



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

Department of Labor and Training, Workers' Compensation Administrative Fund  
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100

**WCAF ID#**

Please use this ID# on all correspondence relating to your assessment.

**WORKERS' COMPENSATION ADMINISTRATIVE FUND  
INFORMATION REQUEST FOR CALENDAR YEAR 2015  
PLEASE COMPLETE AND RETURN BEFORE March 31, 2016**

**FAX (401) 462-8714**

**INSURER INFORMATION:**

Please make changes to any incorrect information

**CONTACT INFORMATION:**

Contact Name: \_\_\_\_\_  
Ins Group Name: \_\_\_\_\_  
Contact Phone/Ext: \_\_\_\_\_  
Contact Email: \_\_\_\_\_

**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 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: \_\_\_\_\_

Completed and signed forms may be returned by mail, fax or e-mailed to: Natalie.Gray@dlt.ri.gov