MINNESOTA ERM-6 FORM
WORKERS COMPENSATION EXPERIENCE RATING

NAME OF EMPLOYER _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE____ZIP _____

ASSOCIATION FILE NO _____ EFFECTIVE DATE OF RATING_____ POLICY EFFECTIVE DATE _____

(1) Upd Type P/R	(2) Claim Number	(3) Acc Date	(4) Class Code	(5) Payroll	(6) Total Incurred Indemnity	(7) Total Incurred Medical	(8) Paid Indemnity	(9) Paid Medical	(10) Inj Type	(11) 0/1/2	(12) Part/Nat/Cause		

PLEASE FOLLOW THE INSTRUCTIONS ON THE FOLLOWING PAGES FOR COMPLETING THIS WORKSHEET AND RETURN IT TO MWCIA PRIOR TO THE RATING EFFECTIVE DATE.

INSTRUCTIONS FOR SUBMITTING EXPERIENCE RATING DATA FOR ERM-6

COLUMN 1 — When submitting a 1st report, place a "R" (Revised Report) in the space provided or leave blank. When submitting a Subsequent or a Correction Report, indicate whether the Update Type is (P) Previously Reported or (R) Revised Report by placing a "P" or "R" in the space provided..

COLUMN 2 — Provide the Claim Number used for internal record keeping. Claims must be reported individually.

COLUMN 3 — Fill in the Accident Date (Date of Loss) of the Claim being reported.

COLUMN 4 — Fill in the Classification Code(s) that best describe your type of business. If you have any questions regarding classifications, please contact your insurance agent.

COLUMN 5 — Fill in the Payroll amounts associated with the Classification Code(s) for each year being reported rounded to the nearest dollar amount.

COLUMN 6 — Fill in the sum of Incurred (paid plus reserved) Indemnity rounded to the nearest dollar amount. If no claims occurred, place a "0" in that space.

COLUMN 7 — Fill in the sum of Incurred (paid plus reserved) Medical rounded to the nearest dollar amount. If no claims occurred, place a "0" in that space.

COLUMN 8 — Fill in the sum of Paid Indemnity rounded to the nearest dollar amount. If no claims occurred, place a "0" in that space.

COLUMN 9 — Fill in the sum of Paid Medical rounded to the nearest dollar amount. If no claims occurred, place a "0" in that space.

COLUMN 10 — Fill in the appropriate Injury Type Code (see following list). Only one Injury Type Code is applicable per claim. Medical Only claims should be listed as a "6", but claims that include both medical and disability or death benefits should be listed under the applicable disability or death code, such as "5" (Temporary Total or Temporary Partial Disability). Injury Type Codes must be noted for each entry.

1 = Death	6 = Medical Only
2 = Permanent Total Disability	7 = Contract Medical or Hospital Allowance
5 = Temporary Total or Temporary Partial Disability	9 = Permanent Partial Disability

COLUMN 11 — Indicate whether the Claim Status is (0) Open, (1) Closed or (2) Reopened by placing a "0," "1" or "2" in the space provided.

COLUMN 12 — Provide the appropriate 2-digit Injury Description Code in each column that represents the Part of Body, Nature of Injury and Cause of Injury applicable to the corresponding claim. These code lists can be found in the ***Minnesota Statistical Plan Manual***.

Subsequent Reports shall be filed with MWCIA in accordance with the valuation schedule set forth in the ***Minnesota Statistical Plan Manual***. **These are required through a 3rd report level** for each policy where one or more claims have been:

A. Reported as open on the previous report
B. Previously reported as closed but are now open
C. Previously unreported
D. Previously reported and the current valuation differs in any manner from the previously submitted data

The experience rating will be completed in accordance with the ***Minnesota Experience Rating Plan Manual***. However, because we do not verify the accuracy of the data submitted, the modification factor will be issued with a disclaimer.

Name of the employer requesting the rating _____

Name of the party submitting the data (if different) _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

AGREEMENT

We hereby certify that the information given in this report is correct to the best of our knowledge and belief. BY SUBMISSION OF THIS INFORMATION, WE REQUEST THAT MWCIA PRODUCE EXPERIENCE MODIFICATION FACTORS FOR THE EMPLOYER LISTED AND AGREE TO PAY ANY FEES ASSOCIATED WITH THIS SERVICE. In consideration of MWCIA's agreement to produce the requested experience modification(s), we release and discharge MWCIA, its officers, directors, employees and agents from all liability in connection with the production or application of the same.

The person signing this agreement certifies that they have the authority to execute this agreement on behalf of the employer requesting the rating. Authorized signers include the employer, the carrier, and the TPA **ONLY**.

Please check applicable box of person signing below:

☐ **Employer** ☐ **Carrier** ☐ **TPA**

Signed: _____ Date: _____

Printed Name of Signer: _____ Title: _____