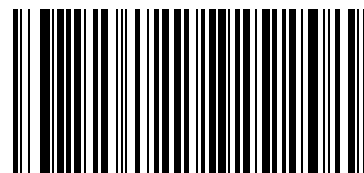




Statistical Handbook

of Data Available to Insurance Regulators

2012



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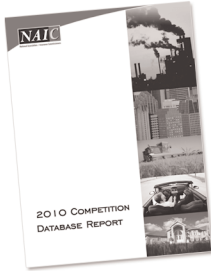
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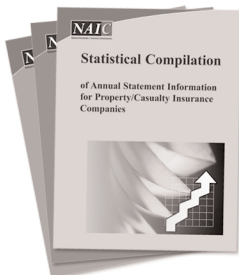
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SECTION 1

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SECTION 1

1. INTRODUCTION TO THE *HANDBOOK* AND TO STATISTICAL REPORTING

1.1 Purpose of the Statistical Handbook

The *Statistical Handbook* addresses the collection, compilation and reporting of insurance statistical information. Please note that, while the *Handbook* also refers to and discusses Annual Statement page 15 data, the *Handbook's* coverage of financial data is neither authoritative nor is it intended to be complete.

1.2 Regulatory Needs for Statistical Data

State laws give insurance regulators various responsibilities to oversee the operations of property/casualty insurers. Responsibilities most relevant to statistical collection include:

- to ensure that rates meet statutory standards, i.e., that they are not inadequate, excessive or unfairly discriminatory and
- to monitor market structure and performance and act if necessary to restore competition or remedy the problems caused by market failure.

Regulatory responsibilities generate needs for several types of data including financial and statistical. Both types of data flow from one source - the transactions conducted by property/casualty insurance companies. This information provides the basis for evaluating solvency, monitoring market trends and assessing the proper relationships between rates and coverages.

Property/casualty insurers are thus required by laws and regulations to prepare extensive statistical and financial reports for state insurance departments to help them meet their regulatory responsibilities.

1.3 Financial Versus Statistical Data

The financial data that insurers must report focuses on quarterly or annual performance as well as current financial status. Regulators can use this financial data as a “snapshot” view of a financial picture that is both larger in scope and longer in duration. With this kind of information, regulators evaluate financial solvency and decide whether to take regulatory action to conserve an insurer’s assets and protect the interests of policyholders.

By contrast, regulators use statistical data to evaluate the rates and rating structures used by insurers in a state. In most cases, calendar year financial “snapshots” do not provide the necessary match of premiums and losses for such an analysis. Statistical data address this and other information needs by providing the essential match of premiums and losses for comparable policies.

The requirements outlined in this *Handbook* pertain to the collection of statistical data. Requirements for financial data reporting appear in the *Annual Statement Instructions* and the *Accounting Practices and Procedures Manual*.

1.4 Insurance Pricing and the Need for Aggregate Data

Central to the analysis of insurance pricing is the availability of reliable data on losses versus corresponding premiums and exposures. As with all forms of statistical data analysis, larger and more consistent statistical samples have a greater probability of producing accurate predictions than smaller ones. Virtually no insurer has enough loss experience to produce a credible database for all aspects of its own pricing decisions. To improve statistical credibility, it is necessary that insurers' data be combined into aggregate databases. To produce more reliable analyses of historic experience and predictions of future costs, both insurers and regulators must commonly look to pooled data.

To carry out this collection and pooling, insurers and regulators customarily rely on statistical agents. These organizations are licensed in many states and can be examined by state regulators. (The laws of the states are not uniform on these points.) As permitted under most state laws, regulators may designate statistical agents to whom insurers must provide their premium and loss experience. These statistical organizations then combine similar information from many reporting companies and give the aggregate information to the states.

1.5 The Statutory Foundation for Statistical Reporting

Data reporting stems from a long history which began with the concept that certain market imperfections justified close public supervision of the insurance business. This supervision primarily took the form of: 1) solvency surveillance to help ensure that insurers can pay the losses they have promised to pay or have contracted and 2) rate regulation to help ensure that rates are not excessive, inadequate or unfairly discriminatory. In more recent years, rate regulatory functions have evolved to include more attention to the monitoring of markets and competition.

The New York State Merritt Committee Report of 1910 recommended that statistical data be combined as a means of facilitating the review of loss experience to monitor solvency and evaluate rates. In 1925, the United States Supreme Court upheld the concept that the exchange of cost and pricing information served the public good.

In 1944, the United States Supreme Court ruled in the Southeastern Underwriters Association case that the selling of insurance was interstate commerce and, therefore, was governed by federal laws regulating interstate commerce. Specifically, the court applied federal antitrust laws to the business of insurance. The decision created uncertainty about the legality of all joint activities within the insurance industry.

The U.S. Congress recognized that the nature of insurance pricing made it necessary to combine premium and loss experience. This was especially important to companies that did not have access to a base of experience large enough to develop credible data on their own. In 1945, Congress passed the McCarran-Ferguson Act, which provided certain antitrust exemptions for the business of insurance to the extent that the states regulated the business. In 1946, the NAIC adopted all-industry model rating laws (one for property and another for casualty) that established the regulation required by the McCarran-Ferguson Act. The NAIC model laws permitted joint action in collection and compilation of data. All

states except California subsequently passed laws patterned after the NAIC model. The relevant language in the original NAIC model laws is shown below:

The commissioner shall promulgate reasonable rules and statistical plans, reasonably adapted to each of the rating systems on file with him, which may be modified from time to time and which shall be used thereafter by each insurer in the recording and reporting of its loss and countrywide expense experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid him in determining whether rating systems comply with the standards set forth in section [].

While the model laws and laws in individual states have changed since then, statutory requirements regarding statistical collection remain similar in most states. (The current NAIC model and the laws in a number of states use “may” instead of “shall.” In addition, the NAIC model and the laws of many states have been revised to be gender-neutral.)

The statutes requiring data reporting generally apply to all licensed property and casualty insurance companies. These companies must file statistics with state insurance departments either through a statistical agent or directly to the department. (As few state insurance departments are equipped to process raw statistical data directly from insurers, the NAIC Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies contemplates that regulators will customarily require the use of statistical agents and not offer the option for insurers to report raw data directly to the insurance department.) Enforcement of the statutes rests with the state insurance department. Departments have the authority to impose fines or suspend or revoke a company’s license for failure to comply.

1.6 The Role of Statistical Agents

In most situations, state insurance departments designate statistical agents to collect statistical data on their behalf. Further details on specific statistical agents are included in Appendix A of this *Handbook*.

Historically, statistical agents have developed detailed instructions called statistical plans, which define the data elements (e.g., line of business, coverage, class, state, territory, premium, etc.) as well as the formats and time frames for company reporting. These statistical plans instruct insurers how to code and submit their premium and loss data to the statistical agent. Statistical agents continually review their statistical plans and modify them when necessary to conform with state reporting requirements and to correspond with rating structures and coverage programs in common use.

Although “statistical plans” in the traditional sense may be superseded for some insurers and statistical agents by other tools designed to accomplish the same results, it remains imperative that statistical plans and/or such other procedures result in data that can be meaningfully combined. For data from different insurers to be meaningfully combinable, it must conform to common data definitions. Standard definitions provide for stable and reliable databases and are, therefore, the basis of meaningful aggregated insurance data. In addition, standard coverage programs, where prevalent, permit the collection of comparable

statistics and help aggregate statistics to be a valid starting point for regulatory monitoring.

As explained in the next section, the Statistical Information (C) Task Force has adopted a uniform set of suggested minimum statistical reporting requirements for all insurers. Although most insurers will readily note this fact, it must be stressed that the Task Force expects well managed insurers and advisory organizations will continually strive to capture more information for their purposes than is contained in the *Handbook's* relatively minimal plans.

Statistical agents have designed their data collection procedures to ensure that they are able to at least meet these minimum requirements. This provides regulators with the ability to aggregate the experience of all insurers using a common set of classifications and definitions, or they can request the statistical agents to do this for them.

1.7 Relation of the *Statistical Handbook* to the Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies

The reporting “requirements” contained in the *Handbook* reflect the minimum statistical compilation and report formats recommended by the NAIC’s Statistical Information (C) Task Force. Many insurers and some statistical agents collect data in addition to these minimums. Except for occasional descriptive material (e.g., descriptions of so-called “fast track” reports), the *Handbook* does not address such additional data collection.

If adopted by a state, the NAIC Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies (#751) provides that the descriptions contained herein be interpreted as minimum requirements, except where a report or other specification is described as optional or unless the context otherwise clearly states that the *Handbook's* specifications are suggested or descriptive and are not required.

For states that have not adopted the NAIC Model Regulation to Require Reporting of Statistical Data by Property and Casualty Insurance Companies, the *Handbook* is intended to serve as a valuable reference that is generally – but not always – consistent with minimum data collection practices by insurers and statistical agents. Without some sort of regulatory requirement adopted by individual states, there is no assurance that insurers and statistical agents are compiling data in accordance with the suggested requirements described herein.

References to optional reports exist to encourage standardization for those states that need such reports, but where it is not anticipated that such reports will be widely used. An example of this is that the *Handbook* has optional reports for states to use when a major catastrophe strikes. Obviously, states have no need for such reports in the absence of a catastrophe. There will also be times when a catastrophe occurs, but when catastrophe reports (although interesting) serve no substantial regulatory purpose that justifies their expense. For reasons like these, such reports are referred to as optional.

1.8 Confidentiality of Statistical Data

Nothing in the *Handbook* is intended to imply that states either must disclose statistical reports and data or hold them confidential. Such determinations are made under individual state data reporting, public record and/or trade secret laws. In addition, if data identifies individual policyholders or claimants, it is possible that privacy laws may apply as well.

1.9 Scope

The *Handbook's* scope is limited to the statistical data available from statistical agents serving the primary property/casualty insurance industry for the following lines of insurance:

- General Liability
- Private Passenger Automobile
- Commercial Automobile
- Homeowners and Mobile Homes
- Dwelling Fire and Allied Lines
- Commercial/Farm Fire and Allied Lines
- Inland Marine
- Businessowners
- Burglary and Theft
- Glass
- Farmowners
- Boiler and Machinery
- Medical Professional Liability
- Comprehensive Personal Liability
- Aircraft
- Crop (except multiple peril crop insurance reinsured by the Federal Crop Insurance Corporation)
- Fidelity and Surety
- Mortgage Guaranty
- Financial Guaranty (Municipal Bonds)
- Workers' Compensation

Information on the various lines of business contained in divisible premium package policies, such as the Commercial Multiple Peril (CMP) policy, can be found in the individual section for each line of business (General Liability, Commercial Fire, etc.).

1.10 Role and Responsibility of the Statistical Information (C) Task Force

The NAIC's Statistical Information (C) Task Force, originally created in 1987, is responsible for the content and maintenance of the *Handbook*. The Task Force will monitor the data definitions, quality standards and reports described in the *Handbook* to assure that they respond to changes in technology and regulatory needs. As it may be able, the Task Force will also provide limited assistance for states and insurers relating to state-specific or one-time requests for data (commonly referred to as "special calls"). Such involvement will customarily involve situations where the state's interest or situation appears to have substantial applicability or importance to a number of states.

To ensure that the Statistical *Handbook* will continue to be useful, the Statistical Information (C) Task Force will seek to update it regularly. The Task Force encourages all state regulators and other interested parties to suggest changes, additions and deletions.

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2. DATA QUALITY FOR INSURERS AND STATISTICAL AGENTS

The *Statistical Handbook* provides two intertwined sets of requirements – one for insurers, and one for statistical agents. The purpose of these requirements is to provide assurance that reports from statistical agents are acceptably accurate as representations¹ of the insurance written and the losses incurred by insurers. Throughout this section, all requirements refer to data required by the *Handbook*, and do not refer to records or fields that are not required by the *Handbook*.

2.1 Intentionally Inaccurate Coding is Prohibited

For data streams out of which data is routinely reported to statistical agents, data coding and data reporting policies may not condone coding a policy, loss, transaction or other body of data as anything other than what it is known to be in order to enter transactions into computer systems. This does not preclude an insurer from booking a transaction with incomplete detail or from reporting such transactions to statistical agents, but there can be nothing that is known to be inaccurate or deceptive about such coding.

2.2 Edit Exceptions by Statistical Agents Must Be Studied for Systematic Errors

The insurer must study the causes² of edit exceptions noted by the statistical agent(s) to which it reports and, when the cause of an edit exception is noted to be a condition that could produce systematic errors, it must correct the error-producing condition in a timely fashion, with priority given to errors that have the largest likelihood to affect a significant amount of data. When an error is found that is likely to have affected data reported to a statistical agent, then the insurer shall report the nature of the error and the nature of its likely impact to the statistical agent receiving the affected data. Retrospective correction of data subject to systematic errors shall be done when the error affects a significant amount of data that is still being used for reports to the regulator and it is reasonably practical to make the correction through the application of a computer program or a procedure applied to the entire data set without the need to manually examine more than a small number of individual records.

¹ There are subtleties associated with the statement that these requirements will result in “reports that are acceptably accurate as representations of the insurance written....” Statistical procedures, especially those available to statistical agents, cannot easily control for errors associated with underwriting. That is, if an underwriter misjudges the proper classification for an insured, then the “statistical system” has little chance of detecting the error unless the classification is somehow implausible. Such errors are generally detected through routine premium audits (for policies where premium audits are necessary), internal audits (undertaken by some insurers) or through market conduct exams.

² The fact that an insurer does not have an edit check in place to catch a certain type of error is not the “cause” of the error. The “cause” of an error is the condition that leads to the error, not a condition that fails to avoid it.

2.3 Other Data Quality Standards and Requirements Applying to Insurers and Statistical Agents

Statistical agents are required to apply edits and checks to data received from insurers, and insurers are required to respond to the queries presented by statistical agents. Descriptions of insurer and statistical agent requirements follow. The requirements contained in subsection 2.3 do not apply to workers' compensation insurance.³

2.3.1 Completeness – Control Totals Required

Each submission of data filed by an insurer with a statistical agent shall be balanced against a set of control totals provided by the insurer with the submission. At a minimum, these control totals shall include applicable record counts, claim counts, written premiums, paid and unpaid losses. Any submission that does not balance (with the exception of differences due to rounding errors for dollar amounts) to the control totals shall be referred to the insurer for review and resolution.

2.3.2 Completeness – Reconciliation to Annual Statement State Pages

On an annual basis, for each state adopting the program, insurers shall reasonably explain differences between statistical data and Annual Statement State Page amounts that exceed the amounts shown in the following table. Where statistical lines of business and annual statement lines of business are not equivalent, statistical agents may combine State Page lines of business in order to approximate their statistical reporting lines of business. In these cases, the standard applies to the State Page lines of business that have been combined. The explanation must include a listing of causes (e.g., various books of business), the estimated effect of each of these causes, and identification of the processes upon which the insurer relies to estimate the effects of these causes. Such explanations shall account for a sufficient volume of premium and losses so that the premiums and losses that remain unexplained are less than the amounts shown in the following table:

Line of Insurance	Written Premiums	Paid Losses
Private passenger auto	greater of 1% or \$10,000	greater of 1% or \$10,000
Homeowners	greater of 1% or \$10,000	greater of 1% or \$10,000
All other Lines ⁴	greater of 1% or \$10,000	greater of 1% or \$10,000

³ Statistical agents handling workers' compensation data are expected to undertake substantial data quality checking activities, but the necessary standards and activities relevant to workers' compensation are different than those required for other lines of insurance.

⁴ The inclusion of all page 15 lines (except WC, to which this requirement does not apply) may involve types of insurance for which rate filings are not required or for which the statistical agent does not collect data. Reconciliation of data for lines where the statistical agent does not collect data is necessary only to the extent that it is commingled on page 15 with data that is reported to the statistical agent.

Statistical agents shall use their discretion regarding the omission of data from reports where insurers are unable to reconcile it to within these amounts. Completeness of reports is desirable, but not at the risk of including data that appears to have an unreasonably high chance of containing significant errors.

2.3.3 Validity Checks Required

Validity checks are designed to catch incomplete coding⁵ as well as codes that are not contained within the set of possible valid codes or that are contained within the set of possible valid codes but are not valid in conjunction with another code. For instance, individual zip codes are only valid in conjunction with a specific state code, and territory and class codes may be valid only in certain states.

Insurers shall fill in missing data and correct invalid codes until the total dollar amount of premium and loss records (by line, by state, on an annual basis) with missing or invalid codes are less than those shown in the following table. In addition, on no less than an annual basis, statistical agents shall advise every insurer with data for an individual line, state and year combination, for states adopting these requirements, that exceed 50 percent of the tolerances shown in the following table:

Error Tolerances*		
Line of Insurance	Written Premiums	Losses (Paid + Unpaid)
Private passenger auto	greater of \$10,000 or 5%	greater of \$10,000 or 5%
Homeowners	greater of \$10,000 or 5%	greater of \$10,000 or 5%
All other Lines	greater of \$10,000 or 5%	greater of \$10,000 or 5%

* When a record contains an incorrect non-dollar field (i.e., a state, territorial or class code), then the entire dollar amount of the record (premium or loss) shall be counted as in error. Where an error exists in a dollar field, then the absolute value of the dollar error shall be counted as the amount of the error.

It should be noted that the application of a 5 percent validity standard is expected to result in an actual error rate that may be only 1 percent or 2 percent.

Where quality does not appear to be significantly compromised, statistical agents may use records with missing or invalid data if the errors do not involve a field relevant to the report. For insurers with a body of data for a state, line and year that fails to meet these standards, statistical agents shall use their discretion regarding the omission of the entire body of data, including records with valid entries. Completeness of reports is desirable, but not at the risk of including a body of data that appears to have an unreasonably high chance of significant errors.

⁵ There is nothing wrong with incomplete coding as part of an insurer's internal data processing. For instance, an insurer may pay or book a loss before it knows the class code (out of perhaps 5 or 6 on the policy) that applies. It is important, however, that the insurer's procedures provide for proper codes to be determined in a timely fashion so that records can be completed.

2.3.4 Reasonability Checking

Completeness and validity checks are usually straightforward to understand and there is rarely any question whether errors detected through these checks are, in fact, errors. However, if an insurer were to attribute all of a varied book of business to a single valid class code, it is quite likely that this data would pass all completeness and validity checks.

Errors of a consistent nature are usually referred to as “systematic.” They can occur in a number of ways. Incorrect coding instructions can introduce errors of a consistent nature as input. Programming errors within the data processing system of an insurer can produce systematic miscoding as the system converts data to the formats required for statistical reporting. Most systematic errors will produce data that, when reviewed using tests designed to reveal various types of systematic errors, will appear unreasonable and likely to be in error. In addition, some individual coding errors may produce erroneous results that show up when premiums, exposures and losses are compared in a systematic fashion. Such checking often cannot, however, provide a conclusive indication that data with unusual patterns is incorrect. There are, after all, insurers that only write truckers, motorcycles or the like. Some unusual data will ultimately prove to be correct.

Because of this, the design of reasonability checks involves a degree of trial and error as attempts are made to efficiently identify insurer data sets that are likely to contain errors. For instance, if an insurer with a moderate volume attributes all of its experience for a state to a single class code, then statistical agents must check that with the insurer to determine whether this is accurate.

Because reasonability checks cannot ascertain with certainty that a given set of data contains errors, there will be insurers that must undergo the extra expense of rechecking and verifying accurate data in order to respond to queries from statistical agents. If statistical agents use thresholds for their reasonability tests that are too loose, then few insurers with accurate data will be inconvenienced, but too many insurers with data errors will not be required to recheck their submission. On the other end of the spectrum, if statistical agents use thresholds for their reasonability tests that are too tight, then many insurers with accurate data will be inconvenienced and the additional improvement to data quality for such tight standards will not justify the costs. While careful attention to the design of reasonability tests can improve their efficiency, tradeoffs between accuracy and costs will be unavoidable.

2.3.4.1 Reasonability Checking Required by Statistical Agents

Statistical agents shall undertake reasonability checks that shall include the comparison of statistical agent aggregate and company experience for state, territory or ZIP code, class and coverage data elements for the current reporting period to company and aggregate profiles from prior periods or the current period. When reporting instructions are changed, newly reported data elements shall be examined to see that they correlate reasonably with data elements reported under the old instructions. In addition, statistical agents shall compare average premiums, premium volume percentages, loss ratios, loss frequencies and loss development for major data elements to statistical agent aggregates in effect at the time of reporting.

At a minimum, reasonability checks by statistical agents shall include:

- (a) When an insurer has reported all or an unusually large percentage of its data under a single or very limited number of categories.
- (b) When there are unusual or unlikely reporting patterns in an insurer's data (e.g., that written car month relationships between liability and physical damage are reasonable, or whether reported claim counts are especially high or low in relation to reported exposures).
- (c) When premiums appear unusually high or low for the corresponding exposures (for personal lines).
- (d) When losses exist without corresponding premiums and exposures, or where loss frequencies or amounts appear unreasonable in comparison to ranges of expectation that recognize statistical fluctuation.
- (e) When unusual shifts in the distribution of writings occur from one reporting period to the next.

If an insurer's unusual pattern under test categories (a), (b) or (c) is verified as accurate (that is, the reason for the apparent anomaly is an unusual mix of business), then it is not necessary that a similar pattern for the same insurer be reconfirmed year after year.

The design of the tests should recognize the amount of data being examined. Unusual mixes of business are much more likely to occur with small amounts of data. As such, distributional tolerances must take the volume of data being examined into account.

Individual statistical agents shall keep track of their experience with these tests and shall adjust thresholds in successive years to maintain a reasonable balance between the magnitude of errors being found and the cost to insurers.

Results which appear to indicate a significantly higher than average chance that a body of data may contain errors shall be reported to insurers with an explanation of the unusual finding and its possible significance. When the possible or probable errors appear to be of a significant nature, the statistical agent shall indicate to the insurer that this is a "critical indication." "Critical indications" are those that, if not corrected or confirmed, would leave a significant degree of doubt whether the affected data should be used in reports to the regulator. It is intended that statistical agents shall have reasonable flexibility to implement this. Statistical agents may grade the severity of indications, or they may simply identify certain indications as critical (or equivalent terminology). While insurers are expected to undertake a reasonable examination of all indications provided to them, they are not required to respond to every indication except for those labeled by the statistical agent as "critical."

Statistical agents shall use their discretion regarding the omission of data from reports owing to the failure of an insurer to respond adequately to unusual reasonability

indications. Completeness of reports is desirable, but not at the risk of including data that appears to have an unreasonably high chance of containing significant errors.

2.3.4.2 Insurer Responses to Reasonability Queries Required

Insurers shall acknowledge and respond to reasonability queries from statistical agents. This shall include specific responses to all critical indications provided by the statistical agent. Other indications shall be studied for apparent errors as well as for indications of systematic errors. Corrections for substantial errors shall be provided to the statistical agent or, when a correction is not feasible, the extent and nature of the error shall be reported to the statistical agent. For this purpose, insurers must maintain past data for at least five years⁶ unless a shorter period of time is adequate to respond to all reasonability tests applicable to the line of insurance.

2.4 Reports to the State from the Statistical Agent

Each statistical agent shall provide with its standard premium and loss reports two lists, which together comprise the entire set of companies that report data to the statistical agent:

- (a) A listing of companies whose data is included in the compilations; and
- (b) A historical report listing those insurers whose data for the state was excluded from the compilation because it fell outside of the statistical agent's tolerances for missing or invalid data, or because the insurer was unable to reconcile its statistical and financial data within the statistical agent's tolerances, or for any other reason. The report will list such excluded companies by year for the current and the two prior annual reports, and will include an indication of the premium volume of the excluded insurer. For those lines of insurance where an Annual Statement line of business is a good approximation of the statistical submission premiums (such as homeowners insurance), the Annual Statement written premium will be the indication. For those lines of insurance where Annual Statement line of business is not a good approximation of the statistical submission premiums (such as commercial fire), the indication will be the state written premium ranking for the related Annual Statement line (in this example, fire) for the insurer.

2.5 Failure to Meet the Standards Contained in this Section

The purpose of the statistical agent reporting requirements contained in this section are to provide information that will identify whether an insurer appears to be providing data of a substandard quality with such frequency as to indicate a general business practice that involves insufficient attention to data quality. A single reporting instance would be actionable only if, upon examination, it was found to indicate a flagrant and conscious disregard for the data quality standards contained in this section.

⁶ The five-year record retention requirement applies unless a specific state law provides a shorter retention requirement.

2.6 Granting of Exceptions for Individual Statistical Agents

If, using a different set of procedures, a statistical agent can reasonably demonstrate the likelihood of performance that is equal or superior to the set of procedures contained herein, the commissioner may waive or amend requirements contained herein or take other action to assure equivalent or better data quality.⁷

⁷ As the procedures that have been described do not apply to workers' compensation, this section has no effect for workers' compensation.

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3. REPORTS AVAILABLE FROM STATISTICAL AGENTS: SUMMARY

3.1 Introduction

Using the data collected under statistical plans, as adopted by the states, the statistical agents produce aggregate reports. Regulators and others use these reports to review insurer experience, consistent with the coverages and classes of standard programs on file with the states.

Data compilations are evaluated according to four distinct, and often competing, standards: quality, completeness, timeliness and cost. In general, quality is a primary goal in developing any statistical data report. The priorities of the other three standards vary according to the purpose of the report.

For example, certain quarterly reports are designed to give regulators prompt indications of recent insurer activity. These reports must be necessarily less complete—that is they must contain a smaller percentage of industry data—than longer-term reports.

The reports described in this *Handbook* have been developed keeping in mind the inherent capabilities of companies' statistical systems and the minimum requirements of the model statistical plans.

Regulators may modify or enlarge their requirements for information to accommodate changing needs and environments. However, in most cases, changes to existing data reporting systems will be feasible only to provide information on future transactions. Requirements to submit new information may require that companies change their systems. Also, the statistical agents may need several years before they can generate meaningful data meeting the new requirements, with matching premium and loss elements. The exact time frames for implementing new data requirements and producing reports will vary depending on the type of reports.

This section summarizes, generally, the data that statistical agents must maintain and produce. Subsequent sections provide the specific detailed requirements for reporting on the various lines of insurance.

3.2 Design of Reports Linked to Purpose

Fundamental to the design of each report is an evaluation of its purpose and use. The Statistical Information (C) Task Force has specified model reports responding to general regulatory needs, including the need for information on the overall historic premium and loss experience by line of insurance, by specific coverage and by class. These model reports will serve only the basic informational needs of state regulators; to address a particular issue or problem, a regulator may have to request special reports in addition to these model reports.

Generally, the following considerations apply in producing and using reports. Financial data measure insurers' overall solvency and profitability at a particular point in time. For

this purpose, insurers submit calendar year data, which they can produce with the least delay. However, financial data generally cannot be used to evaluate the appropriateness of insurance premiums, because calendar year data on premiums and losses come from different policies.

Regulators use statistical data—generally compiled on a calendar, accident or policy year basis depending on the line—to evaluate the appropriateness of insurance premiums for a specific set of policies. These methods of collecting data generally match premiums and losses for a similar or the same group of policies. Regulators must consider premiums and losses from the similar groups of policies to analyze the appropriateness of the historic premiums for specific categories of insureds.

The statistical data contained in the model reports are not directly usable for ratemaking without certain adjustments. Advisory organizations and insurers must adjust their historic information to reflect estimates for future conditions that will affect premiums and losses.

3.3 Three Basic Report Designs

The Statistical Information (C) Task Force has designated three basic types of reports to meet differing needs and time frames. Subsequent sections of this *Handbook* provide more detailed descriptions of these reports for each specific line of insurance.

Annual Statistical Compilations

Annual Statistical Compilations are annual reports that generally match appropriate premiums and losses to evaluate the historic experience for various lines of insurance, detailed by coverage and class.

Regulators can use Annual Compilations to evaluate most effectively whether rates meet statutory requirements. Based on the statistical plans approved in the states, these annual reports match premiums, losses, exposures and the number of claims for similar groups of policies. The statistics are detailed by coverage, territory and classification (where applicable). The timing of these reports depends on the specific line of insurance.

Fast Track Monitoring System

Fast Track Monitoring Reports present quarterly premium and loss data, including loss ratios, aggregated by state for the **major lines** of insurance. These reports provide an early indication of the underwriting and market experience of the industry by line. To expedite the production of these reports, the statistical agents collect data from only the major carriers for each line. The statistical agents submit these reports 60 to 75 days after the end of each quarter, depending on the line of insurance.

Accelerated Reports

Accelerated Reports contain individual state premium and loss information for each calendar accounting quarter. The statistical agents submit these reports 180 days after the end of each quarter. The reports contain data from more companies and in more subline and classification detail than Fast Track reports, bridging the gap between them and the more detailed Annual Statistical Compilations.

The Fast Track Monitoring System and the Accelerated Reports supplement the Annual Statistical Compilations. By providing information more quickly than that possible for annual reports, the quarterly reports help identify emerging trends or problems. While the quarterly reports can be produced faster, they necessarily provide less detailed information than the annual ones.

3.4 Reporting Bases

The statistical agents compile data to achieve certain purposes. The key is how premiums and losses match and to what extent such matching is necessary for the stated purpose. Also, because such matching necessarily delays report production, regulators must balance its need against the need for more recent information.

Insurers and statistical agents can compile data on any of three general bases:

Calendar Year – premiums earned during a 12-month period and losses incurred during a 12-month period, regardless of the effective dates of the policies on which those transactions took place

Calendar/Accident Year – premiums earned during a 12-month period and incurred losses resulting from accidents that occurred during the same period

Policy Year – premium and loss transactions on contracts effective during a given 12-month period

Appendix C contains a more extensive discussion of these different methods for compiling data.

3.5 Time Frames

Statistical agents produce reports using one or more of the reporting bases described in Section 3.4. The basis selected dictates how quickly the data can be produced. The reason for selecting one basis over another is related to the nature of the program/coverage being analyzed and the purpose of the analysis.

Depending on the reporting basis used, production of the report will lag a certain amount of time beyond the end of the experience period. This time lag is generally due to the need for processing and “maturation” of the losses. To shorten the time lag, the Statistical Information (C) Task Force recommends that regulators allow the statistical agents to issue reports when they have tabulated at least 95 percent of the volume of their companies. However, each state must decide what percentage of the total estimated volume in a line or

market will be acceptable for generating reports. The task force recommends this approach to help ensure timely submission of reports.

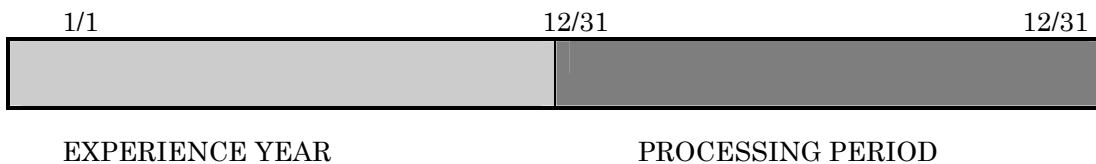
Also, the model regulation allows companies with limited premium volume to submit less detailed statistics. The problems associated with collecting data from small companies and the resulting delays more than offset any benefit from full reporting by all companies.

The following charts explain the time frames for the compilation of various kinds of model statistical reports.

3.5.1 Annual Reports

Calendar Year

Premium and loss data for the calendar year regardless of when the policy was written or when the loss occurred.



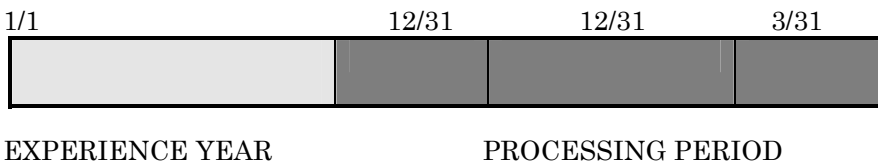
Example: Private Passenger Physical Damage

Recommended Report Date: December 31 of the year following the experience year.

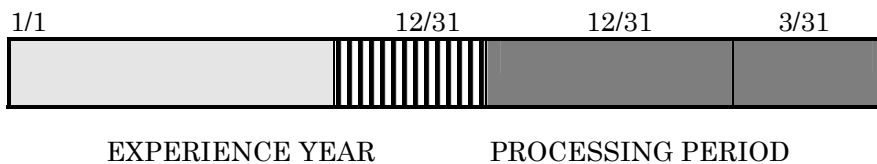
Calendar/Accident Year

Premiums earned during a 12-month period; losses incurred from accidents occurring during the same 12-month period.

Premiums



Losses



DEVELOPMENT PERIOD

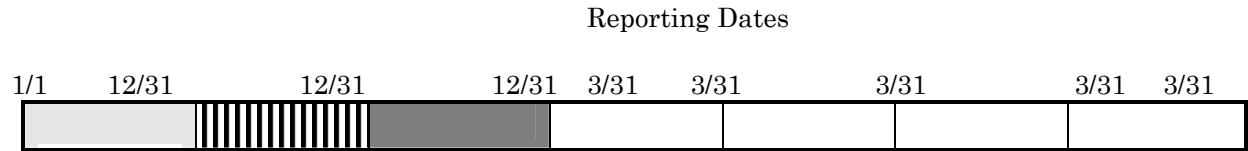
Example: Private Passenger Automobile Bodily Injury Liability

Recommended Report Date: March 31 of the second year following the experience year.

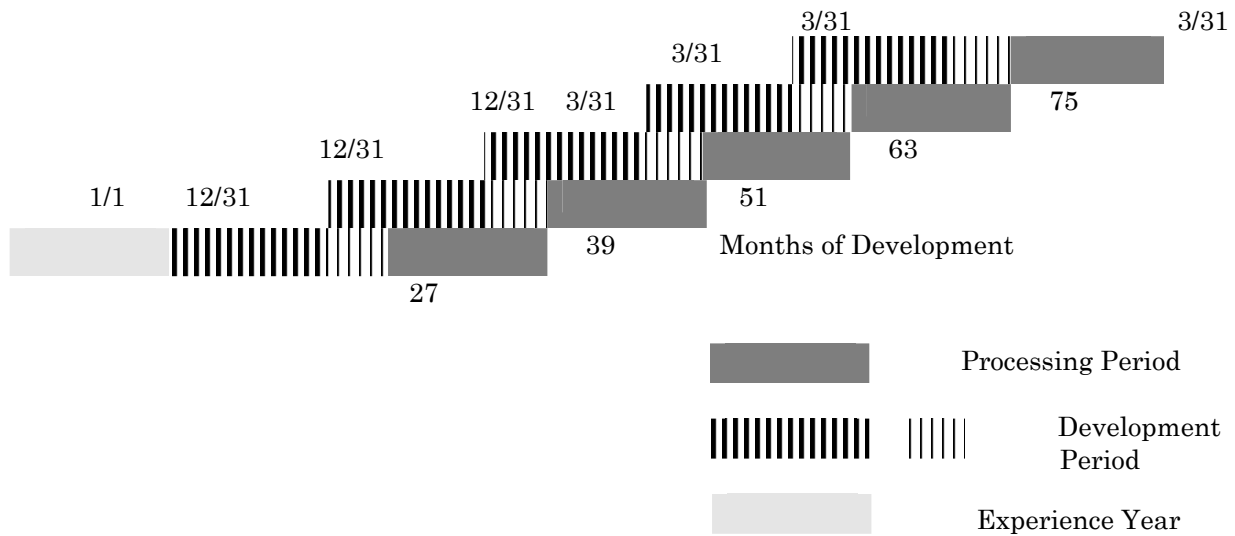
Policy Year

Earned premium and losses incurred on contracts effective during the same 12-month period.

Premiums



Losses



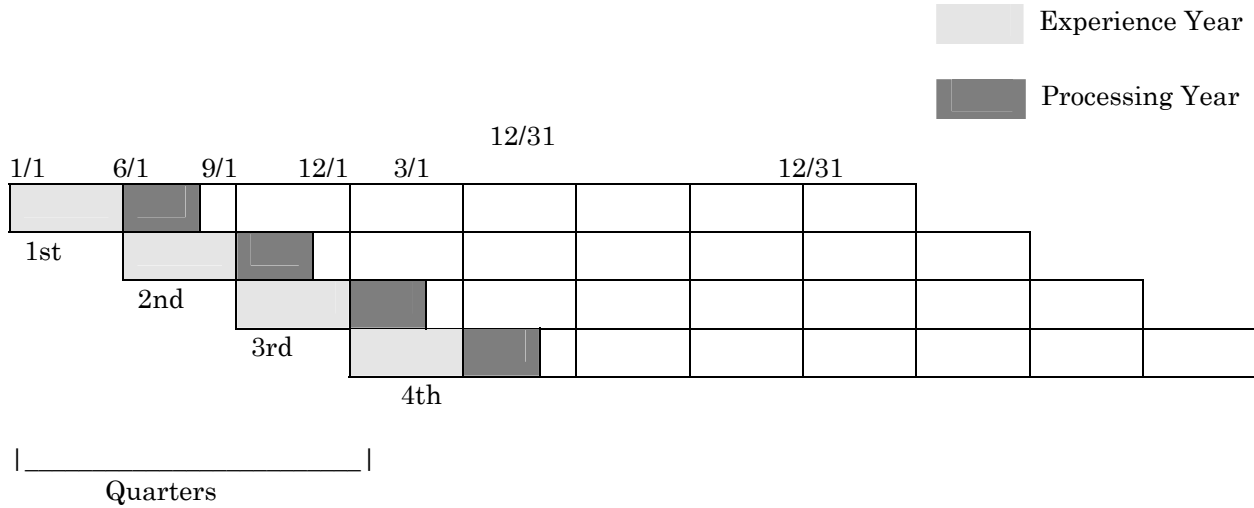
Example: Annual Compilations - General Liability

Recommended Report Date: March 31 of the third year following the policy year and loss development annually thereafter.

3.5.2 Quarterly Reports

Fast Track Monitoring System

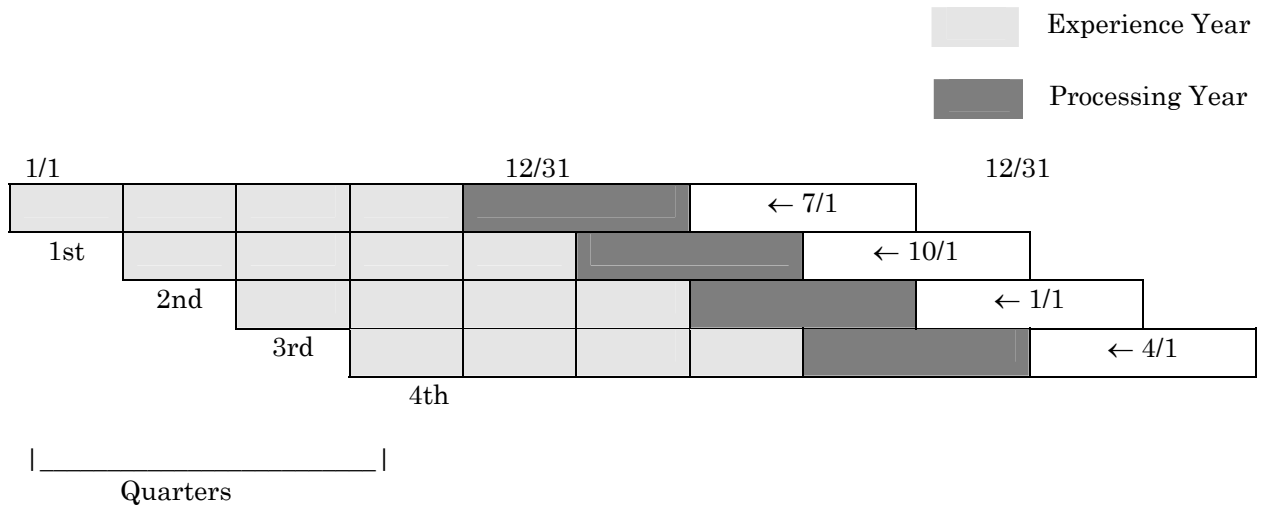
Quarterly data (on a calendar year basis)



Recommended Report Date: 60 days after the end of a quarter for Private Passenger Automobile and Homeowners; 75 days for all other lines.

Accelerated Report

Quarterly data (on a calendar year basis)



Recommended Report Date: 180 days after the end of a quarter.

3.5.3 Supplemental Reports

The sections dealing with the requirements for submitting reports for each of the individual lines of insurance also contain lists of additional reports available upon request from statistical agents. These lists give the time frames for producing the reports. Regulators may also request custom reports, which may contain specific data or experience not regularly produced in other reports, such as loss experience for a particular class reported to an individual statistical agent.

The regulator and the statistical agents must negotiate time schedules for producing supplemental reports. The information in these reports is limited by the amount of data actually available and the manner in which they have been reported.

3.6 Annual Statistical Compilations

Annual Statistical Compilations are detailed annual reports that generally match appropriate premiums and losses to evaluate the historic experience of various lines of insurance. The statistics are detailed by coverage, territory and classification (where applicable). Regulators can use Annual Compilations to evaluate most effectively whether rates meet statutory requirements.

3.6.1 Who Reports

All licensed insurers are required to report at least annually in some level of detail. The level of detail depends in the reporting requirements on the approved statistical plans on file with the insurance departments. In this *Handbook* the specific reporting requirements from the model regulation appear in the specific section for each line.

3.6.2 Lines of Insurance Covered

- General Liability (includes Products Liability and Professional Liability other than Medical)
- Private Passenger Automobile
- Commercial Automobile
- Homeowners and Mobile Homes
- Dwelling Fire and Allied Lines
- Commercial/Farm Fire and Allied Lines
- Inland Marine
- Businessowners
- Burglary and Theft
- Glass
- Farmowners
- Boiler and Machinery
- Medical Professional Liability
- Comprehensive Personal Liability
- Aircraft
- Crop
- Fidelity and Surety
- Mortgage Guaranty

- Financial Guaranty (Municipal Bonds)
- Workers' Compensation

3.6.3 Time Frame

The timing of annual reports depends upon the basis on which data are compiled, which in turn depends on the line of insurance. Subsequent sections of this *Handbook* discuss the specific time frames for annual reports for each line of insurance.

3.6.4 Uses of Annual Statistical Compilations

Regulators can use the annual reports to review the experience both for broad categories and for individual coverages. Regulators can compare the loss ratios, average claim costs, claim frequencies, and pure premiums appearing on the reports for different coverages. For example, a regulator might want to contrast territory experience with experience for the entire state. Or a regulator might want to analyze differences among coverages. Annual reports also allow regulators to review long-term trends in loss ratios, claim cost and claim frequency. Aggregate results may indicate areas warranting additional investigation.

3.6.5 Limitations of Annual Statistical Compilations

The information in the annual reports is not intended for ratemaking. The premiums appearing on the annual reports are “collected earned premiums,” that is, the portion of the written premiums actually collected by a company for coverage provided during the period covered in the report. These premiums are not necessarily at the current rate level. For ratemaking, actuaries must adjust the premiums to this level.

Also, actuaries must adjust the reported incurred losses to bring them to the level anticipated during the period when the rates will be used. For example, for liability insurance, especially bodily injury, reported incurred losses as of a given evaluation date may not have matured enough to yield a good indication of the amount for which they will finally be settled. Therefore, actuaries multiply the losses by a historical loss development factor to bring them to the level of ultimate settlement value. Actuaries determine these loss development factors by examining historical patterns of loss settlement for the insurance coverage and line of business in question.

Actuaries also adjust ratemaking losses to reflect inflation. For most lines this adjustment consists of multiplying the losses by a loss severity trend factor. Where changes in claim occurrence or claim frequency follow a discernible pattern, ratemaking actuaries may also multiply losses by a frequency trend factor.

For the property lines of insurance, actuaries make other adjustments, depending on the coverage. For example, for coverages and lines where natural disasters, such as hurricanes, noticeably affect loss patterns, ratemakers spread the effects of such catastrophes over several years' worth of data. Considering them as part of a single year's losses would distort the experience. This practice would overstate the needed rate level change in years with many catastrophes and understate it in years with few or no catastrophes. Also, where various insurance deductibles are combined for statistical simplicity, actuaries may adjust the losses to put them on a common-deductible basis for use in ratemaking.

3.7 Fast Track Monitoring System

Fast Track reports do not match premiums to losses from the same group of policies. Therefore, they do not provide enough information for analysis of insurance rates. Also, since they use only a sample of the data, Fast Track reports do not give a complete picture. However, the techniques used in the Fast Track Monitoring System provide early reports not otherwise available.

3.7.1 Who Reports

For the Fast Track Monitoring System, the statistical agents collect data from companies that write a large percentage of the total industry premium for major lines. These companies report highly summarized accounting data by quarter, on an accelerated schedule. By limiting the data required and the number of companies reporting, statistical agents can compile this data and produce reports within a relatively short period of time—60 to 75 days after the close of the quarter, depending upon the line of insurance.

An important factor in achieving timeliness is selecting the participating companies. Increasing the number of companies participating lengthens the time needed to process the submissions. By keeping participation at a manageable level and not waiting to match premiums with losses, statistical agents can produce reports significantly faster than they can produce the detailed annual submissions.

3.7.2 Report Types

The Fast Track Monitoring System produces two reports, countrywide and by state:

1. Loss Ratio Report
2. Claim Cost and Claim Frequency Report

The content, lines of insurance covered and time period vary in these reports.

In general, countrywide reports show experience by quarter and for the year-ending quarter. State reports show only the year-ending quarter. For private passenger and commercial automobile liability and physical damage, homeowners and commercial multiple peril, the reports provide both quarterly and year-ending quarter experience by state. For private passenger coverages, the reports also show quarterly claim cost and claim frequency information, countrywide and by state. Exhibits 1 and 2 on pages 3-10 and 3-11 provide a sample of these reports.

Exhibit 1

33 – North Dakota

Fast Track Monitoring System – Loss Ratios-Direct

Year Quarter	Homeowners		Loss Ratio
	Earned Premiums	Incurred Losses*	
98 1st	2,089,665	664,051	0.318
98 2nd	2,126,904	796,589	0.375
98 3rd	2,160,561	2,430,556	1.125
98 4th	2,172,312	1,915,505	0.882
99 1st	2,165,241	1,213,974	0.561
99 2nd	2,193,163	1,264,146	0.576
99 3rd	2,196,587	586,007	0.267
99 4th	2,215,873	944,610	0.426
00 1st	2,219,456	704,650	0.317
00 2nd	2,255,721	1,195,284	0.530
00 3rd	2,297,388	3,668,296	1.597
00 4th	2,326,673	965,802	0.415
01 1st	2,339,898	1,114,944	0.476
01 2nd	2,361,951	2,639,550	1.118
01 3rd	2,403,987	11,460,701	4.767
01 4th	2,446,899	1,860,575	0.760
02 1st	2,483,180	950,272	0.383
02 2nd	2,532,437	1,199,957	0.474
02 3rd	2,604,821	3,998,244	1.535
02 4th	2,671,884	1,251,389	0.468
03 1st	2,713,672	1,222,220	0.450
Prior 4 Quarters Ending			
98 4th	8,549,442	5,806,701	0.679
99 1st	8,625,018	6,356,624	0.737
99 2nd	8,691,277	6,824,181	0.785
99 3rd	8,727,303	4,979,632	0.571
99 4th	8,770,864	4,008,737	0.457
00 1st	8,825,079	3,499,413	0.397
00 2nd	8,887,637	3,430,551	0.386
00 3rd	8,988,438	6,512,840	0.725
00 4th	9,099,238	6,534,032	0.718
01 1st	9,219,680	6,944,326	0.753
01 2nd	9,325,910	8,388,592	0.899
01 3rd	9,432,509	16,180,997	1.715
01 4th	9,552,735	17,075,770	1.788
02 1st	9,696,017	16,911,098	1.744
02 2nd	9,866,503	15,471,505	1.568
02 3rd	10,067,337	8,009,048	0.796
02 4th	10,292,322	7,399,862	0.719
03 1st	10,522,814	7,671,810	0.729

* Losses include all loss adjustment expenses and adjustment for IBNR reserves

Exhibit 2

33 – North Dakota

Fast Track Monitoring System – Claim Cost and Frequency

Homeowners					Policy Form 4				
Year Quarter	Earned House Years	No. of Paid Claims	Paid Losses	Paid Claim Frequency	Percent Change from Same Quarter Prior Year	Average Loss	Percent Change from Same Quarter Prior Year	Pure Premium	Percent Change from Same Quarter Prior Year
98 1st	1890	52	23591	2.75	*****	454	*****	12.48	*****
98 2nd	1928	57	19909	2.96	*****	349	*****	10.33	*****
98 3rd	2000	96	64962	4.80	*****	677	*****	32.48	*****
98 4th	2029	71	47184	3.50	*****	665	*****	23.25	*****
99 1st	2094	71	71460	3.39	23.3	1006	121.6	34.13	173.5
99 2nd	2135	63	18394	2.95	-0.3	292	-16.3	8.62	-16.6
99 3rd	2175	93	47202	4.28	-10.8	508	-25.0	21.70	-33.2
99 4th	2190	68	41106	3.11	-11.1	605	-9.0	18.77	-19.3
00 1st	2221	65	48523	2.93	-13.6	747	25.7	21.85	-36.0
00 2nd	2272	81	83877	3.57	21.0	1036	254.8	36.92	328.3
00 3rd	2318	112	81118	4.83	12.9	724	42.5	34.99	61.2
00 4th	2331	84	93409	3.60	15.8	1112	83.8	40.07	113.5
01 1st	2342	64	152935	2.73	-6.8	2390	219.9	65.30	198.9
01 2nd	2363	84	79855	3.55	-0.6	951	-8.2	33.79	-8.5
01 3rd	2367	102	118424	4.31	-10.8	1161	60.4	50.03	43.0
01 4th	2391	100	71004	4.18	16.1	710	-36.2	29.70	-25.9
02 1st	2422	65	8379	2.68	-1.8	129	-94.6	3.46	-94.7
02 2nd	2524	91	57189	3.61	1.7	628	-34.0	22.66	-32.9
02 3rd	2604	103	71958	3.96	-8.1	699	-39.8	27.63	-44.8
02 4th	2697	106	67576	3.93	-6.0	638	-10.1	25.06	-15.6
03 1st	2776	94	51691	3.39	26.5	550	326.4	18.62	438.2
Prior 4Quarters Ending									
98 4th	7847	276	155646	3.52	*****	564	*****	19.84	*****
99 1st	8051	295	203515	3.66	*****	690	*****	25.28	*****
99 2nd	8258	301	202000	3.64	*****	671	*****	24.46	*****
99 3rd	8433	298	184240	3.53	*****	618	*****	21.85	*****
99 4th	8594	295	178162	3.43	-2.6	604	7.1	20.73	4.5
00 1st	8721	289	155225	3.31	-9.6	537	-22.2	17.80	-29.6
00 2nd	8858	307	220708	3.47	-4.7	719	7.2	24.92	1.9
00 3rd	9001	326	254624	3.62	2.5	781	26.4	28.29	29.5
00 4th	9142	342	306927	3.74	9.0	897	48.5	33.57	61.9
01 1st	9263	341	411339	3.68	11.2	1206	124.6	44.41	149.5
01 2nd	9354	344	407317	3.68	6.1	1184	64.7	43.54	74.7
01 3rd	9403	334	444623	3.55	-1.9	1331	70.4	47.29	67.2
01 4th	9463	350	422218	3.7	-1.1	1206	34.4	44.62	32.9
02 1st	9543	351	277662	3.68	0.0	791	-34.4	29.10	-34.5
02 2nd	9704	358	254996	3.69	0.3	712	-39.9	26.28	-39.6
02 3rd	9941	359	208530	3.61	1.7	581	-56.3	20.98	-55.6
02 4th	10247	365	205102	3.56	-3.8	562	-53.4	20.02	-55.1
03 1st	10601	394	248414	3.72	1.1	630	-20.4	23.43	-19.5

3.7.3 Lines of Insurance Covered

1. Loss Ratio Reports

- Private Passenger Automobile Liability
- Private Passenger Automobile Physical Damage
- Commercial Automobile Liability
- Commercial Automobile Physical Damage
- Homeowners
- Dwelling Fire
- Dwelling Allied Lines
- Commercial Fire
- Commercial Allied Lines
- Farm Business
- Commercial Multiple Peril
- Premises/Operations
- Products *
- Composite Rated Risks (General Liability)
- All Other General Liability
- Medical Professional Liability (Malpractice)

* Countrywide only

2. Claim Cost and Claim Frequency Report

- Private Passenger Automobile Bodily Injury Liability
- Private Passenger Automobile Property Damage Liability
- Private Passenger Automobile Personal Injury Protection (No-Fault)
- Private Passenger Automobile Physical Damage - All Collision Combined
- Private Passenger Automobile Physical Damage - All Comprehensive Combined

3.7.4 Definitions of Claims Arising

In view of the time frames for reporting Fast Track information, companies typically have been allowed flexibility in reporting the number of claims arising in a given quarter. However, each company must use a consistent definition of when claims arise for all quarters reported. Variations among companies do not distort any trend observed in the data. Companies reporting this information may base the number on:

- Number of claim notices
- Number of claims for which a reserve is established
- Number of claims incurred

3.7.5 Time Frame

For private passenger and homeowners Fast Track reports, the model regulation allows 60 days after the close of a quarter for collecting and processing data. For Fast Track reports on other lines, the model regulation allows 75 days for collecting and processing data.

