

**CERTIFICATION FOR WORKER'S COMPENSATION CARRIERS**

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

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

of \_\_\_\_\_ (Carrier) and that I have knowledge of the 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 **2021** totaled \$\_\_\_\_\_.

I further CERTIFY that I have calculated Carrier's 2023 assessment for the Second Injury Fund by dividing the above number representing Carrier's Direct Written Premiums by 775,316,000 (which, in dollars represents the total direct written premiums for all worker's compensation carriers in Indiana in 2021), and then multiplying that figure by 7,633,689 (which, in dollars represents the amount for all carriers' portion of the 2023 assessment for the Second Injury Fund). This calculation produces \_\_\_\_\_, 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 31, 2023**, 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 2023 *without notice* to the Board by **June 15, 2023, to avoid penalties.**

OR

\_\_\_\_\_ I further CERTIFY that the enclosed sum of \$\_\_\_\_\_ represents the entire assessment of Company.

**PLEASE PAY ELECTRONICALLY VIA <http://www.in.gov/wcb> and submit a copy of this certificate with each installment.**

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(k) 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.**