data Reports

Medical Data Call Reporting *MED-1*

Medical Data Call Reporting Overview

Medical Data Call Reporting Stakeholders

Use of Medical Call Data

Medical Data Call Participation/Eligibility

Electronic Medical Data Call Reporting

Medical Data Call State and Reporting DCO

Residual Market *RESM-1*

Editing *EDIT-1*

Editing Overview

Types of Edits

Reports

Electronic Reporting Technology *TECH-1*

File Transfer Protocol (FTP)

Edit and Entry Tools

Glossary ***GLOS-1***

Change Tracking Guide Key

- Section column—Lists the part of the Data Reporting Handbook that has changed.
- Item column—Lists the specific item within the section of the Data Reporting Handbook that has changed.
- Change column—Summarizes the specific information that has changed.
- Reason column—Provides the reason for the change.

Change Tracking Guide Updates

This guide provides useful information about each update to the handbook. Additions and changes are indicated in red text and deletions are indicated by ~~strikethrough~~.

Section	Item	Change	Reason
Policy Data Reporting	Policy Transaction Code Notes/Instructions	Added Policy Change Effective/Expiration Dates explanation and examples.	To provide assistance to reporters on how you use the Policy Change Effective Date and Policy Change Expiration Date Fields correctly.
	Policy Name Coding Examples	Removed FEIN column from existing examples. Added an example for reporting a Long Name.	For clarification.
Unit Statistical Data Reporting	Electronic Submission Unit Report Record Set Matrix	Replacement Reports to 1st Reports is now applicable to NJ and NY.	DCO requirement change.
	Statistical Plans - Overview	Removed check mark for NCCI under the Statistical Plan Difference Chart—Incentive (Fine) Program column.	DCO requirement change.
Residual Market	Bullets 3 and 4	Removed Tennessee from bullet 3 and added to bullet 4.	DCO requirement change.

INTRODUCTION TO THE WCIO DATA REPORTING HANDBOOK

One of the more important products of the WCIO is the WCIO *Workers' Compensation Data Specifications Manual*. This manual is the basis for the electronic reporting of workers' compensation data to the Data Collection Organizations (DCO).

The WCIO Data Reporting Handbook has been developed under the direction of the DCOs as a companion guide to the WCIO Data Specification Manuals and includes:

- Data Reporting Overview for each data type
- Electronic Reporting Guidelines
- State and Reporting Data collection Organization (DCO) Guidelines
- Forms
- Transaction Code Notes/Instructions
- Examples
- Reports

This handbook also includes any notes specific to transaction, records, or specifications. These data type specific notes were previously contained in the individual data specification.

The Data Reporting Handbook does not replace, rewrite or change any jurisdictions' or states' statistical plans. WCIO encourages the use of this handbook in conjunction with the appropriate instructional manuals published by the various DCOs.

The WCIO makes no warranties of any kind with regard to the use of the handbook for any purpose. In no event shall the WCIO be liable or responsible for any damages arising out of, or in connection with, the use of the guidelines by any person or organization.

WORKERS COMPENSATION INSURANCE ORGANIZATIONS (WCIO)

The WCIO is a voluntary association of statutorily authorized or licensed rating, advisory, or data service organizations that collect workers' compensation insurance information in one or more states. The WCIO is composed of the managers of the various DCOs. The purpose of the WCIO is to provide a forum for the exchange of information about workers' compensation insurance, to the extent provided by law.

The WCIO has developed standards for the electronic transmission of information between insurers and rating/advisory organizations. These specifications are available for policy information, unit statistical reporting, experience modifications, detailed claim information, individual case reports, and criticisms.

The members of the WCIO are:

- Workers' Compensation Insurance Rating Bureau of California
- Delaware Compensation Rating Bureau, Inc.
- Indiana Compensation Rating Bureau
- Insurance Services Office, Inc.
- Workers' Compensation Rating and Inspection Bureau of Massachusetts
- Compensation Advisory Organization of Michigan
- Minnesota Workers' Compensation Insurers Association, Inc.
- National Council on Compensation Insurance, Inc.
- New Jersey Compensation Rating and Inspection Bureau
- New York Compensation Insurance Rating Board
- North Carolina Rate Bureau
- Pennsylvania Compensation Rating Bureau
- Wisconsin Compensation Rating Bureau

OVERVIEW OF WORKERS COMPENSATION

There are as many definitions of workers' compensation as there are states where workers' compensation is required. Simply stated, workers' compensation is insurance that pays when an employee gets hurt on the job.

In 1911, Wisconsin adopted the first workers' compensation law in the United States. All other states followed shortly thereafter.

Prior to the enactment of these laws, an employee injured on the job could sue his or her employer or the individual liable for the injury. With the introduction of workers' compensation insurance laws, liability for compensation was imposed irrespective of fault, and this was the employee's exclusive remedy against the employer.

Workers' compensation is written by state funds (both exclusive and non-exclusive); insurance companies; self-insured groups, etc.

Workers' compensation is written on both a voluntary and non-voluntary (commonly called assigned risk or residual market) basis.

STAKEHOLDERS

Data Providers: An organization which produces data.

- Carriers: An insurance company (other than State Funds) that issues the policy for the insured.
- State Funds: An insurer that is generally owned or originally funded by state government. In some cases they are considered to be a state entity, others are independent with some state oversight. Some state funds are competitive, meaning that they write insurance in competition with private insurers. Others are monopolistic, meaning that competition by private insurers is prohibited by statute.
- Self-Insurers: A business or other entity that sets aside funds to provide for losses that would ordinarily be covered under an insurance program.
- Third Party Administrators (TPA): A third party administrator reports data on behalf of an insurance carrier (e.g., private carrier, state fund, or self-insurer).
- Vendors: A company which supplies services to another company.

Regulators: Regulatory authorities may be called different things in different states but the following two provide examples of names and responsibilities.

- Departments of Insurance: Have regulatory oversight for rates and compliance.
- Department of Labor: Have regulatory oversight for employee rights and coverage.

Data Collection Organizations (DCO): Are defined as organizations collecting data on behalf of their members. The following are considered DCOs for workers' compensation:

- Workers' Compensation Insurance Rating Bureau of California (WCIRB)
- Delaware Compensation Rating Bureau, Inc. (DCRB)
- Workers' Compensation Rating and Inspection Bureau of Massachusetts (WCRIBMA)
- Compensation Advisory Organization of Michigan (CAOM)
- Minnesota Workers' Compensation Insurers Association, Inc. (MWCIA)
- National Council on Compensation Insurance, Inc. (NCCI)
- New Jersey Compensation Rating and Inspection Bureau (NJCRIB)
- New York Compensation Insurance Rating Board (NYCIRB)
- North Carolina Rate Bureau (NCRB)
- Pennsylvania Compensation Rating Bureau (PCRB)
- Wisconsin Compensation Rating Bureau (WCRB)

Standards Organizations—Standards-setting organizations for the insurance industry:

- International Association of Industrial Accident Boards and Commissions (IAIABC)
- Association for Cooperative Operations Research and Development (ACORD)

NAMING AND CODING CONVENTIONS CRITERIA

The criteria described below were used to identify fields in the WCIO *Workers Compensation Data Specifications Manual* that need to be standardized. Some data fields that are commonly used in forms, manuals and other documents were not changed according to the criteria due to the impact. In addition, the naming conventions for some data elements were modified to appropriately reflect current reporting rather than require a system change to meet the criteria. Examples of these exceptions are noted below. All future data elements will adhere to these naming and coding standards.

Name	Description
Amount	Amounts are always numeric and represent quantities or monetary amounts. Amounts are to be reported in whole dollars unless otherwise noted in the specification. Examples: Seat Surcharge, Per Capita Exposure
Code	Data elements called “codes” are associated with a table or an approved list of value choices. Code lists or tables include descriptions. This applies to alpha and numeric codes. Examples: Name Type Code, Address Type Code NOTE: The WCIO/EDI Committee is aware that some data elements such as “Carrier Group Code” do not meet these criteria. Data elements that have been commonly used throughout a number of forms, manuals, and other documents will not be changed due to the overall impact. However, when creating/adding new data elements, these criteria will be observed.
Date	The calendar year, and/or month, and/or day on which something occurs or is completed. Examples: Effective Date, Expiration Date, Accident Date
Factor	A number expressed as a decimal that is used in a calculation. Examples: Experience Modification Factor, Carrier Premium Deviation Factor
Identifier	A set of letters and/or numbers assigned by the carrier to provide unique distinction of a data element. Examples: Policy Number Identifier, Claim Number Identifier NOTE: The WCIO/EDI Committee is aware that some data elements such as “Bureau Version Identifier” and “Carrier Version Identifier” do not meet these criteria. Data elements that have been commonly used throughout a number of forms, manuals, and other documents will not be changed due to the overall impact. However, when creating/adding new data elements, these criteria will be observed.
Indicator	An indicator identifies the applicability of a specific condition. Valid indicator codes are “Y” (Yes) and “N” (No). Examples: Lump Sum Indicator, Vocational Rehabilitation Indicator NOTE: The WCIO/EDI Committee is aware that some Yes/No values are assigned codes 1 and 2, such as “Deductible” (WCCDCI). Because changing these to meet the “Indicator” criteria with values Y and N would require system/coding changes, the code values 1 and 2 will not be changed. Existing values 1 and 2 will be called codes. However, when creating/adding new data elements these criteria will be observed.

Name	Description
Number	Data elements, which represent information commonly used as or known as a “number” (may include alpha characters representing a numeric value), are named as such. Examples: Report Number, Catastrophe Number
Percentage	Data elements reported as whole numbers, without a decimal, and are not used in a calculation. Example: Deductible Percentage
Rate	The basis for pricing insurance premiums, which is generally the cost per unit of exposure (e.g., payroll, remuneration, per capita, population, etc.). Example: Classification Rate, Manual/Charged Rate
Total	Amounts resulting from the sum or aggregate of items are called “Totals.” Examples: Standard Premium Total, Number of Claims Total

SPECIFICATIONS MANUAL DEFINITIONS

The following are definitions for certain terms used throughout the WCIO *Workers Compensation Data Specifications Manual*.

NOT APPLICABLE (N/A): Wherever a field or record is indicated as "Not Applicable," this means that the field or record is "Not Required" or "Not Allowed" to be reported to the DCO(s). A field or record that is "Not Allowed" will be edited for compliance by some DCOs.

OPTIONAL: Wherever a field or record is indicated as "Optional," the field or record is not required to be reported to the DCO indicated, but **may** be edited, captured or ignored by the DCO(s) if reported.

ALPHA (A): Field contains only alphabetic characters. Data field is to be left justified and right blank-filled.

ALPHANUMERIC (AN): Field contains alphabetic and numeric characters. Data field is to be left justified and right blank-filled.

FORMAT: Provides the computer input format expected.

NUMERIC (N): Field contains only numeric characters. Data field is to be right justified and left zero-filled.

RESERVED FOR FUTURE USE: Wherever a field or record is indicated as "Reserved for Future Use," the field or record is to be left blank. ***In all cases where you have a doubt, contact the DCO to which you are reporting.***

DATA COLLECTION ORGANIZATION (DCO): The organization collecting data, whether a bureau, jurisdiction, statistical agency, etc.

INSURER: The carrier of the workers compensation insurance coverage.

JURISDICTION: Used to refer to a state requirement or applicability. When used, it is not necessarily referring to a DCO.

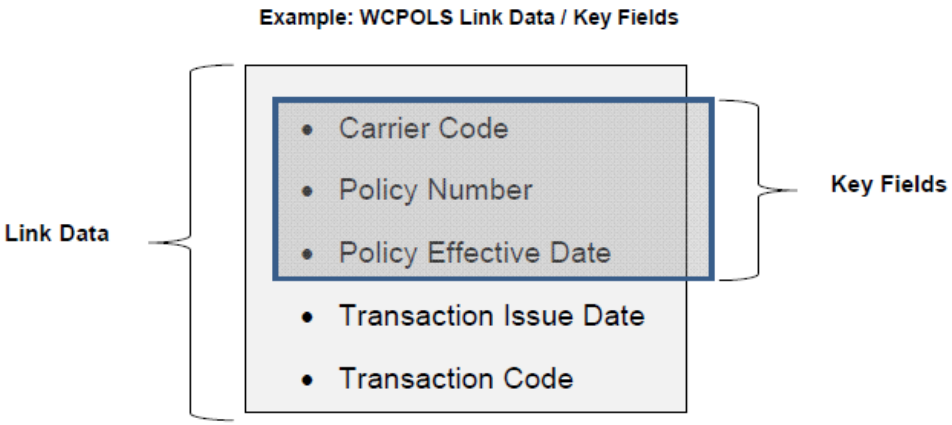
LINK AND KEY FIELD DATA ELEMENTS

OVERVIEW

Link data are data elements which are required to be reported consistently for all records within a transaction. Link data is used to keep these records connected for processing, storage and identifying duplicate data.

Key fields are a subset of link data elements which are required to be reported consistently for all records of related transactions. They are used to keep these transactions connected and identify duplicate data.

This is a representation of WCPOLS showing the Key Field data elements as a subset of Link Data.



LINK AND KEY FIELD DATA ELEMENTS

Data Type	Data Element	Link /Key Fields	Description
WCPOLS	Carrier Code	Both	A 5-digit numeric code that identifies the insurer. It is assigned by NCCI or other jurisdictions. The carrier code is also known as: Data Provider Code Carrier Number Company Code Coverage Provider ID **Note**: NAIC also assigns a 5-digit carrier code which is different than the 5-digit carrier code assigned by NCCI
WCPOLS	Policy Number Identifier	Both	A unique number assigned by the insurance company to a policy.
WCPOLS	Policy Effective Date	Both	The year, month, and day (YYMMDD) upon which the policy becomes operational (effective) and the insured has coverage.
WCPOLS	Transaction Issue Date	Link	Carrier's system processing date, of the transaction being submitted, in Julian date format (YYDDD).
WCPOLS	Transaction Code	Link	A code used to define the type of transaction being submitted.
WCSTAT	Carrier Code	Both	See WCPOLS Carrier Code definition.
WCSTAT	Policy Number Identifier	Both	See WCPOLS Policy Number Identifier definition.
WCSTAT	Exposure State Code	Both	The state in which coverage has been provided for the classifications and corresponding exposures, if any, and to which the payrolls of injured workers have been assigned.
WCSTAT	Policy Effective Date	Both	See WCPOLS Policy Effective Date definition.
WCSTAT	Report Level Code/Report Number	Link	Identifies the report level of the unit report being submitted. Each level corresponds to the time frame for which the losses on the unit are valued.
WCSTAT	Correction Sequence Number	Link	The number of correction reports submitted within a particular report level
WCCDCI	Carrier Code	Key	See WCPOLS Carrier Code definition.
WCCDCI	Policy Number Identifier	Key	See WCPOLS Policy Number Identifier definition.
WCCDCI	Policy Effective Date	Key	The year, month, and day (CCYYMMDD) upon which the policy becomes operational (effective) and the insured has coverage.
WCCDCI	Reported to Insurer Date	Key	The date the claim was originally reported to the insurer. The date used to determine loss valuation.

Data Type	Data Element	Link /Key Fields	Description
WCCDCI	Claim Number Identifier	Key	The unique set of numbers and/or letters that identify the specific claim that the report applies to.
WCMED	Carrier Code	Key	See WCPOLS Carrier Code definition.
WCMED	Policy Number Identifier	Key	See WCPOLS Policy Number Identifier definition.
WCMED	Policy Effective Date	Key	The year, month, and day (CCYYMMDD) upon which the policy becomes operational (effective) and the insured has coverage.
WCMED	Bill Identification Number	Key	A unique number assigned to each bill by the administering entity.
WCMED	Line Identification Number	Key	A unique number that the administering entity assigns to each line associated with the Bill Identification Number.
WCCRIT	Carrier Code	Both	See WCPOLS Carrier Code definition.
WCCRIT	Policy Number Identifier	Both	See WCPOLS Policy Number Identifier definition.
WCCRIT	Exposure State Code	Both	A code used to identify the state in which coverage has been provided for the classifications and corresponding exposures, if any, and to which the payrolls of claimants have been assigned.
WCCRIT	Policy Effective Date	Both	The year, month, and day (CCYYMMDD) upon which the policy becomes operational (effective) and the insured has coverage.
WCCRIT	Product Data Type Code	Link	A code used to identify the type of criticism (WCPOLS or WCSTAT).
WCCRIT	Report Level Code/Report Number	Link	A code used to identify the report level based on the loss valuation date.
WCCRIT	Transaction Code	Link	A code used to define the type of transaction being submitted (WCPOLS Only).
WCCRIT	Correction Sequence Number	Link	The number of correction reports submitted within a particular report level.
WCCRIT	Transaction Issue Date	Link	The accounting date of issuance of the transaction (CCYYMMDD).

POLICY DATA REPORTING OVERVIEW

The policy is another name for the written contract of workers' compensation insurance. Policy data is the coverage information from the documents included and attached to a workers compensation policy. The information contained in this section of the handbook should be used in combination with the **Workers Compensation Policy** (WCPOLS) reporting specifications.

POLICY DATA REPORTING STAKEHOLDERS

Data Providers:

Carriers
State Funds
Self-Insurers
Third Party Administrators (TPAs)

Data Collection Organization:

Workers' Compensation Insurance Rating Bureau of California (WCIRB)
Delaware Compensation Rating Bureau, Inc. (DCRB)
Workers' Comp Rating and Inspection Bureau of Massachusetts (WCRIBMA)
Compensation Advisory Organization of Michigan (CAOM)
Minnesota Workers' Compensation Insurers Association, Inc. (MWCIA)
National Council on Compensation Insurance, Inc. (NCCI)
New Jersey Compensation Rating and Inspection Bureau (NJCRIB)
New York Compensation Insurance Rating Board (NYCIRB)
North Carolina Rate Bureau (NCRB)
Pennsylvania Compensation Rating Bureau (PCRB)
Wisconsin Compensation Rating Bureau (WCRB)

USE OF POLICY DATA

Policy reporting starts the data flow between the data reporting company and the DCO.

The primary uses of policy data are as follows:

- To perform a review for the accuracy of the policy data.
- To allow the DCO to create a diary or reminder when the unit report is due.
- To populate the Proof of Coverage (POC) program.
- To identify accounts for experience rating or other programs.

Policy information (policy, endorsement, cancellation, reinstatement, etc.) is reported to the various DCOs in an electronic format.

ELECTRONIC POLICY DATA REPORTING

The guidelines for reporting policy data electronically are found in the WCPOLS section of the WCIO *Workers' Compensation Data Specifications Manual* located at *www.wcio.org*.

The WCPOLS format is a 300-byte record.

Contact the individual DCOs for their accepted methods of electronic submissions, testing requirements, and to determine which of the Transaction Codes they will accept and the applicability of all notes, instructions, and rules associated with Transactions.

POLICY STATE AND REPORTING DCO

This chart illustrates the state and the DCO to which the policies should be submitted. The exceptions are noted below the chart.

STATE	DCO
Alabama	NCCI
Alaska	NCCI
Arizona	NCCI
Arkansas	NCCI
California	Workers' Compensation Insurance Rating Bureau of California
Colorado	NCCI
Connecticut	NCCI
Delaware	Delaware Compensation Rating Bureau, Inc.
District of Columbia	NCCI
Florida	NCCI
Georgia	NCCI
Hawaii	NCCI
Idaho	NCCI
Illinois	NCCI
Indiana	NCCI
Iowa	NCCI
Kansas	NCCI
Kentucky	NCCI
Louisiana	NCCI
Maine	NCCI
Maryland	NCCI
Massachusetts	Workers' Compensation Rating and Inspection Bureau of Massachusetts
Michigan	Compensation Advisory Organization of Michigan
Minnesota	Minnesota Workers' Compensation Insurers Association, Inc.
Mississippi	NCCI
Missouri	NCCI
Montana	NCCI
Nevada	NCCI
New Hampshire	NCCI
New Jersey	New Jersey Compensation Rating and Inspection Bureau
New Mexico	NCCI
New York	New York Compensation Insurance Rating Board
North Carolina	North Carolina Rate Bureau
North Dakota	Exclusive State Fund
Ohio	Exclusive State Fund
Oregon	NCCI
Pennsylvania	Pennsylvania Compensation Rating Bureau
Puerto Rico	Exclusive State Fund
Rhode Island	NCCI
South Carolina	NCCI
South Dakota	NCCI
Tennessee	NCCI
Texas	NCCI
Utah	NCCI
Vermont	NCCI
Virginia	NCCI
Washington	Exclusive State Fund
West Virginia	NCCI
Wisconsin	Wisconsin Compensation Rating Bureau

STATE	DCO
Wyoming	Exclusive State Fund

Exceptions**:**

Massachusetts, Minnesota, New York, North Carolina, and Wisconsin use NCCI for their interstate rating services. When an account qualifies for interstate rating, a copy of the policy must be sent to both the individual state DCO and to NCCI.

Policies in North Dakota, Ohio, Washington, and Wyoming providing employers' liability, voluntary compensation or U.S. Longshore and Harbor Workers coverage are collected by NCCI.

POLICY FORMS

Forms are used to provide or revise coverage for workers' compensation utilize an identification numbering system.

The two most common policy forms are:

WC 00 00 00	Workers' Compensation and Employers' Liability Policy*
WC 00 00 01	Information Page

*An alpha character following a form number indicates the bureau version, see numbering system below.

Line of Insurance	**General Or State Specific**	**Type of Endorsement**		**Sequence Number**	**Bureau Version Identifier**
	(XX=00-99)	Federal Coverage and Exclusions	= 01	(XX=00-99)	The bureau version identifier is used by DCOs to identify the proper revision level of an endorsement or other forms after the original printing.
		Maritime Coverages and Exclusions	= 02		
		Other Coverages and Exclusions	= 03		
		Premium	= 04		
		Retrospective Premium	= 05		
		Miscellaneous	= 06		

Example 1

WC 00 04 02

The above indicates a workers' compensation (WC) general (00) premium (04) endorsement and second (02) in the sequence.

Example 2

WC 29 01 01 A

The above indicates a workers' compensation (WC) state specific for New Jersey (29) federal (01) endorsement, first in the sequence (01) and the first version (A) after the original printing.

