

**CERTIFICATION FOR WORKER'S COMPENSATION CARRIERS**

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

I, \_\_\_\_\_, hereby CERTIFY that I am \_\_\_\_\_  
(Official Title)

of \_\_\_\_\_ and that I have knowledge of the  
(Carrier)

worker's compensation records of Carrier. I further CERTIFY that the amount of **direct written premiums** issued by Carrier for Indiana Worker's Compensation Insurance in the calendar year **2008** totaled \$\_\_\_\_\_.

I further CERTIFY that I have calculated Carrier's 2010 assessment for the Second Injury Fund by dividing the above number representing Carrier's Direct Written Premiums by 710,109,000 (which, in dollars represents the total direct written premiums for all worker's compensation carriers in Indiana in 2008), and then multiplying that figure by 5,791,780 (which, in dollars represents the amount for all carriers portion of the 2008) assessment for the Second Injury Fund). This calculation gave me \_\_\_\_\_, which in dollars represents Carrier's total annual assessment.

I further CERTIFY that the enclosed sum of \$\_\_\_\_\_ represents one half of Company's calculated assessment, which is the first installment of the statutory assessment due by **January 31, 2010** and payable to the Worker's Compensation Board of Indiana for the Second Injury Fund. I agree to pay \$\_\_\_\_\_ as payment of the second half of Company's assessment for 2010 *without notice* to the Board by **June 15, 2010**.

I hereby verify, subject to penalties of perjury, that the facts contained herein are true.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Carrier Name

\_\_\_\_\_  
Federal ID Number

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Telephone Number

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E-mail Address

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Mailing Address

Contact Email Address\*

**\*Please note that IC§22-3-3-13(j) requires each company subject to this assessment to provide to the Board the name, address, and E-mail address of a representative authorized to receive the notice of assessment.**