Delaware Compensation Rating Bureau, Inc.

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One South Penn Square
Philadelphia, PA 19107-3577
(302) 654-1435 (215) 568-2371
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January 31, 1997

BUREAU CIRCULAR NO. 686

To All Members of the Bureau:

Re: **FINANCIAL DATA INCENTIVE PROGRAM**

With approval of the Governing Board a Financial Data Incentive Program will apply to selected Delaware financial data submissions of 1996 experience reported during 1997, The program is in response to a recommendation made as part of the Delaware Department of Insurance's 1996 audit of the Bureau's operations.

The Financial Data Incentive Program for 1997 covers the following data submissions.

Policy Year Call No. 1
Calendar Year Expense Data Call No. 2
Net (As Written) Large Deductible Call No. 8
Gross (First Dollar) Large Deductible Call No. 9
Assigned Risk Policy Year Call No. 12

The most significant aspects of the program are as summarized below:

- For late reporting purposes Calls No. 1, 8, 9 and 12 as a group will be treated as a single entity. Call No. 2 will be treated as a second, separate entity.

- An assessment of $50 per business day per entity will be imposed for late submissions. Imposition of late submission charges could be applied for submission of calls after the due date, failure of Preliminary Edits and incomplete submissions. Late submission assessments will be subject to a cumulative maximum of $5,000.

- For edit purposes Calls No. 1, 2, 8, 9 and 12 will be treated as one single entity and edited together.

- For edit purposes any documents which have not been received when the Bureau attempts to perform the program edits will be treated as being in error. In such case no further late reporting assessments will be charged, but edit charges will begin to apply.

- Basic edit errors will be subject to a Financial Data Error Assessment Schedule which will include a flat fee component and a component which reflects a carriers' market share. The assessment schedule applies for a maximum period of 55 business days with the fine for the first ten business days equaling zero (in effect providing a ten-day grace period).

- Actuarial edit criticisms will allow a ten business day period for the carrier to respond before being subjected to the Financial Data Error Assessment Schedule described above. If the carrier satisfactorily responds within that time frame without the necessity for resubmissions, no actuarial edit assessment will be imposed.

- All resubmissions received after the due date will be subject to a $100 per entity charge.

- Total Financial Data Incentive Program assessments for a carrier or group of carriers will be subject to a maximum of 50 percent of the carrier's Annual Statement Pennsylvania Workers Compensation Direct Written Premium for the calendar year immediately preceding the data reportable in the latest Calls.

- If a carrier group elects to submit separate Calls for individual carriers within their group or to submit separate Calls for subsets of the carriers comprising their entire group, each separate Call submission will be treated separately for all purposes of the FDIP. Thus, carriers are encouraged to consider potential ramifications of the FDIP in deciding on the basis (carrier, group or subgroup) to be used in reporting their 1997 data.

- Incomplete resubmissions (i.e., those which do not address all failed edits or inquiries previously identified by the Bureau) or resubmissions which can be determined based on a cursory review not to satisfy the failed edits or inquiries previously identified by the Bureau will not be accepted and will not stop the accrual of assessments from the date of the previous Bureau notice letter.

While the above summary is intended to be helpful in identifying significant aspects of the FDIP for 1997, it is each carrier's responsibility to read and understand the entire 1997 program. Any questions which may arise in a carrier's reading of the program should be directed to the Bureau's Actuarial Department for clarification.

Enclosed is a copy of the 1997 Financial Data Incentive Program.

Timothy L. Wisecarver
President

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Attachment

DELAWARE COMPENSATION RATING BUREAU, INC.

FINANCIAL DATA INCENTIVE PROGRAM

I. INTRODUCTION

Beginning with calls received in 1997, the DCRB is applying the Financial Data Incentive Program (FDIP). This program recognizes the critical importance of the Bureau receiving quality financial data on time so that it can be used in support of filings made with the Delaware Insurance Department. In addition, this program is intended to more equitably allocate costs to the DCRB associated with late or inaccurate data submission.

II. APPLICATION

The FDIP will apply to the following Financial Calls.