The Endorsement Number and Bureau Version Identifier are required fields on the WCPOLS Endorsement record. Many DCOs edit these fields as part of their policy review.

For electronic reporting the text for forms may be reported using a state specific record. These records are identified by state alpha character, followed by a second record type alpha identifier; i.e., DA = California Longshore and Harbor Workers' Compensation Act Coverage Endorsement, where D = California and A = WC040101A (Longshore and Harbor Workers' Compensation Act Coverage Endorsement).

The state record identifiers are:

Jurisdiction	Code
New Jersey	A
Delaware and Pennsylvania	B
New York	C
California	D
Wisconsin	E
Massachusetts	F
Michigan	G
Minnesota	H

POLICY TRANSACTION CODE NOTES/INSTRUCTIONS

Transaction Codes identify what type of electronic policy transaction is being reported. The following are the notes and/or instructions to provide information about the proper use of Transaction Codes. Read the notes carefully as they may not apply to all Transactions.

Contact each DCO to determine which of the Transaction Codes they will accept and the applicability of all notes, instructions, and rules associated with Transactions.

Rules for Replacement:

- A complete replacement must be submitted when reporting changes to the policy for which there is not a specific endorsement record layout in the Specification Records section of the Data Specification Manual.
- A complete replacement of a policy should include all revised policy (Record Type Codes 01–07) and endorsement (Record Type Codes 09–ZZ) data resulting from the change, as well as all policy and endorsement data previously reported that is not impacted by the change.
- Cancellation and Reinstatement (Record Type Code 08) data are not to be considered a part of the basic policy and should not be included as part of a total replacement for Transaction Codes 06, 08, 10, 14, and 15. Cancellation or reinstatement status is retained when a policy is replaced with Transactions 08, 10, 14 and 15. Cancellation or reinstatement status is not retained when a policy is replaced with Transaction Code 06.
- Changes to the policy for which there is a specific endorsement layout in the Specifications Records section of the Data Specifications Manual must be reported by one of two methods:
    1. As a separate Transaction Code 03 endorsement record or,
    2. As a Transaction Code 06, 08, 10 or 14 complete replacement policy including all the applicable endorsement records.
- If there are multiple transactions corresponding to Transaction Codes 08, 10, 14, and 15 processed on the same transaction issue date, only the latest version of the policy must be reported under the appropriate transaction code.
- If a rating change and non-rating change occur simultaneously (Transaction Codes 08 and 10), use the transaction code corresponding to the rating change (08).
- If the insurer is aware of an experience modification factor, contingent rating factor, policy period, or deductible that is to be effective on a date subsequent to the policy effective date, when preparing a Transaction Code 01, 02, or 04, the endorsement containing this data may be submitted as part of Transaction Code 01, 02, or 04 with the appropriate endorsement effective date. **N/A: CA, DE, MA, MI, MN, NJ, NY, NC, PA, WI**
- As an option, the insurer may submit a complete replacement of the policy using one of the Transaction Codes 08, 10, or 14 on the same issue date as Type 01, 02, 04, or 06.

Rules for Deletion:

- If the insurer's intent is to delete data from the entire policy period, a Transaction Code 08, 10, 14 or 15 should be submitted. The transaction should include all data on the Policy Effective Date, and on subsequent policy change effective dates, but which excludes the data or record(s) to be deleted.

- If the insurer's intent is to delete data for only part of the policy period, a Transaction Code 08, 10, 14, or 15 should be submitted, which includes all data on the policy, as follows:

  Policy Change Effective Date will be reported only on the record(s) being eliminated and will be equal to the policy effective date (or date previously added).

  Policy Change Expiration Date will be reported only on the record(s) being eliminated and will be the "delete" date.

  N/A: NCCI

  NCCI: NCCI only accepts formal deletes of Record Type 02—Name Record and Record Type 03—Address Record. If the insurer's intent is to delete names and/or addresses for only part of the policy period, a Transaction Code 08, 10, 14, or 15 should be submitted, which includes all data on the policy, as follows:

  Policy Change Effective Date will be reported only on the name or address record(s) being eliminated and will be the "delete" date.

  Policy Change Expiration Date will be reported only on the name or address record(s) being eliminated and will be the "delete" date.

The following provides specific notes and instructions by Transaction Code.

CODE	DESCRIPTION	NOTES
01	New Policy	This code is used to report to the jurisdiction that the insured has been issued a policy for the first time.
		It must include, on the Endorsement ID Record (Record Type Code 07), any endorsements that are attached to the policy at issuance. If an endorsement listed on the Endorsement ID Record has a layout in the Specifications Records section of the Data Specifications Manual, then this record must also be submitted on this transaction.
		Transaction Code 01 must always be submitted separately regardless of any additional transactions processed on a given policy on the same transaction issue date.
		Prior Policy Number Identifier (positions 77-94 on the Header Record) is not to be reported when reporting policy data with Transaction Code 01 - New Policy.
02	Renewal Policy	This code is used to report coverage that has been continued for another policy term by the insurer.
		It must include, on the Endorsement ID Record (Record Type Code 07), any endorsements that are attached to the policy at issuance. If an endorsement listed on the Endorsement ID Record has a layout in the Specifications Records section of the Data Specifications Manual, then this record must also be submitted on this transaction.
		Transaction Code 02 must always be submitted separately regardless of any additional transactions processed on a given policy on the same transaction issue date.

CODE	DESCRIPTION	NOTES
03	Endorsement **N/A: MI, MN**	This Transaction Code is used to report endorsements (other than annual rerate) having record layouts in the Specifications Records section of the Data Specifications Manual of these specifications and issued subsequent to the policy.
		Multiple 03 transactions for the same policy, same transaction issue date and for the same record type are not permissible for some endorsement record types. Refer to the individual record descriptions for additional information.
04	Annual Rerate Endorsement	This Transaction Code is used to report two types of coverage: 1—To report the second or third year of a three-year variable rate policy. **N/A: MN** 2—To report the remaining portion of policies with a coverage period greater than annual.
		There are no unique record types for annual rerate endorsements. They are to be reported using all record types applicable to new or renewal business and are identified by Transaction Code 04.
		Transaction Code 04 must always be submitted separately regardless of any additional transactions processed on a given policy on the same transaction issue date.
		Transaction Code 04 cannot be used to add or delete a state.
		State Premium Record 04 and Exposure Record 05 reported on Transaction Code 04 are bound by the period effective and expiration date. All other record types reported are effective from the period effective date through the policy expiration date. Any subsequent change effective and expiration dates will not be applied. Midterm changes must be reported via the appropriate change Transaction Code (08, 10, 14 or 15). **N/A: CA, DE, MI, NCCI, NJ, PA**
05	Cancellation/Reinstatement	This Transaction Code is used to report a cancellation or reinstatement of a policy or Proof of Coverage (POC) Notice/Binder previously reported. Only Record Type Code 08 is valid for this transaction code.
		The cancellation record must include the carrier code, policy number identifier and policy effective date of the policy term being cancelled or reinstated in the appropriate link data fields (Positions 1–43).

CODE	DESCRIPTION	NOTES
06	Policy Replacement Due to Key Field Change	This Transaction Code is used to report a replacement policy for a previously issued policy that has had one or more key data fields (Carrier Code, Policy Number Identifier, Policy Effective Date) changed.
		This transaction must contain the original carrier code, original policy number identifier and original policy effective date of the policy term being replaced in Positions 221–249 of the Header Record.
		Only one Transaction Code 06 may be submitted per policy on the same issue date. **N/A: NCCI**
		NCCI: NCCI can accept multiple Transaction Code 06 per day, but only one Transaction Code 06 per submission.
		Some jurisdictions may require a cancellation record (Record Type Code 08) with a Transaction Code 05 and the values of 9, 0 and 00 in Positions 48–51 for the previously issued policy this transaction replaces. **N/A: NCCI**
		MA: The policy effective date on Transaction Code 06 must be the same date as the effective date of cancellation of the policy that the Transaction Code 06 replaces.
		NCCI: Rating, nonrating, and miscellaneous policy changes (excluding Add/Delete State) will be accepted on a Transaction Code 06 as of the original date the record with the change was reported.
07	Reserved for Future Use	
08	Policy Replacement due to Rating Change	This Transaction Code is used to report a change to the policy that impacts premium amounts and for which an additional premium amount bill or return premium amount is sent to the insured.
		All records that are submitted for Transaction Code 08 must contain the policy number identifier, policy effective date, and carrier code in the link data of the policy term for which the change is applicable. Policy number identifier, policy effective date, and/or carrier code may not be changed under Transaction Code.
		When using Transaction Code 08 to modify data (with the exception of deleting data), the Policy Change Effective Date and Policy Change Expiration Date are required only on the record(s) containing the change. If an entire record is being deleted at inception, the record should be omitted. For records being deleted midterm, the record must be included and the midterm deletion date must be reported in the Policy Change Expiration Date field.
		Only one set of Transaction Code 08 records per Transaction Issue Date per submission. A transaction may have more than one Policy Change Effective Date.

CODE	DESCRIPTION	NOTES
		If there are multiple transactions corresponding to Transaction Code 08 processed on the same transaction issue date, only the latest version of the policy must be reported under the appropriate transaction code.
		When submitting a Transaction Code 08 for a multi-year policy without change effective and expiration dates, the following rules apply: a) If policy effective date is reported in Link Data and policy expiration date is reported in Header Record (01), information in State Premium and Exposure Records (04 and 05) will be applied to the first period only. Information on all other records is assumed to apply to the full policy period. b) If policy effective date reported in Link Data reflects the effective date of a policy period as reported on an Annual Rerate Transaction Code 04 and the expiration date reported in the Header Record is the period expiration date, the premium and exposure information is for the reported period. Information on the Header and all other records is effective as of the period effective date and continues until the policy expiration date. **N/A: CA, DE, MI, NCCI, NJ, PA**
		CA, NCCI: Rating, non-rating, and miscellaneous policy changes (excluding Key Field changes and Add/Delete State) will be accepted when submitted as Transaction Codes 08, 10 or 14. For processing purposes, these DCOs do not distinguish between Transaction Codes 08, 10 and 14.
		If an insurer submitting Transaction Code 08 is not able to supply previously submitted records, printed endorsements may be required. Insurers should discuss this with each DCO.
09	Reserved for Future Use	
10	Policy Replacement due to Non-Rating Change	This Transaction Code is used to report a change to the policy that does not impact premium amounts.
		All records that are submitted for Transaction Code 10 **must** contain the policy number identifier, policy effective date, and carrier code in the link data of the policy term for which the change is applicable. Policy number identifier, policy effective date, and/or carrier code may not be changed under Transaction Code 10.
		When using Transaction Code 10 to modify data (with the exception of deleting data), the Policy Change Effective Date and Policy Change Expiration Date are required only on the record(s) containing the change. If an entire record is being deleted at inception, the record should be omitted. For records being deleted midterm, the record must be included and the midterm deletion date must be reported in the Policy Change Expiration Date field.
		Only one set of Transaction Code 10 records per Transaction Issue Date per submission. A transaction may have more than one Policy Change Effective Date.

CODE	DESCRIPTION	NOTES
		If there are multiple transactions corresponding to Transaction Code 10 processed on the same transaction issue date, only the latest version of the policy must be reported under the appropriate transaction code.
		When submitting a Transaction Code 10 for a multi-year policy without change effective and expiration dates, the following rules apply: a) If policy effective date is reported in Link Data and policy expiration date is reported in Header Record (01), information in State Premium and Exposure Records (04 and 05) will be applied to the first period only. Information on all other records is assumed to apply to the full policy period. b) If policy effective date reported in Link Data reflects the effective date of a policy period as reported on an Annual Rerate Transaction Code 04 and the expiration date reported in the Header Record is the period expiration date, the premium and exposure information is for the reported period. Information on the Header and all other records is effective as of the period effective date and continues until the policy expiration date. **N/A: CA, DE, MI, NCCI, NJ, PA**
		Rating, nonrating, and miscellaneous policy changes (excluding Key Field changes and Add/Delete State) will be accepted when submitted as Transaction Codes 08, 10 or 14. For processing purposes, these DCOs do not distinguish between Transaction Codes 08, 10, and 14.
		If an insurer submitting Transaction Code 10 is not able to supply previously submitted records, printed endorsements may be required. Insurers should discuss this with each DCO.
11	Reserved for Future Use	
12	Reserved for Future Use	
13	Reserved for Future Use	
14	Policy Replacement due to Miscellaneous Change/Non-Key Field Change	This Transaction Code is used at the insurer's option for policy changes (excluding key data field changes and adding/deleting states) in place of Transaction Codes 08 and 10.
		All records that are submitted for Transaction Code 14 **must** contain the policy number identifier, policy effective date, and carrier code in the link data of the policy term for which the change is applicable. Policy number identifier, policy effective date, and/or carrier code may not be changed under Transaction Code 14.

CODE	DESCRIPTION	NOTES
		When using Transaction Code 14 to modify data (with the exception of deleting data), the Policy Change Effective Date and Policy Change Expiration Date are required only on the record(s) containing the change. If an entire record is being deleted at inception, the record should be omitted. For records being deleted midterm, the record must be included and the midterm deletion date must be reported in the Policy Change Expiration Date field.
		Only one set of Transaction Code 14 records per Transaction Issue Date per submission. A transaction may have more than one Policy Change Effective Date.
		If there are multiple transactions corresponding to Transaction Code 14 processed on the same transaction issue date, only the latest version of the policy must be reported under the appropriate transaction code.
		When submitting a Transaction Code 14 for a multi-year policy without change effective and expiration dates, the following rules apply: a) If policy effective date is reported in Link Data and policy expiration date is reported in Header Record (01), information in State Premium and Exposure Records (04 and 05) will be applied to the first period only. Information on all other records is assumed to apply to the full policy period. b) If policy effective date reported in Link Data reflects the effective date of a policy period as reported on an Annual Rerate Transaction Code 04 and the expiration date reported in the Header Record is the period expiration date, the premium and exposure information is for the reported period. Information on the Header and all other records is effective as of the period effective date and continues until the policy expiration date. **N/A: CA, MI, NCCI, NJ**
		Rating, nonrating, and miscellaneous policy changes (excluding Key Field changes and Add/Delete State) will be accepted when submitted as Transaction Codes 08, 10 or 14. For processing purposes, these DCOs do not distinguish between Transaction Codes 08, 10, and 14.
		If an insurer submitting Transaction Code 14 is not able to supply previously submitted records, printed endorsements may be required. Insurers should discuss this with each DCO.

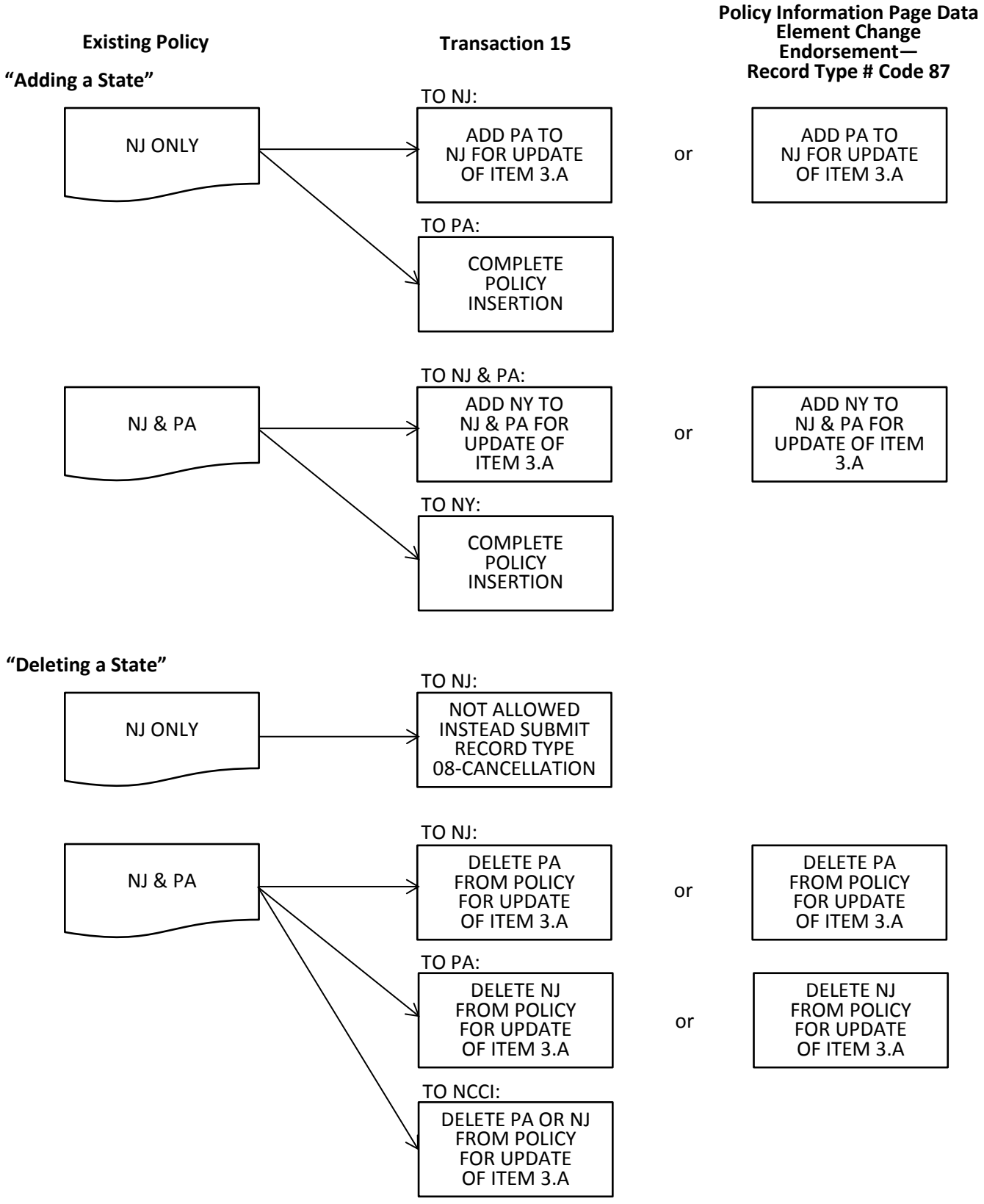
15	Policy Replacement due to Add/Delete State Change	This Transaction Code is used to add or delete a state.
		1) Reporting to DCOs (other than NCCI): Reporting to the DCO of the state being added with this transaction: Notifies the DCO that the state is being added to the policy and therefore this is the first submission of this policy to the state. Reporting to the DCO of the state being deleted with this transaction: Cannot be reported using this transaction. Submit a cancellation using Transaction Code 05 with Record Type Code 08 (only). Reporting to a DCO other than that of the state being added or deleted with this transaction: Notifies the DCO that another state is being added to or deleted from the policy. No other changes, other than those directly associated with adding or deleting the state (i.e., premium) are to be made with this transaction. If unable to exclude other changes from this transaction, then the transaction must be reported using one of Transaction Codes 08, 10 or 14 where applicable.
		When submitting a Transaction Code 15 for a multi-year policy without change effective and expiration dates, the following rules apply: a) If policy effective date is reported in Link Data and policy expiration date is reported in Header Record (01), information in State Premium and Exposure Records (04 and 05) will be applied to the first period only. Information on all other records is assumed to apply to the full policy period. b) If policy effective date reported in Link Data reflects the effective date of a policy period as reported on an Annual Rerate Transaction Code 04 and the expiration date reported in the Header Record is the period expiration date, the premium and exposure information is for the reported period. Information on the Header and all other records is effective as of the period effective date and continues until the policy expiration date. **N/A: CA, DE, MI, NCCI, NJ, PA**
		2) Reporting to NCCI: Notifies NCCI of the state(s) being added and/or deleted to/from Item 3.A.
		The Policy Change Effective Date field on the State Premium Record (Record Type Code 04) and on the Exposure Record(s) (Record Type Code 05) will indicate the date the state is to be added or deleted.
		If the state is to be deleted on the inception date of the policy, the deleted state will have only one accompanying Exposure Record (Record Type Code 05). The Exposure Record must contain zeros in the following fields: Classification Codes, Exposure Act/Exposure Coverage Code, Manual/Charged Rate, Exposure Period Effective Date, Estimated Exposure Amount, Estimated Premium Amount, Exposure Period Code, Amount of Pieces of Apparatus, Amount of Volunteers, and Policy Surcharge Factor.

		When using Transaction Code 15 to modify data (with the exception of deleting data), the Policy Change Effective Date and Policy Change Expiration Date are required only on the record(s) containing the change. If an entire record is being deleted at inception, the record should be omitted. For records being deleted midterm, the record must be included and the midterm deletion date must be reported in the Policy Change Expiration Date field.
		The Policy Changes Expiration Date field on the State Premium Record (Record Type Code 04) and on the Exposure Record(s) (Record Type Code 05) of the state in question will be reported as follows: a) State Added—Report the Policy Expiration Date or zero-fill. b) State Deleted—Report the Policy Changes Effective Date.
		For single state policies, transaction code 15 is not applicable to delete the state. Submit a cancellation using Transaction Code 05 with Record Type Code 08 (only). Rating, nonrating, and miscellaneous policy changes (excluding Key Field changes) will be accepted on a Transaction Code 15 as of the Policy Change Effective Date, if provided.
		Only one set of Transaction Code 15 records per Transaction Issue Date per submission. A transaction may have more than one Policy Change Effective Date.
		If there are multiple transactions corresponding to Transaction Code 15 processed on the same transaction issue date, only the latest version of the policy must be reported under the appropriate transaction code.
16	Proof of Coverage (POC) Notice/Binder **N/A: MI, NC, NJ, NY**	This Transaction Code is used to report coverage when the insurer does not have all the information available that is required for a complete establishing document. The policy itself must be submitted to the DCO on a subsequent submission, unless the Proof of Coverage (POC) Notice/Binder has been cancelled as of the POC Notice effective Date.
		Transaction Code 16 requires all data elements necessary to establish Proof of Coverage when reporting to DCOs.
		Minimum requirements for filing include: a) All Link Data b) Record Type Code 01—Header Record: At a minimum it must contain Field #1, link data information. c) Record Type Code 02—Name Record: Submit at least one Name of Insured or as many Name Records as required by the DCO. d) Record Type Code 03—Address Record: Submit the Mailing Address (Address Type 1) corresponding to the required Name Record. Also report as many Address of Location of Operations (Address Type 2 and/or 6) records as known. **NCCI**: On Transaction Code 16, Proof of Coverage (POC) Notice/Binder, the minimum requirements can be found in NCCI's Policy and Proof of Coverage Reporting Guidebook.
		Submit the Address of Carrier Issuing/Servicing Office (Address Type 3) record.