3.7.6 Uses of Fast Track Reports

Quarterly Fast Track reports supplement the loss ratios appearing in the annual statistical reports. Regulators can use Fast Track reports in several ways:

- By comparing recent Fast Track loss ratios with those for corresponding earlier periods, regulators can identify emerging premium and loss trends.
- Analyzing Fast Track claim cost and claim frequency data may provide insight into external factors that affect costs.
- Because Fast Track loss ratio data are comparable to Page 14 Annual Statement data experience (both are on calendar year basis), they serve as early indicators of Page 14 results.

3.7.7 Limitations of Fast Track Reports

With all of their advantages in terms of timeliness, Fast Track reports also have certain limitations. Because the Fast Track reports reflect a significant sample of the data for a line of insurance—but not the entire industry’s experience—they indicate trends, but they do not provide definitive measurements of actual experience.

Rate level changes do not immediately affect loss ratios. Therefore, Fast Track trends in loss ratios do not give the regulator enough information for rate analysis. Because Fast Track reports use calendar year data, changes in a company’s book of business may distort the loss ratios. The premium data would reflect changes in a company’s business before the loss data. For a company with an increasing book of business, the Fast Track loss ratios could appear to be improving when the real loss ratios are remaining the same or worsening. For a company with a decreasing book of business, the opposite could appear to be happening.

In addition, the earned premiums underlying Fast Track loss ratios combine policies with different limits. Consequently, the regulator should not draw definite conclusions about the appropriateness of a state’s current rates using Fast Track reports, although it may be possible to make some tentative inferences.¹

Also, several companies include the experience of assigned risks, FAIR plans, pools and similar mechanisms in their fast track submissions. These data would not be included in ratemaking.

¹The data used in Fast Track reports are not collected on the same basis as statistics typically used for ratemaking. Ratemaking data are collected on an accident or policy year basis.

3.8 Accelerated Reports

Accelerated Reports provide countrywide and individual state premium and loss information on a calendar year basis for specific general liability selected markets earlier than the traditional annual statistical compilations. These reports bridge the gap between the Fast Track Monitoring System and the Annual Statistical Compilations.

3.8.1 Who Reports

The Accelerated Reports use the monoline and multiline data from programs reported to the statistical agents in general liability class detail. Under the approved statistical plans, companies with small premium volume may not be required to report statistics in great detail for general liability. The following criteria from the model regulation assure that the statistical agents collect meaningful data for this report.

1. A company must report at least quarterly according to specifications of the Model Commercial General Liability Statistical Plan if the company is large enough to meet any of the following criteria:
 - It is in the 80th percentile of the total countrywide written premium for all commercial general liability lines;
 - It has greater than 1 percent of the statewide written premium for all commercial general liability lines; or
 - It has greater than \$5 million written premium statewide for all commercial general liability lines.

2. A company must report at least quarterly in selected market detail consistent with the specifications of the Model Commercial General Liability Statistical Plan if the company has not already met the above criteria for reporting quarterly but does meet any of the following criteria:
 - It has greater than \$1 million written premium statewide for a selected market; or
 - It has greater than 10 percent written premium statewide for a selected market and greater than \$100,000 written premium for that market.

3.8.2 Report Types

Two reports present the accelerated statistical data for selected general liability markets:

1. Calendar Year Premium and Loss Report

The Calendar Year Premium and Loss Report displays earned premium and incurred losses on a calendar quarter basis. With the exception of class data by state, the underlying number of claims supplements the incurred loss experience. To facilitate review on an

annual basis and to smooth the extreme fluctuations inherent in such a finely detailed review, the report displays a four quarters ending total.

2. Policy Year Breakdown of Calendar Year Losses

The Policy Year Breakdown of Calendar Year Losses shows, for the latest calendar year, total limits incurred losses by the policy year in which the losses were incurred. For example, a claim newly reported in June 2003 on a policy in effect from April 2000 to April 2001 will be included in the data for the second quarter 2003 in the Calendar Year Premium and Loss Report. But the Policy Year Breakdown of Calendar Year Losses will assign the claim to policy year 2000.

The losses do not include any estimates of incurred but not reported (IBNR) losses or subsequent development of outstanding case reserves.

The reports are available countrywide and by state, except for products liability, which is available only countrywide. Exhibits 3 and 4 on pages 3-15 and 3-16 present a sample of the two accelerated reports.

Exhibit 3

32 North Carolina

**Accelerated Statistical Report
Calendar Year Premium and Loss Report
State - General Liability
Recreational Classes**

REPY	REPQ	Earned Premium	T/L Incurred Losses Incl. LAE
01	4	509,124	358,020
02	1	562,735	128,157
02	2	658,666	276,019
02	3	778,886	283,378
02	4	881,351	290,736
03	1	951,954	45,442
03	2	967,857	113,392
03	3	961,849	561,894
03	4	982,207	52,328
TOT		7,254,629	2,109,366

Prior 4 Quarters Ending		Earned Premium	Total Limits Incurred Losses Including LAE
02	3	2,509,411	1,045,574
02	4	2,881,638	978,290
03	1	3,270,857	895,575
03	2	3,580,048	732,948
03	3	3,763,011	1,011,464
03	4	3,863,867	773,056

The individual policy year incurred losses displayed above include only contributions from the latest available calendar year. They do not include paid losses reflected in prior years (i.e. prior to the latest calendar year). The ultimate incurred losses include unallocated loss adjustment expenses by a factor of 1.070.

Exhibit 4

32 North Carolina

**Accelerated Statistical Report
Statewide - General Liability
Policy Year Breakdown of Calendar Year Losses
Calendar Year Ending 4th Quarter 2003
Recreational Classes**

Year	Total Limits Incurred Losses
95	
96	1,529
97	87,241
98	-40,622
99	-11,246
00	8,969
01	183,089
02	301,772
03	242,324
Total	773,056

The individual policy year incurred losses displayed above include only contributions from the latest available calendar year. They do not include paid losses reflected in prior years (i.e. prior to the latest calendar year) nor do they include any estimates of IBNR or subsequent development of outstanding case reserves. The incurred losses include unallocated loss adjustment expense by a factor of 1.070.

3.8.3 Lines of Insurance Covered

The Accelerated Reports show data for major general liability sublines and for selected markets (special covered class groupings) that have experienced availability or affordability problems.

1. Major Sublines

- Premises/Operations (includes Owners, Landlords & Tenants, Manufacturers & Contractors, Storekeepers, Contractual Liability under old general liability programs)
- Products/Completed Operations

2. Selected Markets

- Day Care
- Municipal
- Public Schools
- Recreational
- Liquor Law
- Lawyers' Professional

As conditions warrant, regulators may request additional classes. Data for these additions will be available only for future accounting periods.

3.8.4 Time Frame

The statistical agents produce Accelerated Reports 180 days after the end of each quarter.

3.8.5 Uses of Accelerated Reports

Accelerated Reports have several uses:

- The Accelerated Reports provide the most current historical look at experience for specific general liability sublines and classes of business.
- These reports indicate any changes that have occurred since the last issued Annual Statistical Compilations.
- By comparing experience from the most recent Accelerated Report with that of earlier periods, a regulator can identify emerging premium and loss trends.
- Regulators can use the Policy Year Breakdown Report to document and evaluate the lag time inherent in “long tail” general liability classes.

3.8.6 Limitations of Accelerated Reports

The Accelerated Reports are on an accounting-quarter calendar year basis. Therefore, the premiums and losses do not match. Because of the “long tail” of general liability insurance, this mismatch is particularly acute for these reports.

The losses in the Accelerated Reports do not include estimates for losses that have occurred but have not yet been reported to companies. For general liability, these incurred but not reported (IBNR) losses are a significant portion of the ultimate loss experience. Therefore, this report does not show full current liabilities.

Because of the mismatch of premiums and losses and the lack of IBNR losses, the Accelerated Reports are not suitable for ratemaking. Their usefulness in evaluating the adequacy of existing rates is limited.

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SECTION 4

4. COMMERCIAL GENERAL LIABILITY REPORTS

4.1 Introduction

Annual Statistical Compilations have different requirements and features depending on the line of insurance. This section details specific reporting requirements for and features of commercial general liability. See Section 3.6 for a discussion of the general features of Annual Statistical Compilations.

4.2 Nature of General Liability Insurance

General liability insurance, for the purposes of this section, encompasses standard or similar forms of commercial liability insurance written on monoline and package policies, except automobile insurance and medical professional insurance.

Liability coverage is often called “third party” coverage, because the insurance policy is a contract between the insured and insurer (first and second parties) to pay for loss to a third party caused by the insured’s tortious acts.

Liability insurance pays for the bodily injury or property damage losses the policyholder may cause to others up to the policy’s limit. This insurance also covers any legal expenses and court costs needed to defend the claim. Some of these liabilities arise from:

- the ownership and maintenance of premises
- the conduct of a business or operation
- the manufacture, distribution or selling of a product
- completed operations
- work done by independent contractors or subcontractors
- liabilities assumed by contract

The policy forms in use, as well as the structure for classifying and rating risks, dictate the amount of detail in reported data.

For most property lines of insurance, losses are paid almost immediately, since negligence questions do not enter the picture and since the parties can usually determine the amount of damage objectively and quickly. By contrast, many general liability claims require prolonged investigation into the extent of loss and/or the cause of loss. Also, many claims are litigated and some claims may not be discovered or made until years after the policy has expired. Therefore, general liability insurance has many “long tail” losses—losses paid many years after the premium has been collected and the policy has expired. The exposure bases used for measuring relative risk in general liability often require auditing at the close of the policy period. For example, for manufacturers and contractors coverage, the premium charged may be based on payroll. At policy inception, the insurer and the insured estimate the payroll to determine the tentative premium. At the end of the policy period the insurer audits the risk’s payroll and adjusts the premium, if necessary.

The "long tail" of general liability insurance and the nature of the exposure base dictate the use of a policy year compilation for the annual reports. Only in this way can insurers and regulators accurately match premium and loss information for an appropriate analysis of the historical experience.

Traditionally, insurance companies have produced general liability coverage on an "occurrence" basis. An "occurrence" contract covers losses stemming from all incidents that "occurred" during the term of a policy, usually a 12-month period, no matter when those claims are reported or paid.

A newer form of coverage, "claims-made," covers all claims made during the policy term, no matter when the incidents occurred. When an insured with a "claims-made" policy no longer has this kind of coverage—because the policy is cancelled or not renewed or because the insured replaces the policy with "occurrence" coverage—the insured may need coverage for incidents that occurred during the "claims-made" policy period but are reported afterward. To fill this need, the insured must buy an extended reporting period endorsement, or "tail" coverage.

4.3 General Liability Sublines

Insurers report general liability data by subline, consistent with coverages and classes their underwriters use to develop the premiums for every policy. This section describes the major sublines. These form the basis for the statistical plan requirements as well as the Annual Statistical Compilations for general liability.

Owners, Landlords and Tenants (OL&T)

Owners, landlords and tenants liability insurance protects the insured from claims for damages from bodily injury or property damage on premises that the insured owns, maintains or leases. The insured may be held responsible if damage arises from some unsafe condition of the premises. Types of classifications within the OL&T subline include restaurants, bowling alleys, day care centers, apartments, and governmental subdivisions and related municipal classes. The exposure bases (units used to measure exposure to risk) vary greatly by type of classification. Examples of exposure bases include hundreds of square feet, hundreds of dollars of receipts or payroll, or number of unit-months.

Manufacturers and Contractors (M&C)

Manufacturers and contractors liability insurance covers the risks of manufacturing and contracting firms both on and off the firms' premises. The types of classifications within the M&C subline include industrial manufacturing, construction, erection and wrecking, utilities, and oil and gas wells. The primary exposure base is hundreds of dollars of payroll.

Products/Completed Operations Liability

Products/completed operations liability insurance protects against financial loss a manufacturer or distributor of a product may suffer because of bodily injury and property damage claims resulting from the use of a covered product. This coverage protects against claims arising from defective products, negligent use of a product, and even use of an

altered product. Types of classifications within the products subline include asbestos goods, manufacturing, canneries, firearms manufacturing, sporting goods or athletic equipment dealers and gas dealers. The main exposure base is thousands of dollars of receipts. The statistical agents produce reports for this subline on a countrywide basis, since the exposure is national in scope. Although the insurer issues a products liability policy for a production plant or distributor in a particular state, the product may be used or cause a loss in any state.

New Premises/Operations and Products/Completed Operations Programs

Many insurers use a new policy form that combines OL&T, M&C and Products sublines into one simplified Commercial General Liability (CGL) policy. Insurers can write this new policy on either an “occurrence” or a “claims-made” basis. Under the new program, new exposure bases apply to many risks. The primary exposure bases are thousands of dollars of payroll and gross sales. Insurers report their data under two sublines: CGL Premises/Operations, which is equivalent to the combination of OL&T and M&C, and CGL Products/Completed Operations.

Most companies writing insurance under these new programs first reported data for policies becoming effective in 1989. Until new reports containing this data are available, the Annual Compilations will be available on the basis of the older programs.

Miscellaneous Coverages

Liquor liability policies protect the owner of an establishment that serves alcoholic beverages against liability arising from the acts of an intoxicated patron.

Lawyers Professional liability insurance protects members of the legal profession against claims arising from negligent performance of legal services.

Owners and Contractors Protective liability insurance covers bodily injury and property damage the insured has agreed to assume on premises or operations owned by the insured but leased or contracted to others. Classifications include railroad protective liability and principals protective liability. Exposure bases vary by type of risk.

Contractual liability insurance covers bodily injury and property damage the insured has contractually agreed to assume in excess of the amount imposed by law. Construction agreements and elevator maintenance service agreements are examples of classifications. Exposure bases are similar to owners and contractors protective liability.

4.4 Statistical Plan Reporting Requirements

The minimum data elements required for commercial general liability reporting are specified in the Model Commercial General Liability Statistical Plan. They include:

- Company Number
- Transaction Identifier and Amount
- Accounting/Calendar Date
- Policy Effective Year
- State Indicator
- Territory Indicator
- Type of Program Indicator
- Subline Identifier
- Classification
- Type of Policy Contract Identifier
- Number of Years in Claims Made Program
- Coverage Identifier
- Exposure
- Type of Loss
- Claim Count

The required data items are to be reported for direct business only. Therefore, reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier; nor, shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded.

4.5 Who Reports Data: Minimum Reporting Standards For Insurers

The statutory requirement to report statistics applies to all licensed insurers. In establishing the standards for reporting to the statistical agents, regulators recognize the need for efficiency by permitting companies with limited premium volume to report less detailed statistics. Regulators must weigh the benefits from full detail reporting for all companies against the costs in terms of delayed reports and other related problems.

The model regulation includes the following standards for statistical reporting:

1. Quarterly Reporting

- A. A company must report at least quarterly in accordance with specifications of the Model Commercial General Liability Statistical Plan if the company is large enough to meet any of the following criteria:
- It is in the 80th percentile of the total countrywide written premium for all commercial general liability lines;
 - It has greater than 1 percent of the statewide written premium for all commercial general liability lines; or
 - It has greater than \$5 million written premium statewide for all commercial general liability lines.
- B. A company must report at least quarterly in selected market detail consistent with the specifications of the Model Commercial General Liability Statistical Plan if the company has not already met the above criteria for reporting quarterly but does meet any of the following criteria:
- It has greater than \$1 million written premium statewide for a selected market; or
 - It has greater than 10 percent written premium statewide for a selected market and greater than \$100,000 written premium for that market.

2. Annual Reporting

- A. A company must report at least annually according to the Model Commercial General Liability Statistical Plan specifications if the company has not already met the criteria in 1A for reporting quarterly but it is in the 98th percentile of the total statewide written premium for all commercial general liability lines.
- B. A company must report at least annually in selected market detail consistent with the specifications of the Model Commercial General Liability Statistical Plan if the company has not already met any of the above criteria but it has greater than 10 percent written premium statewide for a selected market and less than \$100,000 written premium for that market.
- C. The experience of all other companies and any experience not reported according to 1A, 1B, 2A and 2B above must be reported annually according to the instructions of a company's statistical agent.

4.6 Specific Annual Report Features

The two types of annual reports for commercial general liability have the following specific features:

1. Subline Report

The subline report provides five policy years of data by state and coverage, detailed by major subline. For risks written under the old general liability programs, the report uses the following sublines:

- Owners, Landlords and Tenants
- Manufacturers and Contractors
- Products/Completed Operations (countrywide only)

For risks written under the new general liability programs, the report uses the following sublines:

- Premises/Operations
- Products/Completed Operations (countrywide only)

Insurers will first report data under the new sublines for policies becoming effective in 1989. The first reports will be available in 1992.

The subline report gives premiums on a collected earned basis. It separates incurred losses into basic limit and excess limits components. Basic limits losses include all indemnity losses up to \$25,000 for bodily injury liability, \$5,000 for property damage liability and \$25,000 for single limit coverage, as well as all allocated loss adjustment expenses. Excess limits losses reflect any losses above basic limits. The report shows losses valued at 27, 39, 51, 63 and 75 months after the beginning of the policy year. In addition, the report shows these loss evaluations with projected development to a minimum maturity of 87 months using loss development factors. The report also shows total limits loss ratios based on losses developed to 87 months.

Finally, the report shows incurred claim counts and average claim costs. The data includes at least the experience of companies meeting the criteria specified in 1A and 2A of Section 4.5. Exhibits 5, 6, and 7 on pages 4-8, 4-9 and 4-10 provide a sample of GL subline reports.

2. Selected Market Report

This report provides five policy years of premium and loss data for markets (classes) selected by the Statistical (D) Task Force:

- Municipal
- Public Schools
- Recreational
- Liquor Law
- Day Care
- Lawyers Professional

The data elements included in the report are the same as those specified for the subline report. It includes at least the experience of companies meeting the criteria specified in 1A, 1B, 2A and 2B of Section 4.5.

The first report combining the data for all statistical agents will be for the report that contains 1989 policy year data.

3. Supplemental Reports

Although not necessary to submit on a regular basis, these reports have been determined to be of such value that they should be available (“on the shelf”) upon request, consistent with the time frames for the subline and selected market reports. These reports supplement the standard reports and provide information in finer statistical breakdowns.

- Class Groups—statewide data by coverage and each class group (not just selected markets). The data elements included in the report are the same as those specified for the Subline Report. It shall include at least the experience of companies meeting the criteria specified in 1A and 2A of Section 4.5.
- Loss Development--loss development data for bodily injury will be available by state and subline of business. The report will provide policy year incurred losses as of evaluation dates: 27, 39, 51, 63 and 75 months after the beginning of the policy year. See Exhibits 8 and 9 on pages 4-11 and 4-12 for an example of the format and content.
- Countrywide by Subline—countrywide data will include the same detail and experience as specified for the State Subline Report
- Other Sublines Statewide —
 - Contractual Liability
 - Owners and Contractors Protective Liability
 - Storekeepers Liability
 - All Other

Custom Reports

Recognizing that the majority of the General Liability data is reported in the detail listed on page 4-3 of the *Handbook*, reports may be generally requested for any element or combination of elements consistent with filed programs and statistical plans.

It must be recognized that because custom reports are not shelf products, i.e., they are not readily available, the timeframes for such reports will require negotiation. The detail requested must be consistent with the structure of the data base from which the data will be extracted.

4.7 Time Frame

Because general liability losses often take many years to surface and to be settled, and because many of the exposure bases are audited, the statistical agents compile and tabulate the data on a policy year basis. Therefore, the statistical agents distribute general liability annual reports approximately 39 months after the beginning of the policy year.

EXHIBIT 5

INSURANCE SERVICES OFFICE
OWNERS LANDLORDS AND TENANTS LIABILITY
POLICY YEARS ENDING DECEMBER 31, 1983 THROUGH 1987
BODILY INJURY STATE DATA FOR ALL CLASSES

ILLINOIS

MONOLINE

STATE	POL YR. ENDING DEC.31	EARNED PREMIUM	+- - - - - BASIC LIMIT	INCURRED LOSSES - - - - + EXCESS	NO. OF CLAIMS	MED PAY INCURRED LOSSES	TOT LIM LOSS RATIO
12	1983	14,783,455	12,922,404	5,905,163	2,460	233,645	1.289
12	1984	14,537,081	12,144,384	5,343,700	2,173	390,299	1.230
12	1985	12,587,239	11,951,469	5,381,169	1,702	303,939	1.401
12	1986	17,074,190	9,761,108	4,254,005	1,415	326,258	0.840
12	1987	20,467,610	6,430,365	2,244,793	1,019	328,345	0.440
12	TOTAL	79,449,575	53,209,730	23,128,830	8,769	1,582,486	0.981

MULTILINE

STATE	POL YR. ENDING DEC.31	EARNED PREMIUM	+- - - - - BASIC LIMIT	INCURRED LOSSES - - - - + EXCESS	NO. OF CLAIMS	MED PAY INCURRED LOSSES	TOT LIM LOSS RATIO
12	1983	21,807,715	23,938,054	10,005,819	4,885	767,597	1.592
12	1984	21,625,502	28,814,882	14,869,792	5,060	1,023,341	2.067
12	1985	22,892,648	28,783,435	12,837,668	4,707	1,424,008	1.880
12	1986	34,036,454	21,549,732	10,047,742	3,849	1,620,752	0.976
12	1987	44,438,768	12,778,187	3,959,462	2,408	947,731	0.398
12	TOTAL	144,801,087	115,864,290	51,720,483	20,909	5,783,429	1.197

EXHIBIT 6

INSURANCE SERVICES OFFICE
MULTILINE MANUFACTURERS AND CONTRACTORS LIABILITY
POLICY YEARS ENDING DECEMBER 31, 1983 THROUGH 1987

ILLINOIS

BODILY INJURY

STATE	POL YR. ENDING DEC. 31	EARNED PREMIUM	+- - - - - BASIC LIMIT	INCURRED EXCESS	LOSSES NO. OF CLAIMS	- - - - + MED PAY INCURRED LOSSES	TOT LIM LOSS RATIO*
12	1983	9,105,954	7,107,641	5,439,800	621	230,848	1.403
12	1984	9,164,848	8,838,964	5,630,158	814	37,989	1.583
12	1985	11,260,381	9,419,010	9,296,854	741	33,579	1.665
12	1986	17,109,524	7,125,270	5,333,929	661	64,747	0.732
12	1987	21,832,118	4,165,998	2,205,735	442	59,711	0.295
12	TOTAL	68,472,825	36,656,883	27,906,476	3,279	426,874	0.949

PROPERTY DAMAGE

STATE	POL YR. ENDING DEC. 31	EARNED PREMIUM	+- - - - - BASIC LIMIT	INCURRED EXCESS	LOSSES NO. OF CLAIMS	- - - - + TOT LIM LOSS RATIO*	+ - BASIC LIMIT	ADDITIONAL CHARGES INCURRED EXCESS	LOSSES NO. OF CLAIMS	- +
12	1983	3,207,429	3,241,055	1,993,519	1,983	1.632	90,413	10,699	100	
12	1984	3,467,252	3,585,614	2,616,384	2,557	1.789	75,916	21,300	77	
12	1985	4,250,946	3,820,247	2,279,100	2,596	1.435	73,849	101,828	76	
12	1986	6,911,883	2,235,000	1,479,926	1,730	0.537	30,526	0	34	
12	1987	10,393,249	1,523,796	1,079,636	1,112	0.250	66,208	24,814	35	
12	TOTAL	28,230,759	14,405,712	9,448,565	9,978	0.845	336,912	158,641	322	

* EXCLUDING ADDITIONAL CHARGE LOSSES FOR PROPERTY DAMAGES

EXHIBIT 7

INSURANCE SERVICES OFFICE
MONOLINE MANUFACTURERS AND CONTRACTORS LIABILITY
POLICY YEARS ENDING DECEMBER 31, 1983 THROUGH 1987

ILLINOIS

BODILY INJURY

STATE	POL YR. ENDING DEC.31	EARNED PREMIUM	← - - - - - BASIC LIMIT	INCURRED LOSSES EXCESS	- - - - - NO. OF CLAIMS	MED PAY INCURRED LOSSES	TOT LIM LOSS RATIO*
12	1983	14,483,305	9,903,519	9,274,953	715	85,098	1.330
12	1984	14,055,658	9,457,305	8,605,915	779	63,729	1.290
12	1985	13,642,500	10,058,975	6,055,716	736	60,495	1.186
12	1986	22,471,433	7,054,815	5,104,355	507	25,327	0.542
12	1987	23,156,680	3,496,546	1,377,563	358	44,339	0.212
12	TOTAL	87,809,576	39,971,160	30,418,502	3,095	278,988	0.605

PROPERTY DAMAGE

STATE	POL YR. ENDING DEC.31	EARNED PREMIUM	← - - - - - BASIC LIMIT	INCURRED LOSSES EXCESS	- - - - - NO. OF CLAIMS	TOT LIM LOSS RATIO*	+ - - - - BASIC LIMIT	ADDITIONAL CHARGES INCURRED LOSSES EXCESS	- - - - - NO. OF CLAIMS
12	1983	5,183,956	4,040,144	3,433,283	2,963	1.442	122,952	7,424	142
12	1984	5,225,277	3,870,017	2,218,242	2,938	1.165	102,325	24,229	137
12	1985	4,926,940	3,213,514	1,591,346	2,605	0.975	128,764	27,821	120
12	1986	8,567,511	2,640,884	2,699,561	1,779	0.623	99,183	81,356	73
12	1987	10,789,340	1,556,271	814,541	1,163	0.220	535,282	818	16
12	TOTAL	34,693,024	15,320,830	10,756,773	11,448	0.752	988,506	141,648	488

* EXCLUDING ADDITIONAL CHARGE LOSSES FOR PROPERTY DAMAGES

EXHIBIT 8

INSURANCE SERVICES OFFICE, INC.		PREMISES AND OPERATIONS (SUBLINE 334) MANUFACTURER & CONTRACTORS BODILY INJURY BASIC LIMITS LOSSES* MONOLINE & MULTILINE									
ALL COMPANIES REPORT TO ISO		27 MONTHS	39 MONTHS	51 MONTHS	63 MONTHS	75 MONTHS	87 MONTHS	99 MONTHS	111 MONTHS	123 MONTHS	135 MONTHS
POLICY YEAR	ENDING										
	12/31/74					107323083	109434891	110064266	110727207	110993719	
	12/31/74X				106480598	109427880	111109426	112999421	112409429	86199720	86165047
	12/31/75								84476206	84099981	84181090
	12/31/75X			101292080	107384768	111632626	114902365	116973818	87376282	87537702	88321119
	12/31/76										
	12/31/76X		91050427	103757103	112335903	115988802	119915850	88359755	88545928	90571200	
	12/31/77										
	12/31/77X	75613388	103963547	121373460	131856536	136008152	106277867	110810609	111320831		
	12/31/78										
	12/31/78X	83117081	117115309	138565299	149326117	118854057	120345251	127408402			
	12/31/79										
	12/31/79X	74960835	109631481	128333866	135259267	135775497	144162585	146275845	149407830	151523283	
	12/31/80										
	12/31/80X	101197250	146925864	174043946	191270571	196131490	203036578	205730901			
	12/31/81										
	12/31/81X	123494102	145950150	174043946	191270571	196131490	203036578	205730901			
	12/31/82										
	12/31/82X	124811920	177639821	213819952	229238662	243124751	250216411				
	12/31/83										
	12/31/83X	146833533	179937978	215688882	242642826	253061733					
	12/31/84										
	12/31/84X	159754591	219789601	272885333	294694140						
	12/31/85										
	12/31/85X	155201684	245896771	301068678							
	12/31/86										
	12/31/86X	139421371	233350383								
	3YR MEAN	1.513	1.222	1.092	1.043	1.026	1.013	1.013	1.002	1.001	

		RATIOS									
POLICY YEAR	ENDING	39:27	51:39	63:51	75:63	87:75	99:87	111:99	123:111	135:123	
	12/31/74					1.020	1.006	1.006	1.002	1.000	
	12/31/75				1.028	1.015	1.017	.995	.996	1.001	
	12/31/76			1.060	1.040	1.029	1.018	1.002	1.009		
	12/31/77		1.140	1.083	1.033	1.034	1.002	1.023			
	12/31/78	1.375	1.167	1.086	1.031	1.043	1.005				
	12/31/79	1.409	1.183	1.078	1.013	1.059					
	12/31/80	1.463	1.171	1.084	1.062	1.015	1.021	1.014			
	12/31/81	1.452	1.192	1.099	1.025	1.035	1.013				
	12/31/82	1.438	1.204	1.072	1.061	1.029					
	12/31/83	1.442	1.199	1.125	1.043						
	12/31/84	1.497	1.242	1.080							
	12/31/85	1.539	1.224								
	12/31/86	1.504									
	3YR MEAN	1.513	1.222	1.092	1.043	1.026	1.013	1.013	1.002	1.001	

POLICY YEAR		LOSS DEVELOPMENT FROM										FACTOR
ENDING	27/39	39/51	51/63	63/75	75/87	87/99	99/111	111/123	123/135	135/ULT#		
12/31/83					1.026	1.013	1.013	1.002	1.001	1.008	1.063	
12/31/84				1.043	1.026	1.013	1.013	1.002	1.001	1.013	1.115	
12/31/85			1.092	1.043	1.026	1.013	1.013	1.002	1.001	1.018	1.223	
12/31/86		1.222	1.092	1.043	1.026	1.013	1.013	1.002	1.001	1.027	1.508	
12/31/87	1.513	1.222	1.092	1.043	1.026	1.013	1.013	1.002	1.001	1.039	2.308	

* INCLUDES ALLOCATED LOSS ADJUSTMENT EXPENSE
INCLUDES ADJUSTMENT FOR HIGHER DEVELOPMENT OF ALAE

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EXHIBIT 9

INSURANCE SERVICES OFFICE, INC.		PREMISES AND OPERATIONS (SUBLINE 334)										
ALL COMPANIES REPORT TO ISO		MANUFACTURER & CONTRACTORS										
POLICY YEAR		PROPERTY DAMAGE										
ENDING		BASIC LIMITS LOSSES*										
POLICY YEAR		MONOLINE & MULTILINE										
ENDING	27 MONTHS	39 MONTHS	51 MONTHS	63 MONTHS	75 MONTHS	87 MONTHS	99 MONTHS	111 MONTHS	123 MONTHS	135 MONTHS		
12/31/74					59360144	59951145	60502437	61045922	61278718			
12/31/74X					57581201	58231585	59039598	59562090	60007989			47933589
12/31/75									47622778			
12/31/75X									45057235			45828748
12/31/76			55863080	56906618	58112734	58948779	60098284					
12/31/76X							44883212	45624033				
12/31/77		57622060	60533165	62328954	64130754	65756378						
12/31/77X							48548407	49066269	49746764			
12/31/78	60124647	66150930	71169495	73370670	75258772	75446724						
12/31/78X							59341355	61108289				
12/31/79	70046525	77727532	82042653	85655451	86215789	88539238						
12/31/79X							70217191					
12/31/80	65651713	73001440	77558751	74911161	78974138	82512407						
12/31/80X							84994709	88209214	89360222			
12/31/81	82150187	93814845	100638939	108345688	114153710	119907622						
12/31/81X		93003063	100638939	108345688	114153710	119907622	123940380					
12/31/82X	102230594	113589834	124551036	131275303	142381586	148522089						
12/31/83X	109971115	125419693	133497273	146087971	155074480							
12/31/84X	130281012	146193915	163033318	176123229								
12/31/85X	138232310	156521443	174356693									
12/31/86X	112674372	130748308										
12/31/87X	90473511											
POLICY YEAR		RATIOS										
ENDING	39:27	51:39	63:51	75:63	87:75	99:87	111:99	123:111	135:123			
12/31/74					1.010	1.009	1.009	1.004	1.007			
12/31/75					1.011	1.009	1.007	1.004	1.013			
12/31/76			1.019	1.021	1.014	1.019	1.017	1.015				
12/31/77		1.051	1.030	1.029	1.025	1.011	1.014					
12/31/78	1.100	1.076	1.031	1.026	1.033	1.030						
12/31/79	1.110	1.056	1.044	1.035	1.024							
12/31/80	1.112	1.062	1.054	1.045	1.030	1.038	1.013					
12/31/81	1.142	1.082	1.077	1.054	1.050	1.034						
12/31/82	1.111	1.096	1.054	1.085	1.043							
12/31/83	1.140	1.064	1.094	1.062								
12/31/84	1.122	1.115	1.080									
12/31/85	1.132	1.114										
12/31/86	1.160											
JYR MEAN	1.138	1.098	1.076	1.067	1.041	1.034	1.015	1.008	1.010			
POLICY YEAR		LOSS DEVELOPMENT FROM										
ENDING	27/39	39/51	51/63	63/75	75/87	87/99	99/111	111/123	123/135	135/ULTS	FACTOR	
12/31/83					1.041	1.034	1.015	1.000	1.010	1.045	1.160	
12/31/84				1.067	1.041	1.034	1.015	1.008	1.010	1.051	1.248	
12/31/85			1.076	1.067	1.041	1.034	1.015	1.008	1.010	1.114	1.423	
12/31/86		1.098	1.076	1.067	1.041	1.034	1.015	1.008	1.010	1.136	1.593	
12/31/87	1.138	1.098	1.076	1.067	1.041	1.034	1.015	1.008	1.010	1.118	1.784	

* INCLUDES ALLOCATED LOSS ADJUSTMENT EXPENSE
 # INCLUDES ADJUSTMENT FOR HIGHER DEVELOPMENT OF ALAE

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Model Commercial General Liability Statistical Plan

LIST OF DATA ITEMS

1. Company Number
2. Transaction Identifier and Amounts
3. Accounting/Calendar Dates
4. Policy Effective Year
5. State Indicator
6. Territory Indicator
7. Type of Program Indicator
8. Commercial General Liability Subline Identifier
9. Class Groups
10. Classifications
11. Type of Policy Contract Identifier
12. Number of Years in Claims Made Program
13. Coverage Identifier
14. Exposure
15. Type of Loss
16. Claim Count

DATA ITEMS

1. Company Number

Use the number assigned by the statistical agent.

Note: Statistical agents will be required to convert company numbers to NAIC group and company code numbers, if requested.

2. Transaction Identifier and Amounts

Identify the following items and the respective amounts:

- Written Premiums
- Paid Losses (excluding all Loss Adjustment Expenses)
- Paid Allocated Loss Adjustment Expenses
- Outstanding Losses
- Outstanding Allocated Loss Adjustment Expenses (where separately identified)

3. Accounting/Calendar Dates

- Accounting Quarter (where applicable)
- Accounting Year

4. Policy Effective Year

- This is the effective date of the policy.
- For Claims Made Supplemental Extended Reporting Period, the date on which Supplemental Extended Reporting Period began is required.

5. State Indicator

Alabama	Illinois	Montana	Puerto Rico
Alaska	Indiana	Nebraska	Rhode Island
Arizona	Iowa	Nevada	South Carolina
Arkansas	Kansas	New Hampshire	South Dakota
California	Kentucky	New Jersey	Tennessee
Colorado	Louisiana	New Mexico	Texas
Connecticut	Maine	New York	Utah
Delaware	Maryland	North Carolina	Vermont
District of Columbia	Massachusetts	North Dakota	Virginia
Florida	Michigan	Ohio	Washington
Georgia	Minnesota	Oklahoma	West Virginia
Hawaii	Mississippi	Oregon	Wisconsin
Idaho	Missouri	Pennsylvania	Wyoming

6. Territory Indicator

Common industry territorial breakdowns currently in use will be maintained.

7. Type of Program Indicator

- monoline
- package

8. Commercial General Liability Subline Identifier

A. The following are applicable to risks rated under the new Commercial General Liability Policy only:

- Premises/Operations Liability (Including Farm Liability)
- Owners or Contractors Protective Liability
- Products/Completed Operations Liability (Including Farm Liability)
- Liquor Law Liability
- Pollution Liability
- All Other

B. The following are applicable to risks not rated under the new Commercial General Liability Program:

- Contractual Liability
- Liquor Law Liability
- Manufacturers and Contractors Liability
- Owners, Landlords and Tenants Liability
- Products/Completed Operations Liability
- Professional Liability Other Than Medical Professional
- Storekeepers Liability
- All Other

9A. Class Groups

The following class groups apply when using advisory or rate service organization or similar programs.

<u>SUBLINE</u>	<u>CLASS GROUP</u>
Premises/Operations	Food and Beverage (Retail) Restaurants Stores Vending and Rental Food and Beverage Distributors Non-Food and Beverage Distributors Clubs, Amusements and Sports Health Care Facilities Hotels and Motels Schools and Churches Apartments Buildings and Offices Miscellaneous Premises A-Rated (Premises)
	Service Light Contracting Medium Contracting Heavy Contracting Dealer or Distributors Light Manufacturers Medium Manufacturers Heavy Manufacturers Miscellaneous Operation A-Rated (Operations)
Products/Completed Operations	Retail Stores – Food or Drug Retail Stores – Not Food or Drug Manufacturers, Dealers or Distributors – Food or Drug Dealers or Distributors – Not Food or Drug Manufacturers – Not Food or Drug (Low) Manufacturers – Not Food or Drug (Medium) Manufacturers – Not Food or Drug (High) Completed Operations (Low) Completed Operations (Medium) Completed Operations (High) A-Rated Products A-Rated Completed Operations

Professional Liability Other
Than Medical

Owners or Contractors
Protective Liability
Pollution Liability

All Other

Composite Rated:

- Agricultural
- Mining
- Contract Construction
- Manufacturing
- Transportation
- Communication
- Electric, Gas and Sanitary Services
- Wholesale
- Retail Trade
- Finance, Insurance and Banking
- Services
- Governmental

9B. Selected Market Class Groups

Data from all programs shall be reported for the following Selected Market Class Group.

CLASS GROUP

Selected Markets:

- Liquor Law Liability
- Day Care Liability
- Municipal Liability
- Recreational Liability
- Public School Liability
- Lawyer Professional Liability

10. Classifications

Individual classification experience shall be maintained in accordance with the classification requirements of the various statistical agents. Classification detail may be obtained from the NAIC Publications department, if desired.

11. Type of Policy Contract Identifier

- claims made coverage – basic
- claims made coverage – supplemental extended reporting period
- occurrence coverage

12. Number of Years in Claims Made Program

Identify the number of years after the retroactive date, with separate identification if there is no retroactive date, or if the retroactive date is more than five years.

13. Coverage Identifier

- Bodily Injury
- Medical Payments
- Bodily Injury and Medical Payments Combined
- Property Damage
- Combined Single Limit Policy, with or without Medical Payments
- All Other

14. Exposure

- Refer to class table for reporting basis.

15. Type of Loss

- Bodily Injury
- Property Damage
- Medical Payments
- All Other

16. Claim Count

- Number Paid
- Number Outstanding

INSERT

SECTION 5

TAB HERE

SECTION 5

5. PRIVATE PASSENGER AUTOMOBILE INSURANCE

5.1 Introduction

This section describes reporting requirements and features of statistical collection for private passenger automobile insurance.

5.2 Scope of Private Passenger Automobile Insurance Data

Private passenger automobile insurance, for the purposes of this section, encompasses all forms of policies covering vehicles rated as private passenger automobiles and reported on the Annual Statement Exhibit of Premiums and Losses (Statutory Page 14) as private passenger auto. This generally includes those policies issued on automobiles owned or leased by an individual or by husband and wife resident in the same household. It does not cover those vehicles rated as private passenger fleet. It includes four-wheel vehicles including station wagons, vans, or pick-up trucks that are not customarily used in the occupation, profession or business of the insured. It includes private passenger vehicles written through the voluntary market, as well as vehicles insured through various state residual market mechanisms. It includes miscellaneous types of personal vehicles such as motorcycles, snowmobiles, dune buggies and the like when rated as private passenger automobiles. It also includes such vehicles owned by a corporation, co-partnership or unincorporated association and rated as private passenger automobiles.

5.3 Automobile Coverages

Private passenger automobile insurance data includes the five major types of coverage normally available under an automobile insurance policy: liability, medical payments, uninsured and underinsured motorist, no-fault (in states with no-fault statutes) and physical damage.

Liability coverage protects the insured against damages resulting from an automobile accident for which the insured is legally responsible. Liability coverages normally include bodily injury and property damage, which may be written and reported as a combined coverage with a single premium, or as separate coverages with individual premiums. Loss information is reported separately for bodily injury and property damage.

Medical payments coverage pays for medical and funeral expenses incurred because of injuries sustained in an automobile accident. Data reported for medical payments coverage provides meaningful information except in states with no-fault coverage (personal injury protection – PIP) because PIP provides first party medical and funeral expense coverage in these states. Medical payments information will therefore be provided in statistical reports detailed in this section only in states without no-fault coverage.

Uninsured and underinsured motorist coverages are designed to cover the insured for bodily injury, and in some states property damage, caused by an uninsured motorist or a motorist having insufficient limits of liability to cover losses to the insured. Uninsured and

underinsured motorist coverages are written and reported either on a combined basis with a single premium charge for both coverages, or separately with a premium charged and recorded for the uninsured motorist and underinsured motorist coverages. Losses are identified as either uninsured motorist or underinsured motorist losses.

No-fault coverage is an approach for compensating automobile accident victims where each party collects medical expenses, wage loss and other services from his or her own insurer regardless of fault. Experience for no-fault coverage (Personal Injury Protection, or PIP) is collected for each state with a no-fault requirement and is included in the statistical compilation.

Physical damage coverage pays for losses resulting from damage to or theft of a covered automobile. Basic coverages include collision and other than collision (comprehensive).

5.4 Timeframes for Reports from Statistical Agents to Regulators

Statistical agents shall distribute standard private passenger automobile annual reports described in this section 15 months after the end of the calendar or accident year. (This time lag allows for loss evaluation and statistical agent processing and compilation.)

5.5 List of the Data Items Reported by Insurers to Statistical Agents

The minimum data items required for private passenger automobile reporting are detailed in the following material. Reporting requirements include:

Premium reporting:

1. Company Identifier
2. Type of Business
3. Dates and Amounts of Premiums and Exposures
4. State
5. ZIP Code or Territory
6. Class Group
7. Coverage Identifier

Additional Detail for Loss reporting:

8. Amount of Loss
9. Year of Loss
10. Type of Loss
11. Excess Loss Reports

Reports by insurers to statistical agents shall be made periodically or continuously as losses are reported, developed and are paid. At a minimum, such reports must include evaluations of losses as follow:

- Liability Bodily Injury and UM/UIM – Reports shall be made as of 15, 27, 39, 51 and 63 months.

- Liability – Property Damage – Reports shall be made as of 15, 27 and 39 months.
- Medical Payments – Reports shall be made as of 15, 27 and 39 months.
- No-Fault – Reports shall be made as of 15, 27, 39, 51 and 63 months.
- Physical Damage – Paid and case-basis unpaid losses shall be reported as of year-end. (This allows statistical agents to report calendar year incurred losses on a basis very similar to the Annual Statement Exhibit of Premiums and Losses (Statutory page 14). The difference will be that the unpaid losses used by statistical agents will be undeveloped case-basis losses, while unpaid losses used for the Annual Statement are developed losses that include IBNR.)

5.6 Description of the Data Items

1. Company Identifier

Experience is to be reported separately for each insurer. Statistical agents are required to convert their internal company numbers to NAIC group and company code numbers if a state requests this in conjunction with a special report. (No standard reports provide insurer-specific information.)

2. Type of Business

- Voluntary
- Residual

3. Dates and Amounts of Premiums and Exposures

Written premiums and exposures (written car months where applicable and meaningful) shall be reported by policy period and accounting/calendar year. At a minimum, statistical agents shall collect data for 6-month policies separately from those for other policy terms (generally presumed to be 12-month policies). Earned premiums and exposures may then be estimated for reports to regulators.

4. State

Experience is to be reported using a state code applicable to the principal place of garaging.

5. ZIP Code or Territory

The *Handbook* considers ZIP code reporting as the standard reporting requirement. The ZIP codes to be reported are the 5-digit ZIP code of the garaging address of the insured vehicle. (Explanatory note – for states and statistical agents that have not adopted *Handbook* requirements or ZIP code reporting, data is customarily available for the territories that had been in use prior to the time of reporting by the state's major private passenger advisory organization.) ZIP code or territory are not required for miscellaneous personal vehicles.

6. Class Group

All coverages, except for uninsured and underinsured motorist coverages, are to be reported by class group as follows.

A. Voluntary Risks

1 – No male driver under 25; non-business use

1F – No male driver under 25; Farm use

1A – No male driver under 25; non-business use; non-farm; no driving to work

1B – No male driver under 25; non-business use; drives to work - limited number of miles each way

1C – No male driver under 25; non-business use; drives to work - over a limit of miles each way

1D – No male driver under 25; non-business use, drives to work - no distance restriction

3 – No male driver under 25; business use

2 – Driver under 25; business and non-business use

2A – Male driver under 25; business and non-business use; married; or single male not owner or principal driver

2B – Married male driver under 25; business and non-business use

2C – Unmarried male driver under 25; business and non-business; owner or principal driver

2D – Female driver under 25

2E – Single male operator age 25-29 inclusive; owner or principal operator

Sr. Citizen – Operator age 65 and over

All Other PPNF – No class plan or other class plan used; military post coverage, all other private passenger cars

B. Assigned Risks

Utilize state assigned risk classification plans.

C. Miscellaneous Personal Vehicles (including motorcycles)

7. Coverage Identifier

- Bodily Injury
- Property Damage
- Bodily Injury and Property Damage written with a single indivisible premium
- Indivisible Premium Policies
- Medical Payments
- No-Fault - where applicable
- Uninsured Motorist (UM) and Underinsured Motorist (UIM). These are to be reported separately except when combined with an indivisible premium.
- Physical Damage:
 - Collision Coverages
 - Comprehensive Coverages
 - All Other Physical Damage including indivisible premium policies

8. Amount of Deductibles

Deductible amounts are to be reported to the statistical agent for:

- Collision
- Comprehensive
- All other physical damage coverages

Additional Detail for Loss Reporting

The matching exposure detail provided in this section of the *Handbook* shall be reported with each loss. In addition, the following elements of detail shall be provided:

9. Amount of Loss

- Paid losses
- Case-basis outstanding losses
- Paid and outstanding allocated loss adjustment expenses are reported for liability coverages only. Such expenses and reserves shall be reported, whenever practicable, using definitions consistent with definitions used for financial reporting.

Losses are to be reported net as to third party recoveries (salvage and subrogation).