Name	Due Date
Policy Year Call #1	March 17, 1997
Calendar Year Expense Data Call #2	April 15, 1997
Net (As Written) Large Deductible Call #8	March 17, 1997
Gross (1st Dollar) Large Deductible Call #9	March 17, 1997
Assigned Risk Policy Year Call #12	March 17, 1997

For purposes of determining fees for late submission and resubmissions, Calls # 1, 8, 9 and #12 will be treated as a single entity. Similarly, Call #2 will be treated as a second, separate entity. For purposes of determining fees for data errors Calls #1, 2, 8, 9 and 12 will collectively be edited and treated as one entity.

III. GENERAL INFORMATION

Under the program, assessments will be levied on carriers for Financial Calls that are not received by the DCRB with a postmarked date prior to or on the required due date. There will be no extensions granted for any reason. Also, assessments will be levied on carriers for errors detected on submitted Financial Calls. In addition, any resubmission of data after the due date, whether requested or submitted on a voluntary basis, will carry an assessment charge. Note the resubmission of data is recorded by the DCRB on the actual date received and not by the postmarked date.

ALL DATA SHOULD BE MAILED TO THE FOLLOWING ADDRESS:

Delaware Compensation Rating Bureau
Attention: Actuarial Department
The Widener Building, 6th Floor
One South Penn Square
Philadelphia, PA 19107-3577

Designation of Contact Person forms were distributed in January of 1997 for purposes related to the submission of financial call data. A carriers' submission of the 1997 Designation of Contact Person form to the Bureau established permanent documentation of contact person information. Therefore, it is the carriers' responsibility to notify the Bureau in writing of any future changes to contact person information. All changes must be sent to the address shown on page 1.

IV. GROUP REPORTING

As noted in the instructions for the various Calls, carriers have the option of reporting their data on a group basis or an individual carrier basis.

The FDIP and its attendant assessments will be applied in the same manner as the data is reported. Thus, assessments will be levied on a group basis if the data is reported on a group basis. Likewise, assessments will be levied on an individual carrier basis if the data is reported on an individual carrier basis.

Carriers are advised to consider the potential costs associated with individual versus group reporting as it relates to assessments under the FDIP.

V. PROCEDURES

A. Timeliness

1. General

Assessments for late submissions will be governed by the required due date for the particular Call. If the carriers' submission is not postmarked with a date prior to or on the required date due, that particular submission will be considered late and assessments will accrue until the data is submitted.* The DCRB will not accept facsimile versions of original submissions.

* It is the carriers' responsibility to retain all receipts for proof of mailing (i.e., certified mail return receipt, signed and returned Bureau Transmittal letter, etc.) to support its case in the event of a carrier appeal.

2. Assessments -- Original Submissions

Calls #1,8, 9 & 12 will be grouped as a single entity, as will Call #2 for purposes of levying assessments. ASSESSMENTS FOR TIMELINESS WILL CONSIST OF A PER DAY AMOUNT AS FOLLOWS:
Late fee of $50 per business day per entity subject to a maximum total of $5,000 in late submission assessments. Business days will exclude Saturdays, Sundays, and holidays.

3. Assessments -- Resubmissions

The resubmissions of Calls will be subject to a $100 fee per entity (Any of Calls #1,#8, #9 and/or #12 counting as one entity and Call #2 counting as another, separate entity) per submission whether requested or submitted on a voluntary basis. Each resubmission sent will be subject to this charge. No quality edit assessments will be applied to any data corrected by a voluntary resubmission received before the carrier is advised of the edit failure by the DCRB, but the flat resubmission rate of $100 will still be applicable.

4. Assessments -- Completeness

Calls that are received with any missing pages will be considered late and subject to the same late fee of $50 per day per entity. If one or more pages are omitted from the submission, the date that the last of the pages is received will be considered the receipt date for the document for purposes of FDIP. All Calls for a carrier/group will be edited at the same time. At that time fees for late submissions will stop accruing. Calls which have not been received by that time will simply be considered in error for purposes of editing and quality assessment purposes.