		Additional data elements may be required when reporting to various DCOs, e.g., Federal Employer Identification Number, State Unemployment Number, Type of Plan ID Code, etc. Please contact the DCO to which you would submit this Proof of Coverage.
		CA, WI: On Transaction Code 16, Proof of Coverage (POC) Notice/Binder, the minimum requirements will also include, Header Record (Record Type Code 01) position 108, Type of Plan ID Code and either a State Premium Record (Record Type Code 04) with 04/48 in position 44-45, or an Other States Coverage Record (Record Type Code 06) with 04/48 as an included state.
		MA: On Transaction Code 16, Massachusetts Issue notice, the minimum requirements also include Header Record (record 01) position 108 Type of Plan ID Code, positions 58-63 Policy Expiration Date, position 75 Employee Leasing Policy Type Code, and a State Premium Record (Record Type Code 04) with 20 in positions 44-45. If issue notice is for a PEO client then the Transaction Code 16 must contain the Employee Leasing Endorsement Record FA and may contain the name of the client on the appropriately identified Name Record.
		Report as many elements that are known at the time of the issuance of this transaction.
17	Noncompliance/Compliance of Policy Terms and Conditions **N/A: CA, MI, NJ, NY, PA, WI**	This Transaction Code is used to report noncompliance issues as a result of undisputed premium due, and/or noncompliance with the policy terms and conditions on a policy or Proof of Coverage (POC) Notice/Binder previously reported.
		This Transaction Code is also used to report compliance on a previously reported noncompliance transaction.
		Only Record Type Z1 is valid for this transaction code. The Noncompliance/Compliance record must include the carrier code, policy number identifier, and effective date of the policy for which it applies in the appropriate link data fields (Positions 1-43).
		All carriers must notify the Plan Administrator of any undisputed premium obligation and or any noncompliance issues on prior or current assigned risk workers compensation insurance policies.
		This transaction is optional for voluntary market policies.
18	Renewal Certificate/Renewal Agreement **N/A: DE, MA, MI, MN, NC, NCCI, NJ, NY, PA, WI**	**CA:** This Transaction Code is used to report coverage that has been continued for another policy term by the insurer.
		CA: Renewal Certificates and Renewal Agreements shall be used only for the purpose of renewing the policy and showing the proper experience modification for the renewal period. Renewal Certificates and Renewal Agreements cannot be used to make any other changes to the policy.

Policy Transaction 15 Example

The following is an example of how to use Transaction Code 15 to add or delete a state:



POLICY NAME CODING EXAMPLES

The following are examples of how different insured names may be submitted when following the data specifications:

Applicability is subject to the individual DCO, IAIABC POC state rules, and/or to states with independent DCOs where policy data is required for interstate experience ratings. Contact your DCO or IAIABC POC vendor if further clarification is needed.

Policy Example	Name of Insured:	ABC Corporation dba ABC Industries Kyle Smythe and Sara Brown dba Smythe and Brown Industrial Co.
	Address:	123 Main Street (Mailing Address)
	Additional Locations:	456 South Street 789 North Avenue

If able to define each name or group of names with a separate Name Link Identifier, the records should appear as follows:

Example 1—Reporting by Personal/Commercial Format

Name Record

Name Type Code	Name Link Identifier	Name of Insured	Continuation Sequence Number	~~FEIN~~
2	001	ABC Corporation	001	~~39-1234567~~
2	001	dba ABC Industries	002	~~39-1234567~~
1	002	Smythe, Kyle	001	~~39-3456789~~
1	002	Brown, Sara	002	~~39-3456789~~
2	002	Smythe and Brown Industrial Co	003	~~39-3456789~~

Example 2—Reporting by String Format

Name Record

Name Type Code	Name Link Identifier	Name of Insured	Continuation Sequence Number	~~FEIN~~
3	001	ABC Corporation dba ABC Industries	001	~~39-1234567~~
3	002	Smythe, Kyle and Brown, Sara dba Smythe and Brown Industrial Co	001	~~39-3456789~~

Example 2~~3~~—Reporting by String Format

Name Record

Name Type Code	Name Link Identifier	Name of Insured	Continuation Sequence Number	~~FEIN~~
3	001	ABC Corporation	001	~~39-1234567~~
3	001	dba ABC Industries	002	~~39-1234567~~
3	002	Smythe, Kyle and Brown, Sara	001	~~39-3456789~~
3	002	dba Smythe and Brown Industrial Co	002	~~39-3456789~~

Example 3—Reporting a Long Name

Name Record

Name Type Code	Name Link Identifier	Name of Insured	Continuation Sequence Number
3	001	The Amalgamated Association of Agricultural Farmers and Dairymen of America Trust Fund Dated Sept	001
3	001	ember 22, 2013	002

POLICY NAME/ADDRESS/EXPOSURE/LINK CODING EXAMPLES

The following are examples of how different insured names with address and exposure links may be submitted when following the data specifications:

Name Link Identifier	Name Records	Address	Legal Nature Of Insured	~~FEIN~~
001	ABC Corporation dba ABC Industries	123 Main Street, Brookfield WI 53086	Corp	~~39-1234567~~
002	Smythe, Kyle and Brown, Sara dba Smythe & Brown Industrial Co	123 Main Street, Brookfield WI 53086	Partnership	~~39-3456789~~

POLICY NAME/ADDRESS/EXPOSURE LINK

Name Link Identifier	State Code Link	Exposure Record Link	Mailing Address Record
001	48		123 Main Street

POLICY OTHER LOCATIONS RECORDS

(Listing for addresses is for example clarity only)

001*	48	00001	123 Main Street
002	48	00001	123 Main Street
002	22	00001	No Specific Location (Optional Address Type Code 6)

POLICY EXPOSURE RECORDS

Name Link Identifier	State Code Link	Exposure Record Link	Classification Code	Exposure	Manual/ Charged Rate	Premium Amount
001	48	00001	8810	100,000	1.00	1,000
001	48	00002	9082	100,000	1.00	1,000
002	48	00001	8810	100,000	1.00	1,000
002	22	00001	8742	100,000	1.00	1,000

*Whenever an insurer is supplying an address record/exposure record link, it may do so via either the Mailing Address record or Other Location record.

POLICY INDEPENDENT DCO RISK ID NUMBER / FILE NUMBER / ACCOUNT NUMBER REPORTING

The following provides specific information and examples for reporting these numbers.

Examples by jurisdiction:

CA, MA, MN, NY, NJ, WI

Bytes: 7
Class: Numeric
Leading Zeros: Must be expressed

Example	Reported As	Data Positions	Blank Positions
1234567	1234567	58-64	65-72
123	0000123	58-64	65-72

DE, PA

Bytes: 7
Class: Numeric
Leading Zeros: Are optional

Example	Reported As	Data Positions	Blank Positions
1234567	1234567	58-64	65-72
1234	0001234	58-64	65-72

Or if zeros are not expressed:

1234	1234	58-61	62-72

MI

Bytes: 9
Class: Alphanumeric
Leading Zeros: Must be expressed

Example	Reported As	Data Positions	Blank Positions
1234567AB	1234567AB	58-66	67-72
123A	0000123A	58-65	66-72

NC

Bytes: 8
Class: Numeric
Leading Zeros: Must be expressed

Example	Reported As	Data Positions	Blank Positions
12345678	12345678	58-65	66-72
123	00000123	58-65	66-72

Note: NC Coverage ID Number must be reported.

EXAMPLE OF EXPERIENCE MODIFICATION / ANNIVERSARY RATING DATE APPLICATION

This example explains how to report the Anniversary Rating Date on multiple State Premium Records in conjunction with the Experience Modification Effective Date. If the Experience Modification Effective Date or Anniversary Rating Date fields are zero filled or left blank these dates are equal to the policy effective date. N/A: MA, MN, NJ

Record Type	Policy Effective Date	Policy Expiration Date	Experience Modification	Experience Modification Effective Date	Anniversary Rating Date
04	01-01-12	01-01-13	1.24		
04			.98		05-01-12
04			1.23	09-01-12	

This example explains how the Anniversary Rating Date must be reported on multiple State Premium Records. Multiple State Premium Records cannot have the same Anniversary Rating Date. If the field is left blank or zero filled this equals the policy effective date. N/A: MA, MN

Record Type	Policy Effective Date	Policy Expiration Date	Experience Modification	Experience Modification Effective Date	Anniversary Rating Date
04	01-01-12	01-01-13	1.24		
04			.98		05-01-12
04			1.23		09-01-12

MA Example: This example explains how to report the Anniversary Rating Date on multiple State Premium Records in conjunction with the Experience Modification Effective Date. An Experience Modification Effective Date must be reported on every record. For the Anniversary Rating Date, the initial record must contain the policy effective date or zeros. The second and any additional splits must contain the policy effective date or Anniversary Rating Date, whichever is appropriate to the split.

Record Type	Policy Effective Date	Policy Expiration Date	Experience Modification	Experience Modification Effective Date	Anniversary Rating Date
04	01-01-12	01-01-13	1.24	01-01-12	
04			.98	05-01-12	05-01-12
04			1.23	09-01-12	05-01-12

POLICY CHANGE EFFECTIVE/EXPIRATION DATES

For Transaction Codes 01, 02, 04, 06, 16 and 18

The Policy Change Effective Date (position 289-294 of Records 01-07) and the Policy Change Expiration Date (position 295-300) must be zero-filled for policy reporting.

For Transaction Codes 08, 10, 14 and 15

Records that are being added or changed must show the add/change date in the Policy Change Effective Date (position 289-294) of that record. The Policy Change Expiration Date (position 295-300) may be zero-filled or reported as the Policy Expiration Date.

Records that are being deleted must show the deletion date in the Policy Change Expiration Date of that record or if deleted at inception, the record is simply not reported. The Policy Change Effective Date of that record may be zero-filled or reported as of the Policy Effective Date or the date previously reported as an added record. N/A: NCCI

NCCI: Records that are being deleted must show the deletion date in the Policy Change Effective Date and Policy Change Expiration Date of that record or if deleted as of the inception date, the record is simply not reported.

The Policy Change Effective Date and Policy Change Expiration Date fields must be zero-filled for records that are not being added, changed, or deleted.

Examples – Name Changes

The correct reporting of Policy Change Effective and Policy Change Expiration Dates is most critical on name change endorsements. The examples below are based on name changes. The policy term for these examples are 1/1/2015-1/1/2016 and mid-term changes are effective 7/1/2015.

If the Name Reporting for Transaction Codes 01, 02, 04, 06, 16 and 18 is as follows:

Name Link Identifier	Name	Continuation Seq #	Policy Change Effective Date	Policy Change Expiration Date
001	Acme Company, Inc.	001	000000	000000
001	Good Stuff (dba)	002	000000	000000

Example 1 Changing the Primary Name at Policy Effective Date

Name Link Identifier	Name	Continuation Seq #	Policy Change Effective Date	Policy Change Expiration Date
001	Acme Enterprises, Inc.	001	150101	000000
001	Good Stuff (dba)	002	000000	000000

Example 2A Changing the Primary Name Mid-Term N/A: DE, PA, NCCI

Keep in mind that name changes are really adds and deletes. When you change a name, the old name is deleted and the new name is added. In the case of a mid-term change, you must delete the old name at the mid-term date and add the new name at the mid-term date.

Name Link Identifier	Name	Continuation Seq #	Policy Change Effective Date	Policy Change Expiration Date
001	Acme Company, Inc.	001	000000	150701
001	Acme Enterprises, Inc.	001	150701	000000
001	Good Stuff (dba)	002	000000	000000

Example 2B Changing the Primary Name Mid-Term – NA: CA, MA, MI, MN, NC, NJ, NY& WI

Name Link Identifier	Name	Continuation Seq #	Policy Change Effective Date	Policy Change Expiration Date
001	Acme Enterprises, Inc.	001	150701	000000
001	Good Stuff (dba)	002	000000	000000

Example 3 Adding a Name Effective at Policy Effective Date

Name Link Identifier	Name	Continuation Seq #	Policy Change Effective Date	Policy Change Expiration Date
001	Acme Company, Inc.	001	000000	000000
001	Good Stuff (dba)	002	000000	000000
002	Fun Times, Inc	001	150101	000000

Example 4 Adding a Name Mid-Term

Name Link Identifier	Name	Continuation Seq #	Policy Change Effective Date	Policy Change Expiration Date
001	Acme Company, Inc.	001	000000	000000
001	Good Stuff (dba)	002	000000	000000
002	Fun Times, Inc	001	150701	000000

Example 5A Deleting an Additional Name at Inception Option 1—Reporting Policy Change Expiration Date Only N/A: DE, PA, NCCI

Name Link Identifier	Name	Continuation Seq #	Policy Change Effective Date	Policy Change Expiration Date
001	Acme Company, Inc.	001	000000	000000
001	Good Stuff (dba)	002	000000	150101

Example 5B Deleting an Additional Name at Inception Option 1—Reporting Policy Change Expiration Date Only -NCCI only

Name Link Identifier	Name	Continuation Seq #	Policy Change Effective Date	Policy Change Expiration Date
001	Acme Company, Inc.	001	000000	000000
001	Good Stuff (dba)	002	150101	150101

Example 5C Deleting an Additional Name at Inception-Option 2—Record Not Reported

Name Link Identifier	Name	Continuation Seq #	Policy Change Effective Date	Policy Change Expiration Date
001	Acme Company, Inc.	001	000000	000000

Example 6A Deleting an Additional Name at Mid-Term N/A: DE, PA, NCCI

Name Link Identifier	Name	Continuation Seq #	Policy Change Effective Date	Policy Change Expiration Date
001	Acme Company, Inc.	001	000000	000000
001	Good Stuff (dba)	002	000000	150701

Example 6B Deleting an Additional Name at Inception Date or Mid-Term - NA: CA, MA, MI, MN, NC, NJ, NY& WI

Name Link Identifier	Name	Continuation Seq #	Policy Change Effective Date	Policy Change Expiration Date
001	Acme Company, Inc.	001	000000	000000
001	Good Stuff (dba)	002	150701	150701

If you are adding a record, you may also report the Policy Expiration Date as the Policy Change Expiration Date.

If you are deleting a record, you may also report the Policy Effective Date, if the name was present at inception or the date the name was previously added, as the Policy Change Effective Date. N/A: DE, PA, NCCI

PROOF OF COVERAGE (POC)

Proof of Coverage is a process that is utilized by state industrial accident boards and commissions to verify that an employer is covered by workers' compensation insurance.

In most jurisdictions; where the insurer submits policy data to a DCO, the DCO provides the Proof of Coverage information to the state board. This is accomplished either by sending data to the state board or providing the state board with access to the DCO's database.

States have a variety of requirements to fulfill their POC needs. Applicability is subject to the individual DCO, IAIABC POC state rules, and/or to states with independent DCOs where policy data is required for interstate experience rating. Contact your DCO or IAIABC POC vendor if further clarification is needed.

POLICY REPORTS

DCOs may produce reports to inform data providers about the results of their submission. These reports provide key details about data that may be informational or require action. Reports are distributed through a variety of delivery mechanisms and formats. Refer to the appropriate DCO for additional information.

QUALITY REPORTS

- Edit Reports – Alerts data providers as to the results of edits applied to the data reported. DCOs may send follow-up reports when edit issues remain unresolved. The format, timing, and naming of these reports will vary by DCO.

PERFORMANCE REPORTS

- Report Cards – A performance report produced by some DCOs that grades a data provider's reporting performance.

WCCRIT is a WCIO standard issued by some DCOs when a discrepancy or error is found. Criticisms are used by some DCOs instead of error reports to request a correction to an error or to notify the insurer of a possible problem or request additional information. Refer to the Editing section of this Handbook for details.

UNIT STATISTICAL DATA REPORTING OVERVIEW

Unit Statistical data is the exposure, premium, and loss information that is first valued 18 months after the Policy Effective Date and annually thereafter. It is required for submission for policies based on the Statistical Plan for the jurisdiction. The information contained in this section of the handbook should be used in combination with the **Workers Compensation Statistical** (WCSTAT) reporting specifications.

UNIT STATISTICAL REPORTING STAKEHOLDERS

Data Providers:

Carriers
State Funds
Self-Insurers
Third Party Administrators (TPAs)

Data Collection Organization:

Workers' Compensation Insurance Rating Bureau of California (WCIRB)
Delaware Compensation Rating Bureau, Inc. (DCRB)
Workers' Comp Rating and Inspection Bureau of Massachusetts (WCRIBMA)
Compensation Advisory Organization of Michigan (CAOM)
Minnesota Workers' Compensation Insurers Association, Inc. (MWCIA)
National Council on Compensation Insurance, Inc. (NCCI)
New Jersey Compensation Rating and Inspection Bureau (NJCRIB)
New York Compensation Insurance Rating Board (NYCIRB)
North Carolina Rate Bureau (NCRB)
Pennsylvania Compensation Rating Bureau (PCRB)
Wisconsin Compensation Rating Bureau (WCRB)

USE OF UNIT STATISTICAL DATA

Unit statistical data is payroll, premium and loss information.

The primary uses of unit statistical data are:

- To establish rates and loss costs for each classification within a state.
- To produce experience and merit ratings which establish the experience modification for rated risks.
- To produce summarized data for Schedule Z purposes.
- To provide explanatory information on claim cost trends.

Unit statistical data (commonly known as unit reports) is reported to the various DCOs electronically.

Statistical plans define business rules, instructions, definitions, etc. for required reporting of unit statistical data.

Policy, exposure, premium, and/or loss information is required for unit reports. Data is reported on direct workers' compensation and employers' liability insurance.

ELECTRONIC UNIT STATISTICAL DATA REPORTING

The guidelines for reporting unit statistical data electronically are found in the WCSTAT section of the WCIO *Workers' Compensation Data Specifications Manual* located at *www.wcio.org*.

The WCSTAT format is a 250-byte record.

It is best to check with the DCOs for their accepted methods of electronic submissions.

While the WCSTAT section of the WCIO *Workers' Compensation Data Specifications Manual* is very specific and contains guidelines pertinent to the filing of unit statistical data, some of the more important guidelines are:

- There are four types of unit reports:
    1. 1st Unit Report: Unit report that contains exposure, premium, and loss information (losses are valued 18 months after the policy effective month and year, due by the 20th month).
    2. Replacement Unit Report: Unit report that replaces an original report.
    3. Subsequent Unit Report (2^{nd} –10^{th}): Unit report that updates loss information, which is reported at annual intervals following the 1st unit report.
    4. Correction Unit Report: Unit report that revises data reported in error, or as a result of other changes that require corrections.
- The minimum records required for first reports or exposure corrections are:
    1. Record Type 1 – Header – contains link data (Policy number, Carrier Code, Effective Date, etc.) along with other date fields and information about the risk being reported, e.g., Pol. Type ID, Deductibles, etc.
    2. Record Type 2 – Name – contains link data along with name of the insured.
    3. Record Type 4 – Exposure – contains link data along with classification code, payroll and premium information.
    4. Record Type 5 – Loss – (this record is not required if there are no applicable losses) contains link data along with claim number, accident date, loss amounts, etc.
    5. Record Type 6 – Total – (this record is not required by all DCOs) contains link data along with totals for numeric fields.
- The minimum records required for subsequent reports or loss corrections are:
    1. Record Type 1 – Header
    2. Record Type 2 – Name
    3. Record Type 5 – Loss – (this record is not required if there are no applicable losses)
    4. Record Type 6 – Total (this record is not required by all DCOs.)
- WCSTAT Record Types 7A – 7J are required by some DCOs when the claim meets one of the following conditions:
    1. Death – Injury Type 1
    2. Permanent Total – Injury Type 2

ELECTRONIC SUBMISSION UNIT REPORT RECORD SET MATRIX

The chart below lists the unit report record types (Header Record, Name Record, Address Record, etc.) that are required for each unit report type (e.g., 1st report, subsequent report, correction report, etc.) for reporting unit statistical data.

