

## Workers' Benefit Fund Assessment CORRECTIONS AND CHANGES NOTIFICATION

• Use this form to update your Workers' Benefit Fund assessment account\*

Business Name	Oregon Business Identification Number (BIN)
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<b>CORRECTIONS</b> (enter corrected information)			
Is this address to be used for forms only? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Business Name		BIN	
Mailing Address		Federal Employer Identification Number (FEIN)	
City	State	ZIP Code	Telephone Number (     )

<b>CHANGES IN STATUS</b> (check and complete all that apply)
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- 1. No longer in business.** Effective date of closure: \_\_\_\_\_
- 2. Still in business, but have no paid employees.** Effective date: \_\_\_\_\_  
 I maintain workers' compensation insurance coverage:
  - Not for myself and/or corporate officers, but in case I hire employees.
  - To cover myself and/or corporate officers exclusively; no employees.
  - To cover volunteer workers exclusively.
- 3. I no longer have workers' compensation insurance coverage:**
  - I have canceled my workers' compensation insurance coverage.  
 Effective date of cancellation: \_\_\_\_\_
  - I will be canceling my workers' compensation insurance coverage.  
 Effective date of cancellation: \_\_\_\_\_
- 4. I now use leased employees only.** Effective date: \_\_\_\_\_
- 5. Other.** Please explain: \_\_\_\_\_

<i>DCBS Use Only</i>
<i>RC02</i> _____
<i>RC06</i> _____
<i>A/L</i>
<i>RC06</i> _____
<i>RC02</i> _____
<i>RC02</i> _____
<i>RC05</i> _____

\* **Contact your insurance carrier to make any changes in name, partnership, corporate status, or changes in the number of personal elections taken.** Check with your insurance company to see if it will accept a copy of this form as notification of any changes or corrections to your insurance policy.

**Note:** Submitting this notice to the Workers' Compensation Division will affect **only** your Workers' Benefit Fund assessment account for purposes of reporting. It will **not** affect your workers' compensation insurance coverage or claims liability. You need to contact your insurance provider to notify it of the changes.

I understand that I am required to report and pay the Workers' Benefit Fund assessment at any time that the law requires or I choose to carry workers' compensation insurance coverage for myself or for any of my paid workers in Oregon.	Mail your completed form to:  <b>WC Assessments Section</b> <b>DCBS Fiscal and Business Services</b> <b>PO Box 14480</b> <b>Salem OR 97309-0405</b>
X _____ Signature <span style="float: right;">Date</span>	
_____ Print Name <span style="float: right;">Telephone Number</span>	