B. Quality

1. General

Assessments for the quality of data submitted will be based on three levels of editing.

a. Preliminary Edits -- Preliminary Edits are criteria that apply to all Calls and are prerequisites to the DCRBs' processing of a carriers' submission. Failure of one or more Preliminary Edits will subject a company to assessments for timeliness and/or completeness according to the $50 per day Late Submission Assessment described above.

b. Basic Edits -- Basic edits are primarily validation checks that identify conditions that can only occur as the result of an error or omission and can be determined based on a comparison of data elements on one or more statistical calls. A major source of Basic Edit errors are incorrect arithmetic or careless data entry.

   Assessments for Basic Edit errors will be charged according to the Financial Data Error Assessment Schedule. This schedule includes a flat fee component and a component which reflects a carrier's market share (rounded to one decimal place - for example 3.45% would be rounded to 3.5%). The assessment schedule applies for a maximum period of fifty-five (55) business days.

Carriers will be notified by letter, sent via certified mail with return receipt requested, of failed edits. Once the carrier has received notification of the failed edits, each subsequent day will generate charges according to the Assessment Schedule until such time as the carrier submits accurate revisions to its data Calls.

The Bureau will issue a reminder letter, sent via certified mail with return receipt requested, no later than 21 days after the initial failed edit letter has been sent, if the Bureau receives no response from a carrier. Apart from that single reminder letter, the Bureau will not initiate additional interim contacts with a carrier during the time that the carrier is responsible for working to provide explanations and/or corrections for failed edits and/or inquiries. It is the carrier's responsibility to be aware that assessment days and fines are accruing and that explanations and/or resubmissions are required as soon as possible.

Carriers are reminded that changes to one Call may well have an impact on other Calls and on reconciliation pages. It is the carriers' responsibility to be mindful of such situations and make all corrections as appropriate.

Upon receipt of resubmissions, the Bureau will edit the carrier's data. If errors are found to continue, or new problems are created, notification by letter sent via certified mail with return receipt requested will again be made to the carrier and assessments will again be invoked. For assessment purposes, the count of business days without revision will start where it had left off upon the Bureau's receipt of the prior resubmission. For example, assume a carrier submits a revision on the fifteenth day after notification by the Bureau and incurs assessments corresponding to fifteen business days on the Assessment Schedule. If that carrier is subsequently notified of continuing errors by the Bureau, the Assessment Schedule will apply beginning at the sixteenth business day.

If the resubmission is found to be incomplete, i.e., it does not address all failed edits or inquiries identified by the Bureau, a carrier will continue to be assessed from the date of receipt of the Bureau's previous failed edit inquiry letter.

Resubmissions which, upon a cursory review by the Bureau, do not satisfy our requirements will not be accepted, and incentive charges will continue to accrue until a complete resubmission is provided.

c. Actuarial Edits -- Note that Actuarial Edits are checks on the reasonableness of data. Actuarial edit criticisms will allow for a ten (10) business day period for the carrier to respond before being subjected to the Financial Data Error Assessment Schedule described above. If the carrier satisfactorily responds within that time frame without the necessity for resubmissions, no actuarial edit assessment will be imposed.

If a carrier is already incurring Assessment Schedule charges due to Basic Edit errors, no additional assessments will be made beyond that indicated by the Assessment Schedule.

If a carrier had previously incurred charges due to Basic edit errors which were subsequently corrected, Actuarial edit charges will commence at the first business day subsequent to the point at which Basic edit charges ceased. For example, if a carrier had previously been charged with Basic Edit error assessments corresponding to fifteen (15) business days, then a lack of response by the eleventh day to Actuarial Edit inquiries will be considered the sixteenth business day on the Assessment Schedule.

Carriers that have submissions failing Basic or Actuarial Edits will be contacted in writing by the DCRB (and possibly by telephone or fax) and advised of the error condition. The DCRB will mail the letter via certified mail with a return receipt requested allowing the DCRB to be notified of the date the letter was received. The date the letter or fax is received will determine when the assessment period begins. If a corrected resubmission is faxed that same day and the data is correct or a satisfactory explanation is received, there will be no quality/error assessment. In these circumstances, a resubmission charge will still apply.