Unit Report Type	Header Record (Type 1)	Name Record (Type 2)	Address Record (Type 3)	Exposure Record (Type 4)	Loss Record (Type 5)	Total Record (Type 6)	ICR (Type 7)
1st Reports	Must have 1 and only 1	Must have 1 and only 1 See note 2-1: MA	**Optional**: All DCOs*	At least 1 required; no maximum **See note 4-1:** DE, MA, MN, NJ, NY, PA, WI See note 4-2: NCCI See note 4-3: TX	Required only if loss data must be reported in accordance with the jurisdictional Statistical Plan; no maximum	No more than 1 allowed **OPT**: MA, NCCI	Required only if ICR data must be reported in accordance with the Jurisdiction; no maximum **N/A:** CA, MA, MI, MN, NCCI, NJ, NC, WI
Replacement Reports to 1st Reports **N/A:** CA, DE, ~~NJ, NY,~~ PA **NCCI:** Contact NCCI for reporting requirements	Must have 1 and only 1	Must have 1 and only 1 See note 2-1: MA	**Optional**: All DCOs*	At least 1 required; no maximum	Required only if loss data must be reported in accordance with the Jurisdiction; no maximum	No more than 1 allowed **OPT**: MA, NCCI	Required only if ICR data must be reported in accordance with the Jurisdiction; no maximum **N/A:** MA, MI, MN, NCCI, NJ, NC, WI
Subsequent Reports	Must have 1 and only 1	Must have 1 and only 1 See note 2-1: MA	**Optional**: All DCOs*	None allowed	At least 1 required; no maximum	No more than 1 allowed **OPT:** MA, NCCI	Required only if ICR data must be reported in accordance with the Jurisdiction; no maximum **N/A:** CA, MA, MI, MN, NCCI, NJ NC, WI
Replacement Reports to Subsequent Reports **N/A:** CA, DE, NCCI, NY, PA	Must have 1 and only 1	Must have 1 and only 1 See note 2-1: MA	**Optional**: All DCOs*	None allowed	At least 1 required; no maximum	No more than 1 allowed **OPT:** MA	Required only if ICR data must be reported in accordance with the Jurisdiction; no maximum **N/A:** MA, MI, MN, NJ, NC, WI
Correction Reports—Correction Type H (Header)	Must have 1 and only 1	None required* **Must have 1 and only 1:** DE, MI, NJ, NY, PA, WI See note 2-1: MA	**Optional**: All DCOs*	None allowed	None allowed	None allowed	None allowed
Correction Reports—Correction Type E (Exposure)	Must have 1 and only 1	Must have 1 and only 1 See note 2-1: MA	**Optional**: All DCOs*	At least 1 required; no maximum	None allowed	No more than 1 allowed **OPT:** MA, NCCI	None allowed

Unit Report Type	Header Record (Type 1)	Name Record (Type 2)	Address Record (Type 3)	Exposure Record (Type 4)	Loss Record (Type 5)	Total Record (Type 6)	ICR (Type 7)
Correction Reports—Correction Type L (Loss)	Must have 1 and only 1	Must have 1 and only 1 See note 2-1: MA	**Optional**: All DCOs*	None allowed	At least 1 required; no maximum	No more than 1 allowed **OPT:** MA, NCCI	None allowed **Required only if ICR data must be reported in accordance with the Jurisdiction; no maximum:** DE, PA
Correction Reports—Correction Type M (Multiple)	Must have 1 and only 1	Must have 1 and only 1 See note 2-1: MA	**Optional**: All DCOs*	None required; no maximum	None required; no maximum	No more than 1 allowed **OPT:** MA, NCCI	None allowed **Required only if ICR data must be reported in accordance with the Jurisdiction; no maximum:** DE, PA
Correction Reports—Correction Type T (Total)	Must have 1 and only 1	Must have 1 and only 1 See note 2-1: MA	**Optional**: All DCOs*	None required; no maximum None allowed: CA, DE, MI, NJ, PA, WI	None required; no maximum None allowed: CA, DE, MI, NJ, PA, WI	No more than 1 allowed	None allowed
Correction Reports—Correction Type A (Aggravated Inequity) **N/A:** CA, DE, NJ, NY, PA	Must have 1 and only 1	Must have 1 and only 1 See note 2-1: MA	**Optional**: All DCOs*	None allowed	At least 1 required; no maximum See note 5-1: NCCI	No more than 1 allowed **OPT:** MA, NCCI	None allowed
Replacement Reports to Correction Reports **N/A:** CA, DE, NCCI, NY, PA	**All Correction Types:** Must have 1 and only 1	**All Correction Types:** Must have 1 and only 1 See note 2-1: MA	**All Correction Types**: Optional All DCOs*	Correction Type **E:** At least 1 required; no maximum **H, L, A, C:** None allowed **M, T:** None required; no maximum	Correction Type **L, A:** At least 1 required; no maximum **H, E, C:** None allowed **M, T:** None required; no maximum	Correction Type **H:** None allowed **E, L, M, T, A:** No more than one allowed **OPT**: MA (E, L, M, A)	Correction Type None allowed

* If reported, no more than 1 allowed.

2-1: MA – The name record is optional in MA, except for units reported to NCCI for Interstate Experience Rating. The name record is required for all units reported to NCCI for Interstate Experience Rating.

4-1: DE, MA, MN, NJ, NY, PA, WI — There cannot be more than one exposure record per unit for any classification code with the same manual/charged rate, experience modification, rate effective date, exposure coverage code and experience modification effective date.

4-2: NCCI — There cannot be more than one exposure record per unit for any classification code with the same rate effective date, exposure act/exposure coverage code and experience modification effective date.

4-3: Texas — There cannot be more than one exposure record per unit for any classification code with the same manual/charged rate, rate effective date, exposure act/exposure coverage code and experience modification effective date.

5-1: NCCI — If correction is due to Aggravated Inequity, may use Code “L” or “A”

Submission Control Record (Electronic Data Reporting Only)—Record Type Code 9

Provides the total number of records (excluding Record Type Code 9), unit reports, and ICRs contained in an electronic submission. Only one Submission Control Record (Record Type Code 9) is allowed per submission, regardless of the number of electronic files for the submission, and it must be the last record on the last file. This record type is required.

In order to reduce the number of submissions to be handled, a submission may contain all unit report levels for all the insurers within a carrier group. Data for more than one state may be reported within the same submission to NCCI.

UNIT STATISTICAL STATE AND REPORTING DCO

This chart illustrates the state and the DCO to which the unit statistical report should be submitted. The exceptions are noted below the chart.

STATE	DCO
Alabama	NCCI
Alaska	NCCI
Arizona	NCCI
Arkansas	NCCI
California	Workers' Compensation Insurance Rating Bureau of California
Colorado	NCCI
Connecticut	NCCI
Delaware	Delaware Compensation Rating Bureau, Inc.
District of Columbia	NCCI
Florida	NCCI
Georgia	NCCI
Hawaii	NCCI
Idaho	NCCI
Illinois	NCCI
Indiana	NCCI
Iowa	NCCI
Kansas	NCCI
Kentucky	NCCI
Louisiana	NCCI
Maine	NCCI
Maryland	NCCI
Massachusetts	Workers' Compensation Rating and Inspection Bureaus of Massachusetts
Michigan	Compensation Advisory Organization and Inspection of Michigan
Minnesota	Minnesota Workers' Compensation Insurers Association, Inc.
Mississippi	NCCI
Missouri	NCCI
Montana	NCCI
Nevada	NCCI
New Hampshire	NCCI
New Jersey	New Jersey Compensation Rating and Inspection Bureau
New Mexico	NCCI
New York	New York Compensation Insurance Rating Board
North Carolina	North Carolina Rate Bureau or NCCI
North Dakota	Exclusive State Fund
Ohio	Exclusive State Fund

STATE	DCO
Oregon	NCCI
Pennsylvania	Pennsylvania Compensation Rating Bureau
Puerto Rico	Exclusive State Fund
Rhode Island	NCCI
South Carolina	NCCI
South Dakota	NCCI
Tennessee	NCCI
Texas	NCCI
Utah	NCCI
Vermont	NCCI
Virginia	NCCI
Washington	Exclusive State Fund
West Virginia	NCCI
Wisconsin	Wisconsin Compensation Rating Bureau or NCCI
Wyoming	Exclusive State Fund

Exceptions:

Massachusetts, Minnesota and New York use NCCI for their interstate rating services. When the account qualifies for interstate rating, a copy of the unit statistical report must be sent to both the individual state DCO and to NCCI.

North Carolina and Wisconsin unit data can be reported to the respective bureaus, or to NCCI. The independent DCO's Statistical Plan Manuals should be used to identify each DCO's reporting requirements.

Unit statistical reports on policies in North Dakota, Ohio, Washington, and Wyoming providing employer's liability, voluntary compensation or U.S. Longshore and Harbor Workers' coverage are collected by NCCI.

If Interstate Rated, WCRB will file the unit report with NCCI on behalf of the data provider. Although reporting for this state can be through either the Wisconsin Compensation Rating Bureau or NCCI, the Wisconsin Statistical Plan Manual is to be used to identify this state's actual, special, unique and/or exception reporting requirements.

STATISTICAL PLANS – OVERVIEW

Statistical Plans are published by Bureaus, DCOs and state insurance departments. These plans contain rules, guidelines and procedures for the submission of data.

The following is usually found in all statistical plans:

- General Rules – contains the general reporting rules applicable to premiums and losses; e.g., loss valuation rules.
- Data Common To Premiums and Losses – contains the rules/guidelines for reporting data elements that apply to both premiums and losses; e.g., Carrier Code, Policy Number, etc.
- Premium/Exposure Information – contains the rules/guidelines for reporting data elements that apply to the premium/exposure records only; e.g., Exposure Coverage Code, etc.
- Loss Data – contains the rules/guidelines for reporting data elements that apply to the loss records only; e.g., Injury Type, etc.
- Subsequent Reports And Corrections – contains the rules/guidelines that apply to the submission of corrections, including subrogation, and subsequent reports.

- Pension Tables – contains the factors applicable for calculating pension benefits payable to dependents and/or claimants; e.g., surviving spouse.

There are many manuals, circulars, guides, etc., that supplement the various statistical plans. It is important that data providers, who are required to report data, have each DCOs manuals and guidebooks to ensure that they are reporting the data correctly based on each DCO's reporting requirements.

The following chart identifies some of the differences between the various statistical plans:

DCO	Name of State Plan	Policy Filings	Unit Filings	ICR Filings	Agg./ Financial Reports	DCI	Class Codes	Incentive (Fine) Program	Accepts Hard Copy
CA	California Workers' Compensation Uniform Statistical Reporting Plan		✓		✓		✓	✓	
DE	Delaware Statistical Plan Manual		✓	✓				✓	✓
MA	Massachusetts Workers' Compensation Statistical Plan		✓		✓			✓	
MI	Michigan Workers' Compensation Statistical Plan	✓	✓	✓	✓	✓	✓	✓	✓
MN	Minnesota Statistical Plan Manual		✓					✓	✓
NCCI*	Statistical Plan for Workers Compensation and Employers Liability Insurance		✓					✓	
NJ	NJ Workers' Compensation and Employers Liability Manual of Forms, Rules, Classifications, Rates, Rating and Statistical Plans	✓	✓				✓		✓
NY	New York Workers Compensation Statistical Plan		✓	✓					✓
NC	North Carolina Statistical Plan Manual		✓					✓	
PA	Pennsylvania Statistical Plan Manual		✓	✓				✓	✓
WI	Wisconsin Statistical Plan Manual		✓					✓	

* NCCI's Statistical Plan for Workers Compensation and Employers Liability is applicable in Alaska, Alabama, Arizona, Arkansas, Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia and West Virginia.

The Plan is optional for voluntary compensation, employer's liability, and USL&HW coverage in the following monopolistic fund jurisdictions, North Dakota, Ohio, Washington, Wyoming, and Puerto Rico.

UNIT STATISTICAL LOSS VALUATION AND REPORTING DATES

The losses included in the first report of data must be valued during the 18th month after policy effective date and reported by the end of the 20th month after the policy effective date. For example, for a policy that became effective anytime during January 2010, the data is valued during July 2011, and reported to the DCOs not later than September 2011.

The following table outlines the valuation month and report month for each policy effective date.

Policy Effective Date	Valuation Month 18 Months After Policy Effective Month	Report Month 20 Months After Policy Effective Month
January	July	September
February	August	October
March	September	November
April	October	December
May	November	January
June	December	February
July	January	March
August	February	April
September	March	May
October	April	June
November	May	July
December	June	August

Second through tenth loss reports (subsequent reports) are required at successive 12 month valuations after the first report; 30, 42, 54, 66, 78, 90, 102, 114, and 126 months; and are to be reported by the due month.

Subsequent reports must be reported if any of the following criteria applies:

- A claim was reported as open on the prior report; e.g., if the second report had open claims, then a third report must be filed.
- A claim was reported as closed on any prior report that has since reopened; e.g., first report had a closed claim that reopened subsequent to submission of the first report.
- A claim was reported as closed on any prior report that has had additional payments; e.g., third report had a closed claim that had additional payments made subsequent to submission of the third report.
- A previously unreported claim develops.

Three-Year Fixed Rate Policies

Data for a three-year fixed rate policy usually requires one report. The experience should be valued in the 42nd month and include the complete three years of data. Refer to the appropriate DCO statistical plan manual for additional reporting instructions.

Multiple Year Policies

Data on multiple year policies (other than Three-Year Fixed Rate) must be reported as separate annual policies. For example, a policy January 2011 to January 2014 would require separate unit reports for January 2011, January 2012, and January 2013, where each report covers a separate one-year block of experience.

UNIT STATISTICAL LISTINGS/REPORTS

DCOs may produce reports to inform data providers about the results of their submissions, and data expected to be reported. These reports provide key details about data that may be informational or require action. Reports are distributed through a variety of delivery mechanisms and formats. Refer to the appropriate DCO for additional information.

The following are the more common report types:

Timeliness Reports

- Expected – Alerts data providers of the unit reports that are expected to be reported to each DCO. The notification, format, timing, and naming of these reports will vary by DCO.

  Expected first reports are based on policy data, and expected subsequent reports are based on open claims at the prior report level. These timeliness reports contain key information, e.g., state, policy number, etc. Verifying this key information helps data providers manage the reporting process and improve data availability.

- Overdue – Alerts data providers of expected unit reports that have not been received by the DCO. It is usually produced in the 21st month after policy effective date. Failure to respond to this list could result in fines. DCOs may have a different fining value/method for rated vs. non-rated unit reports.

Quality Reports

- Edit Reports – Alerts data providers as to the results of edits applied to the data reported. DCOs may send follow-up reports when edit issues remain unresolved. The format, timing, and naming of these reports will vary by DCO.

Performance Reports

- Report Cards – A performance report produced by some DCOs that grades a data provider's reporting performance.

WCCRIT is a WCIO standard issued by some DCOs when a discrepancy or error is found. Criticisms are used by some DCOs instead of error reports to request a correction to an error or to notify the insurer of a possible problem or request additional information. Refer to the Editing section of this Handbook for details.

DETAILED CLAIM INFORMATION DATA REPORTING OVERVIEW

Detailed Claim Information (DCI) is a data collection program whereby insurance companies furnish specific information on workers compensation indemnity claims. The information contained in this section of the handbook should be used in combination with the **Workers Compensation Call for Detailed Claim Information** (WCCDCI) reporting specifications.

DETAILED CLAIM INFORMATION STAKEHOLDERS

Data Providers:

Carriers
State Funds
Self-Insurers
Third Party Administrators (TPAs)

Data Collection Organization:

National Council on Compensation Insurance, Inc. (NCCI)

USE OF DETAILED CLAIM INFORMATION DATA (INCLUDING TEXAS)

Detailed claim information provides valuable information in the cost evaluation of benefit changes, fees for medical care, and various types of legislation.

The primary uses of detailed claim data are as follows:

- To provide valuable information for law evaluation.
- To provide valuable information for cost containment.
- To provide “drill down” capabilities on major claims.

DETAILED CLAIM INFORMATION PARTICIPATION PROCESS

DCI is not required to be reported by all Data Reporting Companies. Participation in the detailed claim reporting program is determined on a company group basis, using standard earned premium. For NCCI DCI states, participation is required for companies whose total statewide standard earned premium is at least 1% market share over the most recent three years, in at least three DCI (NCCI and Independent Bureau) states or the market share is greater than or equal to 5% in any one DCI state in the latest year. For Massachusetts and Texas, all workers’ compensation writers must participate.

Participation is usually reviewed every two years. When an insurer is required to report data, the insurer will report for all applicable DCI states in which they write, even if an individual state’s market share in a DCI state is below the threshold. The insurer will continue reporting indefinitely, even if they fall below the eligibility threshold.

All Death and Permanent Total claims must be reported. A percentage of all other indemnity claims, both open and closed, are sampled.

For NCCI DCI states, claims selected must be evaluated 18 months and reported within 21 months after the date the claim was first reported to the company. For example if a claim occurred on September 3, 2009 and was reported to the insurer on September 6, 2009, the claim must be evaluated March 2011 and reported by June 2011. For Texas, claims selected must be evaluated six months and reported within nine months after the date the claim was first reported to the company.

Subsequent reports on this claim are due annually, as long as the claim remains open, includes indemnity or has not reached the eleventh valuation level. For Texas, it goes up to the twelfth valuation level.

DCI is to be reported as long as the claim remains open up to the final valuation level. If a claim closes but additional payments are made during this timeframe, then the claim is reported at the next valuation after the claim reopens. For example:

CLAIM STATUS	REPORT
18th valuation open	Report as open
30th valuation closed	Report as closed
42nd valuation closed	No report due
54th valuation reopens	Report as open
66th valuation closed	Report as closed
78th valuation reopens	Report as open
90th valuation closed	Report as closed
102nd valuation closed	No report due
114th valuation closed	No report due
126th valuation closed	No report due
138th valuation closed	No report due

Replacement reports are required when the data was incorrectly reported.

When reporting the replacement of key data fields, the previous key fields must also be reported.

ELECTRONIC DETAILED CLAIM INFORMATION DATA REPORTING

Detailed claim Information data must be reported to NCCI electronically. NCCI does not accept data on hard copy.

The guidelines for reporting detailed claim data electronically are found in the WCCDCI section of the WCIO *Workers' Compensation Data Specifications Manual* located at *www.wcio.org*.

The WCCDCI format is a 600-byte record.

NCCI only accepts the data electronically using Data Transfer via the Internet (via ncci.com) or Secure FTP.

Before reporting electronically to the NCCI, a test submission is required. The test usually requires the following:

1. Data Provider Profile Form
2. 20-50 records

A submission control record must accompany each electronic submission.

For Texas Detailed Claim Data, individual carrier codes are needed. Texas cannot be reported using a group carrier code.

Data from more than one state can be reported in the same submission.

DETAILED CLAIM INFORMATION STATE AND REPORTING DCO

Detailed claim data, including Texas, is reported to the NCCI. Refer to the NCCI's Detailed Claim Information Reporting Guidebook and the Texas Detailed Claim Information Statistical Plan for reporting instructions.

DETAILED CLAIM REPORTS

NCCI produces reports to inform data providers about the results of their submission, and data expected to be reported. These reports provide key details about data that may be informational or require action.

Timeliness Reports

- Alerts Data Providers of expected and overdue claims. Expected 1st reports are estimates based on unit claim reporting. Expected subsequent are based on open claims at prior report levels.

Quality Reports

- Edit Reports – Alerts data providers as to the results of edits applied to of the data reported.

Performance Reports

- Report Cards – A performance report produced that grades a data provider's reporting performance.

AGGREGATE/FINANCIAL DATA REPORTING OVERVIEW

Aggregate/Financial data is aggregated (summarized) based on specification provided, in most part, by a DCO's Statistical Plan. The information contained in this section of the handbook should be used in combination with the jurisdiction reporting requirements.

AGGREGATE/FINANCIAL DATA REPORTING STAKEHOLDERS

Data Providers:

Carriers
State Funds
Self-Insurers
Third Party Administrators (TPAs)

Data Collection Organization:

Workers' Compensation Insurance Rating Bureau of California (WCIRB)
Delaware Compensation Rating Bureau, Inc. (DCRB)
Workers' Comp Rating and Inspection Bureau of Massachusetts (WCRIBMA)
Compensation Advisory Organization of Michigan (CAOM)
Minnesota Workers' Compensation Insurers Association, Inc. (MWCIA)
National Council on Compensation Insurance, Inc. (NCCI)
New Jersey Compensation Rating and Inspection Bureau (NJCRIB)
New York Compensation Insurance Rating Board (NYCIRB)
Pennsylvania Compensation Rating Bureau (PCRB)
Wisconsin Compensation Rating Bureau (WCRB)

USE OF AGGREGATE/FINANCIAL DATA

Aggregate/Financial data is the main component in the workers' compensation rate making process.

The primary uses of Aggregate/Financial data are to:

- Determine member companies' assessments
- Produce overall rate or loss cost change by state
- Perform premium level analysis
- Test rate adequacy
- Analyze reserve level changes
- Analyze loss development
- Review general and loss adjustment expenses
- Provide industry wide cost summaries

Section 23B of the NAIC Statistical Handbook, entitled Workers' Compensation Call for Aggregate Experience, lists the following calls:

- Net Direct Written Premium Calls (Except New York)
- Semiannual Calendar Year Call
- Policy Year Call for Voluntary Business
- Policy Year Call for Assigned Risk Business
- Calendar/Accident Year Call for Voluntary Business
- Calendar/Accident Year Call for Assigned Risk Business
- Premium by Size of Policy Call
- Reconciliation Call
- 'F' Classification Policy Year Call
- Loss Adjustment Expense Call
- Large Deductible Policy Year Call
- Large Deductible Calendar/Accident Year Call
- Call for Quarterly Reporting of Total Market Direct Written Premium
- Supplemental Call for Schedule Rating Premium Adjustments

Refer to the appropriate DCO for required calls, valuation dates, and due dates.

Data providers are required to complete an acknowledgement form indicating the calls they are reporting, and to verify their completeness and accuracy.

The reporting requirements for aggregate/financial data can be found in some DCO's Statistical Plans. Most aggregate/financial instructions are found in circulars or guidebooks, or accompany the forms used for reporting data.

Some states do not allow group reporting of financial data. A separate financial call must be reported for each carrier code within a group. Although financial data is sent to the DCO, some calls are sent directly to the state.

ELECTRONIC AGGREGATE/FINANCIAL DATA REPORTING

Data reporting standards and record formats for Aggregate/Financial data have not been developed by the WCIO. Guidelines, formats, and reporting methods vary by DCO. Refer to the appropriate DCO.

AGGREGATE/FINANCIAL DATA REPORTS

DCOs may produce reports to inform data providers about the results of their submissions, and data expected to be reported. These reports provide key details about data that may be informational or require action. Reports are distributed through a variety of delivery mechanisms and formats. Refer to the appropriate DCO for additional information.

Timeliness Reports

- Financial Call Reporting Schedule – Identifies all of the Financial Calls and their Due Date(s). The format, timing, and naming of these reports will vary by DCO.
- Overdue Financial Calls – Alerts data providers of expected calls that have not been received by the DCO. Failure to report Financial Calls on a timely manner result in fines. DCOs may have a different fining value/method.

Quality Reports

- Edit Reports – Alerts data providers as to the results of edits applied to the data reported. DCOs may send follow-up reports when edit issues remain unresolved. The format, timing, and naming of these reports will vary by DCO.

Performance Reports

- Report Cards – A performance report produced by some DCOs that grades a data provider's reporting performance for accuracy and timeliness. The format, timing, and naming of these reports will vary by DCO.

MEDICAL DATA CALL REPORTING OVERVIEW

Medical data is reported for medical transaction associated with workers compensation indemnity and medical claims. The information contained in this section of the handbook should be used in combination with the **Workers Compensation Medical Data** (WCMED) reporting specifications.