10. Claim Count

- Number Paid
- Number Outstanding

Note on claim counting: It is recognized that insurer practices differ relating to the counting of claims. Some insurers count claims on a per-accident basis, while others count claims on a per-claimant basis. Either basis of counting is allowable, subject to the following provisions:

- Insurers shall notify their statistical agent of the basis of counting that they use, and they shall notify the statistical agent whenever this basis of counting is changed.
- A claimant-based counting method is considered preferable. Whenever a system rewrite, merger or other major event offers an insurer or group the opportunity to move to claimant-based reporting without a significant additional expenditure simply to change the reporting basis, the insurer or group is encouraged to change to claimant-based reporting.
- So that data may be provided for the excess loss exhibits described in this section, insurers that utilize claimant-based reporting must be able to identify multiple claimants arising from the same accident for those coverages involving a separate per-accident limit.
- Insurers that utilize accident-based reporting must be able to break out data for individual claimants for the excess loss exhibits described in this section.

11. Year of Loss

The year of the loss occurrence shall be reported.

12. Type of Loss

Liability:

- Bodily Injury
- Property Damage
- Medical Payments
- UM/UIM - by ZIP Code or territory for all classes combined
- All other

No-Fault for paid losses:

- Medical expenses
- Loss of income
- All other

For no-fault outstanding losses, statistical agents may choose to collect the total of all types, or they may choose to collect them in detail.

Physical Damage:

- Collision
- Comprehensive
 - Fire and explosion
 - Theft
 - Glass – when the only loss is damaged glass

- Personal effects
- Malicious mischief and vandalism
- Windstorm, hail, and water damage (except from floods and rising waters)
- Flood and rising waters
- Earthquake
- All other causes

13. Excess Limits Losses

Separately for losses reported under bodily injury liability, property damage liability and uninsured motorist coverages, insurers shall identify each individual accident / coverage combination that involves paid and undeveloped unpaid losses that, either alone or combined with other losses for the same coverage arising out of the same accident, exceed the applicable state financial responsibility limits. For every such accident / coverage combination that is identified, the insurer shall report individual losses in the full detail required by the Handbook on a claimant basis and shall, in addition, report individual accident/coverage identifiers so that the statistical agent may combine the losses for multiple claimants involved in the same accident.

Please note that this may involve little or no additional reporting for some insurers. Insurers that already report individual losses on a claimant basis will only need to report accident identifiers for excess limits losses. With some statistical agents, insurers that report on a claimant basis may report accident / coverage identifiers for all losses, in which case no additional reporting will be due for excess limits losses (as the statistical agent will be able to identify and aggregate excess losses without additional information).

5.7 **Standard and Customized Reports for Regulators**

The data collected by statistical agents can be reported to regulators in a variety of formats. The pages that follow show standard report formats that statistical agents will use on a regular basis. These formats can be altered or specialized reports can be generated upon request, as long as the data necessary is contemplated by the data elements listed in this section. For instance, paid development triangles can be generated for bodily injury and property damage liability, but this will only be upon the request of the regulator.

1. Coverage Report

The coverage report provides three accident years of data for liability and no-fault coverages and three calendar years of data for physical damage coverages. The coverage report includes:

- Bodily Injury
- Property Damage
- Policies providing BI and PD Liability (only) for a Single Indivisible Premium
 - Premiums: BI and PD are combined
 - Losses: BI and PD are shown separately
- Other Indivisible Premium Policies
- Medical Payments (non no-fault states only)

- No-fault (Personal Injury Protection – PIP) (where applicable)
- Uninsured/Underinsured Motorist
 - Premiums: UM/UIM combined
 - Losses: UM-BI, UM-PD, UIM-BI, UIM-PD separately
- Physical Damage
 - Comprehensive: Full Coverage, \$50 ded., \$100 ded., \$200 ded., \$250 ded., \$500 ded., \$1,000 ded., all other deductibles combined.
 - Collision: \$50 ded., \$100 ded., \$200 ded., \$250 ded., \$500 ded., \$1,000 ded., all other deductibles combined.

The coverage report will be provided on a statewide basis. Countrywide totals are available on request. Voluntary market and residual market data will be produced separately. Miscellaneous vehicles will be shown separately from private passenger automobile.

Exposures (car years) and premiums are shown on an earned basis. Losses are shown on an incurred basis and include those allocated loss adjustment expenses for which the insurer has consistent transaction records on a claim-by-claim basis and is able to report such expenses on a consistent basis to the statistical agent. Incurred claim counts are also shown.

The coverage report separates incurred losses for bodily injury and property damage coverages into basic limit and excess limit components. The basic limit component will be shown at the statutory financial responsibility limits unless otherwise requested by a state. All other coverages will be provided at total limits. Excess limits losses reflect any losses above the basic limit. The report shows bodily injury liability, UM/UIM and PIP losses and claim counts with projected development to a minimum maturity of 63 months. The report shows property damage liability and medical payments experience developed to a minimum maturity of 39 months. The report shows physical damage losses on a modified “calendar year” basis (that is slightly different than that used for Annual Statement Exhibit of Premiums and Losses (Statutory page 14)), where the incurred losses are the paid losses for the reporting period, plus or minus any increase or decrease in total case-basis reserves from the start of the period to the end of the period. A statistical agent that collects the data necessary to estimate physical damage loss development may, if it so chooses, produce physical damage reports in which losses are reported on a developed accident year basis.

2. Territory / ZIP Code Report (Not applicable to miscellaneous personal vehicles)

This report provides three years of premium, exposure and loss data by territory or ZIP Code as follows:

- For states that have adopted the Handbook’s data reporting requirements including ZIP code reporting: The statistical agent shall provide reports with ZIP code groupings in accordance with specifications agreed to by the regulator at the time the report is developed. (This allows states to group data into territories that are consistent with current industry practices. It also allows a state to request a report by individual ZIP Code, but it is recommended that all but very simple reports by ZIP be made in an electronic format owing to the volume of paper necessary for such reports to be printed.)

- For states that have not adopted the *Handbook's* data reporting requirements including ZIP code reporting: Consistent treatment of territorial reporting will depend on whether the rating territories used by insurers are consistent, both between competing insurers and over time. This will often not be the case. Although statistical agents attempt to collect data from insurers with the territorial detail that is commonly available and/or that they perceive will meet the needs of the regulator, there is no assurance that this will always be possible. In general, the territorial groupings available from statistical agents will be those that were commonly used prior to the time of writing by an advisory organization.

The following specific coverages will be shown by territory:

- Bodily Injury
- Property Damage
- Medical Payments (except in no-fault states)
- No-fault (Personal Injury Protection – PIP) (where applicable)
- Uninsured/Underinsured Motorist
 - Premiums: UM/UIM combined
 - Losses: UM-BI, UM-PD, UIM-BI, UIM-PD separately
- Physical Damage
 - Comprehensive: Full Coverage, \$50 ded., \$100 ded., all other deductibles combined.
 - Collision: \$100 ded., \$200 ded., \$250 ded., all other deductibles combined.

Earned exposures, earned premiums, incurred losses and incurred claim counts will be provided in the same manner as specified in the coverage report.

Optional Trend Data Report

Private Passenger Automobile Experience

For a state that determines that quarterly trend data are needed, the format outlined below is recommended. Quarterly trend data would be available on a prospective basis only. Each state should determine their own market share thresholds for companies required to report trend data. This report is not applicable to miscellaneous personal vehicles.

DATA ITEMS

1. Company Identifier

Experience is to be reported by the company number assigned by the statistical agent. Note: Statistical agents will be required to convert company numbers to NAIC group and company code numbers, if requested.

2. Type of Business

- Voluntary
- Residual

3. Transaction Identifier and Amounts

Identify the following items and the respective amounts:

- Paid Losses (Basic and Excess Limits for Bodily Injury, Property Damage and UM/UIM Coverages)
- Outstanding Losses (Basic and Excess Limits for Bodily Injury, Property Damage and UM/UIM Coverages)

4. Experience Period

The experience period is calendar quarter.

5. State Indicator

Experience is to be reported by the state code applicable to the principal place of garaging.

6. Coverage Identifier

- Bodily Injury
- Property Damage
- Medical Payments
- Uninsured Motorists/Underinsured Motorists
- No-Fault - where applicable
- Collision
- Comprehensive

Note: For Collision and Comprehensive coverages, states may specify which deductibles they would like to have reported.

7. Exposure

The exposure base is written car months.

8. Claim Count

- Number paid
- Number outstanding

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SECTION 6

6. COMMERCIAL AUTOMOBILE REPORTS

6.1 Introduction

This section details specific reporting requirements for and features of commercial automobile annual statistical compilations. The basis for the annual compilation is the proposed Commercial Automobile Statistical Plan that has been presented to the NAIC.

6.2 Scope of Commercial Automobile Insurance Data

Commercial automobile insurance, for purposes of this section, encompasses all forms of commercial automobile policies.

Commercial automobile insurance as used herein generally includes those policies issued on business use private passenger automobiles, business use trucks, public and garages. Trucks include trucks, tractors and trailer types. Private Passenger Cars include all vehicles owned by corporations, co-partnerships or unincorporated associations under a fleet basis and the same under a non-fleet basis when used exclusively for business purposes; also, includes farmers private passenger autos, pickups, panel trucks and vans, under a fleet basis. Public automobiles include taxicabs, limousines, buses (school, church, urban, airport, inter-city, charter, sightseeing, athletic and entertainer), social service automobiles and van pools. Garages include dealer and non-dealer garages and service stations.

This section does not apply to automobiles and trucks for personal use.

This section covers automobile insurance on commercial vehicles written through the voluntary market, as well as vehicles insured through the various state residual market mechanisms such as the Automobile Insurance Plans.

6.3 Automobile Coverages

Insurers report commercial automobile insurance data consistent with the five major types of coverage normally available under an automobile insurance policy: Liability, Medical Payments, Uninsured and Underinsured Motorist, No-fault (in states with no-fault statutes) and Physical Damage.

Liability coverage protects the insured against damages for which the insured is legally responsible that result from an automobile accident. Liability coverages normally include bodily injury and property damage, which may be written and reported as a combined coverage with a single premium, or as separate coverages with individual premiums. Loss information is reported separately for bodily injury and property damage.

Medical Payments coverage pays for medical and funeral expenses incurred because of injuries sustained in an automobile accident. Data reported for medical payments coverage provides meaningful information except in states with No-fault coverage (Personal Injury Protection) because Personal Injury Protection provides first party medical and funeral

expense coverage in these states. Medical payments information will, therefore, be provided in statistical reports detailed in this section only in states without No-fault coverage.

Uninsured/Underinsured Motorist coverages are designed to cover the insured for bodily injury, and in some states property damage, caused by an uninsured motorist or a motorist having insufficient limits of liability to cover losses to the insured. Uninsured/Underinsured Motorist coverages are written and reported either on a combined basis with a single premium charge for both coverages, or separately with a premium charged and recorded for the Uninsured Motorist and Underinsured Motorist coverages. Losses in all cases are identified and reported as either Uninsured Motorist or Underinsured Motorist losses.

No-fault coverage is an approach for compensating automobile accident victims where each party collects medical expenses, wage loss and other services from his or her own insurer regardless of fault. Experience for No-fault coverage (Personal Injury Protection, or PIP) is collected for each state that has a No-fault requirement and is included in the statistical compilation.

Physical Damage coverage pays for losses resulting from damage to or theft of a covered automobile. Basic coverages include Collision and Other Than Collision (Comprehensive). Data is reported separately by the deductible amount applicable to the coverage.

6.4 Statistical Plan Reporting Requirements

The minimum data items required for commercial automobile reporting are specified in the Model Commercial Automobile Statistical Plan. They include:

- Company Identification Number
- Type of Business
- Transaction Identifier and Amount
- Accounting/Calendar Date
- Experience Period
- State (i.e., principal state of garaging)
- Territory
- Class Group
- Coverage Identifier
- Exposure
- Type of Loss
- Claim Count

The required data items are to be reported for direct business only. Therefore, reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier; nor shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded. Losses are to be reported net as to third party recoveries (salvage and subrogation).

6.5 Who Reports Data: Minimum Reporting Standards for Insurers

The statutory requirement to report statistics applies to all licensed insurers. In establishing the standards for reporting to the statistical agents, regulators recognize the need for efficiency by permitting companies with limited premium volume to report less detailed statistics.

The Model Regulation, therefore, has established the following standards for statistical reporting.

All insurers licensed to write commercial automobile policies are required to report statistics at least annually:

1. An insurer must report at least annually in accordance with the Model Commercial Automobile Statistical Plan if it is in the top 98th percentile of the total statewide written premium for commercial automobile.
2. An insurer that does not meet the above criterion must report at least annually its statewide experience by coverage and type of business in accordance with the specifications of commercial automobile statistical plan adopted by the Commissioner.

6.6 Specific Annual Report Features

The annual report for commercial automobile has the following specific features.

1. Coverage/Class Group Report

The coverage/class group report provides three accident years of data for Liability and No-fault coverages by class group and three calendar years of data for Physical Damage coverages by class groups. The coverage/class group report includes:

- Bodily Injury
- Property Damage
- Single BI PD Limits
 - Premiums: BI and PD combined
 - Losses: BI and PD separately
- Indivisible Premium Policies
- Medical Payments (applicable only in states without No-fault)
- No-fault (Personal Injury Protection) (where applicable)
- Uninsured/Underinsured Motorist
 - Premiums: UM/UIM combined
 - Losses: UM-BI, UM-PD, UIM-BI, UIM-PD separately

- Physical Damage
 - Comprehensive: \$100 ded., \$250 ded., \$500 ded., \$1000 ded.
All other deductibles combined.
 - Collision: \$100 ded., \$250 ded., \$500 ded., \$1000 ded.
All other deductibles combined.

Note: These deductibles will be exhibited unless a state specifies otherwise.

This report will be provided on a statewide basis. Countrywide totals will be available on request. Voluntary market and residual market data will be produced separately.

Exposures (as appropriate for the class group) and premiums are shown on an earned basis. Within class groups separate reports will be provided for each different exposure base.

Liability and No-fault will be on an incurred basis; Physical Damage will be on a paid only basis. Loss adjustment expenses will be included. Claim counts will also be exhibited on an incurred basis for liability and a paid basis for Physical Damage.

The coverage/class group report separates incurred losses for Bodily Injury and Property Damage coverages into basic limit and excess limit components. The basic limit component will be shown at the statutory financial responsibility limits unless otherwise requested by a state. All other coverages will be provided at total limits. Excess limits losses reflect any losses above the basic limit. The report shows Liability, Medical Payments, Uninsured/Underinsured Motorist and Personal Injury Protection losses valued at 15, 27 and 39 months from the start of the accident year.

In addition, the report shows these loss evaluations with projected development to a minimum maturity of 63 months for Bodily Injury, Uninsured/Underinsured Motorist and Personal Injury Protection coverages using loss development factors.

Finally, the coverage/class group report includes at least the experience of companies meeting the criteria specified in part 1 of Section 6.5.

6.7 Time Frame

Statistical agents distribute commercial automobile annual reports approximately 15 months after the end of the calendar or accident year. This allows for loss evaluation and statistical agent processing and compilation.

Model Commercial Auto Statistical Plan

LIST OF DATA ITEMS

1. Company Identification Number
2. Type of Business
3. Accounting/Calendar Date
4. Experience Year
5. Principal State of Garaging
6. Territory
7. Transaction Identifiers and Amounts
8. Exposures
9. Claim Count
10. Class Groups
11. Coverage Identifier
12. Type of Loss Codes

DATA ITEMS

1. Company Identification Number

Experience is to be reported by the company number assigned by the statistical agent.

Note: Statistical agents will be required to convert company numbers to NAIC group and company code numbers, if requested.

2. Type of Business

- Voluntary
- Residual Market

3. Accounting/Calendar Date

Accounting Year - Reflects the reporting year

4. Experience Year - period of coverage

- Premiums: Calendar year
- Losses: Liability and No-fault – Accident year
Physical Damage – Calendar year

5. Principal State of Garaging

Experience is to be reported by the state code applicable to the principal place of garaging.

6. Territory

Common industry territorial breakdowns currently in use will be maintained.

7. Transaction Identifiers and Amounts

- Written Premiums
- Paid Losses
- Paid Allocated Loss Adjustment Expense – Liability only
- Outstanding Losses – Liability and No-fault (including Allocated Loss Adjustment Expense Reserves for liability coverages only)

8. Exposures

Appropriate and meaningful exposure bases are used.

9. Claim Count

- Paid
- Outstanding

10. Class Groups

A. Voluntary Risks

- Trucks, tractors and trailers – zone rated
- Trucks, tractors and trailers – all other
- Taxicabs and public livery (includes limousines)
- School buses
- Public buses other than school buses (includes transportation of athletes and entertainers, social services automobiles and van pools)
- Automobile dealers
- Service operations or trailer sales
- All other commercial automobile classes

B. Residual Markets - use state residual market risk classification plans

11. Coverage Identifier

- Bodily Injury
- Property Damage
- Medical Payments
- No-fault
- Combined Single BIPD Limits
- Indivisible Premium Policies
- Uninsured Motorists*
- Underinsured Motorists*
- Physical Damage:
 - Comprehensive Coverages
 - \$100 deductible
 - \$250 deductible
 - \$500 deductible
 - \$1000 deductible
 - All other comprehensive deductibles

*These coverages are combined when written as an indivisible premium.

- Collision Coverages
 - \$100 deductible
 - \$250 deductible
 - \$500 deductible
 - \$1000 deductible
 - All other collision deductibles

12. Type of Loss Codes

Liability

- Bodily Injury
- Property Damage
- Medical Payments
- Uninsured Motorists
- Underinsured Motorists
- All other

No-Fault

- Paid Losses:
 - Medical Expenses
 - Loss of Income
 - All Other
- Outstanding Losses:
 - Total of All Types

Physical Damage

- Collision
- Comprehensive:
 - Fire
 - Theft
 - Glass
 - Personal Effects
 - Malicious Mischief and Vandalism
 - Windstorm, Earthquake, Tornado, Hail, Explosion, Cyclone and Water Damage
 - Flood and Rising Water
 - Towing and Labor Costs
 - All other types

LOSS DEVELOPMENT

Incurred Losses

Liability – Bodily Injury – 63 months

Liability – Property Damage – 39 months

No-fault – 63 months

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SECTION 7

7. HOMEOWNERS AND MOBILEHOME REPORTS

7.1 Introduction

This section details specific reporting requirements for and features of homeowners and mobilehome statistical compilations.

7.2 Scope of the Data

Homeowners

Homeowners insurance, for purposes of this section, encompasses all homeowners policy forms, including those policies issued on buildings and personal property for owner-occupants and policies designed for tenants, condominium and cooperative unit owners. Experience for scheduled personal property floaters is to be reported under the Model Inland Marine Statistical Plan. This section covers homeowners insurance written through the voluntary market, as well as buildings and personal property insured through the various state residual market mechanisms such as FAIR plans.

Mobilehomeowners

Mobilehome insurance as used herein includes those policies issued on a mobilehome that is typically owner-occupied and used only as a private home. Experience for mobilehomes (motor homes) written on an automobile policy is not to be reported under the Model Homeowners and Mobilehome Statistical Plan. Mobilehome policies are written on homes, built for permanent (year-round) living, but which generally have the ability to be transported to other locations. There are certain size specifications for a home to qualify as a mobilehome.

7.3 Description of the Coverages

Homeowners

A homeowners policy is a package policy containing both property and liability coverages. Each homeowners policy form differs with respect to the type and amount of coverage provided for the insured's dwelling building and personal property. The liability coverage is the same (up to the limit of liability) for each homeowners policy form.

Property coverages include:

- Damage to the insured's dwelling, certain attached structures, fences, garage, etc.
- Damage or theft of personal property on or off insured's premises.
- Additional living expenses or fair rental value if the insured's dwelling is damaged and cannot be inhabited.
- Additional coverages such as credit card and debris removal.

Liability coverages include:

- Personal liability coverage for bodily injury and property damage to third parties.
- Medical payments to persons other than insureds. This can include bodily injury suffered on the insured's premises or caused by the insured off the insured's premises.

Loss to an insured's dwelling or personal property is covered by one of two methods:

- Named-perils – Any loss incurred by the insured due to a peril named in the homeowners policy is covered. Named-perils include fire, lightning, windstorm and hail, etc.
- “All-risks” coverage – Any loss incurred by the insured due to a peril not specifically excluded in the homeowners policy is covered.

Homeowners Policies

There are several homeowners policies specific to owner-occupants, condominium and cooperative unit owners and tenants. They are:

- HO-1 Basic named-perils coverage for owner-occupant's dwelling and personal property.
- HO-2 Broad named-perils coverage (basic named-perils plus coverage for additional perils) for the owner-occupant's dwelling and personal property.
- HO-3 Broad named-perils coverage for personal property and “all-risks” coverage for owner-occupant's dwelling.
- HO-4 Broad named-perils coverage for personal property of tenants. Coverage is also provided for any additions or improvements made to the part of the residence premises that is used only by the insured.
- HO-5 “All-risks” coverage for buildings and personal property.
- HO-6 Broad named-perils coverage for personal property of condominium and cooperative unit owners. Coverage is also provided for any additions or improvements made to the insured's unit or for other structures located at the unit, owned only by the insured.
- HO-8 Coverage to owner-occupants for dwellings whose replacement cost is much larger than its actual cash value (market value). Personal property, theft and additional coverages provided under this form are more restrictive than similar coverages provided under HO-1.

Mobilehomeowners

A mobilehome policy also contains both property and liability coverages. Each mobilehome policy differs with respect to the type and amount of coverage provided for the insured's dwelling and personal property. The liability coverage is the same (up to the limit of liability) for each mobilehome policy.

Property coverages include:

- Damage to the insured's dwelling and certain attached structures.
- Damage or theft of personal property on the insured's premises.
- Loss of use of insured's dwelling.

Liability coverages include:

- Personal Liability coverage for bodily injury and property damage to third parties.
- Medical payments to persons other than insureds. This can include bodily injury suffered on the insured's premises or caused by the insured off the insured's premises.

7.4 Time Frames for Reports to Regulators

Statistical agents shall distribute standard homeowners and mobilehome annual reports described in this section 15 months after the end of the calendar or accident year. (This allows for loss evaluation and statistical agent processing and compilation.)

7.5 List of the Data Items Reported by Insurers to Statistical Agents

The minimum data items required for homeowners and mobilehome reporting are detailed in the following material. Most reporting requirements are the same for homeowners and mobilehomeowners coverages. Where no notation is made, the item applies to both. Reporting requirements include:

1. Company Identifier
2. Type of Business *
3. Dates and Amounts of Premiums
4. State
5. ZIP Code or Territory
6. Line of Business / Policy Form *
7. Construction Type *
8. Year of Construction
9. Protection Code
10. Miscellaneous Endorsements
11. Deductible Amount
12. Amount of Insurance

13. Exposure

Additional Detail for Loss Reporting

1. Amount of Loss
2. Year of Loss
3. Type of Loss
4. Claim Count

* Not applicable to Mobilehome Policies

7.6 Description of the Data Items

1. Company Identifier

Experience is to be reported separately for each insurer. Statistical agents are required to convert their internal company numbers to NAIC group and company code numbers if a state requests this in conjunction with a special report. (No standard reports provide insurer-specific information.)

2. Type of Business (HO only)

- Voluntary
- Residual

3. Dates and Amounts of Premiums

Written premiums and exposures shall be reported by policy period and accounting/calendar year. Earned premiums and exposures may then be estimated for reports to regulators.

4. State

Experience is to be reported by the state code applicable to the dwelling location.

5. ZIP Code or Territory

The *Handbook* considers ZIP code reporting as the standard reporting requirement. The ZIP codes to be reported are the 5-digit ZIP code of the location of the dwelling. (Explanatory note – for states and statistical agents that have not adopted *Handbook* requirements or ZIP code reporting, data will customarily be available for the rating territories in use by the state’s major homeowners advisory organization.)

6. Line of Business / Policy Form

- Homeowners
 - Policy Form 1
 - Policy Form 2
 - Policy Form 3
 - Policy Form 4
 - Policy Form 5
 - Policy Form 6
 - Policy Form 8
- Mobilehomeowners
 - Policy Form not applicable

7. Construction Type

- Frame (not otherwise classified)
- Brick Veneer, Stone Veneer or Masonry Veneer
- Brick, Stone or Masonry
- Fire Resistive
- Aluminum or Plastic siding over frame
- Mobilehomes or Trailers
- Specially/Specifically Rated not Fire Resistive
- All Other Constructions

8. Year of Construction

The year of construction or year of renovation of the dwelling is to be reported. This is not applicable when prior to 1960 nor to tenants and condominium policy forms. Manufacturer's model year is used for mobilehomes.

9. Protection Code

- Protected (1 – 8)
- Unprotected (9 – 10)

10. Miscellaneous Endorsements

Only statewide totals are required (exposures are not required) for:

- Earthquake
- Home Day Care Liability

11. Deductible Amount

The deductible size to be reported is the deductible that applies to wind and hail when this is different from the deductible(s) applying to other perils. Select from one of the following deductible options:

- \$50
- \$100
- \$200
- \$250
- \$500
- \$1,000
- All Other

12. Amount of Insurance

Amount of insurance on the dwelling is to be reported and may be rounded to the nearest thousand dollars. Amounts over \$998,500 may be aggregated and reported as \$999,000.

13. Exposure Basis

The exposure base is written dwelling months.

Additional Detail for Loss Reporting

The full exposure detail provided in this section of the *Handbook* shall be reported with each loss. In addition, the following elements of detail shall be provided:

14. Amount of Loss

- Paid losses
- Case-basis outstanding losses

Losses are to be reported net as to third party recoveries (salvage and subrogation), and exclude allocated loss adjustment expense.

15. Year of Loss

The year of the loss occurrence shall be reported.

16. Type of Loss

- Liability
- Medical Payments
- Fire, Lightning, and Removal
- Wind and Hail
- Water Damage and Freezing
- Theft
- All Other

17. Claim Count

- Number Paid
- Number Outstanding

Note on claim counting: Insurer practices differ relating to the counting of claims. Some insurers count claims on a per-accident basis, while others count claims on a per-claimant basis. Either basis of counting is allowable, subject to the following provisions:

- Insurers shall notify their statistical agent of the basis of counting that they use, and they shall notify the statistical agent whenever this basis of counting is changed.
- A claimant-based counting method is considered preferable. Whenever a system rewrite, merger or other major event offers an insurer or group the opportunity to move to claimant-based reporting without a significant additional expenditure simply to change the reporting basis, the insurer or group is encouraged to change to claimant-based reporting.

7.7 Standard and Customized Reports for Regulators

The data collected by statistical agents can be reported to regulators in a variety of formats. A standard annual report is provided every year; plus a variety of optional reports are available upon request. These formats can be altered or specialized reports can be generated upon request, as long as the data necessary is contemplated by the data elements listed in this section. For instance, cause of loss reports can be provided by territory, but these optional reports will only be upon the request of the regulator.

1. Standard Annual Report

The standard annual report shows premiums, exposures and total losses separately for each policy form and territory or ZIP code as follows:

- For states that have adopted the *Handbook's* data reporting requirements including ZIP code reporting: The statistical agent shall provide reports with ZIP code groupings in accordance with specifications agreed to by the regulator at the time the report is developed. (This allows states to group data into territories that are consistent with current industry practices. It also allows a state to request a report by individual ZIP code, but it is recommended that all but very simple reports by ZIP be made in an electronic format owing to the volume of paper necessary for such reports to be printed.)
- For states that have not adopted the *Handbook's* data reporting requirements including ZIP code reporting: Consistent treatment of territorial reporting will depend on whether the rating territories used by insurers are consistent, both between competing insurers and over time. This will often not be the case. Although statistical agents attempt to collect data from insurers with the territorial detail that is commonly available and/or that they perceive will meet the needs of the regulator, there is no assurance that this will always be possible. In general, the territorial groupings available from statistical agents will be those that were commonly used prior to the time of writing by an advisory organization.

2. Reports Available upon Request

Statewide experience for policy forms 1, 2, 3, 5 and 8 combined; policy forms 4 and 6 combined, and mobilehomeowners can be shown in any of the following separate exhibits:

- Construction/Protection Report – each construction class shown separately for protected and unprotected.
- Type of Loss Report – total losses by type of loss.
- Deductible Report – experience by policy deductible.
- Amount of Insurance Report – experience shown by amount of insurance (grouped into ranges)
- Year of Construction Report – experience shown by year of construction (grouped into ranges)

Statewide reports combining all classes that have purchased coverage can also be shown for earthquake or home day care liability.

Except for the Standard Report, all reports described herein are provided on a statewide basis. Voluntary market and residual market data will be combined. Exposures and premiums will be shown on an earned basis, while losses will be on an incurred basis. All loss adjustment expenses will be included. Liability losses will be developed to 63 months. Five calendar/accident years will be exhibited for each report.

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SECTION 8

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SECTION 8

8. DWELLING FIRE AND ALLIED LINES REPORTS

8.1 Introduction

This section details specific reporting requirements for and features of dwelling fire and allied lines annual statistical compilations. The basis for the annual compilation is the Model Dwelling Fire and Allied Lines Statistical Plan that has been adopted by the NAIC.

8.2 Scope of Dwelling Fire and Allied Lines Data

Dwelling insurance, for purposes of this section, encompasses all dwelling policy forms.

This section covers dwelling insurance written through the voluntary market, as well as buildings and personal property insured through the various state residual market mechanisms such as FAIR plans.

8.3 Dwelling Coverages

A dwelling policy provides property coverage for one-family to four-family dwellings. Each dwelling policy form differs with respect to the type and amount of coverage provided for the insured's dwelling building and personal property.

Property coverages include:

- (1) Damage to the insured's dwelling and certain attached structures.
- (2) Damage or theft of personal property on the insured's premises.
- (3) Additional living expenses or fair rental value if the insured's dwelling is damaged and cannot be inhabited.
- (4) Additional coverages such as debris removal and improvements, alterations and additions.

8.4 Dwelling Policies

Dwelling forms differ in the perils covered under each form. They are:

- Standard (excluding Vandalism and Malicious Mischief)

Basic named perils coverage for insured's dwelling. Perils covered include fire, lightning and internal explosion. Perils that can be added on to this policy form for an additional premium are windstorm, hail, volcanic eruption, external explosion, smoke, aircraft, riot or civil commotion and vehicles.

- Standard (including Vandalism and Malicious Mischief)

Basic named-perils coverage as described above, with coverage for vandalism and malicious mischief added as an additional named-peril.

- Broad

Broad named-perils coverage for insured's dwelling. Perils covered include fire, lightning, internal or external explosion, windstorm, hail, riot or civil commotion, vandalism and malicious mischief, aircraft, vehicle damage to the insured's dwelling by a named insured or relative, smoke, smoke from a fireplace, glass breakage, falling objects, weight of ice, snow or sleet and accidental discharge or overflow of water or steam and peril of burglars.

- Special

Special "all-risks" coverage for insured's dwelling. Personal property of the insured is covered by the same perils as named in the Broad Form.

- Dwelling Policies other than the above

8.5 Statistical Plan Reporting Requirements

The minimum data items required for dwelling reporting are specified in the Model Dwelling Fire and Allied Lines Statistical Plan. They are:

- Company Identifier
- Type of Business
- Transaction Identifier and Amount
- Accounting/Calendar Date
- Experience Period
- State
- Territory
- ZIP Indicator
- Line of Business
- Policy Form
- Construction Type
- Protection Code
- Occupancy/Coverage
- Type of Loss
- Deductible Amount

- Amount of Insurance
- Year of Construction
- Exposure
- Claim Count

The required data items are to be reported for direct business only. Therefore, reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier; nor, shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded. Losses are to be reported net as to third party recoveries (salvage and subrogation).

8.6 Who Reports Data: Minimum Reporting Standards for Insurers

The statutory requirements to report statistics applies to all licensed insurers. In establishing the standards for reporting to the statistical agents, regulators recognize the need for efficiency by permitting companies with limited premium volume to report less detailed statistics.

The Model Regulation, therefore, has established the following standards for statistical reporting.

All insurers licensed to write dwelling policies are required to report statistics at least annually:

- (1) An insurer must report in accordance with the Model Dwelling Fire and Allied Lines Statistical Plan if it is in the top 90th percentile of the total statewide written premium for dwelling fire and allied lines, or its total written premium for dwelling fire and allied lines for that state is greater than \$100,000.
- (2) An insurer that does not meet the above criterion must report its statewide experience by line of business and type of business in accordance with the specifications of dwelling fire and allied lines statistical plan adopted by the Commissioner.

8.7 Specific Report Features

The standard annual report for dwelling fire and allied lines has the following specific features.

Standard Annual Report

- All dwelling policy experience shown by line of business

Reports available on request

- All lines of business combined in the following separate exhibits:
 - A. Policy Form
 - B. Territory
 - C. Construction/Protection – each construction shown separately for protected and unprotected
 - D. Type of Loss

Except for the Territory Report, all reports are provided on a statewide basis. Voluntary market and residual market data will be combined.

Exposures (house years) and premiums are shown on an earned basis. Losses and claims will be on an incurred basis. Loss adjustment expenses will be included.

Five calendar/accident years will be exhibited for each report.

All reports include at least the experience of companies meeting the criteria specified in part (1) of the minimum standards.

8.8 Time Frame

Statistical agents distribute dwelling fire and allied lines annual reports approximately 15 months after the end of the calendar or accident year. This allows for loss evaluation and statistical agent processing and compilation.

Model Dwelling Fire and Allied Lines Statistical Plan

LIST OF DATA ITEMS

1. Company Identifier
2. Type of Business
3. Transaction Identifier and Amounts
4. Accounting/Calendar Date
5. Experience Period
6. State
7. Territory
8. ZIP Indicator
9. Line of Business
10. Policy Form
11. Construction Type
12. Protection Code
13. Occupancy/Coverage
14. Type of Loss
15. Deductible Amount
16. Amount of Insurance
17. Year of Construction
18. Exposure
19. Claim Count

DATA ITEMS

1. Company Identifier

Experience is to be reported by the company number assigned by the statistical agent.

Note: Statistical agents will be required to convert company numbers to NAIC group and company code numbers, if requested.

2. Type of Business

- Voluntary
- Residual Market (FAIR Plan)

3. Transaction Identifier and Amounts

Identify the following items and the respective amounts:

- Written Premiums
- Paid Losses (excluding allocated loss adjustment expense)
- Outstanding Losses (excluding allocated loss adjustment expense)

4. Accounting/Calendar Date

Accounting Year – Reflects the reporting year.

5. Experience Period

For losses and claims, the basis is accident year; for all other data the basis is calendar year.

6. State Indicator

Experience is to be reported by the state code applicable to the dwelling location.

7. Territory Indicator

Common industry territorial breakdowns currently in use will be maintained.

8. ZIP Indicator

This will be the 5-digit ZIP code of the residence or other property insured.

9. Line of Business – Dwelling Policies

- Fire Property Damage
- Extended Coverage including Vandalism and Malicious Mischief
- All Other

10. Policy Form Code

- Dwelling Policies
 - Standard (not including V & MM)
 - Broad
 - Special
 - Standard (including V & MM)
 - Dwelling Policies other than the above

11. Construction Type

- Frame (not otherwise classified)
- Brick Veneer, Stone Veneer or Masonry Veneer
- Brick, Stone or Masonry
- Fire Resistive
- Aluminum or Plastic siding over frame
- Mobilehomes or Trailers
- Specially/Specifically Rated not Fire Resistive
- All Other Constructions

12. Protection Code

- Protected (1-8)
- Unprotected (9+)

13. Occupancy/Coverage

- Seasonal
 - Building only
 - Contents only
 - Buildings and Contents combined, when written as such
- Other Than Seasonal
 - Building only
 - Contents only
 - Buildings and Contents combined, when written as such

14. Type of Loss Codes

- Fire, Lightning, and Removal
- Wind and Hail
- Water Damage and Freezing
- Vandalism and Malicious Mischief
- All Other

15. Deductible – Deductible size applies to Wind and Hail where different from another peril(s)

- Amounts
 - \$50
 - \$100
 - \$101-199
 - \$200-249
 - \$250
 - \$500
 - \$1,000
 - All Other

16. Amount of Insurance

Amount of Insurance on dwelling in thousands of dollars. Amounts over \$998,500 will be reported as \$999,000.

17. Year of Construction

Year of construction or year of renovation of the dwelling. Not applicable to contents or to dwellings built prior to 1960.

18. Exposure Basis

The exposure base is written dwelling months

19. Claim Count

- Number Paid
- Number Outstanding

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SECTION 9

9. COMMERCIAL/FARM FIRE AND ALLIED LINES REPORTS

9.1 Introduction

This section details specific reporting requirements for and features of commercial fire and allied lines annual statistical compilations. The basis for the annual compilation is the Model Commercial Fire and Allied Lines Statistical Plan and the Farm Fire and Allied Lines Statistical Plan that have been adopted by the NAIC.

Commercial Fire and Allied Lines

9.2 Scope of Commercial Fire and Allied Lines Insurance Data

This section covers commercial fire and allied lines statistics written through the voluntary market, as well as buildings and business personal property insured through the various state residual market mechanisms such as FAIR plans.

9.3 Coverage and Cause of Loss Forms

Data reported under the commercial fire and allied lines statistical plan represents experience from monoline and package policies containing commercial property coverage forms and cause of loss forms. These policies can provide building, personal property, time element and additional coverages, depending on which forms are included.

Building and business personal property coverages include:

- (1) Damage to the building specified in policy.
- (2) Damage or theft of business personal property if within specified distance of building covered under policy.

Time element coverages include:

- (1) Loss of use of the damaged building.
- (2) Business interruption – loss of income caused by damage to building and business personal property.

Other coverages can include leasehold interest, legal liability and mortgage holder's error and omissions.

Loss to the insured building or business personal property is covered by two methods:

- (1) Named-perils – Any loss incurred by the insured due to a peril named in the policy is covered. Named-perils include fire, lightning, windstorm & hail, vandalism & malicious mischief, etc.
- (2) "All-risks" coverage – Any loss incurred by the insured due to a peril not specifically excluded in the policy is covered.

Farm Fire and Allied Lines

9.4 Scope of Farm Fire and Allied Lines Insurance Data

This section covers farm fire and allied lines statistics written through the voluntary market, as well as farms and farm personal property insured through the various state residual market mechanisms such as FAIR plans.

9.5 Coverage Forms

Data reported under the farm fire and allied lines statistical plan represents experience from monoline and package policies containing farm property, mobile agricultural machinery and equipment, or livestock coverage forms. These policies can provide dwelling, personal property and time element coverages, depending on which forms are included.

Dwelling and personal property coverages include:

- (1) Damage to the dwelling specified in policy.
- (2) Damage or theft of household personal property or farm personal property (scheduled or unscheduled).
- (3) Other farm or private structures.

Time element coverages include:

- (1) Loss of use of the dwelling specified in the policy.

The mobile agricultural machinery and equipment coverage form covers equipment under special ("all-risks") coverage.

The livestock coverage form can provide coverage for death of livestock due to collision with a vehicle on a public road, electrocution and drowning.

Additional coverages can include debris removal, collapse, extra expense and reasonable repairs.

9.6 Cause of Loss Forms

Loss to the insured dwelling or household and farm personal property is covered by two methods:

- (1) Named perils – Any loss incurred by the insured due to a peril named in the policy is covered. Named perils include fire, lightning, windstorm & hail, vandalism & malicious mischief, etc.
- (2) "All-risks" coverage – Any loss incurred by the insured due to a peril not specifically excluded in the policy is covered.

9.7 Statistical Plan Reporting Requirements

The minimum data items required for commercial/farm fire and allied lines reporting are specified in the Model Commercial Fire and Allied Lines Statistical Plan and the Farm Fire and Allied Lines Statistical Plan. They are:

- Company Identifier
- Type of Policy
- Subline of Business
- Accounting/Calendar Date
- Experience Period
- State
- Territory*
- Transaction Identifier and Amount
- Claim Count
- Classification/Classification Group
- Coverage*
- Protection*
- Deductible Amount
- Construction*
- Type of Loss

*applicable to certain Commercial/Farm Fire and Allied Lines Sublines of Business only

The required data items are to be reported for direct business only. Therefore, reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier; nor shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded. Losses are to be reported net as to third party recoveries (salvage and subrogation).

9.8 Who Reports Data: Minimum Reporting Standards For Insurers

The statutory requirements to report statistics applies to all licensed insurers. In establishing the standards for reporting to the statistical agents, regulators recognize the need for efficiency by permitting companies with limited premium volume to report less detailed statistics.

The Model Regulation, therefore, has established the following standards for statistical reporting.

All insurers licensed to write commercial/farm fire and allied lines policies are required to report statistics at least annually:

- (1) An insurer must report in accordance with the Model Commercial Fire and Allied Lines Statistical Plan and the Model Farm Fire and Allied Lines Statistical Plan if:
 - (a) its statewide written premium is in the top 98th percentile of the total statewide written premium for commercial/farm fire and allied lines when the written premium volume at that percentile exceeds \$100,000, or
 - (b) its statewide written premium exceeds \$100,000 when the written premium volume at the 98th percentile is less than \$100,000.
- (2) An insurer that does not meet the above criterion must report its statewide experience by subline of business and type of policy in accordance with the specifications of commercial fire and allied lines statistical plans and farm fire and allied lines statistical plans adopted by the Commissioner.

9.9 Specific Report Features

Commercial Fire and Allied Lines

The standard annual report for commercial fire and allied lines has the following specific features.

Standard Annual Report

- Each state shown separately by subline of business, type of policy and classification group.
- Reports available on request
- Territory (Extended Coverage/Basic Group II only) – each territory shown separately within type of policy.
- Construction/Protection (Fire/Basic Group I only) – each construction shown separately by protection.
- Deductible – each deductible shown separately within subline of business and type of policy.
- Type of Loss – each type of loss shown separately within subline of business, type of policy and coverage.

Voluntary market and residual market data will be combined.

Premiums are shown on an earned basis. Losses and claims will be on an incurred basis. Loss adjustment expenses will be included.

Five calendar or calendar/accident years will be exhibited for each report.

All reports include at least the experience of companies meeting the criteria specified in part (1) of Section 9.8.

Farm Fire and Allied Lines

The standard annual report for farm fire and allied lines has the following specific features.

Standard Annual Report

- Each state shown separately by subline of business, type of policy and classification group.

Reports available on request

All reports are available on a statewide basis:

- Construction/Protection
 - applicable to Fire, Basic Causes of Loss, Broad Causes of Loss/Broad Form, and Special Causes of Loss/Special Form sublines only
 - for each subline, each construction shown separately by protection
- Deductible Amount
 - each deductible amount shown separately within subline of business and type of policy.
- Type of Loss (Losses only)
 - each type of loss shown separately within subline of business, type of policy

Voluntary market and residual market data will be combined.

Premiums are shown on an earned basis. Losses and claims will be on an incurred basis. Loss adjustment expenses will be included.

Five calendar or calendar/accident years will be exhibited for each report.

All reports include at least the experience of companies meeting the criteria specified in part (1) of Section 9.8.

9.10 Time Frame

Statistical agents distribute commercial fire and allied lines and farm fire and allied lines annual reports approximately 15 months after the end of the calendar or accident year. This allows for loss evaluation and statistical agent processing and compilation.

Model Commercial Fire and Allied Lines Statistical Plan

LIST OF DATA ITEMS

1. Company Identifier
2. Type of Policy
3. Subline of Business
4. Accounting/Calendar Date
5. Experience Period
6. State Indicator
7. Territory Indicator
8. Transaction Identifier and Amounts
9. Claim Count
10. Classification Group
11. Coverage
12. Protection
13. Deductible Amount
14. Construction
15. Type of Loss

DATA ITEMS

1. Company Identifier

Experience is to be reported by the company number assigned by the statistical agent.

Note: Statistical agents will be required to convert company numbers to NAIC group and company code numbers, if requested.

2. Type of Policy
 - Monoline Policy
 - Part of a Package (i.e., SMP, CMP, CPP) Policy
 - FAIR Plan or Shared Risk
3. Subline of Business
 - Fire/Basic Group I
 - Extended Coverage/Basic Group II
 - Special Form Perils
 - Broad Form Perils
 - All Other Allied Lines

4. Accounting/Calendar Date

Accounting Year – Reflects the reporting year.

5. Experience Period – Period of Coverage

- Premiums: Calendar Year
- Losses: Accident Year or Calendar Year

6. State Indicator

Experience is to be reported by the (standard) state code applicable to the property location.

7. Territory Indicator (applicable to Extended Coverage/Basic Group II only)

- Beach
- Seacoast
- Inland
- Entire State if not rated above

8. Transaction Identifier and Amounts

- Written Premium
- Paid Losses (excluding allocated loss adjustment expense)
- Outstanding Losses (excluding allocated loss adjustment expense)

9. Claim Count

- Number Paid
- Number Outstanding

10. Classification Groups

- | | |
|--|---------------------------|
| • Apartments | • Other Manufacturing |
| • Other Habitational | • Other Non-Manufacturing |
| • Restaurants & Bars | • Storage |
| • Other Mercantiles | • Farm |
| • Public Buildings | • Food Manufacturing |
| • Motor Vehicle Risks | • Wood Manufacturing |
| • Buildings under Construction | • Wearing Apparel |
| • Offices and Banks | • Chemical Manufacturing |
| • Recreational Facilities | • Metal Manufacturing |
| • Hotels & Motels | • Churches |
| • Hospitals & Nursing HMS | • Schools |
| • Countrywide rated risks | • Highly protected risks |
| • Blanket rated or average rated risks | |

11. Coverage
 - Building
 - Personal Property
 - Building and Personal Property Combined
 - Time Element
 - All Other Coverages

12. Protection (applicable to Fire/Basic Group I only)
 - Protected
 - Semi-Protected
 - Unprotected

13. Deductible Amount
 - No Deductible
 - \$50
 - \$100
 - \$250
 - \$500
 - \$1,000
 - \$2,500
 - \$5,000
 - \$10,000
 - \$25,000
 - \$50,000
 - \$75,000
 - All Other

14. Construction
 - Frame
 - Joisted Masonry
 - Fire Resistive
 - Masonry Non-Combustible
 - Non-Combustible
 - All Other

15. Type of Loss
 - Fire and Lightning
 - Wind and Hail
 - Explosion
 - Riot, Civil Commotion
 - Vandalism and Malicious Mischief
 - Water Damage
 - Theft (Removal)
 - All Other

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SECTION 10

10. INLAND MARINE REPORTS

10.1 Introduction

This section details specific reporting requirements for and features of inland marine annual statistical compilations. The basis for the annual compilation is the Model Inland Marine Statistical Plan that has been adopted by the NAIC.

10.2 Scope of Inland Marine Insurance Data

Inland marine insurance, for purposes of this section, encompasses both personal and commercial inland marine policies.

10.3 Inland Marine Coverages

Inland marine insurance, as used in this section, means insurance covering property subject to risk arising out of some element of transportation. The property is either actually in transit, held by persons (bailees) who are not owners, at a fixed location but an important instrument of transportation (such as bridges, tunnels, radio transmission towers), or is a movable type of goods that is often at different locations (such as jewelry, furs, silverware and works of art). Inland marine insurance encompasses commercial and personal property, and excludes insurance of vessels, crafts and cargoes that are commonly insured under ocean marine policies.

Loss to an insured's property, etc. insured under an inland marine policy is covered by two methods:

- (1) Named perils – Any loss incurred by the insured due to a peril named in the inland marine policy is covered.
- (2) "Risks of direct physical loss" coverage – Any loss incurred by the insured due to a peril not specifically excluded in the inland policy is covered.

10.4 Statistical Plan Reporting Requirements

The minimum data items required for inland marine reporting are specified in the Model Inland Marine Statistical Plan. They are:

- Company Identifier
- Accounting/Calendar Date
- Experience Period
- State
- Transaction Identifier and Amount
- Claim Count
- Classification
- Type of Loss

The required data items are to be reported for direct business only. Therefore, reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier; nor shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded. Losses are to be reported net as to third party recoveries (salvage and subrogation).

10.5 Who Reports Data: Minimum Reporting Standards for Insurers

The statutory requirement to report statistics applies to all licensed insurers. In establishing the standards for reporting to the statistical agents, regulators recognize the need for efficiency by permitting companies with limited premium volume to report less detailed statistics.

The Model Regulation, therefore, has established the following standards for statistical reporting.

All insurers licensed to write inland marine policies are required to report statistics at least annually:

- (1) An insurer must report in accordance with the Inland Marine Statistical Plan if:
 - (a) its statewide written premium is in the top 98th percentile of the total statewide premium for inland marine when the written premium volume at that percentile exceeds \$100,000, or
 - (b) its statewide written premium exceeds \$100,000 when the written premium volume at the 98th percentile is less than \$100,000.
- (2) An insurer that does not meet the above criterion must report its statewide experience by classification in accordance with the specifications of inland marine statistical plan adopted by the Commissioner.

10.6 Specific Report Features

The standard annual report for inland marine has the following specific features.

Standard Annual Report

- Each state shown separately by individual classification

Reports available on request

- Type of Loss (Losses only)
 - each classification shown separately by type of loss, on a countrywide basis

Premiums are shown on an earned basis. Losses and claims will be shown on an incurred basis. Loss adjustment expenses will be included.

Five calendar or calendar/accident years will be exhibited for each report.

All reports include at least the experience of companies meeting the criteria specified in part (1) of Section 10.5.

10.7 Time Frame

Statistical agents distribute inland marine annual reports approximately 15 months after the end of the calendar or accident year. This allows for loss evaluation and statistical agent processing and compilation.

Model Inland Marine Statistical Plan

LIST OF DATA ITEMS

1. Company Identifier
2. Accounting/Calendar Date
3. Experience Period
4. State
5. Transaction Identifier and Amounts
6. Claim Count
7. Classification
8. Type of Loss

DATA ITEMS

1. Company Identifier

Experience is to be reported by the company number assigned by the statistical agent.

Note: Statistical agents will be required to convert company numbers to NAIC group and company code numbers, if requested.

2. Accounting/Calendar Date

Accounting Year – reflects the reporting year.

3. Experience Period – Period of Coverage

- Premiums: Calendar Year
- Losses: Accident Year or Calendar Year

4. State

Experience is to be reported by the state code of the location of the insured's property. For portable objects, report the state of domicile of the insured.

