Minnesota Workers' Compensation
Insurers Association, Inc.
7701 France Avenue South ▪ Suite 450
Minneapolis, MN 55435-3200

August 5, 2009

ALL ASSOCIATION MEMBERS

Circular Letter No. 09-1561

RE: Revised Minnesota ERM-6 Form

The Minnesota Department of Commerce has approved the above filing to become effective 12:01 a.m., September 1, 2009, for new and renewal business. The purpose of this filing is to revise the Minnesota ERM-6 form which is located in the ***Minnesota Experience Rating Plan Manual.***

The revisions made to the Minnesota ERM-6 form include adding two new columns to the form: Column (1) for Update Type and Column (12) Part, Nature and Cause. Also, there were some minor reformatting and other miscellaneous revisions made to help clarify the data needed when submitting the form to MWCIA.

Attached are copies of the Minnesota ERM-6 form showing strikethrough and underlined text. The strikethroughs indicate deleted text, while the underlining indicates new text. A copy of the final version of the form has also been included.

If you have any questions regarding this item, please contact Ora Lowery at 952.897.6423 or by emailing ora.lowery@mwcia.org.

MINNESOTA ERM-6 FORM
WORKERS COMPENSATION EXPERIENCE RATING

NAME OF ~~RISK~~ _____

ADDRESS OF ~~RISK~~ _____ CITY _____ STATE____ZIP _____

~~RISK IDENTIFICATION~~ NO _____ EFFECTIVE DATE OF RATING_____ POLICY EFFECTIVE DATE _____

(1) ~~Claim Number~~	~~(2) Acc Date/ # of Claims~~	~~(3) Class Code~~	~~(4) Payroll~~	~~(5) Total Incurred Medical~~	~~(6) Total Incurred Indemnity~~	~~(7) Paid Medical~~	~~(8) Paid Indemnity~~	~~(9) Injury Type~~	~~(10) Status Open/ Closed~~

PLEASE FOLLOW THE INSTRUCTIONS ON THE ~~NEXT PAGE~~ FOR COMPLETING THIS WORKSHEET AND RETURN IT TO MWCIA PRIOR TO THE RATING EFFECTIVE DATE.

INSTRUCTIONS FOR SUBMITTING EXPERIENCE RATING DATA FOR ERM-6

PAYROLL AND LOSSES MUST BE ROUNDED TO THE NEAREST WHOLE DOLLAR.

COLUMN 1 Provide the Claim Number used for internal record keeping.

~~COLUMN 2~~ Fill in the Accident Date (Date of Loss) ~~or Number of Claims being reported.~~

~~COLUMN 3~~ Fill in the Classification Code(s) that best describe your type of business. If you have any questions regarding classifications, please contact ~~Customer Service at 952-897-1737 (Option 1).~~

~~COLUMN 4~~ Fill in the Payroll amounts associated with the Classification Code(s) for each year being ~~reported.~~

~~COLUMN 5~~ Fill in the sum of Incurred (paid plus reserved) ~~Medical.~~ If no claims occurred, place a "0" in that space. ~~Claims must be reported individually regardless of claim amount.~~

~~COLUMN 6~~ Fill in the sum of Incurred (paid plus reserved) ~~Indemnity.~~ If no claims occurred, place a "0" in that space. ~~Claims must be reported individually regardless of claim amount.~~

~~COLUMN 7~~ ~~Fill in the sum of Paid Medical.~~ If no claims occurred, place a "0" in that space. ~~Claims must be reported individually regardless of claim amount.~~

~~COLUMN 8~~ ~~Fill in the sum of Paid Indemnity.~~ If no claims occurred, place a "0" in that space. ~~Claims must be reported individually regardless of claim amount.~~

~~COLUMN 9~~ 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 ~~10~~ ~~Indicate whether the claim is Open or Closed/Final by placing an "O" or "F" in that space.~~

Subsequent Reports shall be filed with MWCIA in accordance with the valuation schedule set forth in ~~Part VII, Item I of the~~ ***~~Minnesota Statistical Plan Manual~~*** 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

~~Where a claim was previously identified with a Claim Number, all Subsequent Reports of this claim must be submitted on an individual claim basis, even if the claim becomes a Medical Only claim. Subsequent Reports are only required through the 10th report. Refer to Part I of the ***Minnesota Statistical Plan Manual*** for additional instructions on valuation and filing. (Note: Unit statistical data for policies effective 12/31/1998 and prior, which meet the requirements for subsequent reporting, are only required to file the 2nd – 5th Subsequent Reports.)~~

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 ~~RISK~~ 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.

Signed: _____ Date: _____

Printed Name of Signer: _____ Title: _____

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 Medical	(7) Total Incurred Indemnity	(8) Paid Medical	(9) Paid Indemnity	(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

PAYROLL AND LOSSES MUST BE ROUNDED TO THE NEAREST WHOLE DOLLAR.

COLUMN 1 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) Medical 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) Indemnity rounded to the nearest dollar amount. If no claims occurred, place a "0" in that space.

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

COLUMN 9 Fill in the sum of Paid Indemnity 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
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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:

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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.

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

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

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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**.

☐ **Employer** ☐ **Carrier** ☐ **TPA (Please check applicable box of person signing below)**

Signed: _____ Date: _____

Printed Name of Signer: _____ Title: _____

MINNESOTA ERM-6 FORM
WORKERS COMPENSATION EXPERIENCE RATING

09/2009

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 Medical	(7) Total Incurred Indemnity	(8) Paid Medical	(9) Paid Indemnity	(10) Inj Type	(11) 0/1/2	(12) Part/Nat/Cause		

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Phone _____ Fax _____ Email _____

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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**.

☐ **Employer** ☐ **Carrier** ☐ **TPA (Please check applicable box of person signing below)**

Signed: _____ Date: _____

Printed Name of Signer: _____ Title: _____