



**State of California  
Department of Industrial Relations  
DIVISION OF WORKERS' COMPENSATION**

**FROI/SROI**

**ELECTRONIC DATA INTERCHANGE TRADING PARTNER PROFILE**

The EDI Trading Partner Profile is available online at: <http://www.dir.ca.gov/DWC/WCIS.htm>.

**PART A. Trading Partner Background Information:**

Date: \_\_\_\_\_

Sender Name: \_\_\_\_\_

Sender's Master FEIN: \_\_\_\_\_

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Postal Code (Zip+4): \_\_\_\_\_ (Sender's postal code)

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Postal Code: \_\_\_\_\_

**Trading Partner Type (check any that apply):**

Self-Administered Insurer

Self-Administered, Self-Insured (employer)

Third Party Administrator of Insurer

Third Party Administrator of Self-Insured (employer)

Other (Please specify): \_\_\_\_\_

**PART B. Trading Partner Contact Information:**

Business Contact:

Technical Contact:

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Title: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

FAX: \_\_\_\_\_ FAX: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

WCIS Reports Contact:

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_

FAX: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**PART C. Trading Partner Transmission Specifications:**

If submitting more than one profile, please specify:

PROFILE NUMBER (1, 2, etc.): \_\_\_\_\_  
 DESCRIPTION: \_\_\_\_\_

**Part C1: TRANSACTION SETS FOR THIS PROFILE:**

| Transaction Type             | File Format<br>(circle one per row): |   | Production Response Period |
|------------------------------|--------------------------------------|---|----------------------------|
|                              | Flat File Release #                  | ANSI X12 Version #                        |                            |
| First Reports of Injury      | <input type="checkbox"/> 1           | <input type="checkbox"/> 1 - Version 3041 | 3 business days            |
| Subsequent Reports of Injury | <input type="checkbox"/> 1           | <input type="checkbox"/> 1 - Version 3041 | 3 business days            |

**PART C2: SFTP ACCOUNT INFORMATION:**

|  |
|--|
| User Name<br>(To be provided by WCIS contact)                                  |
| Password<br>(To be provided by WCIS contact)                                   |
| Source Network IP Address<br>(Only public IP addresses.<br>Maximum 5 allowed.) |

**PART D. Receiver Information (to be completed by DWC):**

Name: California Division of Workers' Compensation

FEIN: 943160882

Physical Address: 1515 Clay Street, Suite 1800

City: Oakland State: CA Postal Code: 94612-1489

Mailing Address: P.O. Box 420603

City: San Francisco State: CA Postal Code: 94142-0603

Business Contact:

Technical Contact:

Name: (Varies by trading partner)

Name: (Varies by trading partner)

Title: (Varies by trading partner)

Title: (Varies by trading partner)

Phone: (xxx) xxx-xxxx Phone: (xxx) xxx-xxxx

E-mail Address: wcis@dir.ca.gov

E-mail Address: wcis@dir.ca.gov

RECEIVER'S NETWORK IP ADDRESS FOR CONNECTING VIA FILE  
TRANSFER PROTOCOL (SFTP): (Please contact DWC for this information)

RECEIVER'S FLAT FILE RECORD DELIMITER: CR

RECEIVER'S ANSI X12 TRANSMISSION SPECIFICATIONS:

|                                    |                            |                           |           |
|------------------------------------|----------------------------|---------------------------|-----------|
| Segment Terminator: <u>~</u>       | ISA Information:           | TEST                      | PROD      |
| Data Elements Separator: <u>*</u>  | Sender/Receiver Qualifier: | <u>ZZ</u>                 | <u>ZZ</u> |
| Sub-Element Separator: <u>&gt;</u> | Sender/Receiver ID:        | <u>(Use Master FEINs)</u> |           |