5. Transaction Identifier and Amounts

- Written Premium
- Paid Losses (Excluding Allocated Loss Adjustment Expense)
- Outstanding Losses (Excluding Allocated Loss Adjustment Expense)

6. Claim Count

- Number Paid
- Number Outstanding

7. Classification

Experience is to be reported by all statistical agents using the attached list of classifications.

8. Type of Loss

- Fire, Lightning and Smoke
- Windstorm & Hail
- Other Extended Coverage Perils
- Transportation Perils
- Burglary & Robbery, Theft, Non-delivery, Mysterious Disappearance
- All Marine Perils
- Collapse, Subsidence, Landslide or Breakage
- Flood/Water Damage including Sprinkler Leakage
- All Other

Classifications

- Bailees Customers
- Boats & Motors – Commercial Use
- Boats & Motors – Non-commercial (Private) Use
- Bridges & Tunnels
- Cameras – Commercial Use
- Cameras – Non-commercial (Private) Use
- Contractors Equipment
- Cotton Buyers Transit
- Deferred Payment Merchandise (including credit property)
- Difference in conditions
- Farm equipment
- Fine Arts – Commercial Collections
- Fine Arts – Non-commercial (Private) Collections
- Furriers Customers
- Installation Floater
- Jewelers Block
- Livestock Floater
- Motor Truck Cargo
- Musical Instruments – Commercial Use
- Musical Instruments – Non-commercial (Private) Use
- Neon Signs
- Parcel Post
- Personal Effects
- Personal Furs
- Personal Jewelry
- Personal Property Floater
- Processing Risks
- Railroad Risks
- Registered Mail
- Transportation

- Miscellaneous Commercial Floaters
- Miscellaneous Personal Floaters
- All Other

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SECTION 11

11. BUSINESSOWNERS REPORTS

11.1 Introduction

This section details specific reporting requirements for and features of businessowners annual statistical compilations. The basis for the annual compilation is the Model Businessowners Statistical Plan that has been adopted by the NAIC.

11.2 Scope of Businessowners Data

This section covers businessowners insurance written through the voluntary market. Businessowners insurance provides property and liability coverage for small businesses, combined under one policy. Experience for commercial package policies is to be reported under the Model Statistical Plan corresponding to the particular coverage provided.

11.3 Businessowners Coverages

Coverage under a businessowners policy consists of a property form, liability form and any optional endorsements. Two property coverage forms, standard and special, provide coverage for buildings and business personal property (replacement cost coverage), loss of business income and extra expense. Property coverages include:

- (1) Damage to the building specified in policy.
- (2) Damage or theft of business personal property covered under policy.
- (3) Loss of business income and extra expense if building or property is damaged and cannot be used.
- (4) Additional coverages such as outdoor signs, employee dishonesty, exterior grade floor glass, mechanical breakdown, burglary and robbery (standard form only) and money and securities (special form only).

11.4 Businessowners Property Coverage Forms

Businessowners property coverage forms differ in the perils covered under each form. They are:

- Standard – Perils covered include basic causes of loss such as fire, lightning, wind and hail, etc. and transportation perils such as collision, derailment, overturn, collapse of bridges, etc., and off-premises theft or damage. The Standard form has optional burglary and robbery coverage.
- Special – Any direct physical loss incurred by the insured due to a peril not specifically excluded in the policy is covered. The Special form contains fewer restrictions than other commercial property causes of loss forms, such as damage to gutters from weight of snow or ice, theft of building articles, interior damage from snow, rain, etc., and water leakage. The Special form has optional money and securities coverage.

- All Other – Policies that do not consist of the combination of either the Standard or Special property coverage form and liability coverage form.

11.5 Statistical Plan Reporting Requirements

The minimum data items required for businessowners reporting are specified in the Model Businessowners Statistical Plan. They are:

- Company Identifier
- State
- Accounting/Calendar Date
- Experience Period
- Type of Policy
- Transaction Identifier and Amounts
- Claim Count
- Coverage
- Classification
- Type of Loss
- Construction (Buildings and Contents only)
- Protection (Buildings and Contents only)
- Rating Identification Code (Buildings and Contents only)
- Liability Limit (Building, Contents and Liability Coverages only)
- Exposure (Building, Contents and Liability Coverages only)

The required data items are to be reported for direct business only. Therefore, reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier; nor shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded. Losses are to be reported net as to third party recoveries (salvage and subrogation).

11.6 Who Reports Data: Minimum Reporting Standards for Insurers

The statutory requirement to report statistics applies to all licensed insurers. In establishing the standards for reporting to the statistical agents, regulators recognize the need for efficiency by permitting companies with limited premium volume to report less detailed statistics.

The Model Regulation, therefore, has established the following standards for statistical reporting.

All insurers licensed to write businessowners policies are required to report statistics at least annually:

- (1) An insurer must report in accordance with the Model Businessowners Statistical Plan if:
 - (a) its statewide written premium is in the top 98th percentile of the total statewide written premium for businessowners when the written premium volume at that percentile exceeds \$100,000, or
 - (b) its statewide written premium exceeds \$100,000 when the written premium volume at the 98th percentile is less than \$100,000.
- (2) An insurer that does not meet the above criterion must report its statewide experience by type of policy in accordance with the specifications of businessowners statistical plans adopted by the Commissioner.

11.7 Specific Report Features

The standard annual report for businessowners has the following specific features.

Standard Annual Report

- Each state shown separately by type of policy and classification group.

Reports available on request

All reports are available on a statewide basis:

- Coverage
 - each coverage shown separately within type of policy
- Type of Loss (Losses only)
 - each type of loss shown separately within type of policy

Premiums are shown on an earned basis. Losses and claims will be on an incurred basis. Loss adjustment expenses will be included.

Five calendar or calendar/accident years will be exhibited for each report.

All reports include at least the experience of companies meeting the criteria specified in part (1) of Section 11.6.

11.8 Time Frame

Statistical agents distribute businessowners annual reports approximately 15 months after the end of the calendar or accident year. This allows for loss evaluation and statistical agent processing and compilation.

Model Businessowners Statistical Plan

LIST OF DATA ITEMS

1. Company Identifier
2. State Indicator
3. Accounting/Calendar Date
4. Experience Period
5. Type of Policy
6. Transaction Identifier and Amounts
7. Claim Count
8. Coverage
9. Classification Group
10. Type of Loss
11. Construction
12. Protection
13. Rating Identification Code
14. Liability Limit
15. Exposure

DATA ITEMS

1. Company Identifier

Experience is to be reported by the company number assigned by the statistical agent.

Note: Statistical agents will be required to convert company numbers to NAIC group and company code numbers, if requested.

2. State Indicator

Experience is to be reported by the (standard) state code applicable to the property location.

3. Accounting/Calendar Date

Accounting Year – Reflects the reporting year.

4. Experience Period – Period of Coverage

- Premiums: Calendar Year
- Losses: Accident Year or Calendar Year

5. Type of Policy

- Standard Businessowners Policy Form
- Special Businessowners Policy Form
- All Other

6. Transaction Identifier and Amounts
 - Written Premium
 - Paid Losses
 - Outstanding Losses (excluding allocated loss adjustment expense)
 - Paid Allocated Loss Adjustment Expense
7. Claim Count
 - Number Paid
 - Number Outstanding
8. Coverage
 - Building (Indivisible Rating Programs)
 - Contents/Personal Property (Indivisible Rating Programs)
 - Building (Divisible Rating Programs)
 - Contents/Personal Property (Divisible Rating Programs)
 - Liability (Divisible Rating Programs only)
 - All Other
9. Classification Groups
 - Building Materials and Garden Supplies
 - General Merchandise Stores
 - Food Stores
 - Apparel and Accessory Stores
 - Furniture and Home furnishings Stores
 - Eating and Drinking Places
 - Miscellaneous Retail
 - Offices
 - Apartments/Habitational
 - Personal Services
 - Business Services
 - Artisan/Contractors
 - All Other
10. Type of Loss
 - Property Damage – Fire & Lightning
 - Property Damage – Wind and Hail
 - Property Damage – Burglary, Theft, & Robbery
 - Property Damage – Vandalism and Malicious Mischief
 - Property Damage – All Other
 - Time Element
 - Liability

11. Construction
 - Frame
 - Joisted Masonry
 - Non-Combustible
 - Fire Resistive
 - All Other
12. Protection (For Buildings and Contents only)
 - Protected
 - Semi-Protected
 - Unprotected
13. Rating Identification Code (Buildings and Contents only)
 - Sprinklered
 - Non-Sprinklered
14. Liability Limit (Building, Contents and Liability Coverages only)
 - \$300,000
 - \$500,000
 - \$1,000,000
 - All Other
15. Exposure (Building, Contents and Liability Coverages only)
 - Indivisible Rating Programs
 - Report the amount of insurance in thousands of dollars
 - Divisible Rating Programs – Property Coverages
 - Report the amount of insurance in thousands of dollars
 - Divisible Rating Programs – Liability Coverage
 - Report the number of exposure units using the exposure base appropriate to the corresponding Classification Group, as defined by the statistical agent.

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SECTION 12

12. BURGLARY & THEFT REPORTS

12.1 Introduction

This section details specific reporting requirements for and features of burglary & theft annual statistical compilations. The basis for the annual compilation is the Model Burglary & Theft Statistical Plan that has been adopted by the NAIC.

12.2 Scope of Burglary & Theft Data

Burglary & theft insurance, for purposes of this section, encompasses all commercial burglary & theft and personal theft policies.

This section covers burglary & theft and personal theft insurance written through the voluntary market, as well as burglary & theft and personal theft exposures insured through the various state residual market mechanisms such as FAIR plans.

12.3 Burglary & Theft Coverage Forms

Data reported under the burglary & theft statistical plan represents experience from personal theft policies and commercial monoline and package policies containing one or more burglary & theft coverage forms.

Burglary & theft coverage plans combine one or more coverage forms into certain combinations. For example, Storekeepers' Burglary and Robbery Coverage (Plan 4) combines Robbery and Safe Burglary coverage (Form D) with Premises Burglary coverage (Form E).

Burglary & theft coverages can include:

- (1) Theft, disappearance, and destruction of money and securities both inside and outside the covered premises.
- (2) Loss of or damage to covered property other than money and securities due to robbery or safe burglary.
- (3) Loss of or damage to covered property due to computer fraud.
- (4) Loss of or damage to guest's property while in a safe deposit box on covered premises.

Personal theft coverages can include:

- (1) Loss of or damage to personal property caused by theft, vandalism or malicious mischief both on or off-premises.

12.4 Statistical Plan Reporting Requirements

The minimum data items required for burglary & theft reporting are specified in the Model Burglary & Theft Statistical Plan. They are:

- Company Identifier

- Transaction Identifier and Amount
- Accounting/Calendar Date
- Experience Period
- State
- Territory
- Line of Business
- Policy Form

The required data items are to be reported for direct business only. Therefore, reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier; nor shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded. Losses are to be reported net as to third party recoveries (salvage and subrogation).

12.5 Who Reports Data: Minimum Reporting Standards for Insurers

The statutory requirement to report statistics applies to all licensed insurers. In establishing the standards for reporting to the statistical agents, regulators recognize the need for efficiency by permitting companies with limited premium volume to report less detailed statistics.

The Model Regulation, therefore, has established the following standards for statistical reporting.

All insurers licensed to write burglary & theft policies are required to report statistics at least annually:

- (1) An insurer must report in accordance with the Model Burglary & Theft Statistical Plan if it is in the top 90th percentile of the total statewide written premium for burglary & theft.
- (2) An insurer that does not meet the above criterion must report its statewide experience by policy form in accordance with the specifications or burglary & theft statistical plan adopted by the Commissioner.

12.6 Specific Report Features

The standard annual report for burglary & theft has the following specific features.

Standard Annual Report

- All burglary & theft experience shown by state and policy form

Voluntary market and residual market data will be combined.

Premiums are shown on an earned basis. Losses will be on an incurred basis. Loss adjustment expenses will be included.

Three calendar or calendar/accident years will be exhibited for the standard report.

The standard report includes at least the experience of companies meeting the criteria specified in part (1) of Section 12.5.

12.7 Time Frame

Statistical agents distribute burglary & theft annual reports approximately 15 months after the end of the calendar or accident year. This allows for loss evaluation and statistical agent processing and compilation.

Model Burglary and Theft Statistical Plan

LIST OF DATA ITEMS

1. Company Identifier
2. Transaction Identifier and Amounts
3. Accounting/Calendar Date
4. Experience Period
5. State Indicator
6. Territory Indicator
7. Line of Business
8. Policy Form

DATA ITEMS

1. Company Identifier

Experience is to be reported by the company number assigned by the statistical agent.

Note: Statistical agents will be required to convert company numbers to NAIC group and company code numbers, if requested.

2. Transaction Identifier and Amounts

Identify the following items and their respective amounts:

- Written Premium
- Paid Losses
- Outstanding Losses

3. Accounting/Calendar Date

Accounting Year – Reflects the reporting year.

4. Experience Period – Period of Coverage

- Premiums: Calendar Year
- Losses: Calendar Year or Accident Year

5. State Indicator

Experience is to be reported by the state code applicable to the location of the risk.

6. Territory Indicator

Common industry territorial breakdowns currently in use will be maintained.

7. Line of Business

Burglary Policies

8. Policy Form

- Financial Institution – Premises Coverages
- Broad Forms
- Mercantile Open Stock
- Mercantile Safe
- Money Orders and Counterfeit Paper Currency
- Form C (excluding Plans 3, 4, 5, 9, 10) – Theft, Disappearance and Destruction
- Robbery and Safe Burglary
- Form D (excluding Plans 3, 4, 5 and 9)
- Form Q (excluding Plans 4 and 5)
- Forms E-N

- E – Premises Burglary
- F – Computer Fraud
- G – Extortion
- H – Premises Theft and Robbery Outside the Premises
- I – Lessees of Safe Deposit Boxes
- J – Securities Deposited With Others
- K – Liability for Guests' Property – Safe Deposit Box
- L – Guests' Property – Premises
- M – Safe Depository Liability
- N – Safe Depository Direct Loss

- Plans 3, 4, 5, 9 and 10

- 3 – Storekeepers' Broad Form
- 4 – Storekeepers' Burglary and Robbery
- 5 – Office Burglary and Robbery
- 9 – Excess Bank Burglary and Robbery
- 10 – Bank Excess Securities

- Miscellaneous

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SECTION 13

13. GLASS REPORTS

13.1 Introduction

This section details specific reporting requirements for and features of glass annual statistical compilations. The basis for the annual compilation is the Model Glass Statistical Plan that has been adopted by the NAIC.

13.2 Scope of Glass Data

Glass insurance, for purposes of this section, encompasses all personal and commercial glass policies.

This section covers glass insurance written through the voluntary market, as well as glass insured through the various state residual market mechanisms such as FAIR plans.

13.3 Glass Coverage Form

Data reported under the glass statistical plan represents experience from monoline and package policies containing a glass coverage form.

These policies can provide coverage for breakage of glass and chemical damage to glass, whether intentional or accidental.

Coverages include:

- (1) Any direct physical loss of or damage to glass covered in policy.
- (2) Removal of debris of covered property.
- (3) Installation of temporary plates to cover openings containing insured glass when that glass is damaged.
- (4) Repair or replacement to frames encasing the damaged glass.
- (5) Removal or replacement of obstructions when repair or replacement of covered glass is required.

13.4 Statistical Plan Reporting Requirements

The minimum data items required for glass reporting are specified in the Model Glass Statistical Plan. They are:

- Company Identifier
- Transaction Identifier and Amount
- Accounting/Calendar Date
- Experience Period
- State
- Line of Business

The required data items are to be reported for direct business only. Therefore, reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier; nor shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded. Losses are to be reported net as to third party recoveries (salvage and subrogation).

13.5 Who Reports Data: Minimum Reporting Standards for Insurers

The statutory requirement to report statistics applies to all licensed insurers.

The Model Regulation, therefore, has established the following standards for statistical reporting.

All insurers licensed to write glass policies are required to report statistics at least annually in accordance with the Model Glass Statistical Plan.

13.6 Specific Report Features

The standard annual report for glass has the following specific features.

Standard Annual Report

- All glass experience shown by state

Voluntary market and residual market data will be combined.

Premiums are shown on an earned basis. Losses will be on an incurred basis. Loss adjustment expenses will be included.

Three calendar or calendar/accident years will be exhibited for the standard report.

13.7 Time Frame

Statistical agents distribute glass annual reports approximately 15 months after the end of the calendar or accident year. This allows for loss evaluation and statistical agent processing and compilation.

Model Glass Statistical Plan

LIST OF DATA ITEMS

1. Company Identifier
2. Transaction Identifier and Amounts
3. Accounting/Calendar Date
4. Experience Period
5. State Indicator
6. Line of Business

DATA ITEMS

1. Company Identifier

Experience is to be reported by the company number assigned by the statistical agent.

Note: Statistical agents will be required to convert company numbers to NAIC group and company code numbers, if requested.

2. Transaction Identifier and Amounts

Identify the following items and their respective amounts:

- Written Premium
- Paid Losses
- Outstanding Losses

3. Accounting/Calendar Date

Accounting Year – Reflects the reporting year.

4. Experience Period – Period of Coverage

- Premiums: Calendar Year
- Losses: Calendar Year or Accident Year

5. State Indicator

Experience is to be reported by the state code applicable to the location of the risk.

6. Line of Business

Glass Policies

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SECTION 14

14. FARMOWNERS REPORTS

14.1 Introduction

This section details specific reporting requirements for, and features of, farmowners annual statistical compilations. The basis for the annual compilation is the Model Farmowners Statistical Plan that has been adopted by the NAIC.

14.2 Scope of Farmowners Data

This section covers farmowners insurance written through the voluntary market. Farmowners insurance provides property and liability coverage for farm properties.

14.3 Farmowners Coverages

A farmowner policy is a package policy containing, in some policies, both property and liability coverages (i.e. indivisible premium policies). Other farmowner policies contain the property coverages only and the liability portion is written as a Farmers Comprehensive Personal Liability Policy. The farmowner policy recognizes the fact that residential and business exposures are intertwined where agriculture operations are found.

Property coverages include:

- (1) Damage to the dwelling specified in the policy.
- (2) Damage or theft of household personal property (unscheduled).
- (3) Additional living expense.
- (4) Damage to farm personal property (scheduled and unscheduled).
- (5) Damage to barns, buildings, structures and additional dwellings.

Liability coverages (where applicable) include:

- (1) Personal liability coverage for bodily injury and property damage to third parties.
- (2) Medical payments to persons other than insureds.

14.4 Farmowners Property Coverage Forms

Standard Form	–	Basic named perils coverage of the dwelling, the unscheduled household personal property and additional living expense.
Broad Form	–	Broad named perils coverage of the dwelling, the unscheduled household personal property and additional living expense. Adds perils to the basic perils.
Special Form	–	Provides "all-risk" coverage of the dwelling and additional living expense. And provides "all-risk" or broad form named-peril coverage of the unscheduled household personal property.

Tenants Form – Broad named-perils coverage for personal property of tenants. No dwelling coverage available.

Optional forms may be attached to provide coverage for scheduled farm personal property, unscheduled farm personal property, and barns, buildings, etc.

14.5 Statistical Plan Reporting Requirements

The minimum data items required for farmowners reporting are specified in the Model Farmowners Statistical Plan. They are:

- Company Identifier
- State
- Accounting/Calendar Date
- Experience Period
- Policy Form
- Classification (Coverage)
- Type of Loss
- Exposure (Amount of Insurance on Property Coverages)
- Transaction Identifier and Amounts
- Claim Count

The required data items are to be reported for direct business only. Therefore, reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier; nor shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded. Losses are to be reported net as to third party recoveries (salvage and subrogation).

14.6 Who Reports Data: Minimum Reporting Standards for Insurers

The statutory requirement to report statistics applies to all licensed insurers. In establishing the standards for reporting to the statistical agents, regulators recognize the need for efficiency by permitting companies with limited premium volume to report less detailed statistics.

The Model Regulation, therefore, has established the following standards for statistical reporting.

All insurers licensed to write farmowners policies are required to report statistics at least annually:

- (1) An insurer must report in accordance with the Model Farmowners Statistical Plan if:
 - (a) its statewide written premium is in the top 98th percentile of the total statewide written premium for farmowners when the written premium volume at that percentile exceeds \$100,000, or
 - (b) its statewide written premium exceeds \$100,000 when the written premium volume at the 98th percentile is less than \$100,000.
- (2) An insurer that does not meet the above criterion must report its statewide experience by policy form in accordance with the specifications of farmowners statistical plans adopted by the Commissioner.

14.7 Specific Report Features

The standard annual report for farmowners has the following specific features.

Standard Annual Report

- Each state shown separately by policy form and classification.

Reports available on request (statewide basis)

- Type of Loss (Losses only)
 - each type of loss shown separately within policy form

Premiums are shown on an earned basis. Losses and claims will be on an incurred basis. Loss adjustment expenses will be included.

Five calendar or calendar/accident years will be exhibited for each report.

All reports include at least the experience of companies meeting the criteria specified in part (1) of Section 14.6.

14.8 Time Frame

Statistical agents distribute farmowners annual reports approximately 15 months after the end of the calendar or accident year. This allows for loss evaluation and statistical agent processing and compilation.

Model Farmowners Statistical Plan

LIST OF DATA ITEMS

1. Company Identifier
2. State Indicator
3. Accounting/Calendar Date
4. Experience Period – Period of Coverage
5. Policy Form
6. Classification
7. Type of Loss
8. Exposure (Amount of Insurance)
9. Transaction Identifier and Amounts
10. Claim Count

DATA ITEMS

1. Company Identifier

Experience is to be reported by the company number assigned by the statistical agent.

Note: Statistical agents will be required to convert company numbers to NAIC group and company code numbers, if requested.

2. State Indicator

Experience is to be reported by the (standard) state code applicable to the property location.

3. Accounting/Calendar Date

Accounting Year – reflects the reporting year.

4. Experience Period – Period of Coverage

- Premiums: Calendar Year
- Losses: Accident Year or Calendar Year

5. Policy Form

- Standard Form
- Broad Form
- Special Form
- Tenants Form
- All Other

6. Classification (Coverage)

- Dwellings and Contents (household personal prop.)
- Livestock – Scheduled
- Equipment – Scheduled
- Other Scheduled Farm Personal Property (non-household)
- Unscheduled or Blanket Farm Personal Property
- Barns
- Silos
- Other Structures
- All Other

7. Type of Loss

- Fire and Lightning
- Wind and Hail
- Explosion
- Riot, Civil Commotion
- Vandalism and Malicious Mischief
- Theft (Removal)
- Water Damage
- All Other Property Losses
- Liability (losses on indivisible premium policies only)

8. Exposure (Amount of Insurance)

Report the property coverage amount of insurance in thousands of dollars.

9. Transaction Identifier and Amounts

- Written Premium
- Paid Losses
- Outstanding Losses (excluding Allocated LAE)
- Paid Allocated Loss Adjustment Expense (On the Liability losses of indivisible premium policies only.)

10. Claim Count

- Number Paid
- Number Outstanding

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SECTION 15

15. BOILER & MACHINERY REPORTS

15.1 Introduction

This section details specific reporting requirements for and features of boiler & machinery annual statistical compilations. The basis for the annual compilation is the Model Boiler & Machinery Statistical Plan that has been adopted by the NAIC.

15.2 Scope of Boiler & Machinery Data

Boiler & machinery insurance, for purposes of this section, encompasses all boiler & machinery policies.

This section covers boiler & machinery insurance written through the voluntary market.

15.3 Boiler & Machinery Coverages

A boiler & machinery policy contains both property and time element coverages. Coverage may be written to include equipment owned by the insured or for specific objects or groups of objects.

Property coverages include:

- (1) Damage to the insured object or property such as boiler and pressure vessels, mechanical and electrical equipment, and production machinery.
- (2) Damage to property of others while in insured's care.

Optional property coverages include:

- (1) Additional Ammonia Contamination
- (2) Additional Expediting Expenses
- (3) Consequential Damage
- (4) Furnace Explosion
- (5) Hazardous Substances, Increased Limits
- (6) Service Piping
- (7) Water Damage, Increased Limits

Time element coverages include:

- (1) Business Interruption Expenses
- (2) Extra Expense
- (3) Utility Interruption

Boiler and machinery policies also provide liability coverage for injury or death to employees (not covered by workers' compensation laws) and non-employees.

15.4 Statistical Plan Reporting Requirements

The minimum data items required for boiler & machinery reporting are specified in the Model Boiler & Machinery Statistical Plan. They are:

- Company Identifier
- Transaction Identifier and Amount
- Accounting/Calendar Date
- Experience Period
- State
- Territory
- Line of Business
- Claim Count
- Classification
- Type of Equipment
- Coverage
- Exposure (Property Damage and Business Interruption Coverages only)

The required data items are to be reported for direct business only. Therefore, reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier; nor shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded. Losses are to be reported net as to third party recoveries (salvage and subrogation).

15.5 Who Reports Data: Minimum Reporting Standards for Insurers

The statutory requirement to report statistics applies to all licensed insurers. In establishing the standards for reporting to the statistical agents, regulators recognize the need for efficiency by permitting companies with limited premium volume to report less detailed statistics.

The Model Regulation, therefore, has established the following standards for statistical reporting.

All insurers licensed to write boiler & machinery policies are required to report statistics at least annually:

- (1) An insurer must report in accordance with the Model Boiler & Machinery Statistical Plan if it is in the top 90th percentile of the total statewide written premium for boiler & machinery.
- (2) An insurer that does not meet the above criterion must report its statewide experience in accordance with the specifications of boiler & machinery statistical plan adopted by the Commissioner.

15.6 Specific Report Features

The standard annual report for boiler and machinery has the following specific features.

Standard Annual Report

- All boiler and machinery experience shown by state.

Reports available on request

- Classification Report
 - each classification shown separately within coverage and type of equipment

Premiums are shown on an earned basis. Losses and claims will be on an incurred basis. Loss adjustment expenses will be included.

Five calendar or calendar/accident years will be exhibited for the standard report.

The standard report includes at least the experience of companies meeting the criteria specified in part (1) of Section 15.5.

15.7 Time Frame

Statistical agents distribute boiler and machinery annual reports approximately 15 months after the end of the calendar or accident year. This allows for loss evaluation and statistical agent processing and compilation.

Model Boiler and Machinery Statistical Plan

LIST OF DATA ITEMS

1. Company Identifier
2. State Indicator
3. Territory Indicator
4. Accounting/Calendar Date
5. Experience Period
6. Transaction Identifier and Amounts
7. Line of Business
8. Claim Count
9. Classification
10. Type of Equipment
11. Coverage
12. Exposure

DATA ITEMS

1. Company Identifier

Experience is to be reported by the company number assigned by the statistical agent.

Note: Statistical agents will be required to convert company numbers to NAIC group and company code numbers, if requested.

2. State Indicator

Experience is to be reported by the state code applicable to the location of the risk.

3. Territory Indicator

Common industry territorial breakdowns currently in use will be maintained.

4. Accounting/Calendar Date

Accounting Year Reflects the reporting year.

5. Experience Period

- Premiums: Calendar Year
- Losses: Calendar Year or Accident Year

6. Transaction Identifier and Amounts

Identify the following items and their respective amounts:

- Written Premium
- Paid Losses

- Outstanding Losses

7. Line of Business

Boiler & Machinery Policies

8. Claim Count

- Number Paid
- Number Outstanding

9. Classification

- Agricultural
- Breweries, Distilleries and Wineries
- Ceramics Manufacturing
- Glass Manufacturing
- Chemical Manufacturing – Heavy
- Chemical Manufacturing – Light
- Clay, Asphalt, Concrete and Tile Manufacturing
- Cold Storage, Freezing and Ice Making
- Communications, TV and Radio
- Computer Services
- Electric Utility Plants, Generating
- Electric Utility Plants, Non-Generating
- Food Processing and Storage with Refrigeration
- Food Processing and Storage without Refrigeration
- Gas Compressor Stations
- Gas Storage and Transmission Stations
- General Heavy Manufacturing
- General Light Manufacturing
- General Manufacturing
- Grain Elevators
- Hospitals, Health Care Facilities
- Laundry and Dry Cleaners
- Logging, Sawmills and Wood Treating
- Metal Working – Heavy
- Metal Working – Primary – Metal Smelting
- Mining and Crushing
- Offices and Stores
- Petrochemicals and Petroleum Refining
- Places of Public Assembly
- Printing and Publishing
- Pulp Manufacturing
- Roofing Materials Manufacturing
- Rubber Working
- Semi-Conductor Manufacturing
- Sewage and Water Treatment and Distribution
- Steam Plants

- Sugar Manufacturing
- Telephone Exchanges
- Textile Manufacturing
- Transportation Systems
- All Other

10. Type of Equipment

- Full Comprehensive – Other than Small Business Policy
- Other than Full Comprehensive – Other than Small Business Policy
- Miscellaneous – Other than Small Business Policy
- Small Business Policy
- All Other

11. Coverage

- Property Damage
- Business Interruption (Time Element)
- All Small Business Boiler and Machinery Coverage except Spoilage Insurance
- All Other (including Optional Coverages)

12. Exposure (Property Damage and Business Interruption Coverages only)

- Property Damage
 - Report the 100 percent replacement cost of covered machinery and equipment in thousands of dollars
- Business Interruption
 - Report the annual value in thousands of dollars.

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SECTION 16

16. MEDICAL PROFESSIONAL LIABILITY REPORTS

16.1 Introduction

This section details specific reporting requirements for and features of medical professional liability annual statistical compilations. The basis for the annual compilation is the Model Medical Professional Liability Statistical Plan that has been adopted by the NAIC. In turn, the Model Regulation uses the Uniform Medical Professional Liability (UMPL) Statistical Plan as its basis.

The NAIC has adopted a Medical Professional Liability Closed Claim Reporting Model Law, which is included in this *Statistical Handbook* as Appendix G, and a Guideline for Implementation of Medical Professional Liability Closed Claim Reporting, which can be found in the NAIC's *Model Laws, Regulations and Guidelines*. In addition to the annual statistical compilations described in this section, some states require insurers and other entities to report detailed data on each medical professional liability closed claim. State law may vary with respect to the specific data elements reported, the state agency responsible for data collection, the data reporting mechanisms, and the confidentiality of the data.

16.2 Scope of Medical Professional Insurance Data

Medical professional liability insurance or medical “malpractice” insurance provides coverage for tort claims brought against various medical-related institutions and medical professionals.

- Institutions may include hospitals, infirmaries, nursing homes, mental institutions, blood banks, sanitariums and clinics.
- Individual professionals may include physicians, surgeons, dentists, nurses, pharmacists, opticians, optometrists, physiotherapists, chiropractors, laboratory technicians and various specialists.

16.3 Medical Professional Liability Coverages

Virtually all medical professional liability exposures can be classified into five groups:

- (1) hospital professional liability;
- (2) physicians, surgeons and dentists professional liability;
- (3) druggists liability;
- (4) osteopaths professional liability; and
- (5) miscellaneous medical professional liability.

Hospital policies provide protection to hospitals as institutions against injury arising from acts, errors or omissions of its professional staff and employees in rendering or failing to render services, such as:

- (1) medical, surgical, or dental treatment including the furnishing of patient's food and beverage;
- (2) furnishing of drugs, medical supplies and appliances;
- (3) post-mortem examinations; and
- (4) service performed by a member of hospital's accreditation or similar professional board.

The term "injury" is not defined in terms of bodily or personal injury, nor property damage, but rather applies to injury caused by a "medical incident."

Physicians, Surgeons and Dentists policies, as well as Osteopaths policies, cover a wide assortment of medical professionals. Both claims-made and occurrence forms are available. Policies provide coverage against injury caused by a "medical incident," signifying any act or omission in the furnishing of professional medical or dental services.

Druggists policies provide (1) professional liability and (2) products liability coverage. Such policies cover the liability of druggists for bodily injury or property damage arising from the sale and preparation of goods or products, including drugs and medicines.

Miscellaneous medical professional liability coverage is available on a claims-made and occurrence basis. These policies provide coverage for professionals such as nurses, optometrists and podiatrists, as well as associations such as visiting nurse associations, blood banks and X-ray laboratories.

16.4 Statistical Plan Reporting Requirements

The minimum data items required for medical professional liability reporting are specified in the Model Medical Professional Liability Statistical Plan. They include:

- Company Number
- Accounting/Calendar Date
- Transaction Identifier and Amounts
- Subline Identifier
- Classification
- State Indicator
- Territory Indicator
- Policy Effective Year
- Type of Program Indicator

- Date of Entry into the Claims-Made Program
- Type of Policy Contract Identifier
- Exposure
- Claim Count

The required data items are to be reported for direct business only. Therefore, reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier; nor shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded. Losses are to be reported net as to third party recoveries (salvage and subrogation).

16.5 Who Reports Data: Minimum Reporting Standards for Insurers

The statutory requirement to report statistics applies to all licensed insurers. In establishing the standards for reporting to the statistical agents, regulators recognize the need for efficiency by permitting companies with limited premium volume to report less detailed statistics.

The model regulation has established the following standards for statistical reporting. All carriers, including JUAs and “Doctors Mutuals,” are required to report statistics as described below:

- (1) An insurer must report in accordance with the Model Medical Professional Statistical Plan if it is in the top 98th percentile of the total statewide written premium for medical professional liability.
- (2) An insurer that does not meet the above criterion must report its statewide experience in accordance with the specifications of the medical professional statistical plan adopted by the Commissioner.

16.6 Specific Report Features

The standard annual report for medical professional liability has the following specific features.

Standard Annual Report

- Each state shown separately by type of policy contract identifier (claims-made, occurrence) and by subline identifier:
 1. hospitals;
 2. physicians, surgeons and dentists;
 3. other health care professional liability; and
 4. all remaining sublines.

Reports available on request

- The standard annual report but in further detail. Hospital professional experience would be shown in the two subcategories hospitals and other health care facilities. Physicians, surgeons and dentists experience would each be shown individually. Likewise, experience for the remaining sublines would be shown separately for druggists, osteopaths, nurses and other classifications.

All reports give premiums on a collected earned basis. Incurred losses are separated into basic and excess limit components (including loss adjustment expenses). Furthermore, basic and excess losses will be developed to 135 months. In addition, the report also shows total limits loss ratios based on developed losses.

Five policy years of data will be exhibited for each report.

All reports include at least the experience of companies meeting the criteria specified in part (1) of Section 16.5.

16.7 Time Frame

Statistical agents distribute medical professional liability annual reports approximately 39 months after the beginning of the policy year. This allows for loss evaluation and statistical agent processing and compilation.

Model Medical Professional Liability Statistical Plan

LIST OF DATA ITEMS

1. Company Number
2. Accounting/Calendar Date
3. Transaction Identifier and Amounts
4. Subline Identifier
5. Classification
6. State Indicator
7. Territory Indicator
8. Policy Effective Year
9. Type of Program Indicator
10. Date of Entry into the Claims-Made Program
11. Type of Policy Contract Identifier
12. Exposure
13. Claim Count

DATA ITEMS

1. Company Number

Experience is to be reported by the company number assigned by the statistical agent.

Note: Statistical agents will be required to convert company numbers to NAIC group and company code numbers, if requested.

2. Accounting/Calendar Date
 - Accounting Quarter (where applicable)
 - Accounting Year

3. Transaction Identifier and Amounts

Identify the following items and their respective amounts:

- Written Premium
 - Paid Losses
 - Paid Allocated Loss Adjustment Expenses
 - Outstanding Losses
 - Outstanding Allocated Loss Adjustment Expense
4. Subline Identifier
 - Hospital Professional and Other Health Care Facilities Liability
 - Physicians, Surgeons, and Dentists Professional Liability
 - Other Health Care Professional Liability
 - All Composite Rated Risks

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SECTION 17

17. COMPREHENSIVE PERSONAL LIABILITY REPORTS

17.1 Introduction

This section details specific reporting requirements for and features of comprehensive personal liability annual statistical compilations. The basis for the annual compilation is the Model Comprehensive Personal Liability Statistical Plan that has been adopted by the NAIC.

17.2 Scope of Personal Liability Data

Comprehensive personal liability insurance, for purposes of this section, encompasses personal liability, personal umbrella, snowmobile liability and watercraft liability policies.

This section covers comprehensive personal liability insurance written through the voluntary market.

17.3 Comprehensive Personal Liability Coverages

Data reported under the comprehensive personal liability statistical plan represents experience from comprehensive personal liability policies.

Comprehensive personal liability coverages can include:

- (1) Personal liability, watercraft liability, snowmobile liability and personal umbrella liability (bodily injury or property damage) coverage.
- (2) Medical payments to others coverage.
- (3) Additional coverages such as claim expenses, first aid expenses and damage to property of others.
- (4) Home day care coverage.
- (5) Farmowners Personal Liability for insureds whose primary occupation is not farming.
- (6) Business pursuits of insured such as teachers, clerical office employees, salesmen and messengers.

17.4 Statistical Plan Reporting Requirements

The minimum data items required for comprehensive personal liability reporting are specified in the Model Comprehensive Personal Liability Statistical Plan. They are:

- Company Identifier
- Transaction Identifier and Amount
- Accounting/Calendar Date
- Experience Period

- State
- Line of Business
- Classification
- Claim Count

The required data items are to be reported for direct business only. Therefore, reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier; nor shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded. Losses are to be reported net as to third party recoveries (salvage and subrogation).

17.5 Who Reports Data: Minimum Reporting Standards for Insurers

The statutory requirement to report statistics applies to all licensed insurers. In establishing the standards for reporting to the statistical agents, regulators recognize the need for efficiency by permitting companies with limited premium volume to report less detailed statistics.

The Model Regulation, therefore, has established the following standards for statistical reporting.

All insurers licensed to write comprehensive personal liability policies are required to report statistics at least annually:

- (1) An insurer must report in accordance with the Model Comprehensive Personal Liability Statistical Plan if it meets the criteria specified in part (1) of "Who Reports Data: Minimum Reporting Standards for Insurers" for either the Model Homeowners and Mobilehome Statistical Plan or the Model Dwelling Fire and Allied Lines Statistical Plan.
- (2) An insurer that does not meet the above criterion must report its statewide experience by classification in accordance with the specifications of comprehensive personal liability statistical plan adopted by the Commissioner.

17.6 Specific Report Features

The standard annual report for comprehensive personal liability has the following specific features.

Standard Annual Report

- All comprehensive personal liability experience shown by state and classification.

Premiums are shown on an earned basis. Losses and claims will be on an incurred basis. Loss adjustment expenses will be included.

Five calendar/accident years or policy years will be exhibited for the standard report.

The standard report includes at least the experience of companies meeting the criteria specified in part (1) of Section 17.5.

17.7 Time Frame

Statistical agents distribute comprehensive personal liability annual reports approximately 15 months after the end of the calendar or accident year. This allows for loss evaluation and statistical agent processing and compilation. Annual reports prepared on a policy year basis will be distributed approximately 39 months after the beginning of the policy year.

Model Comprehensive Personal Liability Plan

LIST OF DATA ITEMS

1. Company Identifier
2. State Indicator
3. Experience Period – Period of Coverage
4. Accounting/Calendar Date
5. Transaction Identifier and Amounts
6. Claim Count
7. Line of Business
8. Classification

DATA ITEMS

1. Company Identifier

Experience is to be reported by the company number assigned by the statistical agent.

Note: Statistical agents will be required to convert company numbers to NAIC group and company code numbers, if requested.

2. State Indicator

Experience is to be reported by the state code of the location of the risk.

3. Experience Period – Period of Coverage

- Premiums: Calendar Year or Policy Year
- Losses: Accident Year or Policy Year

4. Accounting/Calendar Date

Accounting Year – reflects the reporting year.

5. Transaction Identifier and Amounts

- Written Premiums
- Paid Losses (excluding all Loss Adjustment Expenses)
- Paid Allocated Loss Adjustment Expenses
- Outstanding Losses
- Outstanding Allocated Loss Adjustment Expenses (where separately identified)

6. Claim Count

- Number Paid
- Number Outstanding

7. Line of Business

Comprehensive Personal Liability Policies

8. Classification

Experience is to be reported by all statistical agents using the attached list of classifications.

- Initial Resident – Owner Occupied or Apartment Occupied by Tenant (Named Insured) – no business occupancy
- Initial Residence – Owner Occupied or Apartment Occupied by Tenant (Named Insured) – with permitted incidental occupancy by insured (except Home Day Care)
- Initial Residence – Owner Occupied or Apartment Occupied by Tenant (Named Insured) – with Home Day Care Coverage
- Other Insured Locations – Owner Occupied or Apartment Occupied by Tenant – no business occupancy
- Other Insured Locations – Owner Occupied or Apartment Occupied by Tenant – with permitted incidental occupancy by insured (except Home Day Care)
- Other Insured Location – Non-Owner Occupied
- Farmowners Personal Liability – Farming is no the insured's primary occupation
- Watercraft – Houseboats
- Watercraft – Inboard, Inboard/Outdrive or Outboard Motors
- Watercraft – Sailboats with or without auxiliary power
- Snowmobiles – owned by insured
- Business Pursuits of Insured – Clerical Office Employees
- Business Pursuits of Insured – Salesmen, Collectors or Messengers
- Business Pursuits of Insured – Teachers
- Business Pursuits of Insured – Not Otherwise Classified
- Home Day Care Coverage
- Employer's Liability – medical payments, excess of two
- Incidental Motorized Land Conveyances
- Personal Injury
- Miscellaneous – N.O.C. and Personal Umbrella

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SECTION 18

18. AIRCRAFT REPORTS

18.1 Introduction

This section details specific reporting requirements for and features of aircraft annual statistical compilations. The basis for the annual compilation is the Model Aircraft Statistical Plan that has been adopted by the NAIC.

18.2 Scope of Aircraft Data

Aircraft insurance, for purposes of this section, encompasses all aircraft hull & liability policies.

This section covers aircraft insurance written through the voluntary market.

18.3 Aircraft Coverages

Data reported under the aircraft statistical plan represents experience from personal and commercial aircraft hull policies and liability policies.

Aircraft hull policies can provide coverage for physical damage, either for ground and flight risks (whether or not the plane is in motion) or merely ground risks (when the plane is not moving under its own power or momentum).

Aircraft hull coverages include:

- (1) Any direct physical loss of, or damage to, any operating, navigating, and radio equipment, as well as tools typically carried in the aircraft
- (2) Any direct physical loss of, or damage to, the aircraft

Aircraft liability policies can provide protection against claims arising out of the insured's ownership, maintenance, or use of his aircraft.

Aircraft liability coverages include:

- (1) Any physical or mental anguish suffered by passengers or non-passengers
- (2) Payment for destruction of property or property's use

18.4 Statistical Plan Reporting Requirements

The minimum data items required for aircraft reporting are specified in the Model Aircraft Statistical Plan. They are:

- Company Identifier
- Transaction Identifier and Amount
- Accounting/Calendar Date

- Experience Period
- Subline of Business
- Classification

The required data items are to be reported for direct business only. Therefore, reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier; nor shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded. Losses are to be reported net as to third party recoveries (salvage and subrogation).

18.5 Who Reports Data: Minimum Reporting Standards for Insurers

The statutory requirement to report statistics applies to all licensed insurers. In establishing the standards for reporting to the statistical agents, regulators recognize the need for efficiency by permitting companies with limited premium volume to report less detailed statistics.

The Model Regulation, therefore, has established the following standards for statistical reporting.

All insurers licensed to write aircraft policies are required to report statistics at least annually:

- (1) An insurer must report in accordance with the Model Aircraft Statistical Plan if it is in the top 98th percentile of the total countrywide written premium for aircraft.
- (2) An insurer that does not meet the above criterion must report its statewide experience in accordance with the specifications of aircraft statistical plan adopted by the Commissioner.

18.6 Specific Report Features

The standard annual report for aircraft has the following specific features.

Standard Annual Report

- Countrywide aircraft experience shown by subline of business and classification.

Premiums are shown on an earned basis. Losses will be on an incurred basis. Loss adjustment expenses will be shown separately.

Five calendar or calendar/accident years will be exhibited for the standard report.

The standard report includes at least the experience of companies meeting the criteria specified in part (1) of the minimum standards.

18.7 Time Frame

Statistical agents distribute aircraft annual reports approximately 15 months after the end of the calendar or accident year. This allows for loss evaluation and statistical agent processing and compilation.

Model Aircraft Statistical Plan

LIST OF DATA ITEMS

- Company Identifier
- Transaction Identifier and Amount
- Accounting/Calendar Date
- Experience Period
- Subline of Business
- Classification

DATA ITEMS

1. Company Identifier

- a) Experience is to be reported by the company number assigned by the statistical agent.

Note: Statistical agents will be required to convert company numbers to NAIC group and company code numbers, if requested.

2. Transaction Identifier and Amount

- a) Written Premium
- b) Incurred Losses
- c) Incurred Loss Adjustment Expenses

3. Accounting/Calendar Date

Accounting year – reflects the reporting year

4. Experience Period

- a) Premiums: Calendar Year
- b) Losses: Accident Year or Calendar Year (evaluation as of December 31)
- c) Loss Adjustment Expenses: Accident Year or Calendar Year (evaluation as of December 31)

5. Subline of Business

- a) Aircraft Hull
- b) Aircraft Liability

6. Classification

- a) Private Business and Pleasure
- b) Industrial Aid
- c) Commercial, including Fixed Base Operations, Limited Commercial, Charter, Flying Clubs and Commuter Airlines
- d) Scheduled Airlines
- e) Aviation Products (Aircraft Liability only)
- f) Aviation Premises (Aircraft Liability only)

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SECTION 19

19. CROP INSURANCE REPORTS

19.1 Introduction

This section details specific reporting requirements for and features of crop insurance annual statistical compilations. The basis for the annual compilation is the Model Crop Insurance Statistical Plan that has been adopted by the NAIC.

19.2 Scope of Crop Insurance Data

Crop insurance, for purposes of this section, encompasses all crop insurance written by private insurers, except for Multiple-Peril Crop Insurance (MPCI) reinsured by the Federal Crop Insurance Corporation (FCIC).

19.3 Crop Insurance Coverage Forms

Crop insurance is written on forms covering different crop perils and different means of establishing amounts of coverage. Crop coverage forms shall be classified as one of these three types:

- “Traditional” crop-hail coverage: This coverage is purchased with a specific dollar amount applying to specified crops on specified acres. Hail is the significant peril, although coverage may be present for minor hazards like fire. Losses are adjusted as a percentage of total loss, which is then applied to the total amount of insurance. Percentage deductibles often apply which may “disappear” in accordance with various formulas.
- MPCI: This FCIC-governed program provides protection against many perils that may include drought, insects, wind, disease and flood in addition to hail and fire. Coverage forms, rates, statistical reporting and rules are prescribed by the FCIC, although data compilations are provided to the states.
- Other crop coverages: These are forms of coverage written by private insurers which provide coverage against substantial perils in addition to hail, or which base loss settlements on market crop prices instead of an amount of insurance. Settlement and rating provisions may be similar to either “traditional” crop-hail or MPCI, or the provisions may be unique.

19.4 Statistical Plan Reporting Requirements

The minimum data items required for crop insurance reporting (other than MPCI) are specified in the Model Crop Insurance Statistical Plan. They are:

- Company Identifier
- State

- Experience Period (growing season)
- Policy Form (whether “traditional” crop-hail or other crop insurance)
- Type of Crop
- Cause of Loss (for other than “traditional” crop-hail)
- Exposure (amount of insurance)
- Transaction Identifier and Amounts

The required data items are to be reported for direct business only. Therefore, reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier; nor shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded.

State Exceptions: For all but a small number of states, the total amount of crop insurance written statewide is very small, often less than a million dollars for all crops and insurance forms. In addition, in many states, the hazard of loss does not vary widely between different locations in the state. For such states, reports that combine premiums, exposures and losses for all crops on a statewide basis will be adequate. For states with extensive farming practice where hail hazards vary greatly across the state (generally central plains states from the Dakotas through Texas) and where substantial premiums (i.e., over \$10 million) are present, the regulator may choose to have reports divided by territories (i.e., counties or townships).

19.5 Who Reports Data

All insurers must report in accordance with the Model Crop Insurance Statistical Plan.

19.6 Specific Report Features

The standard annual report for crop insurance (other than MPCI) has the following specific features.

- “Traditional” crop-hail and other insurance shown separately.
- Premiums earned and losses incurred are shown on a growing season basis.
- Total exposures (amounts of insurance) are shown.
- Three years of data will be exhibited for each report.
- Upon request, the statistical agent must be able to provide:

Standard reports going back at least twenty years.

- Reports by cause of loss for other than “traditional” crop-hail coverage.
- Reports showing experience separately for different crops.

19.7 Time Frame

Statistical agents shall distribute crop insurance annual reports approximately 6 months after the end of the year in which the crop is harvested and coverage ceases (crop year).

Model Crop Insurance Statistical Plan

LIST OF DATA ITEMS

1. Company Identifier
2. State Indicator
3. Experience Period (growing season)
4. Type of Policy Form
5. Type of Crop
6. Cause of Loss (for other than “traditional” crop-hail coverage)
7. Exposure (Amount of Insurance)
8. Transaction Identifier and Amounts

DATA ITEMS

1. Company Identifier

Experience is to be reported by the company number assigned by the statistical agent.

Note: Statistical agents will be required to convert company numbers to NAIC group and company code numbers, if requested.

2. State Indicator

Experience is to be reported by the state code applicable to the location of the insured crop.