MEDICAL DATA CALL REPORTING STAKEHOLDERS

Data Providers:

Carriers
State Funds
Self-Insurers
Third Party Administrators (TPAs)

Data Collection Organization:

Workers' Compensation Insurance Rating Bureau of California (WCIRB)
Delaware Compensation Rating Bureau, Inc. (DCRB)
National Council on Compensation Insurance, Inc. (NCCI)
Pennsylvania Compensation Rating Bureau (PCRB)

USE OF MEDICAL CALL DATA

Medical data is the main component used for legislative analysis and pricing.

All medical transactions with a Jurisdiction State in any applicable Medical Call Data state are reportable. This includes all workers compensation claims, including medical-only claims. The Jurisdiction State corresponds to the state under whose Workers Compensation Act the claimant's benefits are being paid.

MEDICAL DATA CALL PARTICIPATION/ELIGIBILITY

Participation is determined by each DCO collecting this data. Refer to the appropriate DCO for more information.

1. Affiliate Group Participation

When an affiliate group is included in the Call, all companies that are aligned within that group are required to report under the Call.

2. Reporting Responsibility

Participants in the Call will have the flexibility of meeting their reporting obligation in several ways, including:

- Submitting all of their Call data directly
- Authorizing their vendor business partners (TPAs, medical bill review vendors, etc.) to report the data

Regardless of who submits the Call, the data submitter must report the standard record layout in its entirety with all applicable data elements populated.

Note: Although data may be provided by an authorized vendor on behalf of an affiliate carrier or affiliate carrier group, quality and timeliness of the data is the responsibility of the carrier.

ELECTRONIC MEDICAL DATA CALL REPORTING

Medical Call data must be reported electronically. Hard copy is not accepted.

The guidelines for reporting medical data electronically are found in the WCMED section of the WCIO *Workers' Compensation Data Specifications Manual* located at *www.wcio.org*.

The format for electronic reporting is called the WCMED format and is a 350-byte record.

Before reporting electronically, a test submission is required.

The WCMED Section of the WCIO *Workers' Compensation Data Specifications Manual* is very specific and contains guidelines pertinent to the filing of Medical Call data. Some of the more important guidelines are:

Electronic submissions shall consist of up to three record types:

1. Medical Data Call Record
2. Submission Control Record
3. Electronic Transmittal Record (Not Applicable: NCCI)

A submission control record must accompany each electronic submission.

MEDICAL DATA CALL STATE AND REPORTING DCO

Requirements may differ for each applicable DCO. Refer to the appropriate DCO for information.

RESIDUAL MARKET

Assigned risk plans and reinsurance pools, involuntary market, market-of-last-resort and joint underwriting associations (JUAs) are all varying forms or names of what is known as the 'Residual Market.'

All states and the District of Columbia provide a method to ensure that workers' compensation insurance coverage is available. Entities unable to purchase workers' compensation insurance in the voluntary market will be insured in the residual market (involuntary market), as long as they meet the eligibility requirements for the respective jurisdictional residual market mechanism.

The following is a breakdown, by jurisdiction, of the form of the existing residual market mechanisms:

- North Dakota, Ohio, Washington, and Wyoming are exclusive or non-competitive, state funds. All employers must purchase workers' compensation insurance through these exclusive state funds or self-insure. These state funds accept all applicants and, therefore, there is no formal separate and distinct residual market in those jurisdictions.
- In the following states, residual market coverage is provided by non-exclusive, or competitive, state funds. These states are California, Colorado, Hawaii, Kentucky, Louisiana, Maine, Maryland, Montana, New York, Oklahoma, Pennsylvania, Rhode Island, Texas, and Utah.
- The following states have plans administered by state rating bureaus or an outside agency. These states are Delaware, Florida, Indiana, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, New Jersey, North Carolina, ~~Tennessee~~, and Wisconsin. Most of these assigned risk plans are reinsured by voluntary market carriers, on a quota share basis, through reinsurance pools (several of which are managed by NCCI), but a few have only excess of loss reinsurance or no reinsurance by the voluntary market.
- The following jurisdictions have assigned risk plans and reinsurance pools administered by NCCI. These states are Alabama, Alaska, Arizona, Arkansas, Connecticut, District of Columbia, Georgia, Idaho, Illinois, Iowa, Kansas, Mississippi, Nevada, New Hampshire, New Mexico, Oregon, South Carolina, South Dakota, Tennessee, Vermont, Virginia, and West Virginia. Most, but not all, of these states assigned risk plans also allow carriers to participate on a direct assignment basis, rather than provide quota share reinsurance through the associated assigned risk pool.

EDITING

OVERVIEW

The editing process is a series of quality checks performed by DCOs that verifies the validity, accuracy, and completeness of the data submitted by data providers. Editing is critical to ensuring that the data submitted is consistent with reporting requirements and meets quality standards. Edits identify data that has errors, or may have errors, so that data providers can take any corrective action necessary.

Refer to your specific DCO for information on the errors by data type and available error reports.

TYPES OF EDITS

Edit may be classified as follows:

- Field edits ensure that the value in each data field is acceptable according to submission guidelines, e.g., numeric, alphanumeric, or equal to a particular value. This may involve accessing a look-up table to validate the value reported for the field.

Field Edit example:

FIELD NAME	WCPOLS RECORD LOCATION	EDIT
Carrier Code	Link	Must be numeric and other than 00000; must be valid per DCO Table.

- Range edits ensure that a field value is within a particular numeric range (dollar, percentage, or high and/or low). This may involve accessing a look-up table to validate the value reported for the field.

Range Edit example:

FIELD NAME	WCPOLS RECORD LOCATION	EDIT
Address Type Code	Address Record	Must be numeric; must be “1” – “6”

- Logical edits verify that the data makes sense in relations to one or more

Logical Edit example: (Unit Report)

FIELD NAME	WCPOLS RECORD LOCATION	EDIT
State Add/Delete Code	State Premium Record	If Transaction Code = “15” State Add Delete Indicator must not be blank on all State Premium Records or must be blank on at least one State Premium Record.

- Relational edits compare the data in a specific field on the unit report with another data field contained in the same submission and/or with a corresponding submission that was previously submitted and already stored on a DCOs database.

Relational Edit example: (Unit Report)

FIELD NAME	WCPOLS RECORD LOCATION	EDIT
Class Code	Loss Record	If loss class code present, must have corresponding exposure class code.

REPORTS

DCOs may produce reports to inform data providers about the results of their submission. These reports provide key details about data that may be informational or require action. Reports are distributed through a variety of delivery mechanisms and formats. Refer to the appropriate DCO.

WCCRIT

WCCRIT is a WCIO standard issued by some DCOs when a discrepancy or error is found. Criticisms are used by some DCOs instead of error reports to request a correction to an error or to notify the insurer of a possible problem or request additional information.

The WCCRIT section of the WCIO *Workers' Compensation Data Specifications Manual* contains the record layout for WCPOLS and WCSTAT criticisms.

Within WCCRIT a Multiple Record Identifiers Field is used to provide additional information that identifies the specific record in error when more than one of the same Record Type Code was included in the corresponding WCPOLS or WCSTAT transaction.

Multiple Record Identifiers Field

The Multiple Record Identifiers field (positions 373-398) is reported in the WCSTAT Error Information Record and the WCPOLS Error Information Record of the WCCRIT Reporting Specification. This field provides additional information to help identify the specific record in error when more than one of the same Record Type Code was included in the corresponding WCPOLS or WCSTAT transaction. The individual identifying fields vary depending on the Record Type Code of the record in error.

NOTE: The Record Type Code is reported in the Error Code (positions 58-59) of the WCSTAT Error Information Record and the WCPOLS Error Information Record.

WCSTAT ERROR INFORMATION RECORD

If the error is in the Exposure Record (Record Type Code 04), the following data will be reported in this field.

Field Name	Class	Positions	Bytes
Split Period Code	N	373-373	1
Classification Code	N	374-377	4
Exposure Act/Exposure Coverage Code	N	378-379	2
Experience Modification Effective Date (Format: CCYYMMDD)	N	380-387	8
Rate Effective Date (Format: CCYYMMDD)	N	388-395	8
Reserved for Future Use		396-398	3

If the error is in the Loss Record (Record Type Code 05), the following data will be reported in this field.

Field Name	Class	Positions	Bytes
Claim Number	AN	373-384	12
Reserved for Future Use		385-398	14

If the error is in the ICR Record (Record Type Code 07), the following data will be reported in this field.

Field Name	Class	Positions	Bytes
Claim Number	AN	373-384	12
Reserved for Future Use		385-398	14

WCPOLS ERROR INFORMATION RECORD

If the error is in the Name Record (Record Type Code 02), the following data will be reported in this field.

Field Name	Class	Positions	Bytes
Name Type Code	N	373-373	1
Name Link Identifier	N	374-376	3
First 20 Characters of Name	AN	377-396	20
Reserved for Future Use		397-398	2

If the error is in the Address Record (Record Type Code 03), the following data will be reported in this field.

Field Name	Class	Positions	Bytes
Address Type Code	N	373-373	1
Name Link Identifier	N	374-376	3
State Code Link	N	377-378	2
First 20 Characters of Address Street	AN	379-398	20

If the error is in the State Premium Record (Record Type Code 04), the following data will be reported in this field.

Field Name	Class	Positions	Bytes
State Code	N	373-374	2
Experience Modification Effective Date (Format: CCYYMMDD)	N	375-382	8
Anniversary Rating Date (Format: CCYYMMDD)	N	383-390	8
Reserved for Future Use		391-398	8

If the error is in the Exposure Record (Record Type Code 05), the following data will be reported in this field.

Field Name	Class	Positions	Bytes
State Code	N	373-374	2
Classification Code	N	375-378	4
Exposure Act/Exposure Coverage Code	N	379-380	2
Exposure Period Effective Date (Format: CCYYMMDD)	N	381-388	8
Reserved for Future Use		389-398	10

If the error is in the Endorsement Identification Record (Record Type Code 07), the following data will be reported in this field.

Field Name	Class	Positions	Bytes
State Code	N	373-374	2
First Endorsement Number on the Record	AN	375-382	8
Reserved for Future Use		383-398	16

If the error is in the Endorsement Record (Record Type Code 09 and greater, including state specific endorsements), the following data will be reported in this field.

Field Name	Class	Positions	Bytes
State Code	N	373-374	2
Endorsement Number	AN	375-382	8
Endorsement Sequence Number	N	383-385	2
Endorsement Effective Date (Format: CCYYMMDD)	N	381-388	8
Reserved for Future Use		394-398	5

If the error is in the Cancellation/Reinstatement/Nonrenewal Record (Record Type Code 08), the following data will be reported in this field.

Field Name	Class	Positions	Bytes
State Code	N	373-374	2
Cancellation/Reinstatement Type Code	N	375-375	1
Cancellation/Reinstatement Sequence Number	N	376-377	2
Cancellation/Reinstatement Effective Date (Format: CCYYMMDD)	N	378-385	8
Reserved for Future Use		386-398	13

If the error is in the Noncompliance/Compliance Record (Record Type Code Z1), the following data will be reported in this field.

Field Name	Class	Positions	Bytes
State Code	N	373-374	2
Noncompliance/Compliance Notification Type Code	N	375-375	1
Primary Noncompliance/Compliance Reason Code	N	376-377	2
Noncompliance/Compliance Transaction Sequence Number	N	378-379	2
Noncompliance/Compliance Effective Date (Format: CCYYMMDD)	N	380-387	8
Reserved for Future Use		388-398	11

ELECTRONIC REPORTING TECHNOLOGY

ACCCT is an organization, which operates as a joint venture of independent workers' compensation advisory and rating organizations. Its purpose is to foster software development and technical cooperation on a project basis among its membership. Any number of members may agree to a joint effort for a given project. ACCCT facilitates this cooperation by providing a venue and support for legal services, billing, and bookkeeping.

FILE TRANSFER PROTOCOL (FTP)

Independent DCOs

CDX is a self-administered service offered to carriers who are members of one or more of the ACCCT members. The use of CDX for the submission or retrieval of data and to provide access to other services or products is subject to availability and the terms and conditions of use established by ACCCT, Compensation Data Exchange, LLC., or individual DCOs. These guidelines may be accessed through the ACCCT web site at www.accct.org. ACCCT disclaims all liability, direct or implied, and all damages, whether direct, incidental, or punitive, arising from the use or misuse of the CDX site or services by any person or entity.

CDX is the first step in the electronic file transfer process. CDX will electronically deliver your file to the DCO. CDX acceptance guidelines are very basic. CDX edits will consist of checking for the presence of both an electronic transmittal record and a submission control record which are needed to validate the record count and to grant the authority to send the file via CDX.

NCCI

Data Transfer via the Internet is used for the submission or retrieval of data between NCCI and data providers This Secure Browser Mailbox allows the exchange of data using an internet browser interface. Secure Browser Mailbox is offered at no charge to help reduce costs and streamline data exchange.

Benefits of using this service include quick and secure transmission of data, email confirmation of data transmission and tracking of file transfers.

EDIT AND ENTRY TOOLS

Independent DCOs

Bureau Entry & Edit Package (BEEP) is specifically designed for the effective manual entry or import, and electronic submission of Unit Statistical Reports. This software product is also designed to work with ACCCT's Compensation Data Exchange (CDX) application for the transfer of files.

Policy Entry & Edit Package (PEEP) is specifically designed for the effective manual entry or import, and electronic submission of policy information. This software product is also designed to work with ACCCT's Compensation Data Exchange (CDX) application for the transfer of files.

NCCI (These tools are all designed to work with NCCI's Data Transfer via the Internet.)

DCA Access® Online allows data providers to view, enter, update, and correct policy, unit statistical, unit report control (URC), and Detailed Claim Information (DCI) data. Product highlights include ability to search and instantly access data, and retrieve standard production and custom reports.

Financial Data Collection allows data providers to view, enter, update and correct aggregate financial call data.

Medical Data Collection allows data providers to view medical call data submission information.

GLOSSARY

This glossary defines terms that are not all insurance related, but are commonly used in the business and data reporting environment. The terms have been defined in a simplified and non-technical manner.

The definitions are not intended to and should not be used as the "legal" definitions of the terms. For example: Permanent Partial – this definition may vary by state.

The purpose of the glossary is to acquaint the reader with easy-to-understand definitions of workers' compensation terms.

Acronyms and abbreviations found in the Acronyms and Abbreviations section of this manual are defined in this glossary.

In an effort to keep the definitions simple, many of the terms in this glossary have been defined in greater detail throughout this manual; e.g., unit reports.

A
AAA – see definition for American Academy of Actuaries
AAI – see definition for Alliance of American Insurers
AASCIF – see definition for American Association of State Compensation Insurance Funds
ACAS – see definition for Associate of Casualty Actuarial Society
ACCCT – see definition for American Cooperative Council on Compensation Technology
ACCEDE Online – Automated Carrier Call Edit and Data Entry program (Minnesota)
ACORD™ – see definition for Association for Cooperative Operations Research & Development
Accident Date the month, day and year on which the injury occurred. For cumulative injuries or disease injuries there may not be an actual accident date. In these cases the accident date may be the last date of exposure or last day of policy.
Accident Year – the year in which the injury occurred
Accident State – a state or foreign location that identifies where the accident took place or where a disease was first contracted.
Accredited Standards Committee (ASC) – see definition for National Committee for Information Technology Standards
Actuary – an individual who computes statistics relating to insurance, such as pricing and reserving.
Add (A)/Change (C)/Delete (D) – a correction procedure in which an update type code indicates that the correction is being done to add (A), change (C) or delete (D) exposure or claim information on unit stat data. The use of A, C, or D is not allowed in all jurisdictions.
ADQIP – Aggregate Data Quality Incentive Program (NCCI)
Aggregate Reports – reports that aggregate data for all insurers reporting to a statistical agent in a state. There are three types of statistical data that may be aggregated: 1. Financial Data 2. Unit Report Data 3. Claim Information Data

AIA –
see definition for American Insurance Association

AIDM –
see definition for Associate Insurance Data Manager

ALAE –
see definition for Allocated Loss Adjustment Expense

Alliance of American Insurers (AAI) –
a National Insurance Trade Association of Property and Casualty member companies. Provides input on critical legislative and regulatory issues.

Allocated Loss Adjustment Expense (ALAE) –
an accumulation of expenses incurred in investigating and settling claims that are directly assignable to specific claims. Examples include: legal fees, adjusting fees, court costs, medical costs containment expenses, services required by law or insurance regulation.

Allocated Loss Adjustment Expense – Incurred –
a specific expense in whole dollars incurred, including paid and outstanding by an insurance company, when handling a claim that can be directly allocated to that particular claim.

Allocated Loss Adjustment Expense – Paid –
a specific expense in whole dollars paid by an insurance company when handling a claim that can be directly allocated to that particular claim.

Alpha (A) –
a field that contains only alphabetical characters. Data field is to be left-justified and right blank-filled.

Alphanumeric (AN) –
a field that contains alphabetic and numeric characters. Data field is to be left-justified and right blank-filled.

Alternative Workers' Compensation Coverage –
this is commercial insurance purchased on the voluntary market. The policy may consist of any combination of life, disability, accident, health or other insurance, provided that the coverage insures without limitation or exclusion any of the workers' compensation benefits as defined in the law of the state.

A.M. Best Company –
a company that rates insurance companies based on their financial condition and operating performance

AMCOMP –
see definition for the American Society of Workers' Compensation Professionals, Inc.

American Standard Code for Information Interchange (ASCII) –
a table of values used for data transmission by minicomputers and personal computers.

American Academy of Actuaries (AAA) –
is the organization representing the entire U.S. actuarial profession. It serves the public and the actuarial profession both nationally and internationally through: (1) establishing, maintaining, and enforcing high professional standards of actuarial qualification, practice and conduct; (2) assisting in the formation of public policy by providing independent and objective information, analysis, and education; (3) advancing the actuarial profession with other organizations representing actuaries; and (4) increasing the public's recognition of the actuarial profession's value.

American Association of State Compensation Insurance Funds (AASCIF) –
an organization whose members are the state compensation insurance funds and the Workers' Compensation Boards and Commissions of Canada.

American Cooperative Council on Compensation Technology (ACCCT) –
a workers' compensation joint venture that shares ideas and technology and, jointly develops software programs and systems with the goal of operating more effectively and efficiently.

American Insurance Association (AIA) –
a property and casualty insurance trade organization. Provides constructive solutions to issues facing the insurance industry.

American National Standards Institute (ANSI) –
encourages the use of US standards internationally and the adoption of international standards as national standards.

American Society of Workers' Comp Professionals, Inc. (AMCOMP) –
a not-for-profit corporation dedicated to the improvement of professional excellence in the multi-disciplined field of workers' compensation.

American Standard Code for Information Interchange (ASCII) –
a table of values used for data transmission by minicomputers and personal computers.

Anniversary Rating Date (ARD) –
a term used in the experience rating process. In general terms, the anniversary rating date is normally the effective date of the policy.

Annual Statement –
a detailed financial statement required to be reported by each insurer to the insurance department in its state of domicile. The annual statement includes a balance sheet, income statement, reinsurance information, and a breakdown of loss payments and reserves by line of business and accident year.

ANSI –
see definition for American National Standards Institute

Antitrust laws –
laws that prohibit companies from working as a group to set prices, restrict supplies, stop competition in the marketplace.

APP –
see definition for Application

Application (APP) –
a statement of information sent to an insurance company made by the insured or his agent to obtain an insurance policy.

ARD –
see definition for Anniversary Rating Date

ARAP –
see definition for assigned Risk Adjustment Program

Assigned Risk Adjustment Program (ARAP) –
an additional adjustment to the experience modification factor, used in states to adjust premium for assigned risk policies.

ARP –
see definition for Assigned Risk Plan

ASC (Accredited Standards Committee) –
see definition for National Committee for Information Technology Standards

ASCII –
see definition for American Standard Code for Information Interchange

ASP –
Application Service Provider

Assigned Risk –
an insured who is unable to acquire coverage in the regular (voluntary) market, and has been assigned to a company that will provide coverage.

Assigned Risk Plan (ARP) –
an involuntary plan where a risk obtains insurance that is not available on the voluntary insurance market. Insurance is handled by a pool (Assigned Risk Pools) or assigned to insurers for which participation is mandatory. Under an assigned risk plan, the Plan Administrator assigns the account to licensed insurers and the insurers issue their own policies and retain the experience of the risk as direct business.

Associate Insurance Data Manager (AIDM) –
to achieve the AIDM designation requires passage of four IDMA examinations.

Associate of Casualty Actuarial Society (ACAS) –
an individual who has passed at least the first seven, but not all, of the examinations of the Casualty Actuarial Society, and has attained an Associateship status.

Association for Cooperative Operations Research & Development (ACORD™) –
a non-profit standards developer for the insurance industry, a resource for information about object technology, EDI, XML and electronic commerce in the United States and other nations.

Assumed –
to accept the risk from the ceding insurer

Audit –
an examination of the insured's books and records to determine actual payroll (exposure) for the purpose of computing premium. Audits are a requirement for workers' compensation.

AWW –
see definition for Average Weekly Wage

Average Weekly Wage (AWW) –
an average of an injured employee's weekly earnings over a period of time.

AY –
see definition for Accident Year

B

Basic Manual –
a manual published by a DCO that contains the underwriting rules and rates for workers' compensation insurance. Other DCOs may publish similar manuals under different titles.

BBS –
see definition for Bulletin Board Services or Bulletin Board Systems

BEEP –
see definition for Bureau Entry & Edit Package

Benefits –
monetary payments and other services provided by the insurer.

Binder –
a legal agreement issued by an agent or company to provide temporary insurance coverage until a policy can be written.

Book of Business –
total amount of insurance on an insurer's books at a particular point in time.

Broker –
a licensed person or organization paid to look for insurance.

BSI 5/17 –
a form used by self-insured groups to report unit report data. Form BSI 5 is for reporting the premium information, and Form BSI 17 is for reporting loss information. BSI 5/17 reporting is unique, in that premium and losses are reported on separate forms. The primary use of each form is to obtain an experience modification.

Bulk Reserves –
an accumulated amount determined to provide for future loss of payments for known claims. These include case reserve inadequacies, additional case reserves, and claims that may reopen or other reserves not allocated to specific claims.

Bulk Self-Insured Premium (5) & Loss (17) Forms –
see definition for BSI 5/17

Bulletin Board Service (BBS) –
a communication medium to report data electronically by telephone, computer and modems.

