

1. SUBSEQUENT REPORTS

a. Reporting Conditions

Subsequent reports (2nd – 10th reports) must be filed with the Rating Board when:

- There are open or reopened claims as of the last report submitted, regardless of whether or not there are changes to the loss data.
- There are claims indicated as closed on a previous report that are reopened.
- There are newly arising claims as of the current valuation date.
- There are changes in loss values in the period between the prior and the current valuation, yet these claims were closed in both valuation periods.

Note: Losses are valued 12 months after the valuation date of the preceding report. Refer to Part I of this Plan for additional instructions on valuation and filing requirements.

b. Revaluation of Losses

If a claim is closed and there is no change in the loss amount in that valuation period, it should not be reported at the next valuation. If a change in the loss value does occur, report the revised loss amounts for each open, reopened or closed claim on the 2nd – 10th reports.

2. CORRECTION REPORTS

Correction reports must be filed **without delay** when any of the conditions outlined below occur:

- An error of any kind is made on a previously filed statistical report(s).
- When the exposure previously reported has been changed by reason of an audit, a re-audit or any other adjustment affecting classification codes, exposure or premiums.
 - If a classification code is revised for a claim on a subsequent report, correction reports must be submitted for all prior reports which include the claim.
- If the carrier performs a final audit on an employer subsequent to performing an estimated audit.
- If the carrier performs a revised final audit on an employer subsequent to performing a final audit.
- If the header/policy information was reported incorrectly.
- The experience modification has been revised.
- Loss values are found to have been included or excluded through clerical errors.
- Corrections to the type of injury are required as defined in Part IV, Item (15) of this Plan.
- A claim, or any part thereof, is declared non-compensable as defined in Part IV, Item (17)(e) of this Plan.
- If the claim number changes during the life of the claim as defined in Part IV, Item (3) of this Plan.
- A claim is ruled or declared to be partially or fully fraudulent subsequent to the 1st Refer to Part IV, Item (8) “Fraudulent Claims” of this Plan.
- The carrier or the claimant has obtained a subrogation recovery in an action against a third party. Refer to Part IV, Item (10) “Recoveries” of this Plan.
- A carrier recovers paid indemnity or medical on a partially fraudulent or fully fraudulent claim under the applicable state law. Refer to Part IV, Item (8) “Fraudulent Claims”.
- The specific Part of Body Code is determined subsequent to reporting Part of Body Code 65, Insufficient Info to Property Identify – Unclassified”.

Correction reports are **not** permissible under the following conditions:

- Any change in loss amounts due to development in loss values from one valuation to the next.
- Any change in injury type of a claim due to development from one valuation to the next.

Correction reports submitted in connection with 1st – 10th reports must be identified with a correction type and sequence number. Refer to Part II, Items (2) and (3) of this Plan for specific codes and instructions.

Correction reports must be filed as soon as the changes are known.

3. METHOD OF REPORTING

a. Header Information

When correcting a policy information data element, all required policy information data elements, including those data elements that are not changing, must be reported. When correcting the report number, correction number, carrier code, policy number, or policy effective date, the original header information (previously reported) must be reported in the respective fields. When correcting any other policy information data elements, report the revised value for the field.

b. Exposure Information

i. Exposures

Where there is a change in any of the data previously reported for a particular classification code, the corrected report must include all of the data previously reported for the classification code (indicated by the Update Type "P"), as well as all of the data, including those data which do not change, on a corrected basis (indicated by the Update Type "R").

Where split policy periods are involved and data for a classification code in one of the split periods are changing, the unchanged data in the other period(s) for that class code must also be reported.

ii. Experience Modification

If the revision involves a change in the experience modification previously reported as well as revised data for each classification code affected by the modification change, the exposures and premiums must be reported as described in (i) above, even if the exposures and premium amounts of all reported classification codes are unchanged. The previously reported and revised experience modifications, as well as the revised Total Subject Premium amount, must also be reported.

iii. Statistical Code

Revised values for applicable statistical codes (e.g., premium discount, flat increase on outstanding policies, etc.) as a result of changes in exposure information must also be reported. The corrected report must include all of the data previously reported for the code (indicated by the Update Type "P"), as well as all of the data, including those data which do not change, on a corrected basis (indicated by the Update Type "R").

c. Loss Information

When there is a change in any of the data previously reported for a particular claim number, the correction report must include all of the data previously reported for the claim record (indicated by the Update Type "P"), as well as all of the data, including those data which do not change, on a corrected basis (indicated by the Update Type "R").

d. Totals

Report the revised report totals resulting from any changes to the exposure and/or loss information.

4. LINK DATA

Key fields must be the same across all report levels, including corresponding corrections. Key fields are Carrier Code, Policy Number, Policy Effective Date and Exposure State Code.

For changes to the carrier code, policy number and / or policy effective date, report a correction to the 1st report only. Report both the revised key field(s) and the previously reported value(s).

5. REPLACEMENT REPORTS

Replacement reports may be used in lieu of correction reports to replace reports that have already been submitted to the Rating Board but have a status of “failed.”

Instructions:

- Report the Replacement Report Code on the Header as “R.”
- Report the Header Record matching fields for that replacement report consistently with the report that you are replacing. A replacement report that does not match a unit report in the Rating Board’s database will be rejected and will **not** be processed.
- Report all other exposure, premium, and/or loss data that are on the report being replaced, in addition to the corrected data.

For additional information on the rules and requirements, refer to Part II – Header/Policy Information of this Plan.

6. PROCEDURE FOR CORRECTION OF CLAIMS AFTER SUBSEQUENT REPORTS HAVE BEEN FILED

In order to correct a unit statistical report for which a subsequent report has already been filed, it is also necessary to submit a correction report for each associated unit statistical report with a higher report level.