PLEASE TYPE OR PRINT LEGIBLY. State Form 12386-b

CERTIFICATION FOR WORKER'S COMPENSATION CARRIERS

STATE OF _____

COUNTY OF _____

I, _____, hereby CERTIFY that I am _____
(Official Title)

of _____ and that I have knowledge of the
(Carrier)
workers' compensation records of Carrier. I further CERTIFY that the amount of **direct written premiums** issued by Carrier for Indiana Worker's Compensation Insurance in the calendar year **2015** totaled $_____.

I further CERTIFY that I have calculated Carrier's 2017 assessment for the Second Injury Fund by dividing the above number representing Carrier's Direct Written Premiums by 889,525,000 (which, in dollars represents the total direct written premiums for all worker's compensation carriers in Indiana in 2015), and then multiplying that figure by 5,437,844 (which, in dollars represents the amount for all carriers portion of the 2017 assessment for the Second Injury Fund). This calculation gave me _____, which in dollars represents Carrier's total annual assessment.

_____I further CERTIFY that the enclosed sum of $_____ represents one half of Company's calculated assessment (only if total assessment is greater than $1,000), which is the first installment of the statutory assessment due by **January 30, 2017** and payable to the Worker's Compensation Board of Indiana for the Second Injury Fund. I agree to pay $_____ as payment of the second half of Company's assessment for 2017 *without notice* to the Board by **June 30, 2017**.

OR
_____I further CERTIFY that the enclosed sum of $_____ represents the entire assessment of Company.

PLEASE PAY ELECTRONICALLY VIA http://www.in.gov/wcb.

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

_____	_____
Signature	Date
_____	_____
Carrier Name	Federal ID Number
_____	_____
Telephone Number	E-mail Address
_____	_____
Mailing Address	City, State, Zip

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