Bulletin Board System (BBS, EBBS) –
a communicating computer equipped to provide informational messages, file storage, transfer and message exchange to dial-up data terminal or personal computer users.

Bureau –
an organization formed for checking rates, developing forms, rules and rates for a line of business. A bureau may be a department of the state or an independent entity. A Bureau also collects and edits data. The term 'Bureau' is often used to describe a rating bureau, audit bureau, advisory rating bureau, inspection bureau and Data Collection Organization, etc.

Bureau Entry and Edit Package (BEEP) –
a software package developed by ACCCT that permits insurance carriers and other reporting organizations to enter workers' compensation unit report information for transmission to any state insurance advisory and/or rating organization.

Bureau of Workers' Compensation of Ohio (BWC) –
a self-supporting exclusive state fund.

Bureau Rates –
refers to rates filed by a rating bureau (see bureau) and approved by the insurance department for use in that state.

BWC –
see definition for Bureau of Workers' Compensation (Ohio)

Byte –
eight (8) bits (a binary digit is a basic binary unit for storing data, it can either be 0 (zero) or 1 (one) treated as a unit and representing a character.

C

"C" Report or Correction Report –
a unit report used to correct any type of error or information on a previously filed unit report.

Comp –
short for workers' compensation.

Calendar Year –
the year in which premiums and losses are booked.

Calendar Year (CY) Report –
a report submitted by companies to jurisdictions pertaining to financial data that provides detail information on the analysis of state(s) and countrywide trends.

Calendar Year Expense (CYE) Report –
a report submitted by companies to jurisdictions pertaining to financial data that is used to substantiate the expenses included in the rate filings.

Calendar Year Reconciliation (CYR) Report –
a report used to reconcile data reported on Line 16 of Page 15 of the Annual Statement with the data reported on aggregate financial calls.

Calendar-Accident Year Assigned Risk (CAYAR) Report –
a report that is the same as CAY, but only contains data of insureds in the involuntary market.

Calendar-Accident Year Capitated Medical (CAYCM) Report –
a report that is the same as CAY, but only contains data from insureds with capitated medical policies.

Calendar-Accident Year Expense (CAYE) Report –
a report that is used to substantiate the expenses included in the rate filings.

Calendar-Accident Year Report (CAY) –
a report that aggregates losses from accidents that occurred during a particular year regardless of when the losses were recorded or reported. For example, if an accident occurred on 12/31/99 but was not reported until 1/5/2000, the Calendar-Accident Year would be 1999.

California Workers' Compensation Institute (CWCI) –
an organization of insurers and self-insured employers conducting and communicating research and analysis to improve the operation of the California Workers' Compensation System.

Calls –
a term used for the request of data by an insurance department, DCO or others. For example, Policy Year "Call".

Cancelled Flat –
a policy that is terminated as of the policy effective date.

Cancellation –
a termination, by either the insured or company, of an insurance policy before its expiration date. There are three types of cancellations.

Flat: termination of the insurance back to the effective date of coverage without a premium charge.

Mid-Term: Pro Rata – termination where the premium is adjusted for the time the coverage was in effect. Cancellation at the request of an insurer is usually on a pro rata basis.

Mid-Term: Short Rate – termination at the request of the insured prior to the expiration date. Therefore, if cancelled by insured, an increased charge is made to cover expenses.

CAOM –
see definition for Compensation Advisory Organization of Michigan

California Insurance Guarantee Association (CIGA) –
if a carrier becomes insolvent in California, this organizations settles unpaid claims and assesses each other carrier its proportional share.

Capitated (Contract) Medical –
an arrangement/contract with an organization where the care of injured employees is administered by a managed care organization including when the provider is reimbursed on a percovered individual, rather than per specific treatment basis.

Card Serial Number –
a number assigned, usually sequential, to the unit report.

Carrier –
an insurance company that 'carries' the insurance coverage.

Carrier Code (Insurer) Number –
a 5-digit numeric code identifying the reporting company (for most states).

Carrier of Last Resort –
the insurance company designated to accept a risk after the risk has been refused coverage by all other insurance companies.

CAS –
see definition for Casualty Actuarial Society

Case –
another name for a claim.

Case Reserve –
an accumulated amount that an insurer's claim professional determines is appropriate to value the unpaid portion of a claim or a group of claims.

Casualty Actuarial Society (CAS) –
an international research, examination and membership organization for actuaries in property and casualty insurance. It also administers a series of examinations leading to Associate status and then to Fellowship.

Catastrophe –
an accident/occurrence that results in two or more claimants being injured.

Catastrophe Number –
a sequential number for two or more claims resulting from the same occurrence, beginning with 01 for the first occurrence, 02 for the second occurrence, etc., and is usually assigned by the Data Collection Organization or the insurance company.

CAY –
see definition for Calendar Accident Year (Report)

CAYAR –
see definition for Calendar Accident Year Assigned Risk (Report)

CAYCM –
see definition for Calendar Accident Year Capitated Medical (Report)

CAYE –
see definition for Calendar Accident-Year Expense (Report)

CBA –
see definition for Cost-Benefit Analysis

CCIA –
see definition for Colorado Compensation Insurance Authority

CCO –
see definition for Coordinated Care Organization

CEO –
see definition for Chief Executive Officer

CEP –
see definition for Company Edit Package

Cede or Ceded –
to pass on to another insurance company all or part of the insurance written by the insurer.

Certified Insurance Data Manager (CIDM) –
to achieve CIDM designation requires completion of the four IDMA study courses plus additional course work from one of four recognized professional/programs; e.g., CPCU.

CFO –
see definition for Chief Financial Officer

Charter Property and Casualty Underwriters (CPCU) –
an organization of more than 28,000 insurance professionals. All members have passed examinations and fulfilled other requirements.

Chief Executive Officer (CEO) –
a title normally given to the highest ranking officer of a company.

Chief Financial Officer (CFO) –
a title normally given to the highest ranking financial/accounting officer of a company.

Chief Information Officer (CIO) –
a title normally given to the highest ranking information technology officer of a company.

Chief Operating Officer (COO) –
a title normally given to the second highest ranking officer of a company.

CIDM –
see definition for Certified Insurance Data Manager

CIGA –
see definition for California Insurance Guarantee Association

CIO –
see definition for Chief Information Officer

Circulars –
a term used to describe newsletters, bulletins, guidelines, etc., in the insurance industry.

Claim –
a demand by an individual or corporation to recover under an insurance policy for a loss.

Claimant –
a person who submits a claim to an insurance company for a loss.

Claim Number –
an alphanumeric code that uniquely identifies the claim.

Claim Status –
a code that indicates whether a claim is opened, closed, reopened or resolved.

Claimant's Attorney Fees –
a whole dollar amount of paid plus outstanding reserves for claimant's legal representation during the settlement of the claim.

Claims Missing From Subsequent List –
a listing that contains claims that were open on a prior report but were not reported on a subsequent report. This list is applicable to Massachusetts only.

Classification (Class) Code –
a numeric code corresponding to the classification assigned to the insured according to the rules of the manual for workers' compensation or the statistical classification code defined by the rating organization.

Client-Server –
a common form of a system in which software is split between server tasks and client tasks. A client sends a request to a server, according to some rules, asking for information or action, and the server responds.

For example, it is like a customer (client) who sends an order (request) to a supplier (server) who sends the goods (response).

Closed Claim –
a claim that has been settled with all payments having been made and one which has no case reserve.

Closed No Payment (CNP) –
a claim that has been settled with no payments made.

Closed Without Payment –
a claim that has been settled with no payments made.

CNP –
see definition for Closed No Payment or Closed Without Payment

Colorado Compensation Insurance Authority (CCIA) –
a quasi-public authority, self-supporting state fund. CCIA is the carrier of last resort in Colorado.

Commissioner of Insurance –
a state official charged with enforcement of the laws pertaining to insurance. Can be called Superintendent or Director of Insurance.

COMP –
see definition for Workers' Compensation. Short for Workers Compensation

Company Code –
see definition for Carrier Code

Company Edit Package (CEP) –
a general term that refers to the software and associated tools that assist the companies in editing and sometimes reporting the data.

Company Use Only Codes –
a special code designated for use within a company's own system to identify certain information.

Compensable –
a term used to describe a loss where an employee is entitled to compensation due to a work related injury.

Compensation Advisory Organization of Michigan (CAOM) –
an organization that captures and compiles workers' compensation data for the state of Michigan.

Competitive State Fund –
refers to a fund established by a state to write Workers' Compensation that also competes with private insurers.

Compilation Report –
a report that aggregates data and is normally used in a state that has multiple rating organizations or statistical agents.

CompSource Oklahoma (CSO) –
CompSource (CSO) is self-supporting and administered by a President/CEO. Formerly known as The Oklahoma State Insurance Fund (SIF).

Compulsory Insurance –
a type of insurance that is required for every insured by state or federal statute. Workers' compensation is compulsory in most states.

Contingent Mod –
a term used to describe an experience modification factor that has been produced from incomplete information. This mod, while temporary, is contingent upon the completion of the missing data, i.e., company went bankrupt.

Contract Medical –
an agreement between an insurance company and doctor(s) that states that for a sum of money the doctor(s) will provide medical service for treatment of injuries sustained by the employees of a particular account insured by the insurance company.

Control List –
a listing of unit statistical reports produced by various DCOs, usually produced near the time of policy audit to assist carriers in identifying those unit reports that will become due. Timing and content vary by DCO.

COO – see definition for Chief Operating Officer
Coordinated Care Organization (CCO) – an organization licensed and certified to provide medical services to an injured worker.
Correction Report or "C" Report – a unit report that is required to correct any type of error on a previously filed unit report.
Correction Sequence Number (Indicator) – the number that corresponds to the number of correction reports submitted within a particular report level.
Correction Type – the code that indicates the type of correction report being submitted.
Cost Benefit Analysis (CBA) – a process used to compute whether the implementation of a procedure, development of a project, etc. is cost-justified, i.e., benefits outweigh the cost.
Countrywide Standard Earned Premium at Uniform Reporting Level – a total premium that would have been earned if the rates were identical to each of the defined premium sizes for all states.
CPCU – see definition for Chartered Property and Casualty Underwriters
Critical Value (CV) – a term used to identify criteria for correcting potential errors; e.g., payroll amounts over $100,000. Also a term used in the ratemaking process where the amount is used to limit losses in a given state.
CRITS – see definition for Letters of Criticism
CSO – CompSource (CSO) is self-supporting and administered by a President/CEO. Formerly known as The Oklahoma State Insurance Fund (SIF).
Cumulative Injury – an injury which results in a disability or death and is not traceable to a definite compensable accident occurring during the employee's present or past employment.
CV – see definition for Critical Value
CWCI – see definition for California Workers' Compensation Institute
CWP – see definition for Closed Without Payment
CY – see definition for Calendar Year (Report)
CYE – see definition for Calendar Year Expense (Report)

CYR –
see definition for Calendar Year Reconciliation (Report)

D

DASD –
see definition for Direct Access Storage Device

Data Collection Agency (DCA) –
see definition for Data Collection Organization.

Data Collection Organization (DCO) –
an organization that collects information. Organization can be a bureau, jurisdiction or statistical agent.

Data Manager Dashboard (DMD) –
NCCI's online data tool that provides access for data providers to view summarized information on data reported. Data providers can generate informational reports, monitor data reporting timeliness and quality performance, and track results for the Data Quality Incentive Program and the Regulatory Exception Report programs. This tool is accessed via ncci.com.

Data Processing (DP) –
an old term that referred to the information technology area in a company.

Data Provider –
a company that reports data/information to a DCO.

Data Provider Code –
this is the 5-digit code corresponding to the originator of the transmission (data) or confirmation. If an insurer is the originator, then it is the 5-digit carrier code. If a DCO is the originator, then it is a 5-digit code consisting of 000 + the 2-digit state code of the DCO or 000XX for entities other than states.

Data Receiver Code –
this is the 5-digit code corresponding to the recipient of the transmission (data) or confirmation. If an insurer is the recipient, then it is the 5-digit carrier code. If a DCO is the recipient, then it is a 5-digit code consisting of 000 + the 2-digit state code of the DCO or 000XX for entities other than states.

Data Reports Online (DRO) –
NCCI's online data tool used for viewing, printing, downloading, and performing searches on reject error reports and reports on data submissions. This tool offers many features and capabilities, and it is accessed via ncci.com.

Data Standards Committee (DSC) –
a committee formed by IDMA to review/study insurance data standards.

Data Transfer via the Internet (DTVI) –
NCCI's online data tool used for sending data submissions and receiving reports/data files online. NCCI supports DTVI in two versions: Secure Browser Mailbox and Secure Software.
This tool is accessed via ncci.com.

Date of Injury –
see definition for Accident Date

DBA –
see definition for Doing Business As

DCA –
see definition for Data Collection Agency

DCA Access® Online–
NCCI's online data tool that allows data providers to view and update their company's unit statistical data, Unit Report Control (URC) information, policy data, Detailed Claim Information (DCI), and Noncompliance/Compliance information. This tool is accessed via ncci.com.

DCI –
see definition for Detailed Claim Information

DCO –
see definition for Data Collection Organization

Death Benefits –
indemnity benefits paid to a survivor of a worker whose injury resulted in death.

Dec Page –
see definition for Declaration Page

DCRB –
see definition for Delaware Compensation Rating Bureau

Declaration Page (Dec Page) –
a page (usually the first page) of an insurance policy that displays the coverage carried by the insured. The Declaration Page is now called the Policy Information Page.

Deductible Amount Aggregate –
a maximum loss amount for all claims to be paid by the insured.

Deductible Amount Per Claim/Accident –
the loss amount by claim/accident to be paid by the insured.

Deductible Percentage –
the whole percent of the deductible to be paid by the insured.

Deductible Program –
deductible coding is made up of five deductible elements and two statistical codes.

Elements:
Deductible Type
Deductible Percent
Deductible Amount Per Claim/Accident
Deductible Amount Aggregate
Deductible Code (Loss)

Deductible Reimbursement –
the whole dollar amount of reimbursement received by the data provider by which the reported gross is to be reduced in order to conform to state requirements for net experience rating.

Deductible Type –
the 2-segment 2-digit code that identifies the type of deductible being reported.

Deductibles –
a clause in an insurance policy that relieves the insurer of responsibility in dollars, percentage of the total or percentage of the loss, before paying the loss.

Defense and Cost Containment Expense –
a new term for Allocated Loss Adjustment Expense. See definition for Allocated Loss Adjustment Expense.

Delaware Compensation Rating Bureau, Inc. –
the authorized data collection organization for the state of Delaware.

Delinquent Listing –
a listing that alerts the insurers of the unit reports that have not been received by the DCO. It is usually produced in the 21st month after policy effective date.

Department of Insurance (DOI) –
an area within a state's government charged with regulating the business of insurance.

Designated Statistical Reporting (DSR) –
refer to the reporting of premium on financial calls. Premium is reported before the application of company deviations.

Deposit Premium –
the premium deposit (usually first month estimated premium) paid by the insured when an application is made for an insurance policy.

Detailed Claim Information (DCI) –
an NCCI program that captures detailed claim data on indemnity losses on a sampling basis. The state of Texas has a detailed claim program that is NOT on a sampling basis.

Deviation(s) –
usually refers to using a rate other than the bureau rate. Each state has specific rules for deviations.

Direct Premium –
premium collected by the insurer from policyholders, before reinsurance premiums are deducted.

Direct Workers Compensation –
policies issued directly by an insurance carrier to its policyholders.

Direct Written Premium (DWP) –
a premium amount as reported on Line 16 of Page 15 of the Annual Statement.

Direct Written Premium Report (DWP) –
a report that is usually used to determine bureau assessments and pool participation.

Direct-Access Storage Device (DASD) –
an IBM mainframe terminology for a disk drive in contrast with a tape drive.

Disability –
a physical or mental impairment that limits one or more of an individual's major life activities.

Disease B –
a disease arising out of and in the course of employment, not an ordinary disease of life to which the general public is exposed outside of the employment.

Dividend –
a return of premium, calculated after policy expiration, based on the over-all performance of the insurance company or of a group of insureds.

Division of Insurance (DOI) –
see definition for Department of Insurance

DNQ –
see definition for Do/Does Not Qualify

Do/Does Not Qualify (DNQ) –
a term used when an account does not qualify for experience rating.

DOI –
see definition for Department or Division of Insurance

Doing Business As (DBA) –
a phrase used to identify the insured's business trade name; e.g., Sammy Smith, DBA Bully Bulldozers, Inc.

DP –
see definition for Data Processing

D-Ratio (Discount Ratio) –
a factor used in experience rating. It is the ratio of smaller losses (under $2,000), plus the discounted value of large losses, compared to the total losses that might be expected of an insured in a particular type of business.

DSC –
see definition for Data Standards Committee

DSR –
see definition for Designated Statistical Reporting

DQ –
Data Quality

DQIP –
Data Quality Incentive Program (NCCI)

DRO –
Data Reports Online (NCCI)

DTVI –
Data Transfer Via Internet

DWP –
see definition for Direct Written Premium (Report)

E

Earned Premium –
a portion of the premium allocated to the expired portion of the policy. For example, a policy effective 1/1/2000 to 1/1/2001 for $1200 has an earned premium of $100 as of 2/1/2000. It should be noted that there are formulas for determining earned premium.

EBCDIC –
see definition for Extended Binary Coded Decimal Interchange Code

EBNR –
Earned But Not Reported

E Commerce –
Short for Electronic Commerce

EDI –
see definition for Electronic Data Interchange

EDI Committee –
a group composed of representatives of each member of the WCIO.

Effective Date –
a date that identifies when a transaction becomes effective. For Workers' Compensation insurance purposes this is normally the policy effective date.

EL –
see definition for Employers' Liability

ELC –
see definition for Employee Leasing Company

Electronic Data Interchange (EDI) –
a general term used to describe the method by which carriers submit data to DCOs via magnetic tape, diskette, BBS, internet or other electronic transmissions.

Electronic Data Submission (Electronic Submission) –
a method by which companies submit data to DCOs via magnetic tape, diskette, BBS, internet, or other electronic transmissions.

Electronic Mail (Email) –
a term that describes mail that is sent through a computer (PC).

ELR Factor –
Expected Loss Rate Factor

EMAIL –
see definition for Electronic Mail

E-Mod –
Short for experience modification. See definition for Experience Modification.

Employee Leasing Company (ELC) –
another name commonly used for professional employer organizations, depending on jurisdictional requirements. It is a company that provides integrated human resource administration and risk management services to its clients, potentially including various services pertaining to the purchase of coverage, loss prevention and mitigation, and/or compliance with respect to workers' compensation insurance.

Employer's Attorney Fees –
a whole dollar amount of paid plus outstanding reserves for an employer's legal representation during the litigation of the claim.

Employers' Liability (EL) –
a coverage for the liability of employers for damage resulting from injuries by accident or disease sustained by employees in the course and scope of employment, but not covered, under the workers' compensation laws who choose to sue the employer denying benefits payable under the workers' compensation laws.

Employment Status–
a code that identifies an injured worker's employment status as of the date the claim was first reported to the insurer. For example: regular, part-time employee, etc. This information is captured on detailed claim reports and individual case/claim reports.

Endorsement – a change to an insurance policy made by using a form containing the language for change.
EPO – see definition for Exclusive Provider Organization
ERM14 – see definition for Experience Rating Modification – Change of Ownership Form
ERM6 – see definition for Experience Rating Modification Form
ERP – California Worker's Compensation Experience Rating Plan
Error Listing – a listing that alerts insurers of errors on the data reported to DCOs.
eSCAD® – California's web-based application that allows insurers to electronically submit aggregate financial data to the WCIRB.
Estimated – a general calculation of size. The term is usually used to describe premium, payroll, losses, etc.
ETD – Estimated Target Date
Excess Policy – a policy that provides coverage when a loss amount equals or exceeds a predefined amount.
Exclusion – certain causes and conditions listed in the policy, which are not covered.
Exclusive Provider Organization (EPO) – a coverage for services only from network providers.
Exclusive State Fund(s) – Also referred to as monopolistic state funds. An entity that insures all of the employers (there may be few exceptions) in a state. An example of an exclusive state fund is the Ohio Bureau of Workers' Compensation (BWC). The private market is not allowed to compete with the BWC. It should be noted that even in a state with an exclusive state fund, employers may be self-insured and not use the fund.
Ex-Med (Excluding Medical) – for data reporting, refers to files, reports or exhibits that excludes data for medical payments.
Expense Constant – a charge applied to all policies to cover company expenses associated with issuing a policy.
Experience – a term used to identify an insured's payroll and loss activity for a given period.

Experience Modification (E-Mod, X-Mod) –
a factor used to modify the computed premium based on an insured's payroll and loss record. The modification factor is determined by comparing actual losses to expected losses, and can be a debit (>1.00) or a credit (<1.00).

Experience Rating –
a term given to the procedure of comparing the insured's previous payroll and loss data over a three-year period to develop an experience modification.

Experience Rating Modification Factor (E-Mod) –
see definition for Experience Modification

Experience Rating Modification – Change of Ownership Form (ERM14) –
a form used to report change of ownership, merger, etc. for experience rating purposes.

Experience Rating Modification Form (ERM6) –
a form used by self-insured groups to report unit report data. In most jurisdictions, ERM6 has been replaced with the ASWG Unit Report. Primary use of this form was to obtain an experience modification.

Experience Rating Status –
a code that indicates the status of the experience modification, final, not final or not applicable.

Expiration Date –
a date that identifies when a transaction ends. For workers compensation insurance purposes, this is normally the policy expiration date.

Exposure –
the basis against which losses are compared; i.e., the payroll or other measure of risk, by class.

Exposure Amount –
a whole dollar amount for each payroll classification assigned to the policy.
Exposure amount is normally on a payroll basis.
Exceptions include: per capita, seat surcharge.

Exposure Coverage (ACT) Code –
a code that identifies the type of exposure coverage.

Exposure Record/Section –
a portion of the unit report that identifies the ***Exposure Information***- classification(s), audited payrolls, carrier rating values, premium amount, employer's liability, experience modification, and miscellaneous premiums and credits.