3. Experience Period (growing season)

- Premiums: Crop Year
- Losses: Crop Year

4. Type of Policy Form

- “Traditional” Crop-Hail
- Other Crop Insurance (except FCIC-reinsured MPC)

5. Type of Crop Insured

- Cotton
- Grain, Grass, Cereal and Miscellaneous Crops
 - Alfalfa (grown for hay)
 - Barley
 - Bluegrass seed
 - Brome grass for seed
 - Broomcorn
 - Buckwheat

Canola
Canary grass seed
Castor beans
Chili Peppers
Clover
Corn (Grain crop)
Corn (Ensilage and Fodder crop)
Corn grown for seek
Emmer (spelt)
Flax
Grain Sorghum
Hay
Meadow Fescue for seed
Millet (seed or grain. Use Hay for Millet hay)
Milo (Milo Maize) or Combined Maize for Grain
Mint
Moroccan canary grass seed
Mustard
Oats
Peanuts
Popcorn
Rapeseed
Rice
Rye
Safflower for seed
Sorgo (Sorghum Cane)
Sorghum for grain
Sorghum for forage
Soybeans
Spelt
Sudax
Sugar Beets (not grown for seed)
Sugar Cane
Sunflowers
Sweetclover seed (Use Hay for Hay)
Sweet Clover
Tascosa Wheat
Timothy seed (Use Hay for Hay)
Triticale
Vetch
Wheat
Wheatgrass
Wild rice
Not Known
 – Use only when application or proof of loss does not contain name of crop
Mixed crops (except wheat mixed with other small grain; 103)
All Other Grains (Use for crops not listed above)

- Tobacco
- Tree Fruits, Grapes, Bush Fruits and Berries
 - Apples
 - Apricots
 - Blueberries
 - Cherries
 - Cranberries
 - Grapefruit
 - Grapes
 - Nectarines
 - Oranges
 - Peaches
 - Pears
 - Pecans
 - Plums
 - All Other Fruits (Not listed above)
- Vegetables
 - Beans: grown for seed (Not soybeans, kidney beans or lima beans)
 - Beans grown for Green Pack or Canning
 - Beets (Not sugar beets)
 - Cabbage
 - Carrots
 - Celery
 - Eggplant
 - Kidney beans (red) dry
 - Lentils – dry
 - Lettuce
 - Lima beans (green pack)
 - Lima beans (dry or for seed)
 - Onion
 - Peas grown for Green Pack or Canning
 - Peas, Austrian (black)
 - Pepper
 - Pepper plants (to be reset)
 - Pinto beans
 - Potatoes (Not sweet potatoes)
 - Spinach
 - Sweet Corn
 - Sweet Potatoes
 - Tomatoes
 - Tomato Plants
 - All Other Vegetables (Not listed above)
- Vine Crop
 - Cantaloupes or Muskmelons
 - Cucumbers
 - Honeydew melon

Pumpkins
Squash
Watermelons
All Other Vine Crops (Not listed above)

6. Cause of Loss

- Hail
- Drought
- Insects
- Wind
- Flood
- All other losses

7. Exposure (Amount of Insurance)

Report the coverage amount of insurance in thousands of dollars.

8. Transaction Identifier and Amounts

- Earned Premiums
- Incurred Losses

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SECTION 20

20. FIDELITY AND SURETY REPORTS

20.1 Introduction

This section details specific reporting requirements for and features of fidelity and surety annual statistical compilations. The basis for the annual compilation is the Model Fidelity and Surety Statistical Plan that has been adopted by the NAIC.

20.2 Nature of Fidelity Insurance

Fidelity insurance indemnifies an employer for loss caused by the dishonest or fraudulent acts of covered employees. This line of business is divided into two major sublines—Financial Institutions and Mercantile & Governmental Entities.

The Financial Institutions subline consists of such insureds as commercial banks, savings banks, savings & loan associations, stockbrokers, insurance companies, credit unions and finance companies. The coverage given to these institutions is almost always on a "blanket" basis, meaning that all employees of the insured are covered for dishonesty. In addition to providing dishonesty coverage, financial institutions blanket bonds provide coverage for loss caused by burglary, robbery and hold-up in the basic insuring agreements. Additional coverage is available on an optional basis for losses caused by forgery, extortion and the inclusion of employees of a private data processing organization as employees of the insured.

The Mercantile & Governmental Entities subline consists of all other types of insureds not classified as financial institutions. Coverage for these insureds is usually provided either as a Coverage Crime Policy or as a Commercial Crime Coverage Part of a Commercial Package Policy. Employee Dishonesty coverage for Mercantile Entities may be written on either a blanket (all employees covered) basis or on a schedule basis where only selected employees are covered. Employee Dishonesty coverage on Governmental Entities is always written on a blanket basis. Both types of insureds may also have coverage for forgery or alteration of instruments they draw. Other crime coverages for Mercantile & Governmental Entities are part of the Burglary line of insurance.

20.3 Nature of Surety Bonding

A Surety Bond is a three party contract that assumes a legal relationship in which the first party (the surety) undertakes to answer to the second party (the obligee) for the debt, default or miscarriage of the third party (the principal) resulting from the principal's failure to pay or perform according to the conditions stated in the surety bond. The Surety line of business is divided into five major sublines—Contract Bonds, Court & Fiduciary Bonds, License & Permit Bonds, Public Official Bonds and Miscellaneous Bonds.

Contract Bonds provide a guarantee of the faithful performance of a construction contract and the payment of all labor and material bills related to it. Contract Bonds comprise roughly two-thirds of the industry total surety premium volume.

Court Bonds are required by law in instances where participants in a lawsuit seek to avail themselves of certain privileges or remedies. These bonds preserve the rights of the opposing party in the granting of such privileges and remedies. Fiduciary Bonds cover the faithful performance of a person who has been appointed by a court to manage the affairs or funds of another.

License and Permit Bonds are those required by state law, municipal ordinance, or by regulation and in some instances by the federal government or its agencies as a condition precedent to the granting of a license to engage in a particular business or the granting of a permit to exercise a particular privilege. Such bonds provide payment to the obligee for loss or damage resulting from violations by the licensee (the principal) of the duties and obligations imposed upon him.

Public Official Bonds guarantee the faithful performance of duty of a public official in a position of trust and provide for an honest accounting of all public funds handled by him. These bonds are given to comply with a statute and, therefore, carry whatever liability the statute imposes.

The Miscellaneous Bonds subline covers a broad range of surety bonds which do not fall within the scope of any of the other sublimes defined above. In many instances these bonds are prescribed and required by a statute while in other instances they are discretionary.

20.4 Statistical Plan Reporting Requirements

The minimum data elements required for fidelity & surety are specified in the Model Fidelity and Surety Statistical Plan. They include:

- Company Number
- Transaction Identifier and Amounts
- Experience Period
- State Identifier
- Class Group
- Line

20.5 Who Reports Data: Minimum Reporting Standards for Insurers

The statutory requirement to report statistics applies to all licensed insurers. In establishing the standards for reporting to the statistical agent, regulators recognize the need for efficiency by permitting companies with limited premium volume to report less detailed statistics.

The model regulation, therefore, has established the following standards for statistical reporting.

All insurers licensed to write fidelity and surety bonds are required to report statistics annually:

- (1) An insurer must report annually in accordance with the Model Fidelity and Surety Statistical Plan if it is in the top 90th percentile of the total countrywide written premium for fidelity or surety.
- (2) An insurer that does not meet the above criterion must report annually its statewide experience by type of business (Fidelity or Surety) in accordance with the specifications of a minimum statistical plan adopted by the Commissioner.

20.6 Specific Annual Report Features

The standard annual report for fidelity & surety has the following specific features:

These reports show state and countrywide direct written and earned premiums and the incurred losses and incurred/earned loss ratios by classification group.

Premiums in these reports are shown on an "as written" basis without any adjustments.

Losses in these reports are shown on a calendar year incurred basis. They do not contain any loadings for loss adjustment expenses nor do they contain any provision for IBNR loss reserves.

20.7 Time Frame

Statistical agents distribute fidelity and surety annual reports approximately 12 months after the end of the calendar year. This allows for statistical agent processing and compilation.

Model Fidelity and Surety Statistical Plan

LIST OF DATA ITEMS

1. Company Identifier
2. Experience Period
3. State Indicator
4. Line Code Indicator
5. Transaction Code
6. Classification Group

DATA ITEMS

1. Company Identifier

Experience is to be reported by the company number assigned by the statistical agent.

Note: Statistical agents will be required to convert company numbers to NAIC group and company code numbers, if requested.

2. Experience Period

- Premiums: Calendar Year
- Losses: Calendar Year

3. State Indicator

Experience is to be reported by the applicable state code.

4. Line Code Indicator

Line code for Fidelity and Surety

5. Transaction Code

- Written Premium
- Paid Losses
- Outstanding Losses

6. Classification Group

- Fidelity and Forgery
 - Mercantile Establishments Bonds (including Forgery Bonds)
 - Agriculture, Forestry and Fishery, Mining and Quarrying
 - Construction and Special Trade Contractors
 - Transportation, Trucking, Warehousing and Public Utilities
 - Manufacturers and Processors
 - Wholesalers and Distributors

Retail Trade and Personal Services
Business Services, Amusement, Recreational and Miscellaneous
Consumer Services and Membership Organizations
Finance, Insurance and Real Estate
Privately Operated Educational Services

- Financial Institutions Bonds (including Forgery Bonds)
- Blanket Bonds
 - Commercial Banks
 - Savings Banks
 - Savings and Loan Associations
 - Stockbrokers and Investment Bankers, etc.
 - Credit Unions
 - Combination Safe Depository Policy for Financial Institutions
 - All Other
- Individual or Schedule Bonds
 - Public Employees Blanket Bonds (including Forgery Bonds)
Federal Government
State and Local Government
- Surety
 - Federal and Public Official – Individual or Schedule
 - Court – Fiduciary Bonds
 - Court – Guarantee Bonds
 - Contract Bonds – Federal Contracts
 - Other Public and Private Contracts
 - License and Permit Bonds
 - Miscellaneous Bonds

INSERT

SECTION 21

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SECTION 21

21. MORTGAGE GUARANTY REPORTS

21.1 Introduction

This section details specific reporting requirements for and features of mortgage guaranty annual statistical compilations. The basis for the annual compilation is the Model Mortgage Guaranty Statistical Plan that has been adopted by the NAIC.

21.2 Scope of Mortgage Guaranty Data

This section covers private mortgage guaranty insurance. Non-conventional mortgages backed by the government are insured by the Federal Housing Administration (FHA) or guaranteed by the Department of Veterans Affairs (VA) or Farmers Home Administration (FMVA) and are beyond the scope of this chapter.

21.3 Mortgage Guaranty Coverage

Mortgage guaranty insurance, for purposes of this section, means insurance against financial loss by reason of non-payment of principal, interest or other sums agreed to be paid under the terms of any note or bond or other evidence of indebtedness secured by a mortgage, deed of trust or other instrument constituting a first lien or charge on real estate if the improvements on such real estate are a residential building or condominium unit or buildings designed for occupancy by not more than four families. Companies writing this business are required, because of laws in several states, to be monoline. Therefore, all companies reporting premium writings will be writing only conventional residential mortgage guaranty insurance.

21.4 Mortgage Guaranty Policy Forms

Data reported under the Mortgage Guaranty Statistical Plan represents experience from individual loans insured under the standard master policies, reporting form policies or delegated policies, and mortgage pool policies.

Coverage under the Mortgage Guaranty policy provides that the mortgage insurer has the option to pay the percentage coverage limits or to pay the entire claim and acquire title to the collateral. A condition precedent to payment in the event of default provides that the property must be restored, reasonable wear and tear expected.

Coverage under a “pool” policy will provide for a coverage limit on individual loans with a total aggregate loss limit applicable to the entire insured pool of loans.

21.5 Statistical Plan Reporting Requirements

The minimum data items required for mortgage guaranty reporting are specified in the Model Mortgage Guaranty Statistical Plan. They are:

- Company Identifier

- Experience Period
- State (countrywide only)
- Line (mortgage guaranty)
- Transaction Identifier And Amounts
- Type of Loan
- Use of Property
- Type of Borrower
- Loan to Value
- Loan Coverage
- Premium Payment Code
- Exposure
- Rate Base Code

The required data items are to be reported for direct business only. Therefore, reporting shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier; nor shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from the other carriers on account of reinsurance ceded. Losses are to be reported net as to third party recoveries (salvage and subrogation).

21.6 Who Reports Data: Minimum Reporting Standards For Insurers

Statutory requirements vary among states with respect to the reporting of statistics for mortgage guaranty.

The model regulation has established the following standards for statistical reporting. All insurers licensed to write mortgage guaranty in states which require statistical reporting are required to report, at least annually, in accordance with the Model Mortgage Guaranty Statistical Plan.

21.7 Specific Report Features

The standard annual report for mortgage guaranty has the following specific features:

Standard Annual Reports

- Mortgage guaranty experience will be exhibited countrywide by type of loan (fixed payment, pool, all other)
- Mortgage guaranty experience will be exhibited by type of borrower (owner occupied, non-owner, all other)

All reports will display number of loans, earned premiums, incurred losses, number of incurred claims, loss ratio and average loss. Three calendar/accident years of countrywide experience will be displayed. Losses are exclusive of all loss adjustment expenses.

21.8 Time Frames

Statistical agents distribute mortgage guaranty annual reports approximately 15 months after the end of the accident year. This allows for loss evaluation and statistical agent processing and compilation.

Model Mortgage Guaranty Statistical Plan

LIST OF DATA ITEMS

1. Company Identifier
2. Experience Period
3. State Indicator
4. Line Code Indicator
5. Transaction Identifier and Amounts
6. Type of Loan
7. Use of Property
8. Type of Borrower
9. Loan to Value
10. Loan Coverage
11. Premium Payment Code
12. Exposure
13. Rate Base Code

DATA ITEMS

1. Company Identifier

Experience is to be reported by the company number assigned by the statistical agent.

2. Experience Period

- Premiums: Calendar Year
- Losses: Accident Year (year of first notice of delinquency)

3. State Indicator

Experience is to be reported on a countrywide basis.

4. Line Code Indicator

Line code for Mortgage Guaranty Insurance

5. Transaction Identifier and Amounts

- Written Premium
- Paid Losses
- Outstanding Losses
- Number of Paid Claims
- Number of Outstanding Claims

6. Type of Loan

- Fixed Payment
- Non-fixed Payment

- Pool
 - Other
7. Use of Property
- Residential – 1 to 4 family
 - Other
8. Type of Borrower
- Owner occupied
 - Non-owner investor
 - Other
9. Loan to value
- 90.01 – 95.0 percent
 - 85.01 – 90.0 percent
 - 85.0 percent – and under
 - Pool – NOC
10. Loan Coverage
- Standard

Experience is reported as a percent of the loan coverage.

- Pool Coverage (truncated)

Experience is reported as percent of the loan coverage from one percent to twenty percent separately and all other.

- Other

11. Premium Payment Code

Experience is reported by individual years from one to thirty years and all other.

12. Exposure

Reflects the number of mortgage loans.

13. Rate Base Code

- A) Individual Mortgage balance in thousands of dollars
- B) Pool: Mortgage balances in millions of dollars

INSERT

SECTION 22

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SECTION 22

22. MUNICIPAL BOND REPORTS (Financial Guaranty)

22.1 Introduction

This section details with specific reporting requirements for and features of municipal bond coverage also known as financial guaranty coverage.

22.2 Scope of Municipal Bond Data

This section covers any direct insurer issuing contracts insuring municipal bonds.

22.3 Municipal Bond Coverage

Municipal bond insurance, for purpose of this section, means insurance against loss or damage that may result from the failure of debtors to pay their obligations for personal services, pollution control enforcement and large construction projects. These debtors must be municipalities, which are government agencies either federal or local.

All bonds are loans whereby a borrower promises to repay, on a specific date or dates, the amount borrowed, and also agrees to pay interest for use of the money. The borrower, known as an issuer, may be a government agency, including the federal government and its agencies, and state or local governments and their agencies, or the borrower may be a corporation or other commercial entity. The lender is an investor, who lends the issuer funds in return for regular interest payments. Bond pricing depends on many factors, including the type of issuer, maturity of the bond, the coupon (or stated interest rate) and the credit quality of the issuer.

More than 50,000 state and local governments and agencies issue securities (called municipal bonds) to raise capital for public purposes such as roads, bridges, water treatment facilities, hospitals, and other public facilities. According to the Public Securities Association, between 40 and 50 percent of all municipal bonds finance development or maintenance of infrastructure.

Municipal bonds are one of the few remaining tax-advantaged investments. Under current federal law, the interest income from municipals, in most cases, is exempt from federal income tax. In most states, interest income from securities issued by government units within the state are also exempt from state and local taxes.

In most instances, the insurance premiums are paid by the issuer when the bonds come to market. These premiums are reflected in the interest rate the bonds pay. Usually, the rate is lower than the rate for comparable uninsured bonds. Thus, by bringing an insured bond paying a lower interest rate to market, the issuer can save on financing costs, even after paying the insurance premium. While the investor who buys such a bond gives up a small amount of interest, he or she receives an ironclad guaranty of the timely payment of principal and interest, regardless of what may happen to the issuer.

Defaults of municipal bonds are rare, historically less than one half of one percent of all municipal issues. However, they do occur from time to time. When they do, investors who own insured bonds are protected.

Financial guaranty insurers do not insure preservation of price in the secondary market. Should an investor choose to sell a bond at any time, the sales price is determined by the market at that time. However, while insurance does not guarantee price protection in the secondary market, insured bonds have historically retained more of their value than uninsured bonds.

22.4 Reporting Requirements

Data for this line of insurance are available on the Financial Guaranty Insurance Exhibit filed by each company writing this line. This exhibit is filed with the annual statement in hard copy. At this time, the exhibit is not captured electronically in the NAIC annual statement database.

22.5 Who Reports Data: Minimum Reporting Standards For Insurers

All insurers licensed to write municipal bond insurance (financial guaranty insurance) are required to submit the Financial Guaranty Insurance Exhibit with the annual statement.

22.6 Exhibit Features

The Financial Guaranty Insurance Exhibit includes net exposures, net premiums written, net principal guaranteed, average premium, current year earned premium, prior year reserve, current year addition to reserve, current year withdrawal from reserve and contingency reserve for municipal obligation bonds, special revenue bonds, and industrial development bonds.

22.7 Time Frame

The Financial Guaranty Insurance Exhibit is filed on or before March 1 with the annual statement.

INSERT

SECTION 23

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SECTION 23

23. WORKERS' COMPENSATION REPORTS

23.1 Introduction

This section details specific reporting requirements for and features of workers' compensation annual statistical compilations. The basis for the annual compilation is the Model Workers' Compensation Statistical Plan that has been adopted by the NAIC.

23.2 Scope of Workers' Compensation Insurance Data

Workers' compensation insurance refers to insurance that employers are required (in most states and for most employment) to provide to cover employees against loss of income and/or medical expenses that result from job-related injury, disease or death.

This section covers workers' compensation insurance written through the voluntary market, as well as workers' compensation insurance written through various state residual market mechanisms, such as assigned risk plans.

This section does not cover Federal Coal Mine Workers' Compensation, self-insured workers' compensation, workers' compensation excess insurance written for employers whose primary workers' compensation coverage is self-insured, and in servant/out servant coverage on Homeowners policies.

23.3 Nature of Workers' Compensation Insurance

Workers' compensation insurance benefits are often described as being "long tail" in nature as losses continue to be paid many years after the premium has been collected and the policy has expired. This is in contrast to many other lines of insurance, where a claim file is usually open until a single payment is made, after which it is closed. In addition, it is unusual for a closed claim to be "reopened" in many other lines of insurance, but this is not uncommon for workers' compensation.

The primary exposure base is payroll. Auditing of the insured's exposure is required after the close of the policy period. Before policy inception, the insurer and the insured estimate the payroll and resulting policy premium. After the end of the policy period, the insurer audits the insured's payroll and adjusts the premium, if necessary.

23.4 Workers' Compensation Coverage

Insurers report workers' compensation insurance data consistent with the benefits and coverages provided by a workers' compensation policy: indemnity, medical and employers liability. See Appendix D for policy information data.

- Indemnity benefits pay any wage replacement (commonly computed as a percentage of pre-injury earnings) and other related expenses, while the employee is absent from work because of a job-related injury, disease or death.

- Medical benefits pay for an employee’s medical and other related expenses required to treat a job-related injury, disease or death.
- Employers Liability coverage is often called “third party” coverage. This insurance policy is a contract between the insured and insurer (first and second parties) to pay for loss to a third party caused by torts of the insured that are not covered by the basic workers’ compensation portion of the policy.

23.5 Statistical Plan Reporting Requirements, Reporting Standards, Report Features, and Time Frames

The reports and data items required by all states for workers’ compensation reporting are specified in the Model Workers’ Compensation Statistical Plan for three separate reporting mechanisms: Unit Statistical Reports, Calls for Aggregate Experience, and Detailed Claim Information Reporting. In some states Detailed Claim Information Reporting is referred to as Individual Case Reporting.

- (1) **Unit Statistical Reports**—These reports are used by insurers to report an individual insured’s audited payroll and associated premium and losses by class by state. The primary purposes of the data contained on the Unit Statistical Reports are calculating experience modification factors for individual insurers and classification ratemaking. Refer to Section 23A for reporting requirements, reporting standards, report features, and time frames.
- (2) **Calls for Aggregate Experience**—These reports are used by insurers to report aggregate total losses and premiums. Classification and individual policy and loss detail are not reported on these calls, although losses are split between medical and indemnity. The primary purposes of the data contained on the Calls for Aggregate Experience are for trending and for determining overall rate or loss cost levels. Refer to Section 23B for reporting requirements, reporting standards, report features, and time frames.
- (3) **Detailed Claim Information Reporting**—California, Delaware, Massachusetts, New Jersey, New York, and Pennsylvania use the reporting process referred to as Individual Case Reporting (ICR). Refer to Appendix E for reporting requirements, reporting standards, report features, and time frames for ICR. All states except Alaska, California, Delaware, and Maine and the monopolistic states of Nevada, North Dakota, Ohio, Washington, West Virginia, and Wyoming use the reporting process referred to as Detailed Claim Information Reporting (DCI). Refer to Appendix F for reporting requirements, reporting standards, report features, and time frames for DCI.

SECTION 23A

23A. WORKERS' COMPENSATION INSURANCE – UNIT STATISTICAL REPORTS

23A.1 Introduction

This section details specific requirements for the features of workers' compensation annual statistical compilations using Unit Statistical Report data submitted by insurers to statistical agents and rating organizations. The basis for the annual compilations shown in this section is the Model Workers' Compensation Statistical Plan-Unit Statistical Reports that has been adopted by the NAIC.

23A.2 Current Unit Statistical Plan Reporting Requirements

The following data items are currently required on the Unit Statistical Report (Exhibits 10 and 11) by all of the workers' compensation statistical agents or rating organizations with the exceptions noted.

- Carrier Code (Identifies the insurer)
- Report Number
- Policy Effective and Expiration Date
- Risk ID Number (All states except CA, NJ, PA and DE)
- Exposure State
- Insured Name
- Policy Conditions (Identifies if assigned risk, interstate experience rated, or retrospective rated)
- Policy Number
- Exposure Coverage Code
- Exposure Class Code
- Exposure Amount (Usually amount of payroll)
- Manual Rate
- Premium Amount
- Expense Constant (All states except CA)
- Loss Constant (All states except WI)
- Premium Discount (Not applicable in CA or on any Retro Adjustment policies)
- Experience Modification
- Loss Condition Codes (Loss Coverage Code)
- Claim Injury Type
- Loss Class Code
- Indemnity Incurred
- Medical Incurred
- Number of Claims
- Claim Number
- Accident Date
- Claim Status
- Catastrophe Number

23A.3 New Unit Statistical Plan Reporting Requirements

The following new data elements will be reported by September 1997 on policies effective Jan. 1, 1996, and subsequent. ("NCCI" indicates that all states serviced by that organization will require the data elements.)

	<u>DE/PA</u>	<u>M</u>	<u>MI</u>	<u>M</u>	<u>NCC</u>	<u>NJ</u>	<u>N</u>	<u>WI</u>
▪ Alloc. Loss Adj. Exp. Incurred	*	*			*			*
▪ Allocated Loss Adj. Exp. Paid	X	X			X			X
▪ Attorney Fee Claimant		X						
▪ Attorney Fee Employer	X	X						
▪ Injury Description Code	X	X		X	X		X	
▪ Deductibles								
Type	X	X		X	X		X	
Aggregate Amount	X	X		X	X		X	
Amount Per Claim	X	X		X	X		X	
Indicator					X			
Percent	X	X		X	X		X	
Premium Credit Amount	X	X	X		X			
▪ Jurisdiction State	X	X		X	X	X	X	X
▪ Type of Settlement	X	X	X	X	X	X	X	X
▪ Indemnity Paid	X	X		X	X			X
▪ Medical Paid	X	X		X	X			X
▪ State Effective Date	X	X		X			X	
▪ Managed Care Org. (MCO)								
– Indicator (Policy)	X			X	X	X		
– Type	X			X	X	X		
▪ Voc. Rehab. Indicator	X	X	X	X	X			X
▪ Lump Sum Indicator	X	X						
▪ Fraudulent Claim Indicator					X			

* Reporting is optional if this data element is available.

23A.4 Who Reports Data: Reporting Standards for Insurers

The statutory requirement to report Unit Statistical Reports applies to all insurers licensed to write workers' compensation policies. The following reporting standards apply for Unit Statistical Reports:

Must be filed for each state for which exposure and premium are shown on the associated policy.

Must be filed no later than the twentieth month after policy effective month in accordance with the Model Workers' Compensation Statistical Plan and annually thereafter until all claims on the Unit Statistical Report are closed or, if an individual claim remains open or a closed claim reopens, until a total of five Unit Statistical Reports have been filed.

23A.5 Specific Report Features:

There are three types of Total Experience Annual Reports by state:

1. Total Experience Annual Report For All Industries
 - This report provides data for all industries by state, by policy year detailed by payroll, standard earned premium, and indemnity and medical incurred losses. (Exhibit 12)
 - Incurred indemnity and medical loss data is further displayed by Claim Injury Type (the type of injury displayed would vary based on the requirements of each individual state) with the associated claim count by type of injury. (Exhibit 13)
 - The report shows incurred losses valued at 18, 30, 42, 54 and 60 months after the effective month of the policy.
2. Total Experience Annual Report By Industry Group

This report provides the same information as the Total Experience Annual Report For All Industries except it is shown at an industry group level, e.g., manufacturing, construction, and other.

3. Total Experience Annual Report By Class

This report provides the same information as the Industry Group Annual Report except it is shown at an individual class code level which represents all employees performing the same type of job, e.g., carpenters, plumbers, etc.

Custom reports may be requested for any data items consistent with filed programs and statistical plans.

23A.6 Time Frame

Workers' compensation losses often take many years to be settled. The exposure bases must be audited after the policy expires and the losses have to be compared to the exposures that existed during the same time period. Because of these factors, the data required on Unit Statistical Reports are reported on a policy year basis and, therefore, reports derived from Unit Statistical Report data are on a policy year basis. Depending on the methodology used by the designated statistical agent or rating organization for a state, workers' compensation annual reports, using Unit Statistical Report data, are distributed between 24 to 30 months after the end of the policy year.

The time frame for custom reports should be discussed with the appropriate statistical agent or rating organization.

Exhibit 10

1st Unit Reports (U/Rs)—1st Reporting Level: (1) One U/R required for each state on policy. Both premium and losses are reported; (2) Premiums are only reported on first U/Rs not on subsequent U/Rs. Estimated premium cannot be used. Audited premium by class must be reported; (3) Losses are reported on both first and subsequent U/Rs. Each claim in the state that occurred during policy period must be reported (incurred indemnity and medical by claim plus totals); (4) first U/Rs are due 20 months after policy effective month; (5) Claim valuation first U/Rs—18 months after policy effective month. Gives company one to two months to correct claim errors and produce U/Rs.

REPORT	POLICY NUMBER					STATE	STATE NO.	CARRIER NAME		CARRIER NO.	CARD SERIAL NO.	ADM. FILE NO.			
1	017 C 41571 CCA					AL	01	Sydney Casualty		99999	123				
EFFECTIVE DATE	TERM	EXPIRATION DATE			INSURED	P. D. O. Refining Co.									
07-01-2003		07-01-2004				1 Main Street, Bristol, AL 07112									
COND.	97	98	99	00	01	02	03	04	OTHER						
	X								910765432						
EXP COV	CLASS CODE	EXPOSURE	MANUAL RATE	PREMIUM	CLAIM NUMBER	ACCIDENT DATE OR		CLASS CODE	I N J	INCURRED LOSSES		O P E N	C L O S E D	LOSS COV.	CAT. NO.
						NO OF CLAIMS				INDEMNITY	MEDICAL				
11	4740	1129040	3.36	37936	0-15000	07-22-2003		4740	1	79950	900	0		11	
11	8742	880950	0.57	5021	0-15001	08-02-2003		4740	9	9000	3000	0		11	
11	8810	175020	0.24	420	0-15002	09-25-2003		4740	9	1500	250	0		11	
					0-15003	10-09-2003		4740	5	350	150	1		11	
					0-15004	12-18-2003		4740	5	360	160	1		11	
					0-15005	03-07-2004		4740	9	1000	100	0		11	
					0-15006	04-10-2004		8810	5	650	150	1		11	
					0-15007	06-02-2004		8742	9	2500	1000	0		11	
					0-15008	06-28-2004		8742	5	500	10	1		11	
A - TOTAL SUBJECT PREMIUM				43377											
B - EXPERIENCE MODIFICATION				1.160											
C - TOTAL MODIFIED PREMIUM				(A)*(B)	50317										
D															
E															
F															
G															
RISK TOTALS	STD.	2185010	XXX	50317											
	OTHER		XXX	XXX											
	0063	PREMIUM DISCOUNT	XXX	(2987)											
	0900	EXPENSE CONSTANT		35	TOTALS	51	XXXX	X	95810	6610	X	XX	X		
DO NOT USE	PREM. SIZE	INDUSTRY GROUP	TYPE	INDUSTRY SCHED				KEYPUNCH #					VERIFIER #		
										(MU - 18166) ED. 1-2004					

Exhibit 11

Subsequent (2nd, 3rd, 4th, and 5th) Unit Reports (U/Rs)—2nd, 3rd, 4th, and 5th Reporting Level: (1) One required for each state on policy that had open claims on the previous U/R. Only claim information is reported (no premium info) on subsequent U/Rs; (2) Each open claim and previously closed claim with changes in incurred amounts or coding must be reported plus totals; (3) Subsequent U/Rs are due 32, 44, 56, and 68 months after policy effective month; (4) Only subsequent U/Rs due 32 and 44 months after policy effective month, in addition to first U/Rs, e.g., first, second, and third reporting levels, are used for experience modification calculation. The first and all subsequent U/Rs, i.e., all reporting levels, are used for ratemaking; (5) Claim valuation subsequent U/Rs—30, 42, 54 and 66 months after policy effective month.

REPORT	POLICY NUMBER				STATE	STATE NO.	CARRIER NAME			CARRIER NO.	REVISED SERIAL NO.	ADM. FILE NO.					
2	017 C 41571 CCA				AL	01	Sydney Casualty			99999	150						
EFFECTIVE DATE	TERM	EXPIRATION DATE			INSURED												
07-01-2003		07-01-2004			P. D. O. Refining Co. 1 Main Street, Bristol, AL 07112												
COND.	97	98	99	00	01	02	03	04	OTHER	ORIG. CARD SERIAL NO.							
X									910765432	10							
CLAIM NUMBER OR NUMBER OF CLAIMS PREV. REPORTED		ACCIDENT DATE OR REVISED	CLASS CODE	I N J	PREVIOUSLY REPORTED*				LOSS COV.	CAT. NO.	CLASS CODE	I N J	REVISED*		LOSS COV.	CAT. NO.	
		NUMBER OF CLAIMS			INCURRED LOSSES		O P E N S E E D					INCURRED LOSSES		O P E N S E E D			
					INDEMNITY	MEDICAL						INDEMNITY	MEDICAL				
0-15000		07-22-2003	4740	1	79950	900	0	11		4740	1	81200	900	0	11		
0-15001		08-02-2003	4740	9	9000	3000	0	11		4740	9	9500	3500	1	11		
0-15002		09-25-2003	4740	9	1500	250	0	11		4740	9	1500	300	1	11		
0-15003		10-09-2003	4740	5	350	150	1	11		4740	9	450	200	1	11		
0-15005		03-07-2004	4740	9	1000	100	0	11		4740	9	800	50	1	11		
0-15007		06-02-2004	4740	9	2500	1000	0	11		4740	6		90	1	11		
51		51	TOTAL		95810	6610	X	X	X	TOTAL		94960	6250	X	X	X	
DO NOT USE	PREVIOUSLY REPORTED				REVISED				* INDICATE INDIVIDUAL ITEMS WHERE THERE HAS BEEN A CHANGE IN ANY OF THE DATA PREVIOUSLY REPORTED. ALL "TOTALS" MUST INCLUDE ALL ITEMS INCLUDING THOSE THAT REMAIN UNCHANGED.								
	PR.SIZE	IND.GR.	TYPE	IND.SCHED.	PR.SIZE	IND.GR.	TYPE	IND.SCHED.									
										LOSS CARD (MU-18167) ED. 1-2004							

Exhibit 12

Sample – Workers’ Compensation Annual Report of Unit Statistical Reports Data

Note: The type of information displayed on this page is available from each of the workers’ compensation statistical agents/rating organizations. However, the way that the information is displayed here is a composite of all the statistical agents/rating organizations current reports. Custom reports should be discussed with the appropriate statistical agent or rating organization.

ANNUAL REPORT

STATE – XXX

**Total Experience – All Industries
Payroll, Premium and Losses By Year**

<u>YEAR</u>	<u>PAYROLL (000 OMITTED)</u>	<u>STANDARD EARNED PREMIUM</u>	<u>UNDERDEVELOPED INCURRED LOSSES</u>	<u>LOSS RATIOS (3) / (2)</u>
	(1)	(2)	(3)	
2000	\$59,088,588	\$1,343,625,234	\$1,011,958,390	0.753
2001	\$62,619,394	\$1,481,640,919	\$1,067,283,646	0.720
2002	\$66,802,667	\$1,706,923,514	\$1,174,246,770	0.688
2003	\$71,481,079	\$1,930,495,042	\$1,218,428,593	0.631
2004	\$74,331,299	\$2,102,157,195	\$1,056,254,975	0.502
ALL	\$334,323,027	\$8,564,841,904	\$5,528,172,374	0.645

Exhibit 13

Sample – Workers’ Compensation Annual Report of Unit Statistical Reports Data

Note: The type of information displayed on this page is available from each of the workers’ compensation statistical agents/rating organizations. However, the way that the information is displayed here is a composite of all the statistical agents/rating organizations current reports. Custom reports should be discussed with the appropriate statistical agent or rating organization.

**Incurred Losses as Reported By Type of Injury (1)
(000 Omitted In Dollars Columns)**

LOSSES WITH INDEMNITY

YEAR	ALL LOSSES			DEATH			PERM TOTAL			PERM PARTIAL			TEMP TOTAL			TEMP PARTIAL			LOSSES WITH MEDICAL ONLY		
	IND. DOLLARS	MED. DOLLARS	NO. CLAIMS	IND. DOLLARS	MED. DOLLARS	NO. CLAIMS	IND. DOLLARS	MED. DOLLARS	NO. CLAIMS	IND. DOLLARS	MED. DOLLARS	NO. CLAIMS	IND. DOLLARS	MED. DOLLARS	NO. CLAIMS	IND. DOLLARS	MED. DOLLARS	NO. CLAIMS	IND. DOLLARS	MED. DOLLARS	NO. CLAIMS
2000	\$667,899	\$344,056	207	\$34,126	\$16,753	574	\$138,182	\$67,836	6,730	\$306,844	\$150,636	7,708	\$47,564	\$23,350	52,653	\$141,183	\$69,310	215,154	\$16,171		
2001	\$689,235	\$378,046	183	\$29,869	\$15,613	554	\$129,239	\$67,556	7,307	\$340,178	\$177,819	7,793	\$47,867	\$25,021	53,231	\$142,082	\$74,269	218,946	\$17,768		
2002	\$735,557	\$438,685	185	\$29,015	\$16,491	416	\$98,166	\$55,794	9,108	\$399,837	\$227,255	8,281	\$52,552	\$29,869	56,570	\$155,987	\$88,658	236,355	\$20,618		
2003	\$731,037	\$437,387	176	\$34,867	\$22,154	275	\$59,938	\$38,083	11,995	\$425,616	\$270,424	8,520	\$53,075	\$33,722	58,200	\$157,541	\$100,097	250,956	\$22,907		
2004	\$567,649	\$488,593	136	\$24,108	\$19,775	103	\$21,318	\$17,482	11,772	\$302,564	\$248,189	8,360	\$55,354	\$45,406	57,105	\$164,305	\$134,777	245,599	\$22,964		
ALL	\$3,391,377	\$2,136,767	887	\$151,985	\$90,786	1,922	\$446,843	\$246,751	46,912	\$1,775,039	\$1,074,323	40,662	\$256,412	\$157,368	277,759	\$761,098	\$467,111	1,167,010	\$100,428		

(1) TYPE OF INJURY WILL VARY ACCORDING TO EACH INDIVIDUAL STATE'S REQUIREMENT.

Model Workers' Compensation Statistical Plan for Unit Statistical Reports

LIST OF CURRENT DATA ITEMS

1. Carrier Code
2. Report Number
3. Policy Effective and Expiration Date
4. Risk ID Number
5. Exposure State
6. Insured Name
7. Policy Conditions
8. Policy Number
9. Exposure Coverage Code
10. Exposure Class Code
11. Exposure Amount
12. Manual Rate
13. Premium Amount
14. Expense Constant
15. Loss Constant
16. Premium Discount
17. Experience Modification
18. Loss Condition Code (Loss Coverage Code)
19. Claim Injury Type
20. Loss Class Code
21. Indemnity Incurred
22. Medical Incurred
23. Number of Claims
24. Claim Number
25. Accident Date
26. Claim Status
27. Catastrophe Number

LIST OF NEW DATA ITEMS (Reported on Policies Effective 1/1/96)

28. Allocated Loss Adjustment Expense Incurred
29. Allocated Loss Adjustment Expense Paid
30. Attorney Fee Claimant
31. Attorney Fee Employer
32. Injury Description Code
33. Deductibles
34. Jurisdiction State
35. Type of Settlement
36. Indemnity Paid
37. Medical Paid
38. State Effective Date
39. Managed Care Org. (MCO)
40. Vocational Rehabilitation Indicator
41. Lump Sum Indicator
42. Fraudulent Claim Indicator

CURRENT DATA ITEMS

1. Carrier Code

A unique code assigned by the statistical agent to each insurance company that supplies data.

2. Report Number

A code that indicates the number of times data has been reported on a policy, excluding correction reports, that corresponds to the number of claim valuations.

3. Policy Effective and Expiration Date

The inception date of the policy and the end date of the policy as shown on the policy information page. However, if the policy was canceled, the cancellation date should be reflected as the expiration date.

4. Risk ID Number (All states except CA, NJ, PA and DE)

A code assigned by the statistical agent to uniquely identify insureds that are subject to interstate or intrastate rating.

5. Exposure State

A code that identifies the state of the employer's (insured's) facility. The state under which exposure is rated on the policy.

6. Insured Name

The name of the person or business with whom an insurance contract is made and who is specifically designated by name in Item 1 of the Policy Information Page.

7. Policy Conditions

Codes that identify any special conditions(s) that apply to the policy.

- Assigned Risk
- Interstate experience rated
- Mid term canceled policy
- Retrospective rated
- Three year fixed rate policy
- Estimated exposures

8. Policy Number

The alpha/numeric code assigned by the carrier that uniquely identifies the policy that has been issued to the insured. This number must be identical to the policy number shown on the Policy Information Page.

9. Exposure Coverage Code

A code that identifies the exposure coverage associated with the manual class code.

- State
- United States Longshore and Harbor Act (USL&H)
- other federal

10. Exposure Class Code

A code used in rating that is assigned to a type of worker based on the nature of job he or she performs or a statistical code as defined by the various statistical agents.

Individual classification experience shall be maintained in accordance with the classification requirements of the various statistical agents.

11. Exposure Amount

The measurement used to determine how much premium should be charged to the insured. This measurement is generally the final audited payroll amount, in whole dollars, for the exposure class codes covered by the policy.

12. Manual Rate

The charge per unit of exposure for a specific exposure class code.

13. Premium Amount

The premium for an exposure class normally developed by multiplying unit of exposure by the manual rate, or from the premium assigned to a specific statistical code.

14. Expense Constant (Amount) (All states except CA)

A flat dollar charge added to the Total Standard Premium to cover expenses regardless of the size of the risk. On a multistate policy, the charge is assigned to the state with the highest expense constancy.

15. Loss Constant (Amount) (All states except WI)

A flat premium charge applied to smaller sized policies.

16. Premium Discount (Amount)

Not applicable in California or for Retro Adjustment policies.

The amount deducted from Total Standard Premium in recognition of the smaller relative expense of servicing large policies.

17. Experience Modification

A factor applied to subject premium to reflect a risk's variation from the average risk within the same class code. Using the risk's past experience, the experience modification is determined by comparing the actual losses to expected losses.

18. Loss Condition Code (Loss Coverage Code)

A code that identifies:

- The act under which coverage is provided:
 - State
 - United States Longshore & Harbor Workers' Act (USL&H)
 - Federal Coal Mine Health & Safety Act
 - Maritime/Admiralty
 - Federal Employees Liability Act (FELA)
- The cause of the loss:
 - Trauma
 - occupational disease
 - Cumulative injury
- The basis of liability:
 - Workers' Compensation only
 - Employers Liability only
 - Workers' Compensation and Employers Liability
 - Liability Over
- Whether reimbursement from a third party was received by the carrier.
- Whether the loss involves vocational rehabilitation benefits.
- Whether the loss involves a settlement and, if so, what kind (effective 9/97)
- Whether the benefits are being paid under the statutes of the exposure state.

19. Claim Injury Type (varies by state)

A code that identifies the provision(s) of the law under which benefits are paid or expected to be paid.

- Death
- Permanent Total Disability
- Permanent Partial Disability
- Temporary Total Disability
- Temporary Partial Disability
- Medical Only

20. Loss Class Code

The class code under which the payroll of the injured worker was reported.

21. Indemnity Incurred

The whole dollar amount paid to date and expected to be paid in the future (minus recoveries from third parties) to an injured employee and/or dependent because of the employee's lost wages or inability to work.

22. Medical Incurred

The whole dollar amount paid to date and expected to be paid in the future (minus recoveries from third parties) for medical or hospital treatment to an injured employee because of a work-related injury.

23. Number of Claims (Grouped Claims)

Number of claims reported by the insured by Class Code and Injury Type and the total number of claims reported by the insured for the state.

24. Claim Number

Claim number assigned to the individual loss by the insurer/self-insurer for the life of that loss (except for grouped claims).

25. Accident Date

The date on which the accident occurred (except for grouped claims)

26. Claim Status

Claim status (open/closed).

27. Catastrophe Number

Catastrophe number. A code that identifies any accident (one occurrence) resulting in two or more reported claims.

NEW DATA ITEMS (Reported on Policies Effective 1/1/96)

28. Allocated Loss Adjustment Expense Incurred

Specific expenses in whole dollars that have been paid to date and expected to be paid in the future by an insurance company when handling a claim which can be directly allocated to that particular claim. This amount includes:

- Attorney fees
- Court resolution expenses
 - medical examinations to determine the extent of the carrier's liability, degree of permanency or length of disability
 - expert medical or other testimony
 - autopsy
 - witnesses and summonses
 - copies of documents such as birth/death certificates or medical treatment records; arbitration fees
 - surveillance
 - appeal bond costs and filing fees

Medical cost containment expenses

- bill auditing
 - hospital and other treatment utilization reviews;
 - preferred provider network/organization expenses;
 - medical fee review panel expenses
- Expenses not defined as losses that are directly allocated to handling a claim that are required to be performed by statute or regulation.

This amount does NOT include: salaries, overhead and traveling expenses; fees paid to independent claims professionals or claimant attorneys; indemnity and/or medical expenses.

29. Allocated Loss Adjustment Expense Paid

Specific expenses in whole dollars paid to date by an insurance company when handling a claim that can be directly allocated to that particular claim. This paid amount includes and excludes the same categories specified in ALAE incurred above.

30. Attorney Fee Claimant

Amount incurred by the insurance company for the claimant's legal representation during the settlement of a workers' compensation claim. (This amount should include all fees due the claimant's attorney pursuant to proceedings before any claim resolution board and lump sum settlements).

Note: "Attorney Fee Claimant" is only available to insurers in those few states that require insurers to distribute two checks – one check for the claimant minus attorney fees and one check for the claimant's lawyer for legal fees charged to claimant.

31. Attorney Fee Employer

Amount incurred by the insurance company for the employer's legal representation during the settlement of a Workers' Compensation claim.

32. Injury Description Code

A code comprised of three individual data elements that describes the injury:

- Part of body
- Nature of injury
- Cause of Injury

33. Deductibles

- Type
A code that identifies the way in which a deductible is applied for a policy/state (Per accident, per claim, per policy, percentage of claim cost, percentage of premium, medical only, indemnity only, indemnity and medical combined, coinsurance, etc).
- Aggregate Amount
The maximum aggregate amount of claim costs which would be paid by the insured.
- Amount Per Claim
The aggregate amount of claim costs which are paid by the insured for a single claim.
- Indicator
A code that identifies whether the deductible has been fully recovered.
- Percent
A code that identifies the percentage of the deductible as defined by Deductible Type.
- Premium Credit Amount
The amount of premium reduction calculated by applying the deductible factor to the appropriate premium (Two premium credit statistical codes are used: One for subject to experience rating the other for not subject to experience rating).

34. Jurisdiction State

The governing body/territory, who will administer the claim and whose statutes will apply to the claim adjustment process.

35. Type of Settlement

A code that describes the basis on which the claim was settled, i.e., stipulated award, compromise, judicial award, etc.

36. Indemnity Paid

The whole dollar amount paid to an injured employee and/or dependent as of the loss valuation date due to the employee's lost wages or inability to work.

37. Medical Paid

The whole dollar amount paid as of the loss valuation date for medical or hospital treatment to an injured employee because of a work-related injury.

38 State Effective Date

The date coverage began in a state. This is for multistate policies when states are added mid-term.

39. Managed Care Organization (MCO)

- Indicator

A code that identifies a risk involved in an authorized managed care program designed to manage the cost and utilization of medical care associated with claims.

A premium credit amount, identified by a unique class code would reflect any premium reduction amount due to the use of an MCO by an insurer or claimant.

- Type

A code that identifies the type of organization that will administer the applicable medical losses of the claim.

40. Vocational Rehabilitation Indicator

A code that indicates whether or not the claim includes vocational rehabilitation payments.

41. Lump Sum Indicator

A code that indicates whether or not a lump sum agreement exists for the claim.

42. Fraudulent Claim Indicator

A code that indicates whether any fraud is indicated in the claim.

SECTION 23B

23B. WORKERS' COMPENSATION – CALLS FOR AGGREGATE EXPERIENCE

23B.1 Introduction

This section details specific requirements for the features of workers' compensation annual statistical compilations using the Calls for Aggregate Experience submitted by all insurers to statistical agents or rating organizations. The basis for the annual compilations shown in this section is the Workers' Compensation Statistical Plan-Calls for Aggregate Experience that has been adopted by the NAIC.

23B.2 Statistical Plan Reporting Requirement

The following Calls for Aggregate Experience required to be reported by all insurers to the appropriate workers' compensation statistical agent or rating organization.

- Net Direct Written Premium Calls (Except New York)
- Semiannual Calendar Year Call
- Policy Year Call for Voluntary Business
- Policy Year Call for Assigned Risk Business
- Calendar/Accident Year Call for Voluntary Business
- Calendar/Accident Year Call for Assigned Risk Business
- Premium By Size of Policy Call
- Reconciliation Call
- 'F' Classification Policy Year Call
- Loss Adjustment Expense Call
- Large Deductible Policy Year Call
- Large Deductible Calendar/Accident Year Call
- Call for Quarterly Reporting of Total Market Direct Written Premium
- Supplemental Call for Schedule Rating Premium Adjustments

23B.3 Who Reports Data: Reporting Standards for Insurers

The statutory requirement to report Calls for Aggregate Experience applies to all insurers licensed to write workers' compensation policies.

Except for the semiannual and quarterly calls, the Calls for Aggregate Experience are to be filed annually in accordance with the Model Workers' Compensation Statistical Plan.

23B.4 Specific Report Features

Using data from the Calls for Aggregate Experience, the statistical agents and rating organizations produce a series of annual reports by state. The two most widely used annual reports are the Workers' Compensation Calendar/Accident Year Experience Annual Report (Exhibit 14) and the Workers' Compensation Policy Year Experience Annual Report (Exhibit 15). These reports have the following specific features:

- The Calendar/Accident Year Experience Annual Report
 - The 12 most recent accident year underwriting results are detailed by net earned premium, amount of indemnity and medical losses, incurred loss ratio and the underwriting result.
 - The loss ratios are on a net premium basis. Standard earned premium at company level is included, although it is not used in the calculation of the underwriting results. Only five years of company level earned premium are available. Prior to that standard earned premium was reported at Designated Statistical Reporting (DSR) level. In accordance with the instructions on the call, underground coal mine and “F” classification experience are excluded. The indemnity and medical losses are developed to ultimate and have been adjusted to reflect the average level of assessments included in each state’s rates for each year. Each state’s losses are developed using the methodology utilized in the state’s latest rate review.
 - The incurred losses for the twelve years shown on the report are valued as of December 31 of the previous calendar year.
- The Policy Year Experience Annual Report
 - The 12 most recent accident year underwriting results are detailed by net earned premium, amount of indemnity and medical losses, incurred loss ratio and the underwriting result.
 - The loss ratios are on a net premium basis. Standard earned premium at company level is included, although it is not used in the calculation of the underwriting results. It is developed to a fifth report. In the past, standard earned premium was reported at Designated Statistical Reporting (DSR) level. In accordance with the instructions on the call, underground coal mine and “F” classification experience are excluded. The indemnity and medical losses are developed to ultimate and have been adjusted to reflect the average level of assessments included in each state’s rates for each year. Each state’s losses are developed using the methodology utilized in the state’s latest rate review.
 - The incurred losses for the twelve years shown on the report are valued as of December 31 of the previous calendar annual year.

Custom reports may be requested for any data items consistent with filed programs and statistical plans.