C. Maximum Assessment

All assessments in total are subject to a maximum of 50% of the second prior Calendar Year Direct Net Written Premium per page 14 (15) of the Annual Statement. In the event that application of the Assessment Schedule as set forth herein produces indicated assessments in excess of such amount, the maximum assessment will apply. For example, during the 1997 processing of 1996 data, a carrier's 1995 Direct Written Premiums will be used to determine the maximum allowable assessment.

V. COLLECTION OF ASSESSMENTS

When the entire editing process has been completed, a summary of assessments according to our records will be mailed to each carrier. The amount assessed will be due upon receipt.

VI. APPEAL PROCEDURES

A. Appeal

Carriers will have 30 days after receipt of the DCRB's notice of assessments to appeal the propriety of any assessments.

Any appeal of assessment must be made in writing and must set forth all factors which the carrier wishes to be considered in review of the appeal. Appeals must be sent to:

Delaware Compensation Rating Bureau
Actuarial Department - FDIP Appeals
The Widener Building, 6th Floor
One South Penn Square
Philadelphia, PA 19107-3577

Facsimile submission of appeals may be made to the above addressee at (215) 564-4328.

Appeals of lateness charges should be supported by documentation showing the date received at the DCRB as evidence of timely submission of the Call, or fewer days late than assessed.

Appeals of quality edit charges should be supported by an explanation of why the submission was correct and/or adequately explained and that such explanation was submitted in a timely manner.

Documentation for the timing of submissions by carriers could include certified mail return receipts, signed and returned Bureau Transmittal letters, etcetera.

Assessments will be considered valid only if the submission fails any of the Basic or Actuarial edits that are outlined in the edit criteria. Other quality edit assessments may apply when the failure serves to impact the operations at the DCRB negatively.

Appeals will be reviewed by DCRB staff and management, and carriers will be advised in writing of the DCRB's final decision in appeals within 30 days after receipt of the appeal by the DCRB. In the event that a carrier remains dissatisfied with the DCRB's final decision, the carrier has 30 days to request a hearing in the matter before the DCRB's Governing Board. The carrier's original appeal and the DCRB's final decision letter will be submitted to the Governing Board for review, and the carrier and DCRB staff will be given an opportunity to present their positions and answer questions from the Governing Board. Appeals will be scheduled at the next regular Executive Session meeting of the Governing Board which occurs 20 or more days after the DCRB receives notice that the carrier wishes to appeal a final decision to the Governing Board.

B. Acknowledgment

The DCRB will acknowledge the appeal of an assessment within 10 business days of receipt. All appeals of assessments must be in writing and sent to:

Delaware Compensation Rating Bureau
Actuarial Department - FDIP Appeals
The Widener Building, 6th Floor
One South Penn Square
Philadelphia, PA 19107-3577

C. Response

Within 30 business days of acknowledgment, the DCRB will respond to the carrier's appeal with an explanation of the reasons for affirming, modifying or withdrawing the assessment charges. If the assessment is subject to further review, the carrier will be so notified.

VII. EDIT DESCRIPTIONS

Attached are Basic and Actuarial Edit descriptions for general reference. These lists are provided to assist the carriers in identifying common types of edit failures. It should be noted that Actuarial Edit standards are not rigid criteria, but rather identify situations requiring an explanation of further investigation to verify accuracy. Also, the edit descriptions are not all-inclusive; there may be other types of data problems which could result in the carrier filing a revision and incurring assessments.

DELAWARE COMPENSATION RATING BUREAU, INC.
FINANCIAL DATA ERROR ASSESSMENT SCHEDULE
Effective for December 31, 1996 Calls

