



**Workers' Compensation Insurer
Premium Assessment Report to
Department of Consumer and Business Services
Fiscal and Business Services
P.O. Box 14610, Salem, OR 97309-0445
503-947-7941**

Insurance company name and address (do not leave blank):

Name: _____

For calendar quarter ending: _____

Address: _____

Oregon WCD carrier no.: _____

1. a. Earned premium [from Annual Statement, Oregon Exhibit of Premiums and Losses (Statutory Page 14), column 2, line 16, quarter's portion] <i>If no premiums were earned, enter "None."</i>	\$ _____ -
b. Less exempted earned premium*	(\$ _____)
c. Plus large deductible premium credits applied for the period	\$ _____ -
d. Assessable earned premium (total of Lines 1a, 1b, and 1c)	\$ _____ -
2. Current assessment percentage	_____ 0.00%
3. Subtotal premium assessment due (Line 1d x Line 2)	\$ _____ -
4. Credit balance from previous quarters	(\$ _____)
5. Total premium assessments due (total of Lines 3 and 4)	\$ _____ -

Place all negative amounts in parentheses.

***Exempted earned premium:** Premiums earned on insurance under jurisdiction of the federal government (e.g., U.S. Longshore and Harbor Workers' Compensation Act, Federal Employer's Liability Act, and Jones Act), and employer liability increased limits premium as reported in the insurer's Annual Statement, Exhibit of Premiums and Losses (Statutory Page 14), Business in the State of Oregon, Column 2 Direct Premiums Earned, Line 16 Workers' Compensation. All exempted earned premium must be stated on a direct basis prior to reinsurance transactions.

Preparer's signature _____ Date _____

Please print:

Name: _____
Title: _____
Phone: _____
Fax: _____
E-mail: _____

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