23B.5 Time Frame

Depending on the methodology used by the designated statistical agent or rating organization for a state, the annual reports based on Calls for Aggregate Experience are distributed between ten and twelve months after the end of the calendar year of the data being reported. The time frame for custom reports should be discussed with the appropriate statistical agent or rating organization.

Exhibit – 14
Workers' Compensation Calendar-Accident Year Experience
Valued as of December 31, 2003
State – XXXXXX

	(1) STD. EARNED COMPANY PREMIUM	(2) NET EARNED PREMIUM	(3) INDEMNITY LOSSES	(4) MEDICAL LOSSES	(5) INCURRED LOSSES	(6) LOSS RATIO (5)/(2)	(7) EXPENSE RATIO	(8) DIVIDEND RATIO	(9) UNDER- RESULTS 1,000- ((6)+(7)+(8))
2004 (1st REPORT)	894,654,202	921,207,863	461,452,244	555,036,829	1,016,489,073	1.103	.309	.032	(0.444)
2003 (2nd REPORT)	1,257,538,080	1,268,713,619	629,218,310	715,771,482	1,344,989,792	1.060	.301	.031	(0.392)
2002 (3rd REPORT)	1,628,321,862	1,629,821,931	947,884,467	936,443,828	1,884,328,295	1.156	.295	.020	(0.471)
2001 (4th REPORT)	1,459,319,007	1,444,002,862	1,101,721,863	982,710,336	2,084,432,199	1.444	.294	.029	(0.767)
2000 (5th REPORT)	1,226,354,895	1,165,013,368	982,531,581	896,028,010	1,878,559,591	1.612	.293	.036	(0.941)
1999 (6th REPORT)	(A)	1,075,659,345	794,544,012	729,992,879	1,524,536,891	1.417	.298	.043	(0.758)
1998 (7th REPORT)	(A)	947,809,008	670,080,858	615,580,750	1,285,661,608	1.356	.302	.037	(0.695)
1997 (8th REPORT)	(A)	754,158,995	569,800,575	534,068,183	1,103,868,758	1.464	.311	.040	(0.815)
1996 (9th REPORT)	(A)	586,836,982	449,419,425	444,379,460	893,798,885	1.523	.303	.043	(0.869)
1995 (10th REPORT)	(A)	453,716,654	326,607,385	381,256,073	707,863,458	1.560	.295	.061	(0.916)
1994 (11th REPORT)	(A)	432,063,210	282,222,667	281,286,410	563,509,077	1.304	.278	.066	(0.648)
1993 (12th REPORT)	(A)	505,465,598	269,342,601	260,572,939	529,915,540	1.048	.281	.045	(0.374)

(A) Standard earned premium at company level is included for the most recent five years although it is not used in the calculation of the calculation of the underwriting results. Only five years of company level premium are available. In the past, standard earned premium was reported at Designated Statistical Reporting (DSR) level.

(1) Standard Earned Premium at Company Level

From the Calendar-Accident Year Call for compensation experience by state. Standard earned premium is reported at company level for all states.

(3) & (4) Indemnity and Medical Losses

From the Calendar-Accident Year Call for compensation experience by state. Indemnity and medical losses have been separately developed to an ultimate basis using the methodology utilized in the state's rate review.

(7) Expense Ratio

Combined countrywide private carrier data (38 states) from the Calendar Year Expense Data By State Call is used for production costs, general expense and claim adjustment expense. Ratio is then adjusted to reflect individual state taxes.

(8) Dividend Ratio

Historical data from A.M. Best Company on a calendar year basis.

(2) Net Earned Premium

From the Calendar-Accident Year Call for compensation experience by state. Net (direct) earned premium is reported at company rate level after the application or premium discounts, retrospective rating etc.

Exhibit – 15
Workers' Compensation Policy Year Experience
Valued as of December 31, 2003

State – XXXXXX

	(1) STD. EARNED COMPANY PREMIUM	(2) NET EARNED PREMIUM	(3) INDEMNITY LOSSES	(4) MEDICAL LOSSES	(5) INCURRED LOSSES	(6) LOSS RATIO (5)/(2)	(7) EXPENSE RATIO	(8) DIVIDEND RATIO	(9) UNDER- RESULTS 1,000- ((6)+(7)+(8))
2004 (1st REPORT)	1,060,280,719	1,074,135,605	552,908,073	646,324,408	1,199,232,481	1.116	.304	.031	(0.451)
2003 ((2nd REPORT)	1,458,252,208	1,387,213,045	766,874,691	784,726,821	1,551,601,512	1.119	.297	.024	(0.440)
2002 (3rd REPORT)	1,535,438,977	1,506,242,646	1,061,313,565	986,465,404	2,047,778,969	1.360	.294	.025	(0.679)
2001 (4th REPORT)	1,368,158,646	1,355,683,858	1,056,997,334	976,952,159	2,033,949,493	1.500	.293	.033	(0.826)
2000 (5th REPORT)	1,182,321,304	1,144,869,414	885,657,439	790,197,926	1,675,855,365	1.464	.296	.040	(0.800)
1999 (6th REPORT)	1,078,533,235	1,034,698,256	716,013,651	673,208,144	1,389,221,795	1.343	.300	.039	(0.682)
1998 (7th REPORT)	889,418,356	875,517,275	604,418,159	564,116,320	1,168,534,479	1.335	.307	.039	(0.681)
1997 (8th REPORT)	690,157,936	671,896,439	500,658,616	471,114,639	971,773,315	1.446	.306	.042	(0.794)
1996 (9th REPORT)	540,986,906	529,387,132	365,969,511	398,906,791	764,876,302	1.445	.298	.053	(0.796)
1995 (10th REPORT)	483,207,914	472,206,786	300,414,680	335,275,252	635,689,932	1.346	.285	.064	(0.695)
1994 (11th REPORT)	513,111,390	477,623,093	284,368,153	269,097,024	553,465,177	1.159	.280	.053	(0.492)
1993 (12th REPORT)	626,987,772	538,961,374	231,444,806	224,891,912	455,836,718	0.846	.270	.045	(0.161)

(1) Standard Earned Premium at Company Level

From the Policy Year Call for compensation experience by state. Standard earned premium is reported at company level for all states. Standard earned premium is developed to a fifth report.

(2) Net Earned Premium

From the Policy Year Call for compensation experience by state. Net (direct) earned premium is reported at company rate level after the application of premium discounts, retrospective rating, etc. Net earned premium is developed to a fifth report.

(3) & (4) Indemnity and Medical Losses

From the Policy Year Call for compensation experience by state. Indemnity and medical losses have been separately developed to an ultimate basis using the methodology utilized in the state's rate review.

(7) Expense Ratio

Combined countrywide private carrier data (38 states) from the calendar year expense data by state is used for production costs, general expense and claim adjustment expense. Policy year expense ratios are then calculated using successive calendar years. Ratio is then adjusted to reflect individual state taxes.

(8) Dividend Ratio

Historical data from A.M. Best Company on a calendar year basis. Policy year dividend ratios are then calculated using successive calendar years.

**Model Workers' Compensation Statistical Plans for Calls for Aggregate
Experience**

Net Direct Written Premium (Except NY)

LIST OF DATA ITEMS

1. Company Identifier
2. Exposure State
3. Amounts
4. Submitted Identifier

DATA ITEMS

1. Company Identifier
 - Name of the Carrier
 - A unique code assigned by the bureau that identifies the insurance company.

2. Exposure State

A code that identifies the state of the employer's (insured's) facility. The state under which exposure is rated on the policy.

3. Amounts

Identifies the following items and the respective amounts for the calendar year due:

- Net direct written premium
- Net direct USL&H written premium (Except CA)
- Net direct National Defense Plans written premium (Except CA)
- Net direct excess workers' compensation written premium
- Direct written premium total shown on Page 8 of Annual Statement

4. Submitted Identifier

- Name of submitter
- Title
- Telephone number
- Date of submission

**Model Workers' Compensation Statistical Plans
for Calls for Aggregate Experience**

Semiannual Calendar Year Call

LIST OF DATA ITEMS

1. Company Identifier
2. Exposure State
3. Amounts
4. Submitter Identifier

DATA ITEMS

1. Company Identifier

- Name of the Carrier
- A unique code assigned by the bureau that identifies the insurance company.

2. Exposure State

A code that identifies the state of the employer's (insured's) facility. The state under which exposure is rated on the policy.

3. Amounts

Identifies the following items and the respective amounts for the calendar year:

- Earned standard premium at bureau designated statistical reporting level
- Earned standard premium at company level
- Net earned standard premium
- Incurred losses

4. Submitter Identifier

- Name of the submitter
- Title
- Telephone number
- Date of submission

**Model Workers' Compensation Statistical Plans
for Calls for Aggregate Experience**

**Policy Year Call
Reported separately for Voluntary and Assigned Risk Business**

LIST OF DATA ITEMS

1. Company Identifier
2. Amounts
3. Exposure State
4. Policy Year
5. Claim Counts
6. Submitter Identifier

DATA ITEMS

1. Company Identifier
 - Carrier name
 - A unique code assigned by the bureau that identifies the insurance company.

2. Amounts

Identifies the following items and the respective amounts accumulated by policy year:

- Total standard earned premium at the rating organization's designated statistical reporting level (except CA)
- Total standard earned premium at company level
- Total net earned premium
- Total incurred indemnity and medical losses
- Total paid indemnity and medical losses
- Total paid indemnity and medical on closed claims
- Total outstanding (excluding IBNR) indemnity and medical losses:
 - Bulk
 - Case
- Total IBNR indemnity and medical losses
- Total allocated loss adjustment expense:
 - Paid (Except CA)
 - Case (Except CA)
 - Incurred
 - Bulk/IBNR

3. Exposure State

A code that identifies the state of the employer's (insured's) facility. The state under which exposure is rated on the policy.

4. Policy Year

The year in which the policy was effective.

5. Claim Counts

The number of incurred indemnity claims is reported, separately for accumulated closed and open claims, by each policy year and in total.

6. Submitter Identifier

- Name of Submitter
- Title
- Telephone number
- Date submitted

**Model Workers' Compensation Statistical Plans
for Calls for Aggregate Experience**

**Calendar/Accident Year Call
Reported separately for Voluntary and Assigned Risk Business**

LIST OF DATA ITEMS

1. Company Identifier
2. Amounts
3. Exposure State
4. Calendar/Accident Year
5. Claim Counts
6. Submitter Identifier

DATA ITEMS

1. Company Identifier
 - Carrier name
 - A unique code assigned by the bureau that identifies the insurance company.

2. Amounts

Identifies the following items and the respective amounts accumulated for each calendar/accident year:

- Total standard earned premium at the rating organization's designated statistical reporting level
- Total standard earned premium at company level
- Total net earned premium
- Total incurred indemnity and medical losses
- Total paid indemnity and medical losses
- Total paid indemnity and medical on closed claims
- Total outstanding (excluding IBNR) indemnity and medical losses:
 - Bulk
 - Case
- Total IBNR Indemnity and medical losses
- Total allocated loss adjustment expense:
 - Paid
 - Case
 - Incurred
 - Bulk/IBNR

3. Exposure State

A code that identifies the state of the employer's (insured's) facility. The state under which exposure is rated on the policy.

4. Calendar/Accident Year

The year in which the accident occurred.

5. Claim Counts

The number of incurred indemnity claims, reported separately for accumulated closed and open claims, by each calendar/accident year and in total.

6. Submitter Identifier

- Name of Submitter
- Title
- Telephone number
- Date submitted

**Model Workers' Compensation Statistical Plans
for Calls for Aggregate Experience**

Premium By Size of Policy Call

LIST OF DATA ITEMS

1. Company Identifier
2. Policy Period
3. Amounts
4. Policy Counts
5. Submitter Identifier

DATA ITEMS

1. Company Identifier
 - Name and address of the Carrier
 - A unique code assigned by the bureau that identifies the insurance company.
 - Type of Insurer

2. Policy Period

Identifies the policy effective and expiration dates for the data reported.

3. Amounts

Identifies the following items and the respective amounts for the policy period:

- Direct Policy Standard Earned Premium at the Rating Organization's Designated Statistical Reporting Level
- Direct Countrywide Standard Earned Premium at Company Level

4. Policy Counts

Identifies the volume of policies at each Policy Standard Earned Premium at the Rating Organization's Designated Statistical Reporting Level

5. Submitter Identifier

- Name of the submitter
- Title
- Telephone Number
- Date of Submission

**Model Workers' Compensation Statistical Plans
for Calls for Aggregate Experience**

Reconciliation Call

LIST OF DATA ITEMS

1. Company Identifier
2. Exposure State
3. Amounts

DATA ITEMS

1. Company Identifier

- Name and address of the carrier
- A unique code assigned by the bureau that identifies the insurance company.

2. Exposure State

A code that identifies the state of the employer's (insured's) facility. The state under which exposure is rated on the policy.

3. Amounts

Identifies the following items and the respective amounts for the calendar year:

- Data Reported to statistical agent or rating organization
 - Net direct earned premium from the Calendar Year Call – excluding large deductible policies (Industrial Classes)
 - Net direct earned premium from the 'F' Classification Calendar Year Call
 - Net direct earned premium from the Underground Coal Mine Call
 - Direct incurred losses from the Calendar Year Call – excluding large deductible policies (Industrial Classes)
 - Direct incurred losses from the 'F' Classification Calendar Year Call
 - Direct incurred losses from the Underground Coal Mine Call
- Reconciliation Items
 - Net direct earned premium for calendar year National Defense Projects experience
 - Net direct earned premium for calendar year experience of Large Deductible policies (on a net basis)
 - Direct incurred losses for calendar year experience of Large Deductible policies (on a net basis)
 - Direct incurred losses for calendar year experience of Small Deductible policies – difference between gross losses reported and net losses reported on Annual Statement
 - Net direct earned premium for calendar year experience on Excess Policies

- Direct incurred losses for calendar year National Defense Projects experience
- Direct incurred losses for calendar year experience on Excess Policies
- Annual Statement
 - Net direct earned premium from Page 14, line 16, column 3
 - Direct incurred losses from Page 14, line 16, column 7

**Model Workers' Compensation Statistical Plans
for Calls for Aggregate Experience**

'F' Classification Policy Year Call

LIST OF DATA ITEMS

1. Company Identifier
2. Exposure State
3. Policy Year
4. Amounts
5. Submitter Identifier

DATA ITEMS

1. Company Identifier
 - Name and address of the carrier
 - A unique code assigned by the bureau that identifies the insurance company

2. Exposure State

A code that identifies the state of the employer's (insured's) facility. The state under which exposure is rated on the policy.

3. Policy Year

The year in which the policy was effective.

4. Amounts

Identifies the following items and the respective amounts for the calendar year:

- Total standard earned premium at bureau designated statistical reporting level accumulated by policy year
- Total policy year standard earned premium at bureau designated statistical reporting level through current year
- Total policy year standard earned premium at bureau designated statistical reporting level through prior year
- Total standard earned premium at bureau designated statistical reporting level for current calendar year
- Total standard earned premium at company level accumulated by policy year
- Total policy year standard earned premium at company level through current year
- Total policy year standard earned premium at company level through prior year
- Total standard earned premium at company level for current calendar year
- Total net earned premium accumulated by policy year
- Total policy year net earned premium through current year
- Total net earned premium through prior year

- Total net earned premium for current calendar year
- Total paid losses by policy year
- Total policy year paid losses through current year
- Total policy year paid losses through prior year
- Total paid losses for current calendar year
- Total outstanding losses excluding IBNR accumulated by policy year
- Total policy year outstanding losses excluding IBNR through current year
- Total policy year outstanding losses excluding IBNR through prior year
- Total outstanding excluding IBNR for current calendar year
- Total IBNR losses accumulated by policy year
- Total policy year IBNR losses through current year
- Total policy year IBNR losses through prior year
- Total IBNR losses for current calendar year
- Total incurred losses including IBNR accumulated by policy year
- Total policy year incurred losses including IBNR through current year
- Total policy year incurred losses including IBNR through prior year
- Total incurred losses including IBNR for current calendar year

5. Submitter Identifier

- Name of the submitter
- Title
- Telephone Number
- Date of Submission

**Model Workers' Compensation Statistical Plans
for Calls for Aggregate Experience**

Loss Adjustment Expense Call

LIST OF DATA ITEMS

1. Company Identifier
2. Accident Year
3. Amounts
4. Submitter Identifier

DATA ITEMS

1. Company Identifier

- Name and address of the Carrier
- A unique code assigned by the bureau that identifies the insurance company.

2. Accident Year

The year in which the accident occurred.

3. Amounts

Identifies the following items and the respective amounts for the calendar year:

- Total losses paid accumulated by accident year¹
- Total accident year losses paid through current year¹
- Total accident year losses paid through prior year¹
- Total losses paid for current calendar year¹
- Total losses unpaid (outstanding & IBNR) accumulated by accident year¹
- Total accident year losses unpaid (outstanding & IBNR) through current year¹
- Total accident year losses unpaid (outstanding & IBNR) through prior year¹
- Total losses unpaid (outstanding & IBNR) for current calendar year¹
- Total direct allocated loss adjustment expenses paid accumulated by accident year¹
- Total accident year direct allocated loss adjustment expenses pd through current year¹
- Total accident year direct allocated loss adjustment expenses paid through prior year¹
- Total direct allocated loss adjustment expenses paid for current calendar year¹
- Total direct allocated loss adjustment expenses unpaid (outstanding & IBNR) accumulated by accident year¹
- Total accident year direct allocated loss adjustment expenses unpaid (outstanding & IBNR) through current year¹
- Total accident year direct allocated loss adjustment expenses unpaid (outstanding & IBNR) through prior year¹

¹ Reported separately by all losses and, also, by losses for Large Deductible policies (net basis)

- Total direct allocated loss adjustment expense unpaid (outstanding & IBNR) for current calendar year
- Total direct unallocated loss adjustment expense paid accumulated by accident year
- Total accident year direct unallocated loss adjustment expenses paid through current year
- Total accident year direct unallocated loss adjustment expenses paid through prior year
- Total direct unallocated loss adjustment expenses paid for current calendar year
- Total direct unallocated loss adjustment expenses unpaid (outstanding & IBNR) accumulated by accident year
- Total accident year direct unallocated loss adjustment expenses unpaid (outstanding & IBNR) through current year
- Total accident year direct unallocated loss adjustment expenses unpaid (outstanding & IBNR) through prior year
- Total direct unallocated loss adjustment expenses unpaid (outstanding & IBNR) for current calendar year
- Total loss adjustment expense paid accumulated by accident year
- Total accident year loss adjustment expense paid through current year
- Total accident year loss adjustment expense paid through prior year
- Total loss adjustment expense paid for current calendar year
- Total loss adjustment expense unpaid accumulated by accident year
- Total accident year loss adjustment expense unpaid through current year
- Total accident year loss adjustment expense unpaid through prior year
- Total loss adjustment expense unpaid for current calendar year

4. Submitter Identifier

- Name of the submitter
- Title
- Telephone Number
- Date of Submission

**Model Workers' Compensation Statistical Plans
for Calls for Aggregate Experience**

Large Deductible Policy Year Call

LIST OF DATA ITEMS

1. Company Identifier
2. Exposure State
3. Policy Year
4. Amounts
5. Claim Counts
6. Submitter Identifier

DATA ITEMS

1. Company Identifier

- Name and address of the Carrier
- A unique code assigned by the bureau that identifies the insurance company.

2. Exposure State

A code that identifies the state of the employer's (insured's) facility. The state under which exposure is rated on the policy.

3. Policy Year

The year in which the policy was effective.

4. Amounts

Identifies the following items and the respective amounts for the calendar year:

- Total standard earned premium at bureau designated statistical reporting level accumulated by policy year
- Total policy year standard earned premium at bureau designated statistical reporting level through current year
- Total policy year standard earned premium at bureau designated statistical reporting level through prior year
- Total standard earned premium at bureau designated statistical reporting level for current calendar year
- Total standard earned premium at company level accumulated by policy year
- Total policy year standard earned premium at company level through current year
- Total policy year standard earned premium at company level through prior year
- Total standard earned premium at company level for current calendar year
- Total net earned premium accumulated by policy year
- Total policy year net earned premium through current year

- Total policy year net earned premium through prior year
- Total net earned premium for current calendar year
- Total losses paid accumulated by policy year
- Total policy year losses paid through current year
- Total policy year losses paid through prior year
- Total losses paid for current calendar year
- Total incurred losses outstanding excluding IBNR accumulated by policy year
- Total policy year incurred losses outstanding excluding IBNR through current year
- Total policy year incurred losses outstanding excluding IBNR through prior year
- Total incurred losses outstanding excluding IBNR for current calendar year
- Total IBNR losses accumulated by policy year
- Total policy year IBNR losses through current year
- Total policy year IBNR losses through prior year
- Total IBNR losses for current calendar year
- Total incurred losses including IBNR accumulated by policy year
- Total policy year incurred losses including IBNR through current year
- Total policy year incurred losses including IBNR through prior year
- Total incurred losses including IBNR for current calendar year
- Total indemnity paid accumulated by policy year
- Total policy year indemnity paid through current year
- Total policy year indemnity paid through prior year
- Total indemnity paid for current calendar year
- Total medical paid accumulated by policy year
- Total policy year medical paid through current year
- Total policy year medical paid through prior year
- Total medical paid for current calendar year
- Total incurred indemnity outstanding excluding IBNR accumulated by policy year
- Total policy year incurred indemnity outstanding excluding IBNR through current year
- Total policy year incurred indemnity outstanding excluding IBNR through prior year
- Total incurred indemnity outstanding excluding IBNR for current calendar year
- Total incurred medical outstanding excluding IBNR accumulated by policy year
- Total policy year incurred medical outstanding excluding IBNR through current year
- Total policy year incurred medical outstanding excluding IBNR through prior year
- Total incurred medical outstanding excluding IBNR for current calendar year
- Total IBNR indemnity accumulated by policy year
- Total policy year IBNR indemnity through current year
- Total policy year IBNR indemnity through prior year
- Total IBNR indemnity for current calendar year
- Total IBNR medical accumulated by policy year
- Total policy year IBNR medical through current year
- Total policy year IBNR medical through prior year
- Total IBNR medical for current calendar year
- Total case outstanding excluding IBNR indemnity accumulated by policy year

- Total case indemnity outstanding excluding IBNR accumulated through current year
- Total case indemnity outstanding excluding IBNR through calendar prior year
- Total case indemnity outstanding excluding IBNR for current calendar year
- Total bulk indemnity outstanding excluding IBNR accumulated by policy year
- Total bulk indemnity outstanding excluding IBNR through current year
- Total bulk indemnity outstanding excluding IBNR through prior year
- Total bulk indemnity outstanding excluding IBNR for current calendar year
- Total policy year case medical outstanding excluding IBNR accumulated by policy year
- Total policy year case medical outstanding excluding IBNR through current year
- Total policy year case medical outstanding excluding IBNR through prior year
- Total case medical outstanding excluding IBNR for current calendar year
- Total bulk medical outstanding excluding IBNR accumulated by policy year
- Total policy year bulk medical outstanding excluding IBNR through current year
- Total policy year bulk medical outstanding excluding IBNR through prior year
- Total bulk medical outstanding excluding IBNR for current calendar year

5. Claim Counts

The number of incurred indemnity claims for which an indemnity payment has been made and/or an outstanding reserve exists.

6. Submitter Identifier

- Name of the submitter
- Title
- Telephone Number
- Date of Submission

**Model Workers' Compensation Statistical Plans
for Calls for Aggregate Experience**

Large Deductible Calendar/Accident Year Call

LIST OF DATA ITEMS

1. Company Identifier
2. Exposure State
3. Year
4. Amounts
5. Claim Counts
6. Submitter Identifier

DATA ITEMS

1. Company Identifier
 - Name and address of the Carrier
 - A unique code assigned by the bureau that identifies the insurance company.

2. Exposure State

A code that identifies the state of the employer's (insured's) facility. The state under which exposure is rated on the policy.

3. Year

Premium Calendar Year experience is experience developed on premium transactions in a twelve-month period beginning January 1. Accident Year experience is experience developed on loss transactions occurring during 12 calendar months beginning January 1.

4. Amounts

Identifies the following items and the respective amounts for the calendar year:

- Total standard earned premium at bureau designated statistical reporting level accumulated by calendar year
- Total standard earned premium at bureau designated statistical reporting level through current calendar year
- Total standard earned premium at bureau designated statistical reporting level through prior calendar year
- Total standard earned premium at bureau designated statistical reporting level for current calendar year
- Total standard earned premium at company level accumulated by calendar year
- Total standard earned premium at company level through current calendar year
- Total standard earned premium at company level through prior calendar year
- Total standard earned premium at company level for current calendar year
- Total net earned premium accumulated by calendar year

- Total net earned premium through current calendar year
- Total net earned premium through prior calendar year
- Total net earned premium for current calendar year
- Total losses paid accumulated by accident year
- Total accident year losses paid through current year
- Total accident year losses paid through prior year
- Total accident year losses paid through current calendar year
- Total incurred losses outstanding excluding IBNR accumulated by accident year
- Total policy year incurred losses outstanding excluding IBNR through current year
- Total policy year incurred losses outstanding excluding IBNR through prior year
- Total incurred losses outstanding excluding IBNR for current calendar year
- Total IBNR losses accumulated by accident year
- Total accident year IBNR losses through current year
- Total accident year IBNR losses through prior year
- Total IBNR losses for current calendar year
- Total incurred losses including IBNR accumulated by accident year
- Total accident year incurred losses including IBNR through current year
- Total accident year incurred losses including IBNR through prior year
- Total incurred losses including IBNR for current calendar year
- Total indemnity paid accumulated by accident year
- Total accident year indemnity paid through current year
- Total accident year indemnity paid through prior year
- Total indemnity paid for current calendar year
- Total medical paid accumulated by accident year
- Total accident year medical paid through current year
- Total accident year medical paid through prior year
- Total medical paid for current calendar year
- Total incurred indemnity outstanding excluding IBNR accumulated by accident year
- Total accident year incurred indemnity outstanding excluding IBNR through current year
- Total accident year incurred indemnity outstanding excluding IBNR through prior year
- Total incurred indemnity outstanding excluding IBNR for current calendar year
- Total incurred medical outstanding excluding IBNR accumulated by accident year
- Total accident year incurred medical outstanding excluding IBNR through current year
- Total accident year incurred medical outstanding excluding IBNR through prior year
- Total incurred medical outstanding excluding IBNR for current calendar year
- Total IBNR indemnity accumulated by accident year
- Total accident year IBNR indemnity through current year
- Total accident year IBNR indemnity through prior year
- Total IBNR indemnity for current calendar year
- Total IBNR medical accumulated by accident year
- Total accident year IBNR medical through current calendar year
- Total accident year IBNR medical through prior year

- Total IBNR medical for current calendar year
- Total case indemnity outstanding excluding IBNR accumulated by accident year
- Total accident year case indemnity outstanding excluding IBNR through current year
- Total accident year case indemnity outstanding excluding IBNR through prior year
- Total case indemnity outstanding excluding IBNR for current calendar year
- Total bulk indemnity outstanding excluding IBNR accumulated by accident year
- Total accident year bulk indemnity outstanding excluding IBNR through current year
- Total accident year bulk indemnity outstanding excluding IBNR through prior year
- Total bulk indemnity outstanding excluding IBNR for current calendar year
- Total case medical outstanding excluding IBNR accumulated by accident year
- Total accident year case medical outstanding excluding IBNR through current year
- Total accident year case medical outstanding excluding IBNR through prior year
- Total case medical outstanding excluding IBNR for current calendar year
- Total bulk medical outstanding excluding IBNR accumulated by accident year
- Total accident year bulk medical outstanding excluding IBNR through current year
- Total accident year bulk medical outstanding excluding IBNR through prior year
- Total medical bulk outstanding excluding IBNR for current calendar year

5. Claim Counts

The number of Incurred indemnity claims for which an indemnity payment has been made and/or an outstanding reserve exists.

6. Submitter Identifier

- Name of the submitter
- Title
- Telephone Number
- Date of Submission

**Model Workers' Compensation Statistical Plans
for Calls for Aggregate Experience**

Call for Quarterly Reporting of Total Market Direct Written Premium

**This call is required only for carriers that meet a
specific premium threshold in a state.**

LIST OF DATA ITEMS

1. Company Identifier
2. Exposure State
3. Year
3. Amounts
4. Submitter Identifier

DATA ITEMS

1. Company Identifier
 - Name and address of the Carrier
 - A unique code assigned by the bureau that identifies the insurance company.

2. Exposure State

A code that identifies the state of the employer's (insured's) facility. The state under which exposure is rated on the policy.

3. Year/Quarter

The calendar year that covers a twelve-month period beginning January 1. The three-month period of the calendar year.

4. Amounts

Direct written premium for the quarter/calendar year

5. Submitter Identifier
 - Name of Submitter
 - Title
 - Telephone Number
 - Date of Submission

**Model Workers' Compensation Statistical Plans
for Calls for Aggregate Experience**

Supplemental Call for Schedule Rating Premium Adjustments

LIST OF DATA ITEMS

1. Company Identifier
2. Exposure State
3. Policy Year
4. Policy Year Amount
5. Calendar Year
6. Calendar Year Amounts

DATA ITEMS

1. Company Identifier
 - Name of Carrier
 - A unique code assign by the bureau that identifies the insurance company

2. Exposure State

A code that identifies the state of the employers (insured) facility. The state under which exposure is rated under the policy.

3. Policy Year

The year ranging from the current year (as of 12/31) plus the previous four years for which the policy year amounts are reported.

4. Policy Year Amounts

Identifies the following item and the amount for each policy year:

- Accumulated earned premium – Standard after schedule rating

5. Calendar Year

The current calendar year

6. Calendar Year Amounts

Identifies the following items and their respective amounts for the Current Year:

- Standard premium after schedule rating (Line 'T' from policy year call)
- Schedule rating premium adjustments (separating debits and credits)

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SECTION 24

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SECTION 24

24. SPECIAL AND CUSTOMIZED STATE DATA REQUESTS (“SPECIAL CALLS”)

24.1 Introduction

States sometimes will have questions that insurance data may be able to answer, but that are not answered by the standard reports described in other sections of the *Statistical Handbook*. Sometimes answers can be provided by the creation of a customized report generated from data already collected by statistical agents. Sometimes, however, the only way that these questions can be answered is to ask insurers to make special data submissions to produce the report that is needed. These special data submissions, commonly referred to as “special calls” by those who deal with insurance statistics, are often expensive and difficult for insurers to provide.

Clearly, if the information that a regulator requires can be provided as a customized report using data already in the possession of statistical agents, then this will be the quickest and least expensive course of action. This section will not go into the endless variety of custom reports that can be generated by statistical agents; rather, it strongly recommends that states in need of a nonstandard report first review the applicable sections of the *Handbook* and/or contact their statistical agents to see if the report can be provided from information that is already in the possession of statistical agents.

The Special Calls Technical Assistance Group (SCTAG) referenced in subsection 24.2 will help states determine whether statistical agents already have the data that will enable them to produce a report that meets a regulator’s needs. The purpose of this section and of the SCTAG are to assist in addressing those situations where statistical agents do not have the necessary data.

States that have a data need that appears to require a special call are urged to check the NAIC Web page devoted to P&C statistical purposes and special calls (<http://www.naic.org/pcstat/>). The SCTAG can be contacted from this Web page and the Web page also provides other resources that states looking for data are likely to find helpful.

24.2 Special Calls Technical Assistance Group (SCTAG)

The Special Calls Technical Assistance Group (SCTAG) is a volunteer group of insurers and statistical agents formed and overseen by the NAIC’s Statistical Information (C) Task Force and charged with providing assistance to regulators and legislators with regard to unusual or one-time state data needs. If the state and the SCTAG find that statistical agents do not possess the necessary data, and the state decides to undertake a special call, then the SCTAG will work with the statistical agents to collect the necessary data or will provide assistance to the state should it decide to collect the data directly.

The SCTAG may be contacted by contacting the NAIC’s Statistical Information Manager. In addition, as most statistical agents participate on this group, it is likely that a regulator may be able to contact the group directly by contacting the statistical agent(s) most closely tied to the line(s) of insurance that may be involved. The SCTAG may initiate contact with

a state regulator if it becomes aware of a state data need where its assistance may be valuable. While the SCTAG will also assist legislative bodies, the Statistical Information (C) Task Force has not authorized it to initiate contact with such bodies without first receiving an explicit request to provide such assistance from a regulator in that state.

24.3 Reducing the Cost (and Increasing the Quality) of Special Calls

The suggestions listed below are offered to assist regulators as they strive to minimize costs and increase the accuracy of the information received when a special call is made:

- Use the NAIC statistical/special calls Web page (<http://www.naic.org/pestat/>), both as a resource as well as a means of improving communication with insurers.
- Sunset provisions or other provisions to terminate reporting automatically after a specified period may help avoid periodic reports that extend beyond a useful date.
- Please communicate the discontinuation of a regular call via the NAIC Web page as well as by your normal communication channels.
- Renewal of a data call after an extended period of inactivity should be treated as a new call.
- The number of back years of data required in special calls should be kept to a minimum.
- Careful consideration should be given to the level at which data fields are required. Most commonly, problems occur with requests for unallocated loss adjustment expenses, incurred losses and IBNR. These items involve estimated quantities and such estimates are normally not made at a subline/class/coverage level. Customarily, such estimations are calculated on an Annual Statement Line level, but not at a more detailed level. It can be a complex, expensive (and often arbitrary) process to estimate these amounts at detailed levels. Providing these amounts at a company level (for company groups) further complicates the process. When a regulator's data needs positively require such estimates, it must be remembered that different insurers will use different methodologies to develop them. It may be often more efficient to request this data at the level of detail reported to the statistical agents. This will have the added advantage of allowing statistical agents to handle much of the work and will allow these estimations to be made on a uniform basis by the statistical agent.
- Data elements such as risk count, policy count and exposures can become meaningless if they are requested at the wrong level of detail. Exposure bases vary within subline and coverage so that an aggregation of these elements can result in misleading totals. Policies that cover entities in multiple states or ZIP codes cannot be unambiguously counted by state or ZIP code.
- In some cases, the information requested in special data calls is available from other sources. If data elements are available on the Annual Statement or are already reported to a statistical agent, then reporting costs will be duplicative for the special call. For this reason, it is recommended that states with questions seek the advice of

the SCTAG (see the NAIC Web page) so that possible duplication of requests is reduced.

- Many special calls are due during the March 1 to May 1 timeframe. This stretches resources and increases the possibility of responses being late or erroneous. If state needs can be met with data received a few months later, some overworked insurer personnel will be grateful (and the quality may be better).
- Where possible, establish thresholds for reporting so that if a company falls under a certain cap, then no response or a “none to report” response is all that is required. Null reports should be as simple as possible to make and file.
- It can be helpful if insurers have input into diskette reporting formats in order to promote uniformity across states. Again, the SCTAG (which can be contacted via the Web page) can serve as a resource to provide this input.
- Unless data needs to be precisely allocated to individual insurers, it is often easier for insurers to provide data that combines all affiliated insurers in a company group.
- Making hardcopy forms more uniform and traditional in size can save money by reducing or eliminating outside printing costs for insurers.

24.4 Suggested Formats for Common Types of Special Calls

Section 24A discusses special calls arising out of catastrophes. In time, the Task Force may add other sections for other types of special calls.

The presence of these suggested formats does not mean that the Task Force or the NAIC recommends that data of the nature that is referenced be collected by the states. Although much of this data may be “interesting,” states are encouraged to carefully consider what they will do with information before they request it. Careful consideration will result in data calls that provide the best data to make the decisions that must be made. It will sometimes result in a decision to forego a data request when it is recognized that there is little action that will result from its compilation, or that the cost of the compilation will outweigh any possible benefit.

The purposes of sections 24A and subsequent are to:

- Increase the chance that insurers will be able to provide data in a timely and accurate fashion.
- Provide data definitions. For instance, if a regulator asks “how many private passenger auto insureds?”, one insurer may report the number of policies, one may report the number of vehicles and one may report the number of known drivers. Without good data definitions, it is likely that misunderstandings of this nature will occur, and the resulting data may be of little value.

- Reduce the cost of special calls through standard calls that insurers are able to anticipate. For instance, suppose that a hurricane causes significant damage in three states. These states may each have experience with data collection and may ask for relevant and well-defined data, but each state may ask for it with slightly different timing and format requirements. The cost to insurers to provide the information will be significantly less and the quality is likely to be better if the timing and formats for each of the three states are the same. In addition, once insurers have used a common format a few times, there will be no reporting delay caused by the need for new programming and debugging – insurers will simply need to identify the state and time period and run the reports. While insurers still need to spend time checking data anomalies (it will not be as easy as just pressing a couple of buttons), the result will still be that insurers can provide the regulator with better data more quickly.

The NAIC desires to know of state's experiences using the formats and definitions contained in sections 24A and subsequent. Contact the NAIC's Statistical Information Manager to provide input or to ask questions.

SECTION 24A

24A. CATASTROPHE REPORTS

24A.1 Introduction

If a major disaster occurs, a state may find itself in need of data more quickly and with different details than are provided by standard reports described elsewhere in the *Handbook*. The ability of insurers to respond with timely and accurate data will increase when they know—in *advance* of the catastrophic event—the data requirements and specifications. To this end, this subsection provides the following optional model catastrophe calls:

- Loss Summary Report – Group Direct Basis (one-time or monthly)
- ZIP Code Property Exposure Report – Single State Group Direct Basis (one-time)

This subsection also provides definitions of lines of insurance and of other data-related terms. When needed, the use of these model reports and accompanying definitions will improve timeliness and quality of data received by the states or by statistical agents on behalf of the states.

24A.2 Data and Information Available without a Special Call

A significant amount of catastrophe-related information is often available without a special call. Property Claims Services (PCS) is a unit of Insurance Services Office, Inc. (ISO). After a significant property catastrophe has been identified, PCS will obtain data from major insurers in the affected market (at least 75 percent) in an effort to make a quick and reliable estimate of the total dollars of insured loss. PCS will share information with state insurance departments. For media-related purposes, this can be an excellent tool. PCS estimates are very quick and are provided by professionals that do this on a regular basis for catastrophes in many states. Check <http://www.iso.com/aisg/index.html> for more information.

24A.3 Importance to Identify the Intended Use of Catastrophe Data

Before asking insurers for data, it is important that the regulator consider the decisions that will be made based upon the data. Several motivations for collecting catastrophe data may exist:

- Interest from the news media – Immediately following a catastrophe, the news media and others will want to know how much damage was done. The level of interest will be high. It is suggested that statistical calls may not be the most efficient way to respond to such inquiries. Owing to the delays involved with data collection, the information provided will not arrive as soon as the news media want it. If curiosity and the ability to respond to the media are the only reasons for an interest in data, the regulator is urged to consider the significant cost of a special data call versus the limited benefit of a late response to the news media. PCS reports may be the better choice in these situations.

- Concerns for insurer solvency – Even an industrywide loss of a billion dollars, although it is a huge sum, is unlikely to threaten the solvency of national insurers. Hurricane Andrew, which at \$16 billion is one of the largest insured catastrophes to date, had seven insolvencies directly attributed to it, but all but of two of those were Florida-only insurers, and the other two were small regional insurers with most of their business in Florida. In general, solvency problems arising from catastrophes are likely to affect only single-state insurers with concentrations in the areas hit by the catastrophe. As such, if a state is concerned regarding the solvency impact of a major catastrophe, it is recommended the state identify those specific (probably domestic and probably small) insurers that write most of their business in the state that experienced the brunt of the catastrophe. A state will almost certainly get better information more quickly if they select insurers likely to have been the hardest hit and arrange one-on-one meetings with them to assess losses and probable financial impact. The type of reports necessary to judge financial impact (countrywide net basis by insurer) would be especially difficult for insurers to produce and a blanket call for reports of this nature would cause needless additional expenses for the overwhelming majority of insurers for which there would be no solvency-related impact.

- Information required to monitor claim handling – A major catastrophe presents a problem for insurers because their normal staffing is set up to handle a steady stream of fender benders, thefts, liability claims, occasional fires, etc. An insurer's service cannot help but suffer when its claims office incurs more losses in a single day than it might otherwise receive in several years of "normal" operation. Notwithstanding reasons why insurers should be allowed somewhat greater tolerance when it comes to processing catastrophe claims, experience has shown that some insurers are more effective at adapting to the need for them to change their "normal" procedures, while some may not respond adequately and will generate a high volume of justified consumer complaints. As such, two model calls have been provided, an exposure report that can be made on a one-time basis, and a loss report that can be provided on a periodic basis until a sufficient number of claims have been paid.

As can be seen, it is necessary to carefully consider the intended usage for data before a special data call is made. There can be little question that states will require additional information when faced with extreme situations like Hurricane Andrew or the Northridge earthquake, but it does not follow that the costs of industrywide statistical calls will always be justified by their benefits simply because damages for a disaster amount to many millions of dollars.

24A.4 Reporting and Evaluation Dates

The notice to insurers that they must report data should be made as soon as the regulator has decided that catastrophe data is needed. It is suggested that the first evaluation date for losses be the last business day of the month following a catastrophe, with reporting due either (1) 30 calendar days following the evaluation date, or (2) 30 calendar days after the request is provided to insurers, whichever is later.

For exposures, it is suggested that valuation be done as of the end of the month immediately preceding the catastrophe, with reporting due either (1) 30 days after the

request is provided to insurers, or (2) at the time the first loss report is due if a loss report is also requested, whichever is later.

24A.5 Recommended Duration of Catastrophe Calls

Depending on the needs to be fulfilled, a single loss call to selected insurers may suffice. Another possibility is that a state may choose to make a single industrywide call with follow-ups for selected insurers only. Where updated loss data is required on a periodic basis, putting an end date on the number of reports with updated data, or ending the calls for insurers when most losses are paid, will ensure that calls do not become ongoing requests and continue past the time that they are of value. Where periodic loss reports are necessary, monthly evaluations are suggested for a one-year period, with an option to extend the period to two years if necessary for major catastrophes (e.g., those with an industry impact exceeding \$250,000,000 or \$500,000,000).

24A.6 Group Reporting Versus Individual Insurer Reporting

For most groups, it adds difficulty to break out experience for individual insurers. As such, it is recommended that insurers be allowed to provide all reports on either a group basis or an individual insurer basis.

24A.7 Sample Reports

Sample reports are shown next, followed by a data definitions section. The sample reports are shown in a spreadsheet format, with the columns (A, B, C, etc.) and rows (1, 2, 3, etc.) shown for illustrative purposes and so that insurers can be certain that they have placed data in the correct spreadsheet cells. These reports can then be provided using various electronic media. States that desire reports on paper can request that insurers print these spreadsheets or provide printouts in the same format that is illustrated. States that have experienced a catastrophe and have determined a need for a special data call are encouraged to copy this material and include it with any special instructions to insurers.

24A.7 REPORT 1 (Loss Summary Report – Group Direct Basis)

A	B	C	D	E	F	G	H	I	J
1									
2	LOSS SUMMARY REPORT – GROUP DIRECT BASIS								
3									
4	State	XX							
5	Description of catastrophe	Hurricane Zeke (or St. Louis earthquake or Chicago-area tornadoes)							
6	Date(s) of the catastrophe	9/14/1995 (or 9/14-15/1995 for a period of time)							
7	End Date of Reporting Period	9/30/1995							
8	Report Prepared on	10/6/1995							
9	Company or Group	Quicksand Casualty Group							
10	NAIC Company Code(s)	12345	12346	12347	← Insert as many cocodes as apply, one per cell. Do not use group codes.				
11	Report Prepared by	John E. Doe							
12	Title	Statistical Analyst							
13	Address Line 1	123 Shifting Sands Drive							
14	Address Line 2								
15	City, State, ZIP	Quicksand, XX 99999							
16	Telephone number	(800) 555-1212							
17	Facsimile number	(800) 555-1213							
18	E-mail address	johndoe@quicksand.com							
19									
20	Losses and Claim Counts Incurred and/or Paid IN THIS STATE ONLY	Homeowners	Dwelling Fire and Allied Lines	Commercial Fire and Allied Lines	Businessowners	Farmowners	Personal Auto Physical Damage	Commercial Auto Physical Damage	All Other Lines Totals
21									
22	Paid Loss Count								
23	Paid Loss Amount								
24	Reported Loss Count								
25	Reported Loss Amount								
26	Unreported Loss Count								
27	Unreported Loss Amount								
28									
29	What is the total loss for all states combined? (Include losses already reported in cells J25 and J27.)								
30									
31	What is the total claim count for all states combined? (Include claim counts already reported in cells J24 and J26.)								

Use the format shown above as a template, being careful to place entries in the cells shown. The cells requiring entries are:

- B4 through B9;
- B10, C10, D10, etc., for as many NAIC cocodes are included;
- B11 through B18 (as applicable – leave blanks for address or e-mail cells that are not applicable)
- the array of cells with B22 and J27 in the corners, and
- J29 and J31.

Instructions for the Application of Loss Development in Report 1

All losses reported in this exhibit are those that have been incurred on a **direct basis**. Do not include losses assumed through reinsurance, and do not reduce or remove losses from this report based on reinsurance which will be available for their payment.

Many insurers may not have the data immediately available to provide the loss estimates developed in precisely the manner that they have been requested. In such cases, the insurer should provide reasonable estimates. The common problem is that many insurers' reserve tracking systems are unable to distinguish development occurring on reported losses ("bulk" development) versus development arising from those losses that have not yet been reported (which constitute true IBNR losses). Such insurers' incurred loss calculations go directly from paid losses + case basis reserves to total incurred losses.

Notwithstanding these limitations, Report 1 should be made on the following basis:

- **Paid loss count**

This is the number of claims for which payment has been made to the policyholder as of the report date. Exclude claims where the only payment has been loss adjustment expense.

- **Paid loss amount**

This is the sum of the payments less salvage and subrogation that the insurer has made as of the report date. This includes payments where the insurer continues to keep the claim file open (as the insurer believes that its payment is likely to be the first of two or three payments). Loss adjustment expenses should not be included.

- **Reported loss count**

This is the number of claims that have been reported as of the date cited in the report. Exclude claims that have been closed with no payment.

- **Reported loss amount**

This is the insurer's estimate of the amount that will ultimately be paid less salvage and subrogation for those claims that have been reported as of the date cited in the report. It includes amounts already paid, and it includes development of reported losses, but it does not include IBNR. Loss adjustment expenses should not be included.

- **Unreported loss count**

This is the insurer's estimate of the number of claims that have not been reported as of the report date.

- **Unreported loss amount**

This is the insurer's estimate of the amount that will ultimately be paid less salvage and subrogation on claims that have yet to be reported. Loss adjustment expenses should not be included. PLEASE NOTE—this is true IBNR—it should NOT include development on losses that have already been reported (“bulk reserves”). Bulk reserves should be included in reported losses.

Because Report 1 requires true IBNR to be distinguished from the development of reported claims, it is likely that the loss development systems and procedures that many insurers use for other purposes will not produce numbers that comply. If an insurer's loss tracking and loss development systems do not distinguish true IBNR from the development of reported claims, then adjustments will need to be made. The paid numbers from such a system should be OK, and the totals (reported + unreported) should be OK as well, but it will be necessary for the insurer to allocate the totals between reported and unreported somewhat differently. Rather than subtracting paid losses and simple case basis reserves from total losses to get unreported losses, it will be necessary to estimate what portion of the “unreported losses” calculated in this fashion represent development of losses that have been reported but are under-reserved.

An important point—one that will keep this from being an onerous report because of this distinction—is that this reallocation does not need to involve a great deal of precision. Simply estimate—make a reasonable guess, if you will—the amount of this effect and apply this estimation on a pro-rate basis to the unpaid losses. The most important numbers are the total losses and total loss counts for this state and for companywide. While these numbers need to be allocated more finely, precision in these allocations is not as important as quality in the totals.

24A.8 REPORT 2 (ZIP Code Property Exposure Report – Single State Group Direct Basis)

	A	B	C	D	E	F	G	H	I	J
1										
2	ZIP CODE PROPERTY EXPOSURE REPORT – SINGLE STATE GROUP DIRECT BASIS									
3										
4	State	XX								
5	Description of catastrophe	Hurricane Zeke (or St. Louis earthquake or Chicago-area tornadoes)								
6	Date(s) of the catastrophe	9/14/1995 (or 9/14-15/1995 for a period of time)								
7	End Date of Reporting Period	9/30/1995								
8	Report Prepared on	10/6/1995								
9	Company or Group	Quicksand Casualty Group								
10	NAIC Company Code(s)	12345	12346	12347	← Insert as many cocodes as apply, one per cell. Do not use group codes.					
11	Report Prepared by	John E. Doe								
12	Title	Statistical Analyst								
13	Address Line 1	123 Shifting Sands Drive								
14	Address Line 2									
15	City, State, ZIP	Quicksand, XX 99999								
16	Telephone number	(800) 555-1212								
17	Facsimile number	(800) 555-1213								
18	E-mail address	johndoe@quicksand.com								
19										
20	Line(s) of Insurance	← Enter line(s) of insurance covered below (i.e., Homeowners, Dwelling Property, Farmowners, Businessowners or Commercial Property) NOTE TO STATES: When this report is requested, it will be necessary to specify whether a separate report (spreadsheet page) should be provided for each line – specify which – or for all property lines combined.								
21										
22		Total Policies in Force	Total Written Premium	Building Amount of Insurance	Contents Amount of Insurance	Total Amount of Insurance				
23	Five Digit ZIP Code									
24	12345									
	12346									
	:									
	:									
	55555									
	unknown									
	Statewide Total									

Use the format shown above as a template, being careful to place entries in the cells shown. The cells requiring entries are:

- B4 through B9;
- B10, C10, D10, etc., for as many NAIC cocodes are included;
- B11 through B18 (as applicable – leave blanks for address or e-mail cells that are not applicable)
- B20, and
- The array (as illustrated) starting with row 23, using as many rows as necessary. The ZIP Codes are to be the ZIP Code of the property insured, which may be different than the mailing ZIP Code. ZIP Codes where the other entries would be zero may be omitted.
- If a separate report is made for homeowners and/or dwelling fire, the contents amounts are to be only those where the dwelling is not covered (i.e. for tenants and condo forms). The total amount of insurance may be omitted for homeowners.

