



**State of Rhode Island
Licensed Insurers Assessment Return Form**

Department of Labor and Training, Workers' Compensation Administrative Fund
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8101

WCAF ID#

**WORKERS' COMPENSATION ADMINISTRATIVE FUND
INFORMATION REQUEST FOR CALENDAR YEAR 2010**

PLEASE COMPLETE AND RETURN BEFORE: March 31, 2011

THE COMPLETED FORM MAY BE MAILED OR FAXED TO: (401) 462-8095

INSURER INFORMATION:

Please make changes to any incorrect information

CONTACT INFORMATION:

Contact Name: _____
Contact Phone/Ext: _____
Contact Email: _____
Insurer FEIN: _____

DIVIDEND DEDUCTIONS: (Dividends paid or credited to policyholders)

Net dividends: _____

Dividends received from companies on ceded reinsurance: _____

Dividends paid or credited to companies on assumed reinsurance: _____

PREMIUMS WRITTEN:

Workers' Compensation and Employers' Liability premiums on risks in the State of RI (Gross less returns): _____

Workers' Compensation and Employers' Liability premiums on risks outside Rhode Island, subject to its jurisdiction (Gross less returns): _____

Reinsurance assumed from companies not authorized to do business in RI: _____

Total premium credit on deductible policies written (Total employer would have paid without deductible provision less total written premium paid): _____

List the **TOTAL** number of policies active during the calendar year of this report: _____

I, the undersigned Treasurer, or other duly authorized officer of the company for which this return is made, hereby certify that I have personal knowledge of the statements and other information set forth above, that the same are true, correct and complete to the best of my knowledge and belief, and that this statement is made under the penalty of perjury.

Signature: _____ **Date:** _____

Printed Name: _____ Title: _____