Exposure State –
a state in which coverage has been provided for the classifications and corresponding exposures, if any, and to which the payrolls of injured workers have been assigned.

Extended Binary Coded Decimal Interchange Code (EBCDIC) –
an IBM proprietary 8-bit code for data communications.

Extensible Markup Language (XML) –
a data format that enables delivery of information for applications on the internet, intranet and extranet.

'External data set identifier' –
for a tape, cartridge or diskette. This is a label that is firmly glued to the tape, cartridge or diskette.

F
'F' Classes or Codes – see definition for Federal Classifications or Codes
'F' Classification (Federal Classification) – a classification that is covered under the USL&HW Act.
Fellow of Casualty Actuarial Society (FCAS) – a designation earned by passing a series of Casualty Actuarial Society examinations.
FCAS – see definition for Fellow of Casualty Actuarial Society
FCIP – see definition for Financial Calls Incentive Program (Minn)
FCOL – see definition for Financial Calls Online (NCCI's)
FCRD – see definition for Financial Call Reporting by Diskette (Minn)
FDIP – see Financial Data Incentive Program for the Pennsylvania/Delaware Rating Bureau. Financial Data Incentive Program (FDIP) - Pennsylvania/Delaware Rating Bureau's program that rewards companies for filing financial data early, or fines for late or erroneous filings.
FDRA – see Financial Data Reporting Application (FDRA) - an Internet-based system that allows carriers to enter, edit and submit Forms, Calls and Schedule W (for the Pennsylvania/Delaware Rating Bureau). The FDRA also includes product demo information.
Federal Employers' Liability Act (FELA) – a law that establishes benefits for certain employees, e.g., those engaged in interstate commerce by rail. An act that gives employees of interstate rail carriers an action in negligence against their employers.
Federal Employer Identification Number (FEIN) – a Federal Employer Identification Number of the insured.
FEIN – see definition for Federal Employer Identification Number
Federal Mine Safety and Health Act (FMSHA) – an act that provides benefits to all mine operators and miners.
FELA – see definition for Federal Employer's Liability Act
FIDM – Fellow Insurance Data Manager
Field(s) – a length of a data element within a format. For example: 2-digit code is referred to as a 2-digit "field".

File-and-Use States –
states where insurers must file rate charges with the regulators, but don't have to wait for approval to put them into effect.

File Transfer Protocol (FTP) –
a client-server protocol that allows a user on one computer to transfer files to and from another computer over a network.

Financial Call Incentive Program (FCIP) –
a program of the Minnesota Workers' Compensation Insurers Association, Inc., that encourages the filing of financial data on a timely and accurate basis. The program applies to Policy Year Call, Policy Year Large Deductible Call, Calendar-Accident Year Call and Calendar-Accident Large Deductible Call.

Financial Call Reporting by Diskette (FCRD) –
Minnesota's program for reporting financial data on diskette. It should be noted that there are specific rules that should be followed when using FCRD.

Financial Calls Online (FCOL) –
NCCI's online data tool that allows data providers to report their company's financial data. This tool is accessed via ncci.com.

Financial Data –
a group of financial reports required by the different data collection agencies.

Fine List Final –
a report that alerts the insurers of the unit reports not reported, reported late and subject to fines.

Fine List Original –
a report that alerts the insurers of unit reports not reported or reported late and that may have appeared on overdue/delinquent lists.

First Report –
a first reporting of audited payroll, premium and loss data to be filed as of the initial valuation date which is eighteen (18) months after the policy effective date.

First Report of Injury (FROI) –
a report prepared by the employer or other parties that describes the events and injuries. May be called by other names, e.g., Employer's Report of Work-Related Accident/Occupational Disease.

FMSHA-
see Federal Mine Safety and Health Act (FMSHA) an act that provides benefits to all mine operators and miners.

Follow-up List Quality –
a listing that alerts insurers that errors appearing on a previous error listing have not been corrected.

Fraud –
intentional lying or concealment by policyholders to obtain payment of an insurance claim that would otherwise not be paid.

Fraudulent Claim Indicator –
an indicator that identifies the involvement of fraud in the claim.

FROI –
see definition for First Report of Injury

FTP –
see definition for File Transfer Protocol

G

Governing Class –
a classification, other than a standard exception classification (salespersons, clerical employees, etc.), to which the largest amount of payroll is assigned.

Graphic User Interface (GUI) –
a use of pictures to represent input and output of a program. For example, the program displays icons on the screen and the user controls it by using a mouse.

GUI –
see definition for Graphic User Interface

Grouped Claims –
a procedure where the insurer may opt to combine certain claims by classification and type of injury for reporting purposes.

Guaranteed Cost –
a premium charged on a prospective basis, fixed or adjustable, but never on the basis of loss experience.

Guaranty Fund –
the mechanism by which solvent insurers bail out the policyholders of companies that fail.

H

HCFA –
see definition for Health Care Financing Administration

Header Record –
a portion of data that identifies the key ***Policy Information*** (policy number, carrier, effective/expiration date) ***Report No.*** and ***Type*** of report (correction type, number of report), ***Policy Conditions*** and ***Deductibles***.

Health Care Financing Administration (HCFA) –
an organization that administers Medicare, Medicaid and children's health insurance programs.

Health Insurance Portability and Accountability Act –
a federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. The act also gives Health and Human Services the authority to mandate the use of standards for the electronic exchange of health care data.

Health Maintenance Organization (HMO) –
an entity that provides, offers or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium. Under the Federal HMO Act, an entity must have three characteristics to call itself an HMO:
1. an organized system for providing health care or otherwise assuring health care delivery in a geographic area;
2. an agreed-upon set of basic and supplemental health maintenance and treatment services;
3. a voluntarily-enrolled group of people.

HIPAA –
see definition for Health Insurance Portability and Accountability Act

HMO –
see definition for Health Maintenance Organization

HTTP –
see definition for Hypertext Transfer Protocol

Hypertext Transfer Protocol (http) –
the client server rules used on the world wide web for the exchange of documents.

I

IAIABC –
see definition for International Association of Industrial Accident Boards and Commissions

IBNR –
see definition for Incurred But Not Reported

ICD Codes –
see definition for International Classification of Disease Codes

ICRB –
see definition for Indiana Compensation Rating Bureau

ICRs –
see definition for Individual Case/Claim Reports

IDMA –
see definition for Insurance Data Management Association

IDMS –
see definition for Integrated Database Management System

IEE –
see definition for Insurance Expense Exhibit

If Any –
a term used to indicate that coverage exists "if any" exposure/premium develops for a specific classification or state.

IIA –
see definition for Insurance Institute of America

Impairment Percentage –
a formula to provide an objective, fair and consistent method for evaluating the level of permanent impairment.

Import –
a process to bring data into a computer system from an external source.

Incurred But Not Reported (IBNR) –
loss amounts that are liabilities of an insurer, but which are not yet reported to a statistical agent or rating organization, nor recorded on the company's books.

Incurred Indemnity –
a whole dollar amount of compensation, including all paid and outstanding reserve benefits due an employee as a result of a work-related injury.

Incurred losses –
losses occurring within a fixed period, whether or not adjusted or paid during the same period.

Incurred Medical –
the whole dollar amount of hospital, physician and other medical benefits, including all paid and outstanding reserve benefits.

IND –
see definition for Independent State Rating Organization

Indemnity –
the compensation paid an injured worker due to a work-related injury.

Independent State Rating Organizations (IND) –
the following data collection organizations are considered independent state rating organizations.

- Workers' Compensation Insurance Rating Bureau of California
- Delaware Compensation Rating Bureau, Inc.
- Indiana Compensation Rating Bureau
- Workers' Compensation Insurance Rating and Inspection Bureau of Massachusetts
- Compensation Advisory Organization of Michigan
- Minnesota Workers' Compensation Insurers, Inc.
- New Jersey Compensation Rating and Inspection Bureau
- New York Compensation Insurance Rating Board
- North Carolina Rate Bureau
- Pennsylvania Compensation Rating Bureau
- Wisconsin Compensation Rating Bureau

Indiana Compensation Rating Bureau (ICRB) –
a private, non-profit unincorporated association of all insurance companies licensed to write workers' compensation insurance in the state of Indiana.

Indicator –
as used in data reporting, an indicator is not a code but rather a 'yes or no' type of identification. For example: Attorney involvement; yes (y) or no (n).

Individual Case or Claim Report (ICR) –
a detailed report on an individual claim which contains specific information pertaining to the claimant and the reserve calculation. The ICR is usually filed concurrently with the submission of the unit report. Reporting requirements vary with each jurisdiction.

Individual Practice Association (IPA) –
a network of physicians who will provide medical service to non-network patients covered by insurance.

Individual Risk Rating –
is the procedure an underwriter uses for classifying and rating any risk which presents unique or unusual conditions, exposures or hazards for which he feels a commercial lines manual classification or rate is not appropriate.

Information Page –
usually the first page of the policy contract that contains information about the insured and the insured's coverage; e.g., name and address of insured.

Information System (IS) –
a general term used to describe programming/system development areas.

Information Technology (IT) –
a general term used to describe programming/system development areas.

Injured Workers' Insurance Fund of Maryland (IWIF) –
an independent entity created by state statute. IWIF is entirely self supporting and the market of last resort.

Injury Description Code –
a 6-digit segment that represents the part of body, nature of injury and cause of accident for a given claim.

Injury Type –
a code that identifies under which provision of the law benefits are paid or are expected to be paid.

Insurance –
a contractual relationship that exists when one party (the insurer) assumes a risk faced by another party (insured) in return for consideration (premium).

Insurance Commissioner –
see definition for Commissioner of Insurance

Insurance Company –
an organization chartered under state or provincial laws to act as an insurer.

Insurance Data Management Association (IDMA) –
a not-for-profit, independent professional association of insurance data managers.

Insurance Expense Exhibit (IEE) –
a requirement of the National Association of Insurance Commissioners (NAIC). The data is used to conduct a review of general and loss adjustment expenses by line of business.

Insurance Institute of America (IIA) –
a non-profit organization that offers education, certification, publications and research reports to businesses and individuals in risk management and property and liability insurance.

Insurance Services Office, Inc. (ISO) –
an organization that provides information, including statistics, underwriting and claims information, actuarial analyses, policy language, and consulting and technical services in connection with 18 lines of property/casualty insurance.

Insured –
a person or business (an employer) with whom an insurance contract is made.

Insured Address –
the street address, city, state and zip code of the insured.

Insured Name –
the name of the person or business (employer) with whom an insurance contract is made.

Insurer –
an organization that underwrites or covers an employer (insured) for workers' compensation insurance.

Insurer Code –
see definition for Carrier Code

Integrated Database Management System (IDMS) –
a network management system developed in 1972. It is a management system for integrating a database of pictures and alphanumeric data.

International Association of Industrial Accident Boards And Commissions (IAIABC) –
an organization where workers' compensation specialists from a number of disciplines interact. Government officials and regulators, business and labor leaders, medical providers, law firms, insurance carriers, rehabilitation and safety experts all make up the IAIABC.

International Classification of Disease Codes (ICD Codes) –
a list of diseases and conditions developed by and used by Physicians and hospitals to classify illness, injury or disease of patients.

Interstate –
an interstate account is an employer who operates in more than one state. Interstate rating is subject to different rules and is not applicable to all states. It also references the type of experience modification factor that has been developed for an insured.

Intrastate –
an intrastate account usually refers to an employer operating in only one state. It also references the type of experience modification factor that has been developed for an insured.

IPA –
see definition for Individual Practice Association

IRIS –
Insurance Regulatory Information System

IS –
see definition for Information System

ISO –
see definition for Insurance Services Office, Inc.

ISP –
Internal Service Provider

IT –
see definition for Information Technology

IWIF –
see definition for Injured Workers' Insurance Fund (of Maryland)

J
JCL – Job Control Language
Joint Coverage Claim – is a claim for which it has been determined by adjudication that the coverage furnished by other than the one policy for which the experience is being reported is pertinent to a division of the total incurred loss.
Joint Underwriting Association (JUA) – an entity that allows a limited number of insurers to service certain risks on behalf of all insurers. Servicing carriers write the business on behalf of the JUA, usually on JUA policies, and are not required to retain any of these risks as direct written business. The JUA administrator distributes the collective experience of all policies written by servicing carriers to all insurers writing that particular line of insurance in the state.
Jones Act - the federal act which provides for the covering of ships' crews under a Workers' Compensation plan.
JUA – see definition for Joint Underwriting Association
Julian date – for data reporting, the Julian date is the last two digits of the year and numerical day of the year. For example, 1/1/2002 = 02001.
Jurisdiction – the limit or territory within which a state or regulatory body's authority may be exercised. Used to refer to a state requirement or applicability, when used, it is not necessarily referring to a DCO.
Jurisdiction State – the state code of the governing jurisdiction that will administer the claim and whose statutes will apply to the claim adjustment process when that state is different from the exposure state.
K
KEMI – see definition for Kentucky Employers' Mutual Insurance
Kentucky Employer's Mutual Insurance (KEMI) – a non-profit, independent, self-supporting, de-jure municipal corporation and a political subdivision of the Commonwealth of Kentucky. KEMI is a fully competitive state fund and the market of last resort.
L
LCF – see Labor Contractor For **or** Leased Coverage For, depending on jurisdiction.
LAE – see definition for Loss Adjustment Expense
LAN – see definition for Local Area Network

Labor Contractor For (LCF) –
the phrase "Labor Contractor For" or the acronym "LCF" may be used in the named insured record of a policy that insures a labor contractor to identify the client of the labor contractor

Large Deductible –
a large deductible is usually defined as $100,000 or more per claim or per accident that is the responsibility of the insured. Coverage is provided when this deductible is met.

Last Page Number –
the last page number of multi-page hard copy unit reports.

Leased Coverage For –
the phrase "Leased Coverage For" or the acronym "LCF" may be used in the named insured record of a policy that insures a labor contractor to identify the client of the labor contractor. When the phrase "Leased Coverage For" or the acronym "LCF" is used to identify the client's name, the client's name is not considered when determining the legal policyholder

Legal Nature of Insured Code –
a two-digit numeric code that identifies the legal nature of the insured, e.g., partnership, corporation, etc.

Legal Nature of Entity Code –
see Legal Nature of Insured code.

Letter of Authority (LOA) –
a term usually associated with the experience rating process. It is a document that allows one rating organization to release data to another rating organization, insurer, broker or agent.

Letter of Transmittal –
a form used by the insurer when submitting data on hard copy to the rating organization. A letter of Transmittal is sometimes used with electronic reporting.

Letter of Criticism (Crits) –
a letter of “criticism” is issued by some rating organizations when a discrepancy or error in rates or other calculations is found. Criticisms are used by some DCOs instead of error reports to request a correction to an error or to notify the insurer of a possible problem or request additional information.

Liability Over –
refers to a particular Employers Liability coverage situation where a third party, who is being sued by an employee, in turn sues the employer. Any damages incurred by the employer are classified as ‘liability over’, and are in addition to compensation payments made to the injured employee.

Link Data –
a set of data fields used to connect/match records to a policy, claim, etc.

LOA –
see definition for Letter of Authority

Local Area Network (LAN) –
a data communication network that allows easy interconnections of terminals, computers, etc.

Loss –
a result of a claim for indemnity, medical costs or damages under the terms of a policy.

Loss Adjustment Expense (LAE) –
an expense incurred to investigate and litigate claims, but not the cost of the claim itself.

Loss Adjustment Expense (LAE) Report –
a report that is used to determine the loss adjustment expense portion that is to be included in the manual rate.

Loss Conditions –
a loss condition is made of the following 5 segments:
- Act
- Type of Loss
- Type of Recovery
- Type of Coverage
- Type of Settlement

Loss Constant –
a fixed amount added to the premium to offset losses considered too small to be recorded in the experience.

Loss Cost –
a dollar amount of loss per unit of exposure.

Loss Coverage –
a basis under which the loss is covered by the policy. Loss coverage codes are usually used to describe the liability.

Loss Conversion Factor –
a term used in retrospective rating. It is a factor applied to the loss formula to give the insurer the funds needed to handle the investigation of the claim.

Loss Cost Multiplier –
a factor applied to a loss cost to develop a premium rate.

Loss Development Factor –
a factor that gives the insurer additional money to allow for the subsequent development of incurred but not reported (IBNR) and to reimburse for claim reported late to the insurer. Was introduced to address the effect of inflation on losses.

Loss Limitation –
a term used in ratemaking and retrospective rating. Limit the amount of large losses.

Loss Ratio –
incurred losses divided by earned premiums. a percentage of each premium dollar an insurer spends on claims.

Loss Record/Section –
a portion of the data that identifies the ***Loss Information*** reported during the policy term. It contains required and optional claim information (claim number, accident date, indemnity and medical amounts, class code, injury code, status, etc.).

Loss reserves –
see definition for Reserves

Louisiana Workers' Compensation Corporation (LWCC) –
a private, non-profit mutual insurance corporation. LWCC is a competitive fund and the market of last resort.

Lump Sum –
for data reporting, is a claims settled by agreement of the insurer and claimant that the claimant will accept a specified amount of a specific award or benefit.

Lump Sum Indicator –
an indicator that identifies a lump sum agreement for the claim.

LWCC –
see definition for Louisiana Workers' Compensation Corporation

M

MAAA –
see definition for Member of the American Academy of Actuaries

Magnetic Tape Reporting –
a type of medium for reporting data.

Maine Employers Mutual Insurance Company (MEMIC) –
a private, taxable corporation that guarantees a workers' compensation market for all employers doing business in Maine.

Managed Care Organization (MCO) –
a general term describing associations, members, etc., providing health care, research, advice, etc. See Managed Health Care.

Managed Health Care –
a process that combines quality improvement, analysis, efficiency and accountability for health care systems and delivery. This is accomplished by:

- analyzing the process and results of medical treatment
- developing and communicating guidelines
- building networks of doctors, hospitals and other health care providers
- seeking continuous quality improvement
- coordinating roles among the complex network of payers, providers and patients.

Management Information System (MIS) –
a name given to a company's internal system that provides data needed to manage the company's operations; e.g., number of policies per state.

Managing General Agent (MGA) –
an agent that has the right to bind coverage for an insured without prior approval.

Manual Premium –
premium obtained by applying classification manual rates to their respective exposures.

Manual Rate –
a charge per unit of exposure for each classification.

Maritime coverage –
is a term used to indicate coverage for marine shipping.

Maximum Medical Improvement –
the maximum level of medical improvement of an injured worker's condition.

McCarran-Ferguson –
a federal law in which Congress declared that states would continue to regulate the insurance business.

MCO –
see definition for Managed Care Organization

Medical –
an amount paid or expected to be paid for the treatment of a workplace injury.

Medical Only(s) (MOs) –
an amount paid or expected to be paid for the treatment of a workplace injury that does not result in lost time from work or permanent disability.

MEM –
see definition for Missouri Employers Mutual

Member of the American Academy of Actuaries (MAAA) –
see definition for American Academy of Actuaries

MEMIC –
see definition for Maine Employers Mutual Insurance Company

Merit Rating –
a process that applies prospective experience rating, retrospective experience rating and many other loss-based rating program that may be available in various states.

MGA –
see definition for Managing General Agent

Minimum Premium –
the lowest amount of money (premium) that the insured will pay for the coverage being provided.

Minnesota Workers' Compensation Insurers Association, Inc. –
the authorized data collection organization for the state of Minnesota.

MIS –
see definition for Management Information System

Missing First Reports List –
a listing that alerts insurers of the first unit reports that have not been received by the Worker's Compensation Rating and Inspection Bureau of Massachusetts.

Missouri Employers Mutual (MEM) –
a non-profit, mutual insurance company. MEM is a competitive fund.

Mod –
short for experience modification. See definition for Experience Modification.

Mod Effective Date –
the mod effective date is reported only when different from the policy effective date. If the anniversary rating date is different from the policy effective date, then the mod effective date may equal the anniversary rating date.

Modified Premium –
a premium charge derived from applying the experience modification factors to the manual premium.

Monopolistic State Fund(s) (MSFs) –
a self-supporting direct seller of workers' compensation insurance policies, who is the only provider of workers' compensation insurance in a particular jurisdiction. For example, the Ohio Bureau of Worker's Compensation Insurance (BWC) handles the state of Ohio. Monopolistic state funds are usually called exclusive state funds.

MSF –
see definition for Monopolistic State Fund(s)

Mutual Insurance Company –
a company that does not issue stock and is owned by its policy holders. Also known as a non-stock company.

MWCIA –
see definition for Minnesota Workers' Compensation Insurers Association, Inc.

N

N/A –
see definition for Not Applicable

NAIC –
see definition for National Association of Insurance Commissioners

NAICS –
see definition for North American Industry Classification System

NAII –
see definition for National Association of Independent Insurers

Name Record –
a portion of data that identifies the name information of the insured.

NAPEO –
see definition for National Association of Professional Employer Organizations

National Association of Independent Insurers (NAII) –
a non-profit property and casualty trade association.

National Association of Insurance Commissioners (NAIC) –
an organization of the commissioners, directors, superintendents, or other officials who, by law, are charged with the principal responsibility of supervising the business of insurance within each state, territory or insular possession of the United States.

National Association of Professional Employer Organizations (NAPEO) –
an organization of professional employee leasing companies.

National Committee for Information Technology Standards (NCITS) –
a committee that produces market-driven voluntary consensus standards in the areas of multimedia, databases, security and programming language.

National Council on Compensation Insurance, Inc. (NCCI) –
a shared-services organization committed to the collection, management, and distribution of information that serves and adds value to the workers' compensation industry and all of its stakeholders.

NCCI –
see definition for National Council on Compensation Insurance, Inc.

NCITS –
see definition for National Committee for Information Technology Standards

NCRB –
see definition for North Carolina Rating Bureau

Net –
direct plus assumed minus ceded.

Net Investment Income –
is the revenue obtained from the investment of unearned premium and loss reserves.

New Jersey Compensation Rating and Inspection Bureau –
the authorized data collection organization for the state of New Jersey.

New York Compensation Insurance Rating Board –
the authorized data collection organization for the state of New York.

New York Financial Call Information System –
New York's program for reporting financial data on diskette.

NJCRIB –
see definition for New Jersey Compensation Rating and Inspection Bureau

North Carolina Rating Bureau –
the authorized data collection organization for the state of North Carolina.

