

State of California
Department of Industrial Relations
Commission on Health, Safety and Workers' Compensation
WORKERS' OCCUPATIONAL SAFETY AND HEALTH
EDUCATION FUND ANNUAL REPORT

- **LABOR CODE SECTION 6354.7 REQUIRES ALL WORKERS' COMPENSATION INSURERS TO FUND THE "WORKERS' OCCUPATIONAL SAFETY AND HEALTH EDUCATION FUND" BY PAYING AN ANNUAL FEE OF THE GREATER OF \$100 OR A PERCENTAGE OF THEIR PAID WORKERS' COMPENSATION INDEMNITY CLAIMS AS REPORTED FOR THE PRIOR CALENDAR YEAR ON THE "CALL FOR CALIFORNIA WORKERS' COMPENSATION EXPERIENCE" FILED WITH THE WORKERS' COMPENSATION INSURANCE RATING BUREAU OF CALIFORNIA.**
- **PLEASE COMPLETE AND SUBMIT THIS REPORT FORM WITH THE REQUIRED FEES AND ATTACHMENTS TO THE ADDRESS LISTED BELOW. PAYMENT IS DUE ON OR BEFORE APRIL 1 OF THIS YEAR.**

1. NAME OF INSURER(S): List all insurer names used to write workers' compensation insurance in California. For each insurer listed, attach a copy of each insurer's Certificate of Authority, issued by the California Department of Insurance, to write workers' compensation insurance. (Attach additional pages if needed.)

2. COMPANY OFFICER: Name the person with the authority to establish the program to provide loss control consultation services in California, and authorize the payment of fees into the Fund.

<u>Signature of Company Officer:</u>	<u>Date:</u>
<u>Printed Name of Officer:</u>	<u>Title:</u>

(The address given below will be only address used for all future correspondence from this Office.)

<u>Name of Company</u>		
<u>Address:</u>		
<u>Phone Number:</u>	<u>Fax Number:</u>	<u>E-Mail Address:</u>

3. FEE CALCULATION: Indicate the total amount of Paid Indemnity Claims as reported for the prior calendar year on the "Call for California Workers' Compensation Experience" filed with the Workers' Compensation Insurance Rating Bureau of California for each insurer listed above, and calculate the fees due.

(Include a copy of the prior year's Calendar Year "Call" for each insurer listed on this application.

<u>Calendar Year</u> _____		<u>Enter Total</u>	
Paid Indemnity Claims \$ _____	X 0.0286% =	Fee Here: →	\$* _____

*Attach a check payable to *Workers' Occupational Safety and Health Education Fund* for the greater of \$100.00 or .0286 percent of the amount listed above. [(Example - \$43,060.531.00 (PIC) x 0.000286=\$5,382.57 (Fee)]

4. If you have questions regarding this application or the application process, call (510) 622-3276 or e-mail us at chwsc@hq.dir.ca.gov. Please mail this completed report with the "Call", the Certificate(s) of Authority, and fees to the following address:

Commission on Health, Safety and Workers' Compensation,
Attention: WOSHEF
P. O. Box 420603
San Francisco, CA 94102