24A.9 Line of Business Definitions

Businessowners

These policies provide property and liability coverage for small businesses, combined under one policy. They provide coverage for buildings and business personal property (replacement cost coverage), loss of business income and extra expense.

Commercial Auto Physical Damage

These policies pay for losses resulting from damage to or theft of a covered automobile. Basic physical damage coverages include Collision and Other than Collision (Comprehensive). (Commonly, but not always, these policies also provide liability coverage. However, for purposes of this definition, the key point is whether these policies, regardless of whether they provide liability coverage, also provide physical damage coverage.)

This generally includes policies issued on business use private passenger automobiles, business use trucks, public automobiles and garages. Private passenger automobiles include all vehicles owned by corporation, co-partnership or unincorporated associations under a fleet basis and the same under a non-fleet basis when used customarily for business purposes; it also includes farmers private passenger autos, pickups, panel trucks and vans, under a fleet basis. Trucks include trucks, tractors and trailer types. Public automobiles include taxicabs, limousines, buses (school, church urban, airport, inter-city, charter, sightseeing, athletic and entertainer), social services automobiles and van pools. Garages include dealer and non-dealer garages, service stations and repair operations. It does not apply to personal use of automobiles and personal use of trucks with gross vehicle weight less than 10,000 pounds.

Commercial Fire & Allied Lines

This represents experience from monoline and package policies containing commercial property coverage forms and cause of loss forms. These policies can provide building, business personal property, time element and additional coverages, depending on which forms are included.

Dwelling Fire & Allied Lines

A dwelling policy provides property coverage for one-family to four-family dwellings. Coverage is provided for the insured's dwelling building and personal property.

Farmowners

These are package policies for farming and ranching risks, similar to a homeowners policy, that has been adopted for farms and ranches and includes both property and liability coverages for personal and business losses. Coverages include farm dwellings and their contents, barns, stables, other farm structures and farm inland marine, such as mobile equipment and livestock.

Homeowners

Homeowners insurance is a package policy combining property coverage for structures (except for tenant and condominium forms), personal property and personal liability. It includes mobilehomes at fixed locations.

Personal Auto Physical Damage

These policies pay for losses resulting from damage to or theft of a covered automobile. Basic physical damage coverages include Collision and Other than Collision (Comprehensive). (Commonly, but not always, these policies also provide liability coverage. However, for purposes of this definition, the key point is whether these policies, regardless of whether they provide liability coverage, also provide physical damage coverage.)

This generally includes those policies issued on automobiles owned or leased by an individual or by husband and wife resident in the same household. It covers motorcycles and four wheel vehicles including station wagons, vans, or pick-up trucks with gross vehicle weight less than 10,000 pounds and not customarily used in the occupation, profession or business of the insured. It also includes private passenger rated automobiles owned by a corporation, co-partnership or unincorporated association and insured on a policy for an individual or an individual and spouse.

All Other

Refer to policies covering property other than those listed above.

24A.10 Data Element Definitions

Building Amount of Insurance

Total amount of coverage on all structures for policies included in **Total Policies in Force** as defined below. It is not necessary to reduce these amounts for deductibles.

Contents Amount of Insurance

Total amount of coverage (net of deductibles) on the contents of buildings.

Losses and Claim Counts

See the instructions and loss definitions accompanying Report 1.

Total Amount of Insurance

Total of Building Amount of Insurance and Contents Amount of Insurance.

Total Policies in Force

The total number of direct policies in force during or at the end of the month immediately prior to the catastrophe event that provide coverage for the catastrophe event. Normally, for the lines of insurance involved, this definition includes all direct policies. Exceptions include auto policies without “comprehensive” coverage and also include homeowners and dwelling policies that exclude coverage for hurricanes.

Total Written Premiums

Total direct written premium for policies included in **Total Policies in Force** as defined above.

INSERT

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Appendix A – Statistical Agents

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Appendix A – Statistical Agents

A. Statistical Agents

A.1 National Property and Casualty Statistical Agents

Organizations authorized to perform statistical agent functions for property and casualty lines of insurance **other than workers' compensation** include:

American Association of Insurance Services (AAIS)
1745 S. Naperville Road
Wheaton, Illinois 60187-8132
Contact: Larry Thill
Phone: (630) 681-8347
Fax: (630) 681-8356
Toll-free: (800) 564-AAIS (564-2247)
www.aais.org

ISO Data, Inc. (Statistical Agent)
545 Washington Blvd.
Jersey City, NJ 07310-1686
Contact: Mary E. VanSise
Phone: (201) 469-2652
Fax: (201) 748-1488
www.iso.com

ISO, Inc. (Advisory Organization)
545 Washington Blvd.
Jersey City, NJ 07310-1686
Contact: Mary E. VanSise
Phone: (201) 469-2652
Fax: (201) 748-1488

National Independent Statistical Service (NISS)
3601 Vincennes Road
P.O. Box 68950
Indianapolis, Indiana 46268-0950
Contact: Theresa Szwast
Phone: (317) 876-6200 ext. 1045
Fax: (317) 876-6210
www.niss-stat.org

Property Casualty Insurers Association of America (PCI)
(Created by the merger of the National Association of Independent Insurers—NAII
and the Alliance of American Insurers—AAI)
2600 South River Road
Des Plaines, Illinois 60018
Contact: Stuart Yakes
Phone: (847) 297-7800
Fax: (847) 759-4338
www.pciaa.net

The statistical agents listed above are authorized to collect data for the following lines in all states (except Texas and as noted):

- California and General Liability (includes Products Liability and Professional Liability other than Medical)
- Private Passenger Automobile
- Commercial Automobile
- Homeowners and Mobile Homes
- Dwelling Fire and Allied Lines
- Commercial/Farm Fire and Allied Lines
- Inland Marine
- Businessowners
- Burglary and Theft
- Glass
- Farmowners
- Boiler and Machinery (except AAIS)
- Medical Professional Liability
- Comprehensive Personal Liability
- Aircraft (ISO only)
- Crop (PCI only)
- Mortgage Guaranty (PCI only)
- Fidelity and Surety

Exceptions:

- Massachusetts and South Carolina - Automobile coverages
- New York – Fidelity and Surety

A.2 Regional and Special Purpose Statistical Agents

The following organizations function as statistical agents in the states and lines of business indicated (does not include workers' compensation):

Organization	States Authorized	Lines of Business
California Department of Insurance 300 S. Spring St., S. Tower Los Angeles, CA 90013 Contact: Ben Gentile Phone: (213) 346-6316 Fax: (714) 964-2896 www.insurance.ca.gov	California	Property and Casualty

Organization	States Authorized	Lines of Business
<p>Commonwealth Automobile Reinsurers 100 Summer Street, 21st Floor Boston, MA 02110-2106 Contact: Tim Galligan or Natalie Hubley Phone: (617) 338-4000 Fax: (617) 338-5422 TTY: (617) 880-7248 www.commauto.com</p>	<p>Massachusetts</p>	<p>Auto</p>
<p>MSO, Inc.-formerly Mutual Services Office 139 Harristown Rd. Glen Rock, NJ 07452 Contact: Megan Townley Phone: (800) 935-6900 ext. 133 Fax: (201) 447-9468 www.msonet.com</p>	<p>Delaware, Maryland, New Jersey, Pennsylvania, and Virginia</p>	<p>All lines except Auto and Boiler and Machinery</p>
<p>National Crop Insurance Services 8900 Indian Creek Parkway Suite 600 Overland Park, KS 66210-1567 Phone: (913) 685-2767 Fax: (913) 685-3080 www.ag-risk.org</p>	<p>All states (except Alaska)</p>	<p>Crop</p>
<p>The Surety Association of America 1101 Connecticut Ave., N.W. Suite 800 Washington, DC 20036 Contact: Lynn M. Schubert Phone: (202) 463-0600 Fax: (202) 463-0606 www.surety.org</p>	<p>All states (except Texas)</p>	<p>Fidelity and Surety</p>

Organization	States Authorized	Lines of Business
<p>Texas Insurance Checking Office, Inc.¹ 2801 South IH 35 Austin, TX 78741 Contact: Terry Porter or Gary Gola Phone: (512) 444-9662 or (512) 475-3026 Fax: (512) 326-7605 www.ticostat.com</p>	Texas	<p>All lines Private passenger automobile and residential property insurance under Texas' Department of Insurance statistical plans. In addition, TICO provides manual coding and statistical reporting services for commercial lines and residential property insurance.</p>
<p>Underwriters Rating Board 2932 Curry Road Schenectady, NY 12303 Contact: Mary Shell Phone: (518) 355-8363 Fax: (518) 355-8639 www.urbratingboard.com</p>	New York	<p>Fire and Allied Lines, Homeowners, Special Multi-peril, Farmowners, Crime, Glass, General Liability, Businessowners, and Inland Marine</p>

¹ Statistical plans are promulgated by the Texas Department of Insurance. Questions concerning reporting requirements, definition of data elements, and use of the data should be directed to the Texas Department of Insurance. Questions concerning the physical reporting requirements and reporting format may be directed to TICO.

A.3 Workers' Compensation Statistical Agents/Rating Organizations

There is one multi-state statistical agent for 35 states and the District of Columbia. There are 10 workers' compensation statistical agents or rating organizations that are the designated statistical agent in only one state.

A.3.1 Multi-State Statistical Agency

The National Council on Compensation Insurance (NCCI) is the only multi-state statistical agent for workers' compensation.

States

<p>National Council on Compensation Insurance (NCCI) 901 Peninsula Corporate Circle Boca Raton, FL 33487 Contact: Mona Carter Phone: (561) 893-3045 Fax: (561) 893-5419 www.ncci.com</p>	<p>Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, District of Columbia, Idaho, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia</p>
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A.3.2 Single State Workers' Compensation Statistical Agents or Rating Organizations

In certain states either because of legislative mandate, premium volumes, or other considerations there are organizations that perform the role of statistical agent for workers' compensation exclusively for that state. In such states the statistical agent or rating organization possesses the expertise and understanding of the problems unique to that particular jurisdiction. In these cases the workers' compensation statistical agent or rating organization works closely with the state insurance department or may in some cases be a part of the department.

It is not uncommon for the independent workers' compensation jurisdictions to have certain needs that may not coincide with those of NCCI. There is nevertheless open communication among all the various statistical agents and rating organizations and their individual company membership to maintain maximum uniformity to minimize the cost of furnishing data. Examples are the Workers' Compensation Statistical Plan and Calls for Aggregate Experience where every effort has been made toward uniformity. The differences that exist result from the special characteristics or requirements of a given state.

Statistical Agent/Rating Organization	State
<p>Workers' Compensation Insurance Rating Bureau of California (WCIRB California) 525 Market Street, Suite 800 San Francisco, California 94105-2767 Phone: (888) 229-2472 Fax: (415) 778-7272 www.wcirbonline.org</p>	California
<p>Delaware Compensation Rating Bureau (DCRB) One South Penn Square Widener Building, 6th Floor Philadelphia, Pennsylvania 19107 Phone: (302)-654-1435 Fax: (215) 564-4328 www.dcrb.com/shared/d_contents.htm</p>	Delaware
<p>Hawaii Insurance Bureau, Inc. (HIB) 715 South King St., Suite 320 Honolulu, Hawaii 96813 Phone: (808) 531-2771 Fax: (808) 536-3516 www.hibinc.com</p>	Hawaii ²
<p>Workers' Compensation Rating and Inspection Bureau of Massachusetts (WCRIBM) 101 Arch Street Boston, Massachusetts 02110 Contact: Sandra Alexander Phone: (617) 646-7537 Fax: (617) 439-6055 www.wcribma.org</p>	Massachusetts
<p>Compensation Advisory Organization of Michigan (CAOM) 17197 N. Laurel Park Drive, Suite 311 Livonia, Michigan 48152-2686 Phone: (734) 462-9600 Fax: (734) 462-9721 www.caomrisk.com</p>	Michigan

²NCCI is the designated statistical agent for this state but acts in accordance with the specifications or requirements of the individual rating organization shown.

Statistical Agent/Rating Organization	State
<p>Minnesota Workers' Compensation Insurers Association, Inc., (MWCIA) 7701 France Avenue South, Suite 450 Minneapolis, Minnesota 55435 Phone: (952) 897-1737 Fax: (952) 897-6495 www.mwcia.org</p>	Minnesota
<p>New Jersey Compensation Rating and Inspection Bureau (NJCRIB) 60 Park Place Newark, New Jersey 07102 Contact: Isabel Santos Phone: (973) 622-6014 Fax: (973) 622-1548 www.njcrib.com</p>	New Jersey
<p>New York State Workers' Compensation Board Albany District Office 100 Broadway-Menands Albany, NY 12241 Phone: (800) 877-1373 or (866) 750-5157 Customer Service Information: (212) 932-3367 Fax: (518) 473-9166 www.wcb.state.ny.us</p>	New York
<p>North Carolina Rate Bureau (NCRB) 5401 Six Forks Road Raleigh, North Carolina 27609-4435 Contact: Sue Taylor, Director Workers Compensation Phone: (919) 783-9790 Fax: (919) 783-7467 www.ncrb.org</p>	North Carolina ³
<p>Pennsylvania Compensation Rating Bureau (PCRB) One South Penn Square Widener Building, 6th Floor Philadelphia, Pennsylvania 19107 Phone: (215) 568-2371 Fax: (215) 564-4328 www.pcrb.com/shared/p_contents.htm</p>	Pennsylvania

³NCCI is the designated statistical agent for this state but acts in accordance with the specifications or requirements of the individual rating organization shown.

Statistical Agent/Rating Organization	State
Texas Workers' Compensation Commission Central Office 7551 Metro Center Drive Austin, TX, 78744-1609 Phone: (512) 804-4000 Customer Service Phone: (512) 804-4100 or (512) 804-4636 Fax: (512) 804-4241 www.twcc.state.tx.us	Texas
Wisconsin Compensation Rating Bureau (WCRB) 20700 Swenson Drive, #100 Waukesha, WI 53186 Main Phone Number: (262) 796-4540 Main Fax Number: (262) 796-4400 www.wcrb.org	Wisconsin ⁴

⁴NCCI is the designated statistical agent for this state but acts in accordance with the specifications or requirements of the individual rating organization shown.

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Appendix B – Random Sampling and Verification

B. Random Sampling and Verification

1. Random Sampling and Verification of Statistical Transactions

This appendix to the *NAIC Statistical Handbook* contains a model random sampling and verification requirement for statistical data that one or more states could adopt in order to provide greater assurance of data quality in the reporting of statistical data. This form of quality assurance was not incorporated in Section 2 of the *Handbook* because it would involve significant costs to insurers and because many states, when surveyed, indicated either limited or no interest in its adoption. At the same time, several states did express interest, particularly if several other states chose to adopt such a requirement.

Because adoption by only one state would effectively require most of the property/casualty insurance industry to undertake the sampling contemplated herein, and incur the related expenses, this model is structured so as to become effective when at least five states have adopted it.

2. Model Statistical Data Random Sampling and Verification Requirement

Upon adoption of this model by five states, insurers must check random samples of premium and loss transactions, record any errors that are found and make required reports to the applicable statistical agents. For lines other than workers' compensation, the data elements required by the *Statistical Handbook* must be checked. For workers' compensation premiums, unit-reported premiums must be checked for accuracy of the dollar amount, state code, class code and (where applicable) the payroll amount. For workers' compensation losses, unit-reported losses must be checked for accuracy of the dollar amount, state code, class code and type of loss. When the cause of an error is something that could produce systematic errors, the insurer must correct the error-producing condition. Samples shall be taken separately by line for premiums and losses for the following four "lines":

- (1) Private passenger automobile (all coverages combined);
- (2) Homeowners and mobilehomeowners combined;
- (3) Workers' compensation, and
- (4) All other – consisting of the Annual Statement Exhibit of Premiums and Losses (Statutory page 14) lines of insurance not included in (1), (2) or (3) and for which state statistical reporting requirements apply.

Minimum companywide sample sizes to be taken from the system(s) used for premium and loss processing in the states adopting this shall be determined in accordance with the following formula, except that insurers¹ with less than 0.50 percent market share (0.20 percent for "all other") are not required to take samples:

¹ It is expected that most insurer groups will sample on a group basis and calculate sample sizes on a group basis. Sampling shall apply to all insurer groups with greater than the stated market share, even when the individual insurers in the group may each have less than the minimum state market share.

$$= \text{Target_Sample_Size}^2 \times \text{State_Market_Share}^3 - \text{rounded upwards, subject to the minimum sample sizes shown in the table below}$$

A three percent state market share for an insurer is entered as 0.03 in these formulas. The target sample sizes and minimum sample sizes are shown in the following table:

Line of Insurance	Target Sample Sizes for		State Minimum Market Share (for the program to apply)	Insurer Minimum Sample Sizes
	Premium & Exposure Transactions	Loss Transactions		
(1) Private Passenger Auto	500	300	0.50%	5
(2) Homeowners	500	300	0.50%	5
(3) Workers' Comp	500	300	0.50%	5
(4) All other	750	500	0.20%	10

Reasonable stratification schemes that simplify the sampling process are allowed. For instance, an insurer (group) with several processing systems may divide its total required sample size among its systems based on the volume processed by each, and then select these smaller samples randomly for each system. For insurers and lines where reporting is done more frequently than annual, the sampling may be done from less than the entire year's data except to the extent that this would have the effect of omitting books of business (e.g., crop insurance that is only written in the spring). In addition, the "all other" line includes a number of dissimilar types of insurance (i.e., commercial auto, inland marine, general liability, etc.) and insurers may often find it easier to divide their required sample sizes for these "all other" lines into the various component lines.

The transactions selected shall be verified back to source documents. It is not the intent for this verification requirement to be construed as requiring insurers to maintain more paper or electronic files applying to all of their records than they already maintain. Rather, the "source document" will be those records—paper or electronic—that underlie the calculation of the relevant billing or transaction.

For transactional reporters, samples shall be drawn from reports to statistical agents. For summary reporters, samples shall be drawn from the target file (the last file in the company's statistical data collection and reporting process prior to statistical reporting in which the identity of individual transactions can be determined). After the transactions in the target file have been verified back to the source document, they shall be compared to

² The target sample size represents approximately the total number of industrywide transactions that will be sampled if only one state adopts this sampling program.

³ State market share for an insurer is determined by dividing the insurer's state Annual Statement Page 15 written premiums for the preceding calendar year for the lines under consideration by the total state Annual Statement Page 15 written premiums for the same calendar year for all licensed insurers for those lines. For example, the sample sizes applying to transactions booked during 2004 and reported during 2005 (for an annual reporting insurer) would be based upon market shares during 2003.

records submitted to the statistical agent to assure that there are no conversion errors. Conversion errors found through this process shall also be reported to the statistical agent.

For workers' compensation and alternately for summary-reporting insurers that have retained sufficient detail, samples may be drawn from the unit or summarized reports made to statistical agents. The insurer will then work backward to identify the component transactions and their underlying source documents. While this will result in the insurer having to verify a larger number of transactions, the result will be more complete and there will be no need to separately check for conversion errors.

In conducting this analysis, an insurer (group) is not required to review underwriting information to determine whether the rating classifications and exposure amounts selected by the insurer's underwriters are correct. Rather, the insurer is obligated to determine whether the exposures reported accurately reflect those used by the insurer to rate the policy or generate the billing. The difference between this standard and a "coded as rated" standard is this: whenever it has been brought to the insurer's attention that the exposures used to rate a policy were incorrect, yet the statistical records were not changed to reflect the correct exposure, then that shall be counted as a data reporting error.

Insurers shall separately report the records sampled and any errors that were found to the statistical agent. Such reports shall be converted to coding used by the statistical agent and reported in accordance with a format specified by the statistical agent.

Insurers shall maintain detailed records of these activities and their results for a minimum of five years⁴. These records shall provide a summarization of results and shall also be sufficient to allow a state examiner to verify the sampling methodology and the data submitted prior to verification against the source documentation. In addition, if the source documentation is not otherwise retained, then copies of the source documentation that were checked against these records shall be separately saved.

⁴ The five-year record retention requirement applies unless a specific state law provides a shorter retention requirement.

Appendix C – Statistical Basis

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C. Appendix C – Statistical Basis

The purpose of this paper is to illustrate the flow of premium and loss data from fire and casualty insurance policies. In the interest of clarity, the paper deals exclusively with annual policies. However, the governing principles are applicable to policies written for shorter or longer terms and, with appropriate adjustments for different policy periods, all of the statements and illustrations would become equally appropriate.

1. Statistical Components

1a. Premium

The full annual premium for a policy is considered “written premium” as of the date of the policy is issued. However, since coverage is to be provided throughout the policy period, the written premium is earned by the company pro rata as the policy matures. At any time within the policy period, “earned premium” is the pro rata portion of written premium associated with the period the policy has already been in force. The remainder of written premium is related to the unexpired portion of the policy and is labeled “unearned premium.” This may be illustrated as in Figure 1 for three policies written on January 1, July 1 and September 15 respectively of 2000.

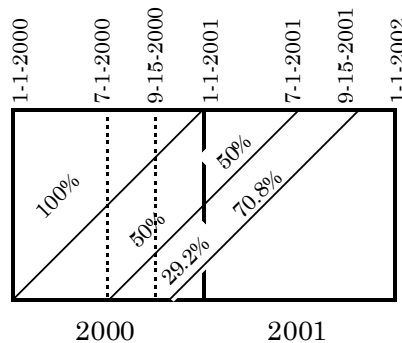


Figure 1. Percentage of premiums earned in 2000 or 2001 from individual policies written during 2000

In Figure 1, each square represents a full calendar year, and the diagonal lines represent premiums earned. The first diagonal runs its full course within the first square and so illustrates that the premium for the first policy is fully earned by the end of 2000. The second diagonal illustrates that one half of the premium written on July 1 is earned during 2000 and one half is earned during 2001. The third policy, written on September 15, is represented by the third diagonal.

Pursuing the same form of illustration, but now considering a very large number of policies, we would expect some to become effective on January 1, some on January 2 and so on throughout the year. The composite graph would therefore contain a diagonal line for each day so as to produce a solid shaded area.

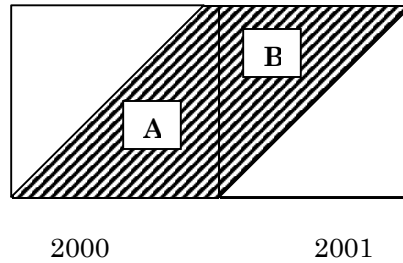
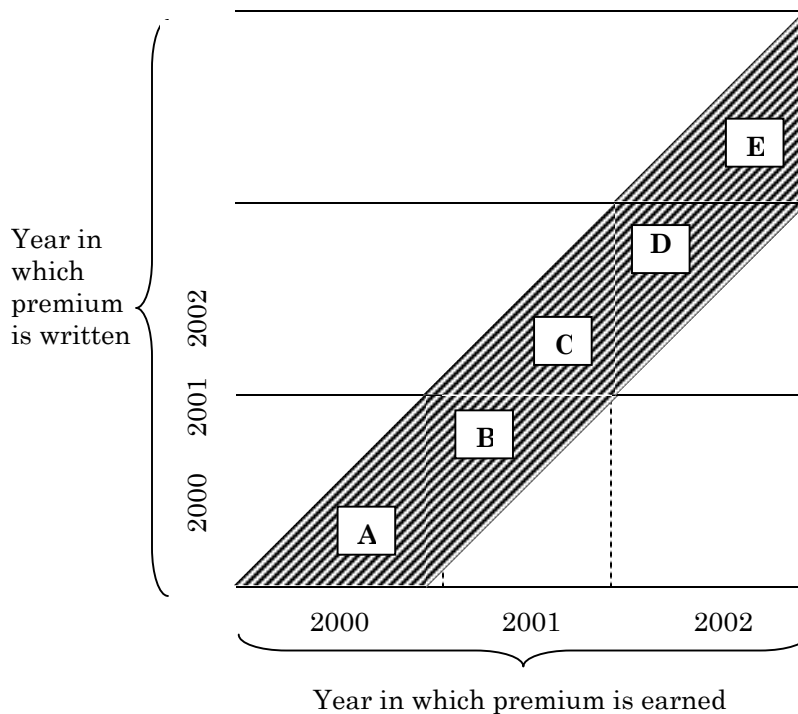


Figure 2. Pattern of premiums earned in 2000 or 2001 from all policies written during 2002.

In Figure 2, the triangle labeled A represents premiums earned during 2000 under policies written during 2000. Triangle B represents premiums earned during 2001 under policies written during 2000. Figure 3 illustrates premiums earned for several successive years:



In Figure 3, shaded areas A and B are the same as were shown in Figure 2. Shaded areas C and D illustrate a corresponding pattern for policies written during 2001. It should also be noted that premiums earned during calendar year 2001 flow in part from policies written during 2000 (area B) and in part from policies written during 2001 (area C).

1b. Exposure

During the entire effective period of coverage under a policy, the insurer is exposed to the possibility of incurring claims thereunder. The term "exposure" is used to express this possibility, usually in units defined to suit the needs of the particular type of policy. For most forms of automobile insurance, the customary unit of exposure is a "car year." One car insured for one year generates one car year of exposure. The same is true of two cars each insured for 6 months, or of three cars each insured for four months.

Units of exposure are written and earned in the same fashion as premiums. Therefore, the principles illustrated in the preceding figures are also applicable to exposures.

Exposure may be looked upon as the common root of both premium and loss statistics. Premiums are earned proportionally with exposures as has already been illustrated. Thus, when an annual policy covering one car has been in force for three months, one quarter of the premium has been earned. Similarly, one quarter of a car year of exposure has been earned, i.e., the company has been exposed to losses arising from the operation of one car for one quarter of a year. Any losses under the policy which arise from accidents which occurred within the period stem from the same one quarter car year of exposure and are therefore related to the corresponding earned premium.

In reviewing statistics for the purpose of ratemaking, it is fundamental that the underlying exposure must be common to both premium and loss information in order to assure that the insurer's loss costs will be matched against corresponding premium revenue.

Just as premiums and exposures are earned proportionally throughout the term of policies, losses may also arise throughout the policy period. However, since the accidents which give rise to losses are fortuitous, it is not possible to graphically represent the losses expected under a single policy, or even under a few in combination. Nevertheless, if all of the losses covered under a very large number of policies are considered, it is reasonable to expect that they will tend to occur more or less randomly throughout the policy period (*Note 1*). It is therefore appropriate to consider losses as having been incurred throughout the period under review. Again, the pattern illustrated in the first three figures is generally appropriate, subject to certain modifications. Thus, losses incurred during 2000 under policies written during 2000 are represented by triangle A in Figure 4.

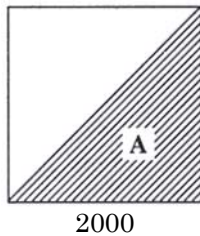


Figure 4. Losses incurred under policies written in 2000 evaluated as of December 31, 2000.

Note 1. Seasonal variations produce effects contrary to this assumption in some cases. However, it is customary to review data as of successive annual development dates so as to minimize or eliminate distortions arising from such variations.

It is important to note that triangle A represents losses incurred during 2002 under policies written during 2000 evaluated as of December 31, 2002. At this date, some of the losses have been paid and the claims finally settled; however, other cases are in negotiation and the amount of loss incurred for each is the company's best estimate of the amount which will ultimately be required to settle. Still other accidents have occurred in the last few days of 2002 and have not yet been reported to the company. It is customary to include a reserve for such cases in order to establish the total value of incurred losses as accurately as possible. Figure 5 continues the illustration for another year:

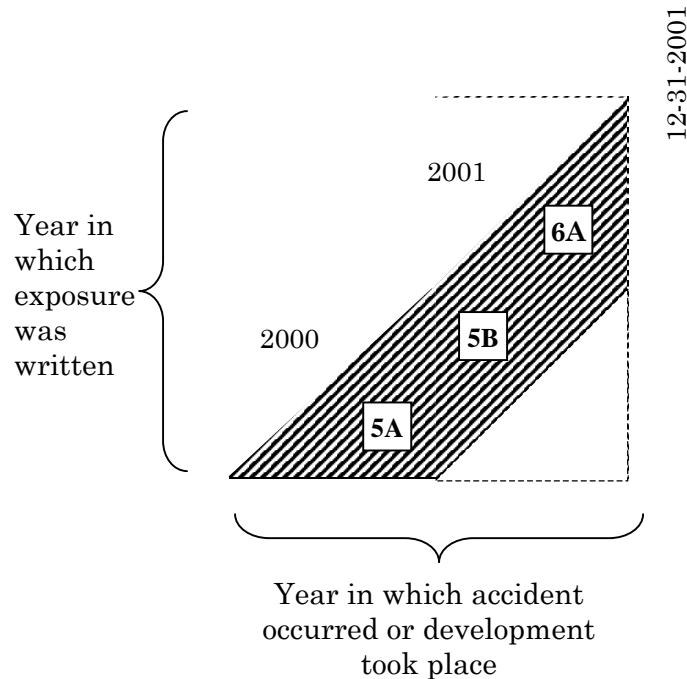


Figure 5. Losses incurred under policies written in 2000 evaluated as of December 31, 2001

Figure 5 illustrates the evaluation of incurred losses as of December 31, 2001. Triangle 5A is the same value as was shown in Figure 4, while triangles 5B and 6A represent losses incurred during 2001 evaluated as of December 31, 2001. Another triangle is added to the right of 5A and 5B to show "development" during 2001 of incurred losses from triangle 5A

The "development" triangle relates exclusively to losses arising from accidents which occurred during 2000 under policies written during 2000, i.e., to triangle 5A. Each such loss which was unsettled as of December 31, 2000, is re-evaluated as of December 31, 2001. If settled, any difference between the prior estimate, or reserve, is treated as 2001 development. Cases settled below the reserve or closed without payment produce negative development by the amount of difference, and cases settled for more than the prior reserve produce positive development.

Reserves for cases still pending may be raised, lowered or continued without change, and the net of all such changes may be positive or negative. Finally, paid amounts and pending case reserves relating to 2000 losses not reported until 2001 may differ from the prior

reserve established for such losses; the difference, or development, may be positive or negative. The aggregate net effect of all such development may, of course, be positive or negative, and the boundary is marked with a broken line to indicate this condition.

Figure 6 continues the illustration for yet another year.

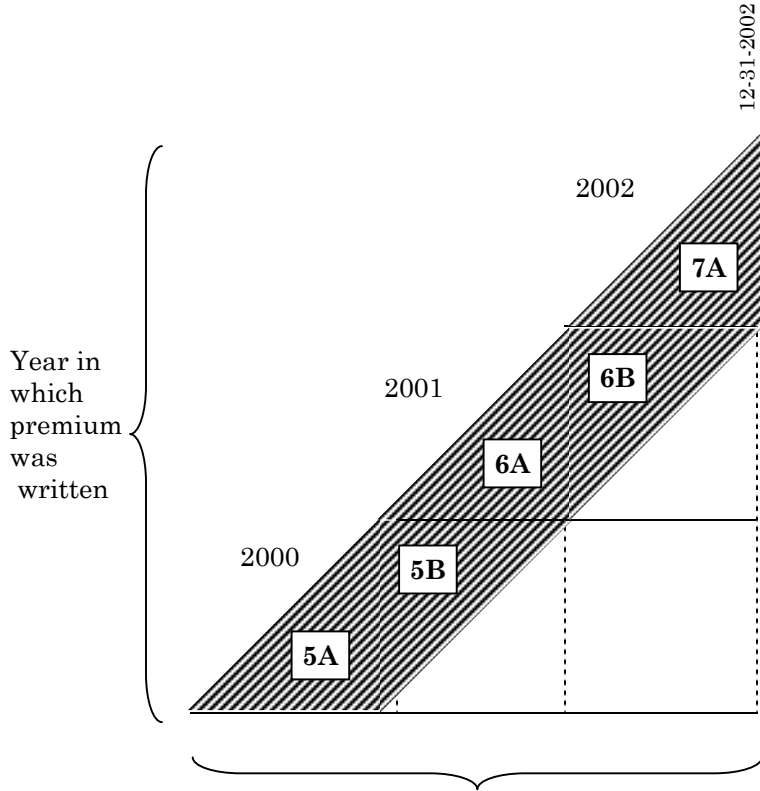


Figure 6. Losses incurred under policies written in three successive policy years evaluated as of the end of the third year.

Figure 6 is drawn to illustrate evaluation as of December 31, 2002, of losses from three successive periods. The figure can be extended for any time period appropriate for the particular type of insurance, depending upon the rapidity of claim settlement. For automobile collision or comprehensive coverages, questions of negligence do not enter and the amount of damage can be objectively determined; thus a relatively short development period is adequate. For the liability coverages, however, settlement values are more subjective and questions of negligence are often present, so that several years may elapse before all claims arising from a selected period are settled.

2. Statistical Compilations

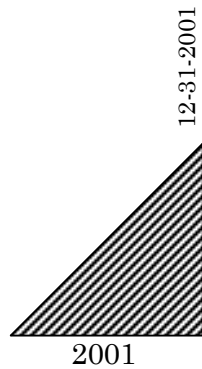
For the purpose of comparing incurred losses with earned premiums so as to derive a loss ratio for use in ratemaking, the policy year basis and the calendar-accident year basis have been widely used by recognized insurance rate making authorities. Both approaches meet the fundamental requirement that premium and loss data must relate to a single set of exposures, and that all premium and loss data arising from such exposures must be considered.

Policy year traces all premium and loss developments related to all exposures **written** during a calendar year. Calendar-accident year traces all premium and loss developments related to all exposures **earned** during a calendar year.

2a. Policy Year Basis

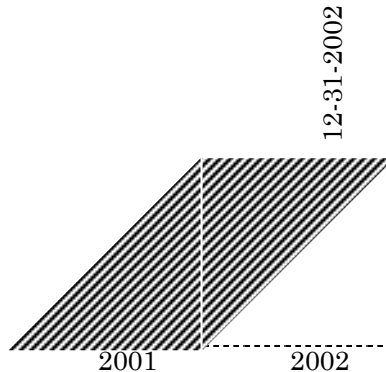
In Figure 7 shown below, the shaded area illustrates the pattern by which policy year 2001 written exposures are earned as of December 31, 2001.

Since all exposures written during 2001 are fully earned as of December 31, 2002, the value of earned exposures for policy year 2001 will be the same at all subsequent review dates. Note, however, that



*Figure 7. Policy year 2001 as of December 31, 2001:
earned premiums or earned exposures*

One year later, policy year 2001 written exposures are fully earned as illustrated in Figure 8.



*Figure 8. Policy year 2001 as December 31, 2002:
Earned premiums or earned exposures*

Since all exposures written during 2001 are fully earned as of December 31, 2002, the value of earned exposures for policy year 2001 will be the same at all subsequent review dates. Note, however, that all data are consolidated and the portions represented in earlier figures by triangles 6A and 6B are not separately identified.

Premiums are earned in exactly the same patterns as exposures.

Policy year 2001 losses incurred as of December 31, 2001, may also be represented by Figure 7. In this context, Figure 7 represents amounts paid and in reserve as of December 31, 2001, under policies written during 2001. One year later, the pattern appears as in Figure 9.

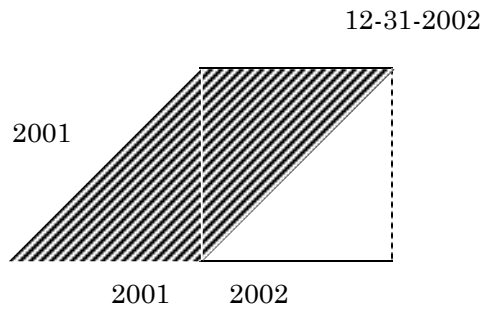


Figure 9. Policy year 2002 as of December 31, 2002: losses incurred

As of December 31, 2002, all accidents which relate to policy year 2001 have occurred. The value of policy year 2001 losses incurred as of this date is the sum of all amounts paid and in reserve under policies written during 2001. Note that this includes payments made and reserves established during 2001 and 2002 in connection with policies written during 2001 plus developments during 2002. However, all data are consolidated and the portions represented in earlier figures as separate triangles are not separately identified.

Incurred losses for policy year 2001 may be evaluated at later dates in order to account for subsequent developments as cases are settled. In Figure 10, the development area is unbounded to the right to indicate this condition:

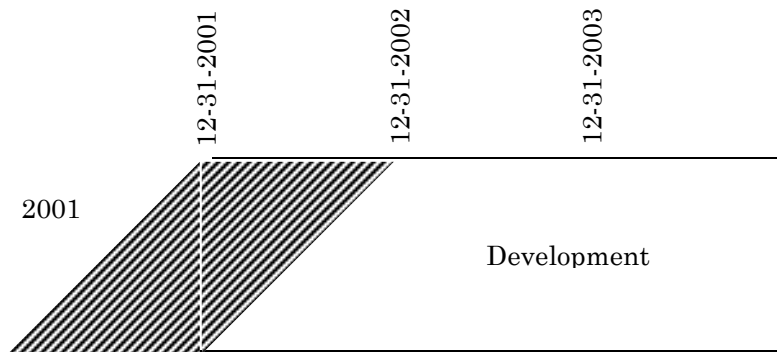


Figure 10. Policy year 2001: development of incurred losses After December 31, 2002

In considering Figure 10, note that the area to the right of the dotted line represents subsequent development of cases initially accounted for by payments or the establishment of reserves closely following occurrence of the accident. The dollar amounts of such development may be positive or negative, but in any case are usually small in relation to the total of incurred losses. The size of the development area in Figure 10 may, therefore, be misleading if this is not borne in mind.

2b. Calendar-Accident Year Basis

Under this basis, all exposures earned during the calendar year are considered. The dotted line in Figure 11 separates triangles 5B and 6A to show that exposures earned during 2001 flow in part from policies written in 2000 and in part from policies written in 2001. However, data are consolidated and exposures are not identified separately as these triangles might suggest.

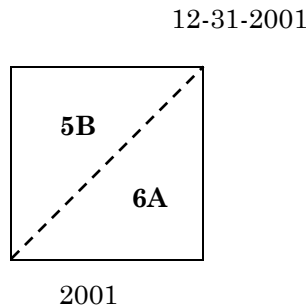


Figure 11. Calendar-accident year 2001 as of December 31, 2001: earned premiums or earned exposures

Since the calendar-accident year basis deals with exposures earned within a calendar year, there will be no change in earned exposures after December 31.

Premiums are earned under the calendar-accident year method in exactly the same pattern as exposures.

Calendar-accident year incurred losses arise from accidents which occur within the calendar year, and they relate to the same exposures from which the calendar-accident year premiums are earned. Figure 11 is, therefore, appropriate as a representation of calendar-accident year incurred losses as of December 31, 2001. Although incurred losses relate in part to part of policy year 2000 (triangle 5B) and in part to part of policy year 2001 (triangle 6A), the respective portions are not separately identified. One year later, the pattern appears as in Figure 12.

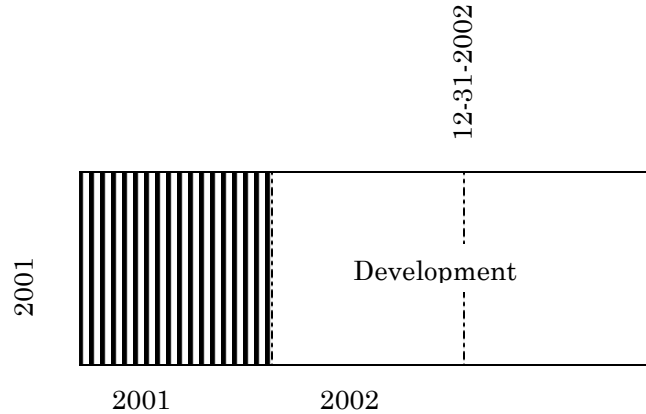


Figure 12. Calendar-accident year 2001 as of December 31, 2001: losses incurred evaluated as of December 31, 2002 and development thereafter

In Figure 12, the component triangles are not shown since the value of incurred losses is the sum of amounts paid and in reserve as of December 31, 2002, with respect to losses which occurred during 2001 as a consolidated total. Further, the figure is unbounded to the right to indicate that subsequent developments will be related back to the same calendar-accident year at any subsequent evaluation date.

Figure 13 carries the illustration forward another year and shows subsequent calendar-accident years as well.

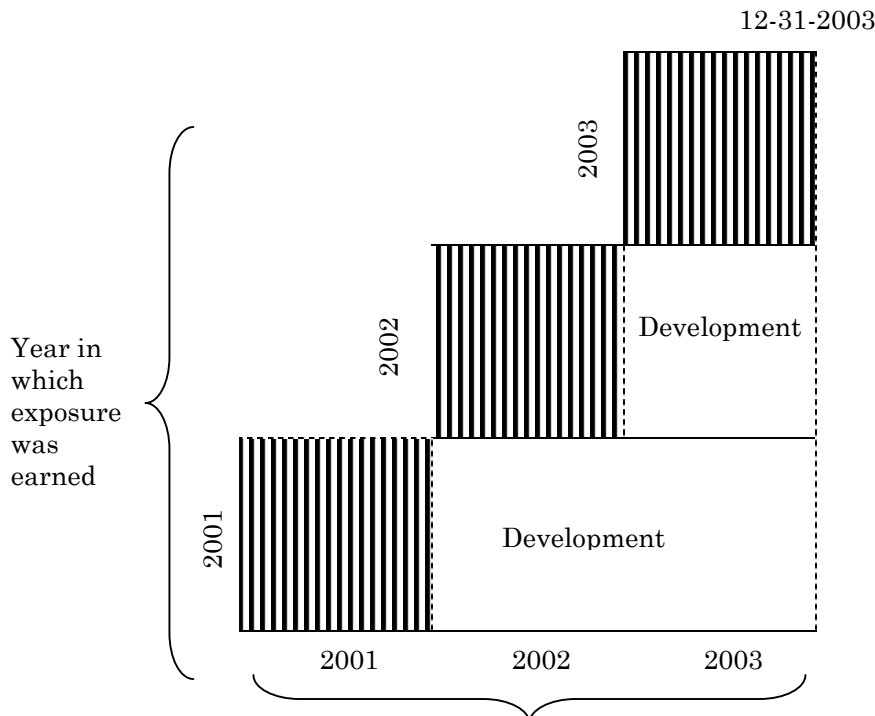


Figure 13. Losses incurred including subsequent development for three successive calendar-accident years evaluated as of the end of the third year

As in the case of policy year data, the sizes of the areas shown in these figures to illustrate development are disproportionately large in relation to the amounts of change in incurred losses. The amounts represented by the areas marked "development" may be positive, negative or nil, and of course, only the aggregate of amounts paid and in reserve as of December 31, 2003, will be identified.

2c. Calendar Year Basis

The calendar year basis is a standard accounting technique which is prescribed by law as the basis upon which insurance companies must prepare their annual statements. It deals with transactions which occur within a specified calendar year and, when compiled as of year-end, represents a closed report which is not subject to further adjustment.

The calendar year basis deals with exposures and premiums developed in exactly the same fashion as under the calendar-accident year basis.

Calendar year incurred losses, however, are equal to payments during the calendar year plus reserves outstanding at the end of the calendar year minus reserves outstanding at the end of the prior year. Calendar year 2001 incurred losses are illustrated in Figure 14.

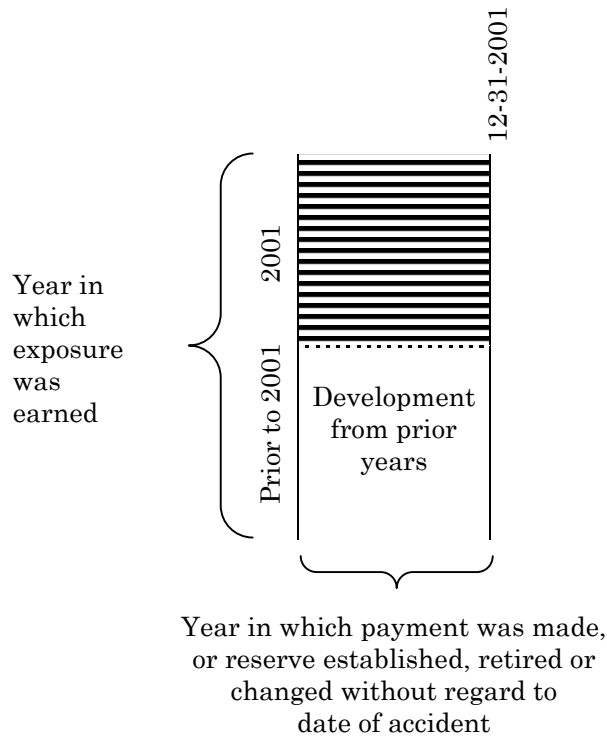


Figure 14. Calendar year 2001: incurred losses

Figure 14 is equivalent to a vertical section from Figure 13. The figure is bounded to the right to indicate that developments subsequent to December 31 can never be reflected in the value of incurred losses. Its lower boundary is broken to show that it reflects development during 2001 arising from all prior years. Comparing Figure 14, which

illustrates calendar year losses incurred, with Figure 11, which illustrates calendar year premiums earned, it is clear that the calendar year includes certain loss data which are not related to premiums earned, and excludes certain other loss data which are so related.

The calendar year basis compares premium information from one set of exposures with part of the loss information from the same set of exposures, plus part of the loss information from other sets of exposures. Therefore, its usefulness for ratemaking purposes is somewhat limited.

2d. Comparisons

Calendar-accident year 2001 earned exposures, earned premiums and incurred losses as of year-end are represented as in Figure 15.

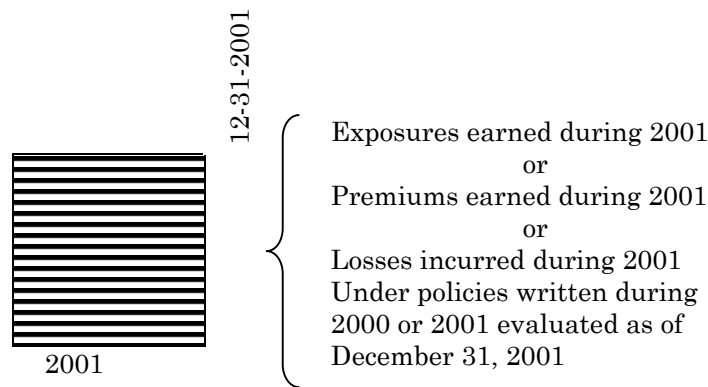


Figure 15. Calendar-accident year 2001 as of December 31, 2001: Earned premiums, earned exposures or losses incurred

Subsequent development of losses is represented by a succession of squares illustrating development of 2001 losses during later years as in Figure 16.

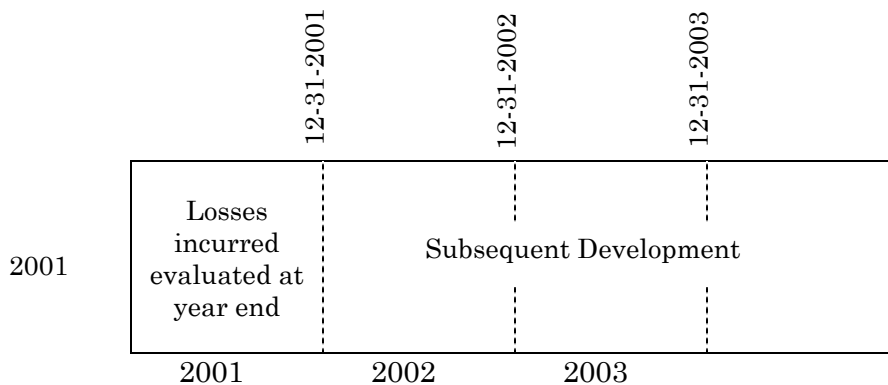


Figure 16. Calendar-accident year 2001: losses incurred as of December 31, 2001, and subsequent development

Policy year 2001 earned exposures, earned premiums and incurred losses as of year-end are represented in Figure 17.

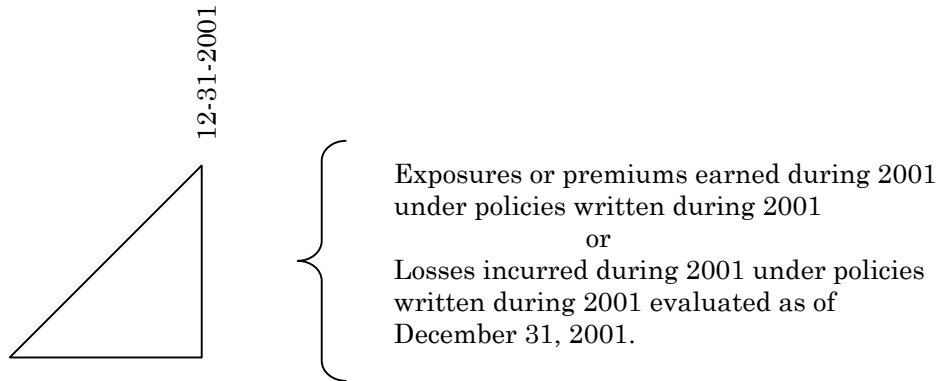


Figure 17. Policy year 2001 as of December 31, 2001: earned premiums, earned exposures or incurred losses

The policy year as of later dates is illustrated as in Figure 18.

