



**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 & 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), employer liability increased limits premium, and excess coverage premium. All exempted earned premium must be stated on a direct basis prior to reinsurance transactions.

Preparer's signature	Date
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Please print:

Name: _____

Title: _____

Phone: _____

Fax: _____

E-mail: _____

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