Department of Consumer & Business Services
Oregon Division of Financial Regulation
350 Winter St. NE
Salem, Oregon 97301-3883
Phone (503) 947-7983

WORKERS' COMPENSATION RATE FILING

APPENDIX TO FILING INFORMATION

Company Name: _____

When filing a revision to one of the factors listed below, this form must be completed. Enter all factors currently approved in the Current column. The Proposed column includes the factors submitted for review in this filing along with any factors not changing.

The Workers' Compensation Rate Factor Log on the Division of Financial Regulation's website is based upon this information. Accuracy in filing this form ensures the carrier's information will be correctly shown in the Log.

		Current	Proposed
16	Automatic Loss Cost Multiplier*	_____	_____
17	Fixed Loss Cost Multiplier*	_____	_____
18	Maximum Premium Discount Percentage	_____%	_____%
19	Maximum Minimum Premium	$_____	$_____
20	Expense Constant	$_____	$_____
35	Retro Expected Loss Ratio	_____	_____
36	US L&H Percentage	_____%	_____%

* When filing a loss cost multiplier to be applicable to future revisions, then complete item 16 above. If the multiplier is applicable to this filing only, then item 17 above needs to be completed. (Refer to Reference Filing Adoption Form 440-3616w, item 9)

Previous SERFF tracking number: _____

For companies that have more than one loss cost multiplier please identify the name used to describe the plan or tier? _____

Number of policy holders for this plan or tier: _____