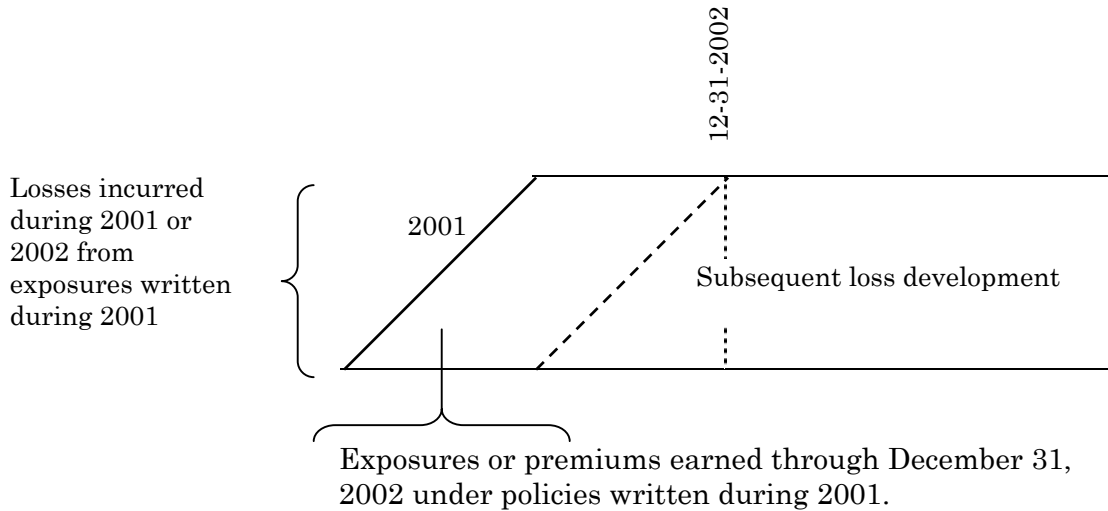


Figure 18. Policy year 2001 as of December 31, 2002: earned premiums, earned exposures or incurred losses, including subsequent development

Calendar year 2001 earned exposures, earned premiums and incurred losses are represented as in Figure 19.

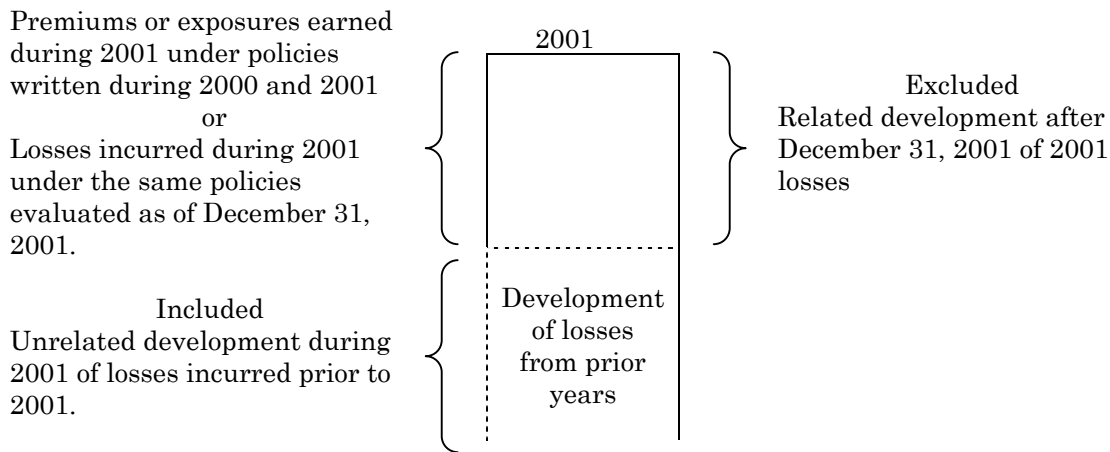


Figure 19. Calendar year 2001 as of December 31, 2001: earned premiums, earned exposures or losses incurred

2e. Summary

Figures 15 through 18 illustrate that both policy year and calendar-accident year statistical methods trace incurred losses throughout their development and relate subsequent developments to the base data. Thus, all premium and loss transactions relating to a particular set of exposures are matched under either method.

On the other hand, Figure 19 illustrates the mismatching of premium and loss information which occurs under the calendar year basis.

If all cases were reported and settled immediately, there would be no pending reserves and no subsequent development. If future settlement values could be foreseen exactly so that reserves could be established perfectly for all cases, there would be no subsequent development. In either case, calendar year data would be reliable for ratemaking and would, in fact, be identical with calendar-accident year data. This, of course, does not occur. As a practical matter, however, this condition is approached in many lines—particularly the property lines—and under those circumstances calendar year data are useful and reliable for ratemaking.

2f. A Specific Comparison

Policy years 2000, 2001, and 2002 evaluated as of December 31, 2002, may be compared with calendar accident years 2000, 2001 and 2002 as in Figure 20.

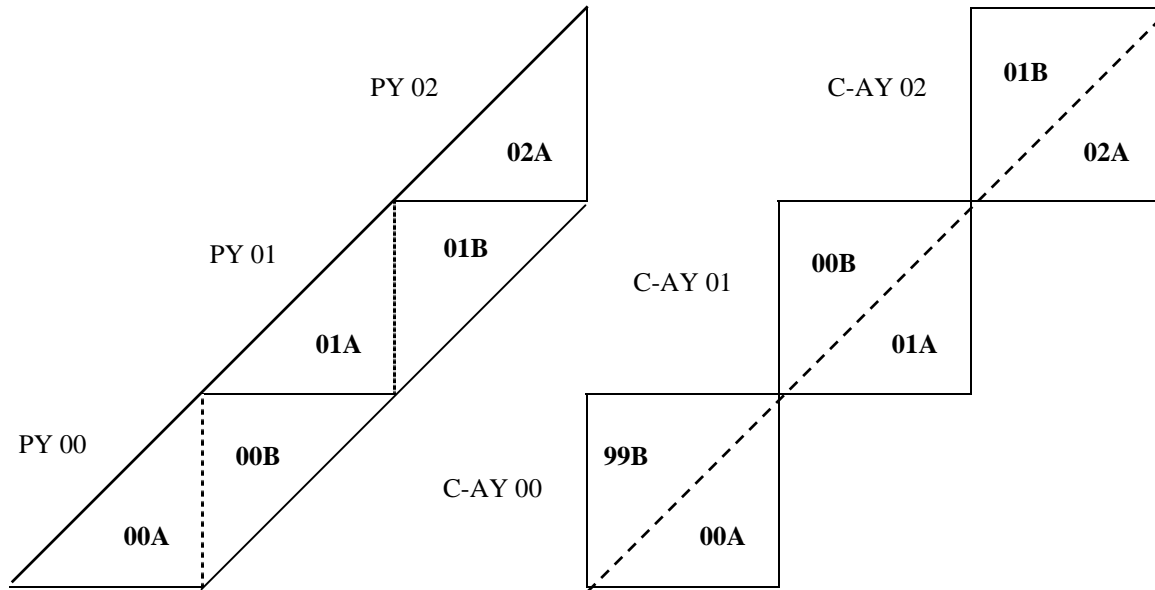


Figure 20. Summary comparison of policy year 2000, 2001 and 2002 and calendar-accident years 2000, 2001 and 2002.

The figures may be taken to be equally representative of exposures, premiums or losses, with the understanding that losses are evaluated in every case to include developments through December 31, 2002. In this figure, triangles are labeled to show that the corresponding components are identical, i.e., triangle 02A in PY 2002 represents data identical with triangle 02A in C-AY 2002. We may change the physical arrangement of the component triangles for more convenient comparison as in Figure 21.

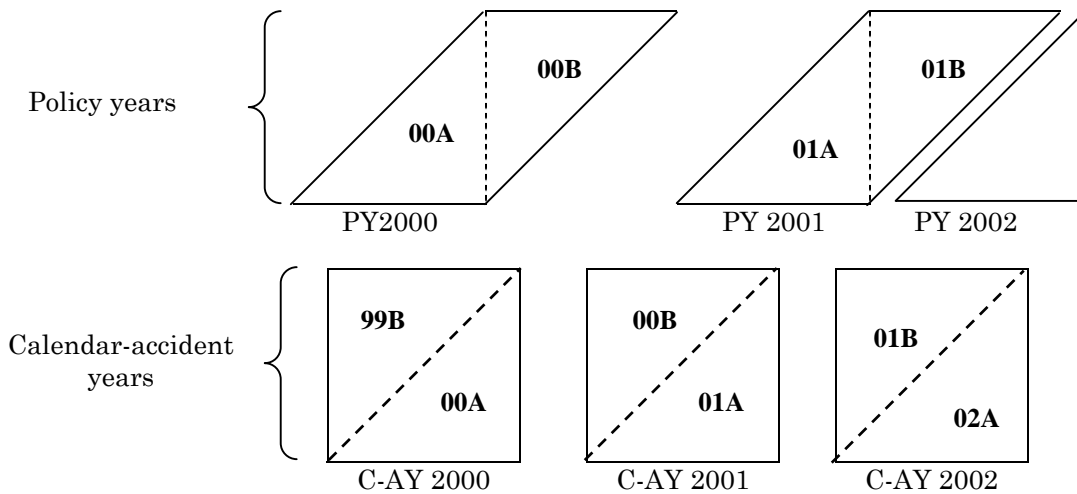


Figure 21. Alternate arrangement of Figure 20 to show direct comparison

Figure 21 illustrates that the only information added by changing from the policy year basis to the calendar-accident year basis is related to exposures earned during 2000 from policies written 1999 (triangle 99B). The figure also illustrates the similarity of the two statistical bases since the only other difference is in the grouping of data.

Still another physical arrangement of the component triangles in a combined figure is shown in Figure 22.

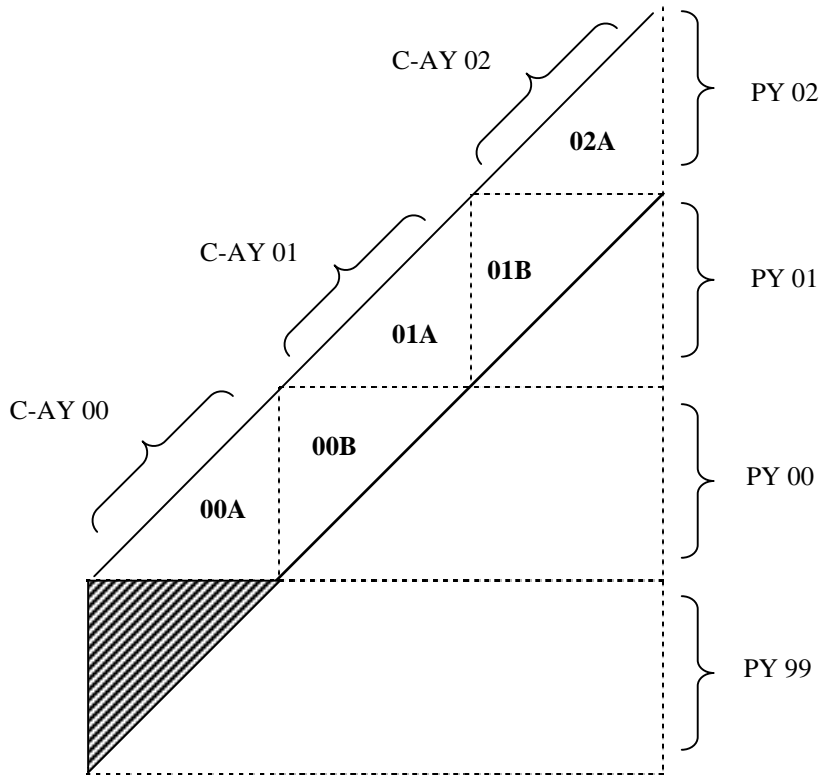


Figure 22. Alternate arrangement of Figure 20 to show the common source of data for policy year and calendar-accident year compilations

In Figure 22, all data are represented by a diagonal bar to illustrate that underlying data are identical under either basis. If a vertical section of the bar is considered, the calendar-accident year basis is represented. A horizontal section, on the other hand, represents the policy year basis.

**Appendix D – Workers’ Compensation Insurance
Individual Case Reports**

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Appendix D – Workers’ Compensation Insurance Individual Case Reports

D. Workers’ Compensation Insurance Individual Case Reports

D.1 Introduction

This section details specific requirements for reporting workers’ compensation Individual Case Reports (ICR) data by insurers to statistical agents and rating organizations. The requirement to report ICRs applies to all insurers licensed to write workers’ compensation policies in California, Delaware, Massachusetts, New Jersey, New York and Pennsylvania.

D.2 Statistical Plan Reporting Requirements

The following data items are currently required on ICRs. For state exceptions refer to the Statistical Plan for ICRs at the end of this appendix.

- Carrier Code
- Report Number
- Policy Effective Date
- Exposure State
- Insured Name
- Policy Number
- Class Code
- Indemnity Incurred
- Indemnity Paid
- Medical Incurred
- Medical Paid
- Temporary Indemnity Incurred
- Loss Condition Codes (Loss Coverage Code)
- Injury Type
- Claimant Data
- Claim Data
- Amount by Class
- Other Claim Data
- Other Claimant Data
- Administrative Data

D.3 Who Reports Data: Reporting Standards for Insurers

Claims which are selected for ICR vary by jurisdiction. In some jurisdictions, ICRs are required on claims with preset dollar amounts. In other jurisdictions, ICRs are required on specified injury types such as death claims or permanent total claims. For example, Pennsylvania requires ICRs for all death and permanent total claims exceeding \$99,999.

ICRs are to be filed no later than the twentieth month after policy effective month in accordance with the Model Workers’ Compensation Statistical Plan and annually thereafter

until the claim involved is closed or until a total of five reports have been filed if the claim involved remains open or if the claim involved, which had previously closed, reopens.

D.4 Ad Hoc Report Development

The ICR process results in a significant amount of detailed information concerning the characteristics of workers' compensation indemnity claims. This information can be useful in identifying the factors which drive workers' compensation claim costs.

For reports developed from ICR information, the appropriate workers' compensation statistical agent for California, Delaware, Massachusetts, New Jersey, New York or Pennsylvania should be contacted. Refer to Appendix B for further information on those organizations. Development of a report will require a clear definition of the information desired, identification of the data elements that will be necessary to obtain that information, the format of the report desired, and the time frame in which it is needed.

Reports may be requested for any element or combination of elements consistent with filed programs and statistical plan. The detail requested should be consistent with the data elements in the Model Workers' Compensation Statistical Plan - Individual Case Reports.

Individual Case Reports (ICR) Form

UNIT STATISTICAL PLAN - INDIVIDUAL CASE REPORT													
CLASS CODE	REPORT NO. CODE	TRAN TYPE CODE	TYPE OF CODE	CARRIER NUMBER	CARRIER NAME				PAYROLL STATE CODE	ADM FILE NUMBER			
POLICY NUMBER		CERT NO	POLICY EFFECTIVE DATE		CLAIM NUMBER	STATUS CODE	DATE ATTNY. DISC		LOSS COV. CODE				
							MO DAY YEAR						
INSURED NAME		ACC DATE		DATE OF DEATH		DATE REPORTED		DATE OF BIRTH		SURG CODE	ATTNY CODE		
		MO DAY YEAR	MO DAY YEAR	MO DAY YEAR	MO DAY YEAR	MO DAY YEAR	MO DAY YEAR						
WORKER LAST NAME	AVG WEEKLY WAGE	INJURY DESC CODE ®	PART	NATURE	CAUSE	OCCUPATION	DATE CLOSED	RESERVE TYPE CODE	DETAILS OF SETTL CODE				
		®					MO YR						
SOCIAL SECURITY NUMBER		DATE SINGLE SUM PAID ®	MO DAY YR	EMPLOYMENT STATUS ®	YEAR LAST EXPOSED ®	DATE OF HIRE	MO DAY YR						
		®	MO DAY YR	®	®	®	MO DAY YR						
BENEFITS OTHER THAN PENSION					PENSION BENEFITS								
KIND OF BENEFIT		% DISAB.	BODY MEM. CODE	NO WEEKS	INCURRED	BENEFICIARY DATA			CALCULATIONS				
1. TEMPORARY INDEMNITY		XXX	XXX			CODE	DATE OF BIRTH						
							MO YR DA						
2. SCHEDULED INDEMNITY													
3. NON-SCHEDULED INDEMNITY			XXX	XXX									
4. EMPLOYERS LIABILITY OR OTHER INDEMNITY													
5. VOCATIONAL REHABILITATION TOTAL INCURRED													
6. CLAIMANT LEGAL EXPENSE						7. PENSION INDEM PAID TO VAL DATE							
PHYSICIAN PAID		TEMP PAID	DISAB			8. PENSION INDEM PREV RSVD NOT PAID							
HOSPITAL PAID		PERM PARTIAL PAID				9. PRES VAL FUTURE INDEM. PMNT.							
APP MEDICAL EVAL PAID		PERM TOTAL PAID				10. FUNERAL ALLOWANCE							
DEFENSE MED. EVAL PAID		DEATH PAID				11. LUMP SUM REMARRIAGE							
INDEPENDENT MED EVAL PAID		SINGLE SUM PAID				12. TOTAL INCURRED INDEM (SUM 1-11)							
LEGAL EXPENSE - DEFENSE		V.R. PAID				13. TOTAL INCURRED MEDICAL							
ANNUITY PURCH AMOUNT		V.R. INDEMNITY INCURRED				14. TOTAL INDEM PAID TO VAL DATE							
TOTAL GROSS INCURRED		V.R. TRAINING INCURRED				15. TOTAL MED PAID TO VAL DATE							
		V.R. EVAL INCURRED				16. SOC SEC OR OTHER OFFSET AMT.							
SEE REVERSE FOR CODING													

Individual Case Reports

LIST OF DATA ITEMS

1. Carrier Code
2. Report Number
3. Policy Effective Date
4. Exposure State
5. Insured Name
6. Policy Number
7. Class Code
8. Indemnity Incurred
9. Indemnity Paid
10. Medical Incurred
11. Medical Paid
12. Temporary Indemnity Incurred
13. Loss Condition Code (Loss Coverage Code)
14. Injury Type (varies by state)
15. Claimant Data
16. Claim Data
17. Amounts By Class (requirements vary by state)
18. Other Claim Data (requirements vary by state)
19. Other Claimant Data (requirements vary by state)
20. Administrative Data (requirements vary by state)

DATA ITEMS

1. Carrier Code

A unique code assigned by the bureau to each insurance company.

2. Report Number

A code that indicates the number of times data for a claim has been reported, excluding correction reports, that corresponds to the number of claim valuations.

3. Policy Effective Date

The inception date of the policy as shown on the policy information page.

4. Exposure State

A code that identifies the state of the employer's (insured's) facility. The state under which exposure is rated on the policy.

5. Insured Name

Identifies the person or business with whom an insurance contract is made and who is specifically designated by name in Item 1 of the Policy Information Page.

6. Policy Number

The alpha/numeric code assigned by the carrier which uniquely identifies the policy which has been issued to the insured. This number must be identical to the policy number shown on the Policy Information Page.

7. Class Code

The class code where the payroll of the injured worker was reported.

8. Indemnity Incurred

The whole dollar amount paid to date and expected to be paid in the future (minus recoveries from third parties) to an injured employee and/or dependent due to the employee's lost wages or inability to work.

9. Indemnity Paid

The whole dollar amount to date (minus recoveries from third parties) to an injured employee and/or dependent due to the employee's lost wages or inability to work.

10. Medical Incurred

The whole dollar amount paid to date and expected to be paid in the future (minus recoveries from third parties) for medical or hospital treatment to an injured employee because of a work-related injury.

11. Medical Paid

The whole dollar amount paid to date (minus recoveries from third parties) for medical or hospital treatment to an injured employee because of a work-related injury.

12. Temporary Indemnity Incurred

The whole dollar amount paid to date and expected to be paid in the future to the injured worker for the period of time designated by the state for "temporary" benefits.

13. Loss Condition Code (Loss Coverage Code)

- The act under which coverage is provided:
 - State
 - USL&H
 - Federal Coal Mine Health and Safety
 - Maritime/Admiralty
 - FELA
- The cause of loss:
 - Trauma
 - Occupational disease
 - Cumulative injury
- The basis of liability:
 - Workers' Compensation only
 - Employers Liability only
 - Workers' Compensation and Employers Liability
 - Liability Over
- Whether reimbursement from a third party was received by the carrier.
- Whether the loss involves vocational rehabilitation benefits.
- Whether the benefits are being paid under the statutes of the exposure state.

14. Injury Type (some categories of injury type vary by state)

A code, which identifies under which provision(s) of the law, benefits are paid or expected to be paid. The minimum information for every state includes:

- Death
- Permanent total disability
- Permanent partial disability
- Temporary total disability
- Temporary partial disability
- Medical only

15. Claimant Data

- Worker's last name
- Date of birth
- Date of death
- Average weekly wage of claimant
- Part of body injured
- Nature of the injury
- Cause of the injury
- Beneficiary date of birth (pension claims only)

16. Claim Data

- Scheduled indemnity – percentage disability
- Claim number assigned to the individual loss by the insurer/self-insurer
- Claim status (open/closed/reopened/resolved)
- Method of settlement
- Date of accident
- Date claim reported to insurer
- Attorney or authorized representative indicator

The following data items are not required by all states that require ICRs. The table on the right designates which states requires the data item.

17. Amounts By Class

	<u>CA</u>	<u>DE</u>	<u>MA</u>	<u>NJ</u>	<u>NY</u>	<u>PA</u>
• Scheduled Indemnity Incurred		X	X	X	X	X
• Non-Scheduled Indemnity Incurred		X	X	X	X	X
• Empl. Liab. or Other Indemnity Incurred		X	X	X	X	X
• Temporary Benefits Paid			X		X	
• Permanent Partial Benefits Paid	X		X			
• Permanent Total Benefits Paid	X		X			
• Vocational Rehab. Indemnity Incurred	X		X			
• Vocational Rehab. Training Incurred	X		X			
• Vocational Rehab. Evaluation Incurred	X		X			
• Total Vocational Rehab. Incurred		X	X	X		X
• Total Vocational Rehab. Paid	X		X	X		
• Total Gross Incurred	X					
• Social Security Offset Amount			X	X	X	
• Single Sum Settlement Paid	X					X
• Hospital Cost Paid	X		X	X		
• Physician Cost Paid	X		X	X		
• Death Benefits Paid	X		X			
• Funeral Allowance Paid		X	X	X	X	X
• Applicant's Medical Evaluation Paid	X		X			
• Defense Medical Evaluation Paid	X		X			
• Independent Medical Evaluation Paid	X		X			
• Lump Sum Remarriage Payment		X		X	X	X
• Pension Indemnity Benefits Paid		X	X	X	X	X
• Pension Prev. Reserved But Not Yet Paid		X	X	X		X
• Annuity Purchased Amount		X				X
• Present Value of Future Indemnity Payments		X	X	X	X	X
• Defense Legal Expense Paid			X	X	X	X
• Claimant Legal Expense Paid (only if avail.)	X	X	X	X		X

18. Other Claim Data

	<u>CA</u>	<u>DE</u>	<u>MA</u>	<u>NJ</u>	<u>NY</u>	<u>PA</u>
• Scheduled Indemnity-Body Part		X	X	X	X	X
• Non-Scheduled Indemnity-Percent Disability		X	X	X	X	X
• Weeks of Temporary Total Benefits		X	X	X	X	X
• Weeks of Scheduled Indemnity Benefits		X	X	X	X	X
• Date of Closing		X	X	X	X	X
• Transaction Type		X	X	X	X	X
• Surgery Indicator	X		X	X		
• Reserve Type Code		X	X	X	X	X

19. Other Claimant Data

	<u>CA</u>	<u>DE</u>	<u>MA</u>	<u>NJ</u>	<u>NY</u>	<u>PA</u>
• Employment Status	X	X		X		X
• Occupation of Claimant		X	X	X	X	X
• Social Security Number	X		X	X		
• Date of Hire	X	X		X		
• Last Year Exposed		X	X	X		X
• Date Attorney Disclosure Form Received	X					
• Date Single Sum Paid		X				X
• Beneficiary Code: Dependency ¹		X				
• Beneficiary Code: Relationship ¹	X	X	X	X	X	X

20. Administrative Data

	<u>CA</u>	<u>DE</u>	<u>MA</u>	<u>NJ</u>	<u>NY</u>	<u>PA</u>
• Certificate Number	X					
• Carrier Name	X	X		X	X	X

¹ Pension claims only. Same field on ICR form. Different definition of use by CA than rest of Bureaus.

**Appendix E – Workers’ Compensation Insurance
Detailed Claim Information Reports**

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Appendix E – Workers’ Compensation Insurance Detailed Claim Information Reports

E. Workers’ Compensation Insurance Detailed Claim Information Reports

E.1 Introduction

This section details specific requirements for reporting workers’ compensation Detailed Claim Information (DCI) data by insurers to statistical agents and rating organizations. The requirement to report DCIs applies to all insurers licensed to write workers’ compensation policies in all states except Alaska, California, Delaware, and Maine and the monopolistic states of Nevada, North Dakota, Ohio, Washington, West Virginia and Wyoming.

E.2 Statistical Plan Reporting Requirements

The following data items are currently required on DCI reports. For state exceptions refer to the Model Statistical Plan for DCIs at the end of this appendix.

- Carrier Code
- Report Number
- Policy Effective Date
- Jurisdiction State
- Insured Name
- Policy Number
- Class Code
- Indemnity Incurred
- Indemnity Paid by Benefit Type
- Medical Incurred
- Medical Paid
- Loss Condition Codes (Loss Coverage Code)
- Benefit Type
- Employer Payroll Code
- Claimant Data
- Claim Data
- Claimant Legal Expense
- Employer Data
- Other Claimant Data
- Other Claim Data

E.3 Who Reports Data: Reporting Standards for Insurers

Indemnity claims are selected for the call for DCI based upon a specified sampling procedure. The percent sample is selected in inverse proportion to the number of workers’ compensation claims per state. The percentage of indemnity claims selected by each insurer ranges from five percent in the largest states to 40 percent in the smallest states. Texas has a \$5,000 threshold for combined medical and indemnity claims.

DCI is to be filed no later than eight months after the claim's report month in accordance with the Model Workers' Compensation Statistical Plan—Detailed Claim Information Reports and annually thereafter until the claim involved is closed or until a total of nine reports have been filed if the claim involved remains open or if the claim involved, which had previously closed, reopens.

E.4 Ad Hoc Report Development

The DCI process results in a significant amount of detailed information concerning the characteristics of workers' compensation indemnity claims. This information can be useful in identifying the factors that drive workers' compensation claim costs.

Refer to Appendix B to identify the appropriate workers' compensation statistical agent from which reports may be requested. Development of a report will require a clear definition of the information desired, identification of the data elements that will be necessary to obtain that information, the format of the report desired, and the time frame in which it is needed.

Reports may be requested for any element or combination of elements consistent with filed programs and statistical plans. The detail requested should be consistent with the data elements in the Model Workers' Compensation Statistical Plan—Detailed Claim Information Reports.

Call For Detailed Claim Information

COMMON INFORMATION																																																																
INSURER NAME					1. CARRIER CODE					2. POLICY NUMBER																																																						
3. POLICY EFFECTIVE DATE				4. CLAIM NUMBER					5. REPORT TYPE			6. TRANSACTION CODE																																																				
7. STATE OF JURISDICTION			8. STATE OF ACCIDENT		9. DATE REPORTED TO INSURER		10. EMPLOYEE SOCIAL SECURITY NO			1 - ORIGINAL REPORT 2 - REVISED REPORT																																																						
CLAIMANT AND EMPLOYER INFORMATION																																																																
11. EMPLOYER FEDERAL TAX NO				12. EMPLOYER SIC CODE		13. EMPLOYER PAYROLL 1 - \$0 4 - \$1,000,01 - \$10,000,000 2 - \$1 - \$100,000 5 - OVER \$10,000,000 3 - \$100,001-\$1,000,000				14. ZIP CODE OF INJURY STATE		15. EMPLOYEE NAME LAST FIRST																																																				
16. SEX 1 - MALE 2 - FEMALE 3 - UNKNOWN		17. MARITAL STATUS 1 - SINGLE 3 - SEPARATED 2 - MARRIED 4 - UNKNOWN			18. DATE OF BIRTH				19. DATE OF HIRE		20. OCC CODE	21. EMPLOYMENT STATUS 1 - REGULAR EMPLOYEE 2 - PART TIME EMPLOYEE 3 - UNEMPLOYED																																																				
22. DATE OF INJURY		23. CLASS CODE	24. PART OF BODY	25. NATURE OF INJURY		26. CAUSE OF INJURY	27. LOSS COVERAGE CODE		28. NO OF DEPENDENTS		4 - ON STRIKE 5 - DISABLED 6 - RETIRED 7 - OTHER																																																					
29. PRE-INJURY WEEKLY WAGE		30. METHOD OF DETERMINING PRE-INJURY WAGE 1-ACTUAL 3-MIN 2-ESTIMATED 4-MAX				31. OTHER WEEKLY PAYMENTS		32. DATE REPORTED TO EMPLOYER		33. SURGERY 1 - YES 2 - NO	34. CLAIM STATUS 1-OPEN 2-OPEN (MED ONLY) 3-REOPENED 4-CLOSED 5-BECAME MED ONLY 6-REOPENED, CLOSED																																																					
35. DATE OF CLOSING			36. DATE OF FIRST PAYMENT			37. DATE DISABILITY BEGAN		38. DATE OF RETURN TO WORK																																																								
BENEFITS AND PAYMENTS																																																																
INDEMNITY BENEFITS																																																																
39. TOTAL INCURRED (INCL. VOC. REHAB.)																																																																
					VOCATIONAL REHABILITATION					MEDICAL BENEFITS																																																						
40. BENEFIT TYPE	41. BENEFITS PAID TO DATE			42. WEEKLY BENEFIT		43. BENEFIT TYPE			44. BENEFITS PAID TO DATE			45. WEEKLY BENEFIT		46. BENEFIT TYPE			47. BENEFITS PAID TO DATE			48. WEEKLY BENEFIT		49. BENEFIT TYPE			50. BENEFITS PAID TO DATE			51. WEEKLY BENEFIT		52. BENEFIT TYPE			53. BENEFITS PAID TO DATE			54. WEEKLY BENEFIT		55. TOTAL INCURRED VOC. REHAB.			56. VOC REHAB EVALUATION EXPENSE PAID TO DATE			57. COV REHAB MAINTENANCE BENEFIT PAID TO DATE			58. VOC REHAB EDUCATION EXPENSE PAID TO DATE			59. OTHER VOC REH EXPENSES PAID TO DATE			60. TOTAL INCURRED MEDICAL			61. HOSPITAL COSTS PAID TO DATE			62. TOTAL PAYMENTS TO PHYSICIANS			63. OTHER MEDICAL PAID TO DATE		
MISCELLANEOUS INFORMATION															OTHER BENEFITS AND PAYMENTS																																																	
64. POST INJURY WEEKLY WAGE			65. PERCENTAGE IMPAIRMENT		66. DATE OF MAXIMUM MEDICAL IMPROVEMENT			67. FUNERAL EXPENSE PAID TO DATE		68. LUMP SUM SETTLEMENT AMOUNT			69. EMPLOYERS LIABILITY PAID TO DATE																																																			
CLAIM ADMINISTRATION DETAILS																																																																
70. ATTORNEY OR AUTH. REP 1 - YES 2 - NO				71. CONTROVERTED CASE 1 - YES 2 - NO			72. DEDUCTIBLE 1 - YES 2 - NO		73. PRODUCT LIABILITY			74. AUTO LIABILITY		75. OTHER																																																		
OTHER AMOUNTS PAID TO DATE																																																																
76. EMPLOYER LEGAL EXPENSE PAID TO DATE				77. CLAIMANT LEGAL EXPENSE PAID TO DATE				78. EXPERT WITNES FEES PAID TO DATE			79. PENALTIES PAID TO DATE			80. ALLOCATED ADJUST EXPENSE PAID TO DATE																																																		
BENEFIT OFFSETS																																																																
81. SOCIAL SECURITY 1 - YES 2 - NO				82. UNEMPLOYMENT 1 - YES 2 - NO				83. PENSION PLAN 1 - YES 2 - NO			84. SPECIAL FUND 1 - YES 2 - NO			85. OTHER 1 - YES 2 - NO																																																		

**Model Workers' Compensation Statistical Plan
Detailed Claim Information (DCI) Reports**

LIST OF DATA ITEMS

1. Carrier Code
2. Report Number
3. Policy Effective Date
4. Jurisdiction State
5. Insured Name
6. Policy Number
7. Class Code
8. Indemnity Incurred
9. Indemnity Paid By Benefit Type
10. Medical Incurred
11. Medical Paid
12. Loss Condition Codes (Loss Coverage Code)
13. Benefit Type (varies by state)
14. Employer Payroll Code
15. Claimant Data
16. Claim Data
17. Claimant Legal Expense (only if known by insurer)
18. Employer Data
19. Other Claimant Data
20. Other Claim Data

DATA ITEMS

1. Carrier Code

A unique code assigned by the bureau to each company.

2. Report Number

A code that indicates the number of times data for a claim has been reported, excluding correction reports, that corresponds to the number of claim valuations.

3. Policy Effective Date

The inception date of the policy as shown on the policy information page.

4. Jurisdiction State

A code that identifies the state of the employer's (insured's) facility. The state under which exposure is rated on the policy.

5. Insured Name

Identifies the person or business with whom an insurance contract is made and who is specifically designated by name in Item 1 of the Policy Information Page.

6. Policy Number

The alpha/numeric code assigned by the carrier that uniquely identifies the policy that has been issued to the insured. This number must be identical to the policy number shown on the Policy Information Page.

7. Class Code

The class code where the payroll of the injured worker was reported.

8. Indemnity Incurred

The whole dollar amount paid to date and expected to be paid in the future (minus recoveries from third parties) to an injured employee and/or dependent due to the employee's lost wages or inability to work.

9. Indemnity Paid By Benefit Type

The whole dollar amount paid to date (minus recoveries from third parties) by benefit type to an injured employee and/or dependent due to the employee's lost wages or inability to work.

10. Medical Incurred

The whole dollar amount paid to date and expected to be paid in the future (minus recoveries from third parties) for medical or hospital treatment to an injured employee because of a work-related injury.

11. Medical Paid

The whole dollar amount paid to date (minus recoveries from third parties) for medical or hospital treatment to an injured employee because of a work-related injury.

12. Loss Condition Codes (Loss Coverage Code)

- The act under which coverage is provided:
 - State
 - USL&H
 - Federal Coal Mine Health and Safety
 - Maritime/Admiralty
 - FELA

- The cause of loss:
 - Trauma
 - Occupational disease
 - Cumulative injury
- The basis of liability:
 - Workers' Compensation only
 - Employers Liability only
 - Workers' Compensation and Employers Liability
 - Liability Over
- Whether reimbursement from a third party was received by the carrier.
- Whether the loss involves vocational rehabilitation benefits.
- Whether the benefits are being paid under the statutes of the exposure state.

13. Benefit Type (varies by state)

A code, which identifies under which provision(s) of the law, benefits are paid or expected to be paid. The minimum information for every state includes:

- Death
- Permanent total disability
- Permanent partial disability
- Temporary total disability
- Temporary partial disability
- Medical only

14. Employer Payroll Code

A code that indicates the range corresponding to the amount of payroll of the employer in the state of jurisdiction.

- 0
- \$1 – \$100,000
- \$100,001 – \$1,000,000
- \$1,000,001 – \$10,000,000
- over \$10,000,000

15. Claimant Data

- Worker's last name
- Date of birth
- Date of death
- Average weekly wage of claimant
- Part of body injured
- Nature of the injury
- Cause of the injury
- Beneficiary date of birth (pension claims only)

The following DCI data items are reported if they are available from the first report of injury and/or if they are required by a particular state.

16. Claim Data

- Scheduled indemnity – percentage disability
- Claim number assigned to the individual loss by the insurer/self-insurer
- Claim status (open/closed/reopened/resolved)
- Method of settlement
- Date of accident
- Date claim reported to insurer
- Attorney or authorized representative indicator

17. Claimant Legal Expense (if known by insurer)

Amount of claimant legal expense paid by the insurer for the claimant.

18. Employer Data

- Employer SIC code
- Federal employers tax ID number

19. Other Claimant Data

- Social security number
- Sex
- Marital status
- Date of hire
- Number of dependents
- Post injury weekly wage

20. Other Claim Data

- Date of return to work
- Percentage of impairment
- Date of maximum medical improvement

**Appendix F – Workers’ Compensation Insurance
Policy Information Data**

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Appendix F – Workers’ Compensation Insurance Policy Information Data

F. Workers’ Compensation Insurance Policy Information Data

F.1 Introduction

This section provides an overview of the data available from the policy information systems of statistical agents and rating organizations.

F.2 Available Data Elements

The following data items are available from the workers’ compensation statistical agents and rating organizations listed in Appendix A. These data are generally obtained from policy declarations and endorsements.

- Carrier Code
- Named Insured
- Address of Insured
- Policy Number
- Voluntary or Assigned Risk
- Policy Effective Date
- Policy Expiration Date
- Experience Modification Factor
- Class Code
- Charged Rate
- Estimated Exposure
- Estimated Annual Premium for the Class
- Total Estimated State Standard Premium
- Policy Total Estimated Standard Premium

It is not practical to list every possible policy information data element. For further information on available data elements, contact the appropriate workers’ compensation statistical agent or rating organization listed in Appendix B.

F.3 Who Reports Data: Reporting Standards for Insurers

All insurers report policy information data. Subject to some state exceptions, insurers must submit policy information pages, all schedule pages and attached endorsements within 30 days of the policy effective date. Such submissions may be made in either electronic or hard copy form.

F.4 Ad Hoc Report Development

Workers’ compensation statistical agents and rating organizations provide proof of coverage information to workers’ compensation administrative agencies in a number of states. Insurance departments can request regular or ad hoc reports. Refer to Appendix B to identify the appropriate workers’ compensation statistical agent from which reports may be

requested. Development of a report will require a clear definition of the information desired, identification of the data elements that will be necessary to obtain that information, the format of the report desired, and the time frame in which it is needed.

Reports may be requested for any element or combination of elements consistent with data available in the policy information system. The utility of policy information arises from the fact that it is collected as policies are issued, not after the policies have expired and have been audited, as is the case for unit statistical data. Data is available shortly after it has been reported. However, a period of time should be allowed to pass when looking at all activity for policies with specific effective dates.

Policy Information

LIST OF MAJOR DATA ITEMS

1. Carrier Code
2. Named Insured
3. Address of Insured
4. Policy Number
5. Voluntary or Assigned Risk
6. Policy Effective Date
7. Policy Expiration Date
8. Experience Modification Factor
9. Class Code
10. Charged Rate
11. Estimated Exposure
12. Estimated Annual Premium for the Class
13. Total Estimated State Standard Premium
14. Policy Total Estimated Standard Premium

DATA ITEMS

1. Carrier Code

A unique code assigned by the bureau to each company.

2. Named Insured

The person or business with whom an insurance contract is made and who is specifically designated by name in Item 1 of the policy information page.

3. Address of Insured

Street number and name, post office box or other description, city, state and zip. (Each piece of this information is collected and available separately.)

4. Policy Number

The alpha/numeric code assigned by the carrier that uniquely identifies the policy that has been issued to the insured. This number must be identical to the policy number shown on the policy information page. It is used to identify the policy and match policy data.

5. Voluntary or Assigned Risk

Indicates whether the policy is voluntary or assigned risk.

6. Policy Effective Date

The inception date of the policy.

7. Policy Expiration Date

The expiration date of the policy.

8. Experience Modification Factor

This is the experience modifier on the policy.

9. Class Code

A statistical code (e.g., 8810 for clerical workers) as defined in rating and statistical plans.

10. Charged Rate

The charge per \$100 of payroll for a specific class code, as shown on the policy.

11. Estimated Exposure

Payroll anticipated for the class codes being reported by the insured during the policy period.

12. Estimated Annual Premium for the Class

The estimated premium amount for the class code being reported.

13. Total Estimated State Standard Premium

The estimated total standard premium for all class codes on a policy for a particular state.

14. Policy Total Estimated Standard Premium

This is the sum of estimated state standard premiums for all states covered by the policy.

**Appendix G – Medical Professional Liability Closed Claims Reporting
Model Law**

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G. Medical Professional Liability Closed Claims Reporting Model Law G-1

MEDICAL PROFESSIONAL LIABILITY CLOSED CLAIM REPORTING MODEL LAW

Table of Contents

Section 1.	Statement of Purpose
Section 2.	Definitions
Section 3.	Applicability and Scope
Section 4.	Reporting Requirements
Section 5.	Required Data Elements
Section 6.	Confidentiality of Data
Section 7.	Authority to Adopt Rules
Section 8.	Effective Date

Drafting Introductory Note: This model law pertains to the collection of data necessary to accomplish the purpose stated in Section 1. It is not intended to discourage states from collecting additional data for other purposes.

Section 1. Statement of Purpose

This Act is intended to ensure the availability of closed claim data necessary for thorough analysis and understanding of issues associated with medical professional liability claims, in order to support the establishment and maintenance of sound public policy.

Section 2. Definitions

As used in this Act:

- A. “Claim” means:
 - (1) A demand for monetary damages for injury or death caused by medical malpractice; or
 - (2) A voluntary indemnity payment for injury or death caused by medical malpractice.
- B. “Claimant” means a person, including a decedent’s estate, who is seeking or has sought monetary damages for injury or death caused by medical malpractice.
- C. “Closed claim” means a claim that has been settled or otherwise disposed of by the insuring entity, self-insurer, facility or provider. A claim may be closed with or without an indemnity payment to a claimant.
- D. “Commissioner” means the commissioner of insurance.
- E. “Companion claims” means separate claims involving the same incident of medical malpractice made against other providers or facilities.
- F. “Economic damages” means objectively verifiable monetary losses, including medical expenses, loss of earnings, burial costs, loss of use of property, cost of replacement or repair, cost of obtaining substitute domestic services and loss of business or employment opportunities.

- G. “Health care facility” or “facility” means a clinic, diagnostic center, hospital, laboratory, mental health center, nursing home, office, surgical facility, treatment facility or similar place where a health care provider provides health care to patients.
- H. “Health care provider” or “provider” means:
- (1) A person licensed to provide health care or related services, including an acupuncturist, doctor of medicine or osteopathy, a dentist, a nurse, an optometrist, a podiatric physician and surgeon, a chiropractor, a physical therapist, a psychologist, a pharmacist, an optician, a physician’s assistant, a midwife, an osteopathic physician’s assistant, a nurse practitioner or a physician’s trained mobile intensive care paramedic. If the person is deceased, this includes his or her estate or personal representative; or
 - (2) An employee or agent of a person described in paragraph (1) of this subsection, acting in the course and scope of his or her employment. If the employee or agent is deceased, this includes his or her estate or personal representative.
- I. “Insuring entity” means:
- (1) An authorized insurer;
 - (2) A captive insurer;
 - (3) A joint underwriting association;
 - (4) A patient compensation fund;
 - (5) A risk retention group; or
 - (6) An unauthorized insurer that provides surplus lines coverage.
- J. “Medical malpractice” means an actual or alleged negligent act, error, or omission in providing or failing to provide health care services.
- K. “Noneconomic damages” means subjective, nonmonetary losses, including pain, suffering, inconvenience, mental anguish, disability or disfigurement incurred by the injured party, emotional distress, loss of society and companionship, loss of consortium, humiliation and injury to reputation, and destruction of the parent-child relationship.
- L. “Self-insurer” means any health care provider, facility, or other individual or entity that assumes operational or financial risk for claims of medical professional liability.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term “commissioner” appears.

Drafting Note: If some of these terms are already defined elsewhere in this State’s statutes, references to those statutes may be substituted for the definitions above. If some types of insuring entities are defined elsewhere in this State's statutes, those definitions may be cited.

Section 3. Applicability and Scope

This Act shall apply to all medical professional liability claims in this State, regardless of whether or how they are covered by medical professional liability insurance.

Section 4. Reporting Requirements

A. For claims closed on or after January 1, [insert year]:

- (1) Every insuring entity or self-insurer that provides medical professional liability insurance to any facility or provider in this State must report each medical professional liability closed claim to the commissioner.
- (2) A closed claim that is covered under a primary policy and one or more excess policies shall be reported only by the insuring entity that issued the primary policy. The insuring entity that issued the primary policy shall report the total amount, if any, paid with respect to the closed claim, including any amount paid under an excess policy, any amount paid by the facility or provider, and any amount paid by any other person on behalf of the facility or provider.
- (3) If a claim is not covered by an insuring entity or self-insurer, the facility or provider named in the claim must report it to the commissioner after a final claim disposition has occurred due to a court proceeding or a settlement by the parties. Instances in which a claim may not be covered by an insuring entity or self-insurer include situations in which:
 - (a) The facility or provider did not buy insurance or maintained a self-insured retention that was larger than the final judgment or settlement;
 - (b) The claim was denied by an insuring entity or self-insurer because it did not fall within the scope of the insurance coverage agreement; or
 - (c) The annual aggregate coverage limits had been exhausted by other claim payments.
- (4) If a claim is covered by an insuring entity or self-insurer that fails to report the claim to the commissioner, the facility or provider named in the claim must report it to the commissioner after a final claim disposition has occurred due to a court proceeding or a settlement by the parties.
 - (a) If a facility or provider is insured by a risk retention group and the risk retention group refuses to report closed claims and asserts that the federal liability risk retention act (95 Stat. 949; 15 U.S.C. Sec. 3901 et seq.) preempts state law, the facility or provider must report all data required by this Act on behalf of the risk retention group.
 - (b) If a facility or provider is insured by an unauthorized insurer and the unauthorized insurer refuses to report closed claims and asserts a federal exemption or other jurisdictional preemption, the facility or provider must report all data required by this Act on behalf of the unauthorized insurer.

- (c) If a facility or provider is insured by a captive insurer and the captive insurer refuses to report closed claims and asserts a federal exemption or other jurisdictional preemption, the facility or provider must report all data required by this Act on behalf of the captive insurer.

Drafting Note: When subsection A(4) applies, the State needs to consider inserting wording regarding who is responsible for notification to facilities and providers. Notification by either the domiciliary state regulator or the insurer must be provided in advance to insureds that they must produce all data required by this act upon behalf of the insurer.

- B. Beginning in [insert year], reports required under subsection A of this section must be filed by March 1. These reports must include data for all claims closed in the preceding calendar year and any adjustments to data reported in prior years.
- C. The commissioner may adopt rules that require insuring entities, self-insurers, facilities and providers to submit all required closed claim data electronically.

Drafting Note: Many State insurance codes specify penalties for failure to timely file statutorily required reports or for submitting materially incorrect data. Each State should determine the applicability of such penalties to this Act. If it is determined that the State does not possess an adequate means to enforce this Act, the State may wish to consider inserting additional enforcement wording in this section.

Drafting Note: The year inserted in subsection B should be the year following the year inserted in subsection A.

Section 5. Required Data Elements

Reports required under section 4 of this Act must contain the following information in a format and coding protocol prescribed by the commissioner. To the greatest extent possible while still fulfilling the purposes of this Act, the format and coding protocol shall be consistent with the format and coding protocol for data reported to the National Practitioner Data Bank.

- A. Claim and incident identifiers, including:
 - (1) A claim identifier assigned to the claim by the insuring entity, self-insurer, facility or provider; and
 - (2) An incident identifier if companion claims have been made by a claimant;
- B. The policy limits of the medical professional liability insurance policy covering the claim;
- C. The medical specialty of the provider who was primarily responsible for the medical malpractice incident that led to the claim;
- D. The type of health care facility where the medical malpractice incident occurred;
- E. The primary location within a facility where the medical malpractice incident occurred;
- F. The geographic location, by city and county, where the medical malpractice incident occurred;

- G. The injured person's sex and age on the incident date;
- H. The severity of malpractice injury using the National Practitioner Data Bank severity scale;
- I. The dates of:
 - (1) The earliest act or omission by the defendant that was the proximate cause of the claim;
 - (2) Notice to the insuring entity, self-insurer, facility or provider;
 - (3) Suit, if a suit was filed;
 - (4) Final indemnity payment, if any; and
 - (5) Final action by the insuring entity, self-insurer, facility or provider to close the claim;
- J. Settlement information that identifies the timing and final method of claim disposition, including:
 - (1) Claims settled by the parties;
 - (2) Claims disposed of by a court, including the date disposed;
 - (3) Claims disposed of by alternative dispute resolution, such as arbitration, mediation, private trial and other common dispute resolution methods; and
 - (4) Whether the settlement occurred before or after trial, if a trial occurred;
- K. Specific information about the indemnity payments and defense and cost containment expenses, including:
 - (1) For claims disposed of by a court that result in a verdict or judgment that itemizes damages:
 - (a) The indemnity payment made on behalf of the defendant;
 - (b) Economic damages;
 - (c) Non-economic damages;
 - (d) Punitive damages, if applicable; and
 - (e) Defense and cost containment expenses, including court costs, attorneys' fees, and costs of expert witnesses; and
 - (2) For claims that do not result in a verdict or judgment that itemizes damages:
 - (a) The total amount of the settlement on behalf of the defendant;
 - (b) The insuring entity's or self-insurer's best estimate of economic damages included in the settlement;

- (c) The insuring entity's or self-insurer's best estimate of noneconomic damages included in the settlement; and
 - (d) Defense and cost containment expenses, including court costs, attorneys' fees, and costs of expert witnesses;
- L. The reason for the medical professional liability claim. The reporting entity must use the same allegation group and specific allegation codes that are used for mandatory reporting to the National Practitioner Data Bank; and
- M. Any other closed claim data the commissioner determines to be necessary to accomplish the purpose of this Act and requires by adopting a rule.

Section 6. Confidentiality of Data

Drafting Note: Each state should determine the extent to which the data collected may be made available to other parties and insert wording consistent with that determination. Options include:

- All data are available to the public.
- All data are subject to release under certain restricted conditions, such as to applicants submitting a research proposal and signing a confidentiality agreement.
- Only individual records that have been "anonymized" may be released. For example, the data can be anonymized to varying degrees by removing elements that may permit identification of the parties to a case, by removing place references such as counties, and by limiting the representation of dates to the corresponding year.
- All data are confidential except data released in summary or aggregate form. Data would be aggregated to a high enough level that readers would not be able to deduce information on any particular provider, facility, claimant, or claim.

Section 7. Authority to Adopt Rules

The commissioner shall adopt any rules needed for implementing the provisions of this Act.

Section 8. Effective Date

This Act shall take effect on [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

2008 Proc. 3rd Quarter 3-323 to 3-330 (adopted). (Comment Letters-8-144 to 8-169).