NOA –
see definition for Notice of Assignment

NOC –
see definition for Not Otherwise Classified

No Payroll Developed (NPD) –
at the time of audit, the state or classification that was covered on the policy with payroll/premium, developed no payroll.

No Payroll Expended (NPE) –
see definition for "No Payroll Developed"

Non-appropriated Fund Instrumentalities Act -
an act to make the provisions of the Longshoremen's and Harbor Workers' Compensation Act applicable to certain civilian employees of non-appropriated fund instrumentalities of the Armed Forces, and for other purposes.

Non-Compensable –
a term used for a claim or loss for which the injured worker is not entitled to compensation under Worker's Compensation laws.

Non-exclusive State Funds –
a self-supporting fund that can compete with the private market and may be the carrier of last resort. Some funds are non-profit and compete. Lately, some of the newer funds operate as a mutual insurance corporation.

Non-rated Policy -
for workers' compensation data reporting, refers to a policy that does not qualify for a rating plan (see rated policy). This is usually a policy with a small premium amount.

North American Industry Classification System (NAICS) –
a system that replaced the Standard Industrial Classification System (SIC codes) in 1997. It provides common industry definitions for Canada, Mexico and the United States.

Not Applicable (N/A) –
wherever a field or record is indicated as "Not Applicable," this means that the field or record is "Not Required" or "Not Allowed" in the jurisdiction(s) [rating organization(s)/bureau(s)/data collection organization(s)]. A field or record that is "Not Allowed" will be edited for compliance in some DCOs.

Not Otherwise Classified (NOC) –
a catch-all term used to indicate a business that can not otherwise be more accurately described by the general classification descriptions.

Notice of Assignment –
a notification that a risk has been assigned to an insurer under an assigned risk program.

Notice of Fines –
a listing that alerts the insurers of unit reports not reported, or reported late, which will be subject to fines by Minnesota.

Notice of Loss –
see 'First Report of Injury'

NPD –
see definition for No Payroll Developed

NPE –
see definition for No Payroll Expended

Number of Claims –
a total of claims that have been grouped by a specific classification. Most companies no longer group claims but rather report them on an individual basis by claim number and accident date.

Numeric (N) –
field contains only numeric characters. Data field is to be right-justified and left-zero-filled.

NYCIRB –
see definition for New York Compensation Insurance Rating Board

NYFCIS –
see definition for New York Financial Call Information System

O

Off The Record –
a term used to signify that the person(s) does not want the information being communicated to be attributed to them; i.e., Confidential.

Occupation Description –
an 18-digit alphanumeric narrative description of the regular occupation of the claimant.

Occupational Disease –
a type of condition that does not result from a specific accident covered under the workers' compensation laws. The condition is caused by repeated exposure overtime to risks inherent in a particular type of employment; e.g., fumes, chemicals, etc. Laws vary by state.

Occupational Hazard –
a condition in an occupation that increases the risk of an accident and sickness.

Occupational Safety and Health Act –
a federal law to ensure worker and workplace safety. The law also created the Occupational Safety and Health Administration (OSHA).

Occupational Safety and Health Administration (OSHA) –
a division of the Department of Labor that oversees the administration of the Occupational Safety and Health Act. It enforces standards in all 50 states.

OCIP –

Oil and other Mineral over Water –
refers to the state or federal acts on the transporting of oil and other mineral over water.

Open Claim –
a claim that has not been settled or on which payments are still being made. Sometimes referred to as an outstanding claim.

Open Competition States –
states where insurance companies can set new rates without prior approval, although the state's commissioner can disallow the rates if they are not reasonable and adequate and are discriminatory.

Optional –
wherever a field or record is indicated as "Optional," the field or record is not required to be reported to the jurisdiction(s) [rating organization(s)/bureau(s)/data collection organization(s)] indicated. Optional elements may be edited, captured or ignored by the DCO(s) if reported.

OSHA –
see definition for Occupational Safety and Health Administration

Outer Continental Shelf Lands Act –
An Act to provide among other things that the Longshoremen's and Harbor Workers' Compensation Act be extended to employees working on the Outer Continental Shelf in the exploration and the development of natural resources.

Outstanding Claim –
see definition for Open Claim

Overdue Report –
a listing that alerts insurers of the unit reports that have not been received by the DCOs. Also referred to as the Delinquent Listing.

Overdue Subsequent Reports –
a listing that alerts the insurers of subsequent unit reports that have not been received by the DCOs. It is produced on the same schedule as the Overdue/Delinquent listing for 1st reports.

P

Page Number –
the page number of multi-page hard copy unit reports.

Paid Indemnity –
a whole dollar amount of compensation paid due to disability or inability to work. Also includes compensation paid to a deceased prior to death, burial expenses, survivor benefits, claimant's attorney fees, vocational rehabilitation benefits, payments to the state and employer's liability losses and expenses.

Paid Medical –
a whole dollar amount of paid physician, hospital or other medical treatment as of the loss valuation date.

Payroll –
an exposure basis for most Workers' Compensation Classifications; refers to wages paid to employees.

Payroll Audit –
see definition for Audit

PCRB –
see definition for Pennsylvania Compensation Rating Bureau

Pending File Number –
a number that identifies the unit report in the rating organization's system that the insurer wants to replace.

Pending Initial Rating (PIR) –
a procedure that is used when an account is close to qualifying for experience rating and the data will have to be linked.

Pension Tables –
are tables to be used to determine benefits to be paid to the injured worker, dependents, etc. Sometimes these tables can be found in the DCO's statistical plan.

Pennsylvania Compensation Rating Bureau –
the authorized data collection organization for the state of Pennsylvania.

PEO –
see definition for Professional Employer Organization

Per Capita –
a measure of exposure where the base is the number of units other than payroll.

Permanent Partial Disability –
an injury that, although permanent; e.g., loss of arm, results in partial disability.

Permanent Total Disability –
an injury that has left the worker permanently disabled and unable to return to work.

PIF –
see definition for Policies-in-Force

PIR –
see definition for Pending Initial Rating

POC –
see definition for Proof of Coverage

Policies-in-Force (PIF) –
a number of policies that are active at a point in time. Companies maintain these figures on a state and countrywide basis.

Policy –
a written contract of insurance.

Policy Conditions –
an indicator that identifies whether the policy and/or unit has any of the following conditions:
Coded: Y = Yes N = No

Three-Year Fixed Rate Indicator
Multi-state Policy Indicator
Interstate Rated Indicator
Estimated Exposure Indicator
Retrospective Rated Indicator
Canceled Mid-Term Indicator
Managed Care Organization Indicator
Certified Healthcare Network

Policy Count –
a total of all policies written on a direct basis, including USL&HW, coal mine, assigned risk, etc.

Policy Effective Date –
the month, day and year upon which the policy became effective.

Policy Expiration Date –
the month, day and year upon which the policy expired.

Policy Information Page –
see definition for Information Page

Policy Number –
the number that uniquely identifies the policy.

Policy Period –
the length of time between the policy effective date and policy expiration date.

Policy Surcharge Factor –
Second Injury Fund, Uninsured Employers Fund, and Plan Surcharge for Rejected Voluntary Coverage.

Policy Type ID Code –
the code that corresponds to the Type of Coverage, Plan Indicator and Non-Standard Indicator provisions of the policy.

Policy Verification Report –
a report that alerts the insurers of unit reports that are expected to be filed with the DCOs. This listing is issued in the 14th month for Minnesota, and in the 13th month for New York, Pennsylvania and Delaware.

Policy Year –
the year of the effective date of the policy.

Policy Year Assigned Risk (PYAR) Report –
a report that aggregates data by policy year for assigned risks.

Policy Year Capitated Medical (PYCM) Report –
a report that aggregates data by policy year for capitated medical only.

Policy Year Federal (PYF) Report –
a report that aggregates data by policy year for federal (F) classifications only.

Policy Year Large Deductible (PYLD) Report –
a report that is used to perform premium level analysis, test rate adequacy and reserve level changes for large deductible policies.

Policy Year Report (PY) –
a report that aggregates data by policy year from policies written in that year, regardless of when the accident occurred or when the loss was reported.

Pool –
insurance companies that have joined together for the purpose of sharing the risks. Term is mostly associated with the involuntary market; e.g., Assigned Risk Pool.

PPO –
see definition for Preferred Provider Organization

Pre-ASWG –
statistical reporting requirements that were required prior to implementation of the expanded ASWG data elements and format. Pre-ASWG filing requirements were for policies effective prior to 1-1-96 (for most states).

Pre-delinquent Report –
a listing that alerts the insurers of unit reports that are expected to be filed with the DCOs. Also known as the Pre-notification Listing.

Preferred Provider Organization (PPO) –
a program that establishes contracts with providers of medical care. Providers under such contracts are referred to as preferred providers. A PPO arrangement can be insured or self-funded. Providers may be, but are not necessarily, paid on a discounted fee-for-service basis.

Preliminary Fine List-Quality –
a listing that alerts insurers of unit reports that contain errors for which corrections have not been received.

Preliminary Modification –
a temporary experience modification factor that is issued to an insured until such time that the rates are approved in a given state.

Premium –
a money amount to be paid for coverage on an insurance policy.

Premium Amount –
by Extension of Payroll: (Payroll x manual rate) divided by 100

Other premium:
As defined by the classification/statistical code or DCO statistical plan.

Premium by Size of Policy (PSP) Report –
a report used to determine premium discounts by state.

Premium Deviation –
means to depart from the standard premium. There are many types of premium deviations.

Premium Discount (Amount) –
a discount in the price of an insurance policy attributable to proportionally lower expense costs for larger policies.

Premium Written –
the total premium on all policies written by an insurer during a specified period of time regardless of what portions have been earned.

Previous and Revised –
a reporting procedure requiring that both last report and revised data be submitted. These data segments are indicated by a **P** (previous) or **R** (revised) as shown in the ***Update Type***. These indicators are used for correction reports and subsequent reports. Certain rating bureaus require Previous and Revised; they will not accept Add (A), Change (C) or Delete (D).

Prior Approval State –
states where insurance companies must file proposed rate changes with state regulators, and gain approval before the proposed rates can go into effect.

Professional Employer Organization (PEO) –
another name commonly used for employee leasing companies, depending on jurisdictional requirements. It is a company that provides integrated human resource administration and risk management services to its clients, potentially including various services pertaining to the purchase of coverage, loss prevention and mitigation, and/or compliance with respect to workers' compensation insurance.

Program for Submission of California Aggregate Data (SCAD) –
see definition for SCAD

Proof of Coverage (POC) –
a process that is utilized by various rating organizations or states to verify the employer is covered for workers' compensation.

Protocol –
a set of formal rules describing how to transmit data.

PSP –
see definition for Premium by Size of Policy

Pure Premium –
a premium necessary to cover the expected loss for a policy. Some states define pure premium as containing no provision for expenses, profit, and contingencies; others include loss adjustment expenses as part of the definition.

PY –
see definition for Policy Year (Report)

PYAR –
see definition for Policy Year Assigned Risk (Report)

PYCM –
see definition for Policy Year Capitated Medical (Report)

PYF –
see definition for Policy Year Federal (Classification Report)

PYLD –
see definition for Policy Year Large Deductible (Report)

Q
QC – see definition for Quality Control
QDWP – see definition for Quarterly Direct Written Premium (Report)
Quality Control (QC) – a term that collectively describes the efforts of a DCO, insurers, etc., to ensure that the data reported and collected is of the highest quality.
Quarterly Direct Written Premium (QDWP) Report – is cumulative and is used to analyze the direct written premium in the voluntary market and to determine bureau assessments and pool participation.
Queries – are issued by rating organizations when a discrepancy or error in rates or other calculations are found. Queries are used by some DCOs instead of error reports to request a correction to an error.
R
Retros – see definition for Retrospective Ratings
'R' Report – see definition for Replacement Report
Rate – a cost for insurance for a unit of exposure, by classification (usually $100 of payroll).
Rate Deviations – a factor that an insurer applies to premiums or pure premiums filed by a statistical agent and/or approved by the department of insurance to determine the rates it will charge its policyholders.
Rate Effective Date – a rate effective date is reported only when different from the policy effective date.
Rated Policy – for workers' compensation data reporting, refers to a policy that qualifies for an experience rating plan, merit rating, schedule rating or other types of rating plans.
Rating Organization – an entity, other than a single insurer, that assists insurers by compiling and furnishing loss or expense statistics and recommending, making or filing rates, forms or supplementary rate information.
Ratemaking – a process used by the DCOs for determining the rates for a given state and classification.
Replace – a policy that replaces a previously issued policy due to changes.
Replacement Report Indicator ('R' Report) – indicates that a unit report should "replace" what the rating organization has in its system.

Report Card –
a performance report produced by NCCI that grades an insurer's reporting performance by data type.

Report Number –
a number code that corresponds to the report level based on the loss valuation date.

Report Level –
see definition for Report Number

Request for Bid (RFB) –
a letter with attached specifications detailing a service and requesting a bid on the service.

Request for Information (RFI) –
a request that solicits input on a process or project. May or may not request a bid.

Request for Proposal (RFP) –
a request for bids that indicates the specification for a project.

Request for Quote (RFQ) –
usually refers to the process whereby data is provided for certain questions, e.g., purchasing insurance online and a price or quote is received from the company.

Reserved for Bureau Use –
reserved for DCO use.

Reserved for Carrier Use –
companies may use this space for internal purposes.

Reserves –
insurer funds set aside to meet future obligations.

Residual Market (RM) –
a term used to describe the various types of insurance that is written on a non-voluntary basis. Collectively includes pools, assigned risk, joint underwriting associations, etc.

Residual Market Application Processing System® (RMAPS®) –
NCCI's online residual market application processing system.

RIMS –
Risk and Insurance Management Society

RISK ID –
Risk Identification Number

S

SAWW –
State Wide Average Weekly Wage

'S' Claims –
a closed death claim compromised over the sole question of applicability of the workers compensation laws of California.

SCAD (Program for Submission of California Aggregate Date) –
a program instituted by the Worker's Compensation Insurance Rating Bureau of California that encourages the filing of financial data on a timely and accurate basis.

Sched Z –
see definition for Schedule Z

Schedule Rating –
a plan that alters the premium based on attributes that are not reflected in the experience of individual employers (insureds).

Schedule Rating Premium (SRP) Report –
a report used to validate premium data reported on other reports. Compilation of the premium data is used in analyzing competitive markets.

Schedule Z (Sched Z) –
a Schedule Z (Sched Z) is a report by:
– Classification Code
– Report Number (1-5 normally)
– Injury Code – on some Sched Zs, this field has a dual purpose and may be called a Transaction Code, where the first position of the Transaction Code is a 1, indicating losses. Therefore, medical only claim would be shown as transaction 16.
– Policy/Claim Count
– Exposure/Indemnity
– Manual Premium/Medical
– Standard Premium

Depending upon the DCO, the Sched Z may contain less or more information. The format can be different by DCO. There is not a standard format utilized by the DCOs for the production of Sched Z data.

SCIF –
see definition for State Compensation Insurance Fund

SF –
State Fund

SIC –
Standard Industry Classification

SIF –
Second Injury Fund or State Insurance Fund (of Oklahoma) or Self-Insured Fund

SIG –
Self-Insured Group

SIIIS –
State Industrial Insurance System (of Nevada)

SRP –
Scheduled Rating Premium (report)

SSN –
Social Security Number

Stat –
short for Statistical, e.g., Stat Agent, Stat Plan, Stat Codes, etc.

SWIF –
State Workers' Insurance Fund (of Pennsylvania)

T

T/A –
Trading As

Temporary Total Disability –
an injured worker's status prior to maximum medical improvement is reached during which the worker is unable to perform any work.

Third-Party Administrator (TPA) –
an organization hired to perform one or more of the business functions of another company.

Terrorism Risk Insurance Act (TRIA) –
Requires property and casualty insurers doing business in the United States to offer coverage for incidents of international terrorism; and reinsures a large percentage of that insured risk.

Terrorism Risk Insurance Program Reauthorization Act of 2007 (TRIPPRA) -
Requires property and casualty insurers doing business in the United States to offer coverage for incidents of terrorism; and reinsures a large percentage of that insured risk. TRIPRA eliminated the distinction between foreign and domestic terrorism found in the initial TRIA program.

Total Allocated Loss Adjustment Expense – Incurred –
the total of the incurred expense amounts that are used to adjust claims that are reported for the state within the policy period. In the case of corrections and subsequent reports, this must be the revised total.

Total Allocated Loss Adjustment Expense – Paid –
the total of the paid expense amounts that are used to adjust claims that are reported for the state within the policy period. In the case of corrections and subsequent reports, this must be the revised total.

Total Claimant's Attorney Fees –
the total of the incurred claimant's attorney fees reported for the state within the policy period. In the case of corrections and subsequent reports, this must be the revised total.

Total Employer's Attorney Fees –
the total of the incurred employer's attorney fees reported for the state within the policy period. In the case of corrections and subsequent reports, this must be the revised total.

Total Incurred Indemnity –
the total of the incurred indemnity amounts for the state within the policy period.
In the case of corrections and subsequent reports, this must be the revised total.

Total Incurred Medical –
the total of the incurred medical amounts reported for the state within the policy period.
In the case of corrections and subsequent reports, this must be the revised total.

Total Modified Premium –
the total subject premium multiplied by the experience modification factor.

Total Number of Claims –
the total number of claims reported for the state within the policy period.
In the case of corrections and subsequent reports, this must be the revised total.

TPA –
see definition for Third Party Administrator

TRIA –
see definition for Terrorism Risk Insurance Act

TRIPPRA –
see definition for Terrorism Risk Insurance Program Reauthorization Act of 2007

U

U/R –
Unit Report

ULAE –
Unallocated Loss Adjustment Expense

Unit –
Short for Unit Statistical Report

URC –
Unit Report Control (NCCI)

URE –
Unit Report Expansion (NCCI)

URQ –
Unit Report Quality (NCCI)

USL&HW –
United States' Longshore and Harbor Workers

USR –
Unit Statistical Report

USRP –
California's Workers' Compensation Uniform Statistical Reporting Plan

V

VOL –
short for Voluntary Insurance. See definition for Voluntary Insurance

Voluntary Compensation (Vol Comp) –
an endorsement to the standard workers' compensation insurance policy that extends coverage to employees not required to be covered under the state's statutory workers' compensation provisions.

Voluntary Insurance (VOL) –
a term where an insurance company freely agrees to insure a risk, using its' own rules, rates and forms.

VR - Vocational Rehabilitation
VSAM – see definition for Virtual Storage Access Method
W
Wage Loss – temporary disability benefits that may be paid when an employee returns to work at less than full earnings.
WAN – see definition for Wide Area Network
WC – see definition for Workers' Compensation
WCCDCI – WCIO's electronic format for reporting Detailed Claim Information.
WCCNTL – WCIO's electronic format for reporting unit report data control listings; e.g. Pre-delinquent, Delinquent, etc.
WCCRIT – WCIO's electronic format for reporting
WCF – Workers' Compensation Fund (of Utah)
WCIO – Workers' Compensation Insurance Organizations
WCIRBC – Workers' Compensation Insurance Rating Bureau of California
WCMODS – WCIO's electronic format for reporting
WCNOA – WCIO's electronic format for notice of assignments.
WCNOTIFY – WCIO's electronic format for reporting
WCPOLS – WCIO's electronic format for reporting policy data.
WCRATE – WCIO's electronic format for rates.
WCRATING – WCIO's electronic format for rating worksheets
WCRB – Wisconsin Compensation Rating Bureau

WCRI –
Workers' Compensation Research Institute

WCRIBM –
Workers' Compensation Rating Inspection Bureau of Massachusetts

WCSTAT –
WCIO's electronic format for reporting unit report and Individual Case/Claim Report data.

Weekly Wage –
an injured employee's weekly earnings.

Wide Area Network (WAN) –
a network extending over distances.

Wisconsin Compensation Rating Bureau –
the authorized data collection organization for the state of Wisconsin.

Workers Compensation Insurance Organizations (WCIO) –
a voluntary association of statutorily authorized or licensed rating, advisory or data services organizations that collect Workers' Compensation insurance information in one or more states.

Workers' Compensation Statistical Plan –
see definition for Statistical Plan

Workers' Compensation Rating and Inspection Bureau of Massachusetts –
the authorized data collection organization for the state of Massachusetts.

Workers' Compensation (WC) –
The NAIC Statistical Handbook, Section 23, defines workers' compensation as: "Insurance that employers are required (in most states and for most employers) to provide to cover employees against loss of income and/or medical expenses that result from job-related injury, disease or death."

Workers' Compensation Data Monitoring (WCDM) –
a program applicable to certain states to monitor the quality of workers' compensation data.

Workers' Compensation Data Specifications Manual –
a manual published and administered by the WCIO of electronic specifications that provides standardized formats for exchanging information on electronically, including policy, unit report and individual case report (ICR) submission requirements.

Workers' Compensation Fund of Utah (WCF) –
a self-supporting non-profit mutual insurance company, and the market of last resort in Utah.

Workers' Compensation Insurance –
coverage to insure the employer's responsibilities for work-related injuries, including occupational diseases.

Workers Compensation Research Institute (WCRI) –
an organization of insurers and Data Collection Organizations conducting research and analysis for the improvement of the workers' compensation system.

Workers' Compensation Unit Report –
see definition for Unit Report

Workforce Safety and Insurance (WSI) - an exclusive, premium-financed, no-fault insurance system covering workplace injuries, illnesses and deaths. (North Dakota)
WSI - see definition for Workforce Safety and Insurance.
Write – to insure, underwrite, or accept an application for insurance.
Written Premium – the entire amount of premium written during a period regardless of whether the premiums are earned or unearned. See Premium Written.
World Wide Web (WWW) – a term used to indicate the client-server hypertext distributed information retrieval system which originated from the CERN High-Energy Physics Laboratories in Geneva, Switzerland.
Wrap-Up/Owner Controlled Insurance Program (OCIP) Code – a code used to report if a policy covers a large construction, erection or demolition project.
X
XML – see definition for Extensible Markup Language
X-Mod – short for experience modification. See definition for Experience Modification
Y
Z
ZIP Code – Zoning Improvement Plan Code.