Business Day After Due Date	Flat Amount		Market Share Factor *	
	Daily	Cumulative	Daily	Cumulative
1	-	-	-	-
2	-	-	-	-
3	-	-	-	-
4	-	-	-	-
5	-	-	-	-
6	-	-	-	-
7	-	-	-	-
8	-	-	-	-
9	-	-	-	-
10	-	-	-	-
11	25	25	500	500
12	50	75	1,000	1,500
13	75	150	1,500	3,000
14	100	250	1,500	4,500
15	125	375	1,500	6,000
16	125	500	1,500	7,500
17	125	625	1,500	9,000
18	125	750	1,500	10,500
19	125	875	1,500	12,000
20	125	1,000	1,500	13,500
21	125	1,125	1,500	15,000
22	125	1,250	1,500	16,500
23	125	1,375	1,500	18,000
24	125	1,500	1,500	19,500
25	125	1,625	1,500	21,000
26	125	1,750	1,500	22,500
27	125	1,875	1,500	24,000
28	125	2,000	1,500	25,500
29	125	2,125	1,500	27,000
30	125	2,250	1,500	28,500
31	125	2,375	1,500	30,000
32	125	2,500	1,500	31,500
33	125	2,625	1,500	33,000
34	125	2,750	1,500	34,500
35	125	2,875	1,500	36,000
36	125	3,000	1,500	37,500
37	125	3,125	1,500	39,000
38	125	3,250	1,500	40,500
39	125	3,375	1,500	42,000
40	125	3,500	1,500	43,500
41	125	3,625	1,500	45,000
42	125	3,750	1,500	46,500
43	125	3,875	1,500	48,000
44	125	4,000	1,500	49,500
45	125	4,125	1,500	51,000
46	125	4,250	1,500	52,500
47	125	4,375	1,500	54,000
48	125	4,500	1,500	55,500
49	125	4,625	1,500	57,000
50	125	4,750	1,500	58,500
51	125	4,875	1,500	60,000
52	125	5,000	1,500	61,500
53	125	5,125	1,500	63,000
54	125	5,250	1,500	64,500
55	125	5,375	1,500	66,000

* Factor to be applied to carrier's market share. For example, a carrier with a 12.3% market share would multiply the above factor by 0.123.

DELAWARE COMPENSATION RATING BUREAU, INC.
FINANCIAL DATA ERROR ASSESSMENT SCHEDULE

Effective for December 31, 1996 Calls

	Example: Market Share 1 %			**Example: Market Share 5.00 %**		
Business	Cumulative Assessment			Cumulative Assessment		
Day After	Flat	Market	Total	Flat	Market	Total
Due Date	Amount	Share	Assessment	Amount	Share	Assessment
1	-	-	-	-	-	-
2	-	-	-	-	-	-
3	-	-	-	-	-	-
4	-	-	-	-	-	-
5	-	-	-	-	-	-
6	-	-	-	-	-	-
7	-	-	-	-	-	-
8	-	-	-	-	-	-
9	-	-	-	-	-	-
10	-	-	-	-	-	-
11	25	5	30	25	25	50
12	75	15	90	75	75	150
13	150	30	180	150	150	300
14	250	45	295	250	225	475
15	375	60	435	375	300	675
16	500	75	575	500	375	875
17	625	90	715	625	450	1,075
18	750	105	855	750	525	1,275
19	875	120	995	875	600	1,475
20	1,000	135	1,135	1,000	675	1,675
21	1,125	150	1,275	1,125	750	1,875
22	1,250	165	1,415	1,250	825	2,075
23	1,375	180	1,555	1,375	900	2,275
24	1,500	195	1,695	1,500	975	2,475
25	1,625	210	1,835	1,625	1,050	2,675
26	1,750	225	1,975	1,750	1,125	2,875
27	1,875	240	2,115	1,875	1,200	3,075
28	2,000	255	2,255	2,000	1,275	3,275
29	2,125	270	2,395	2,125	1,350	3,475
30	2,250	285	2,535	2,250	1,425	3,675
31	2,375	300	2,675	2,375	1,500	3,875
32	2,500	315	2,815	2,500	1,575	4,075
33	2,625	330	2,955	2,625	1,650	4,275
34	2,750	345	3,095	2,750	1,725	4,475
35	2,875	360	3,235	2,875	1,800	4,675
36	3,000	375	3,375	3,000	1,875	4,875
37	3,125	390	3,515	3,125	1,950	5,075
38	3,250	405	3,655	3,250	2,025	5,275
39	3,375	420	3,795	3,375	2,100	5,475
40	3,500	435	3,935	3,500	2,175	5,675
41	3,625	450	4,075	3,625	2,250	5,875
42	3,750	465	4,215	3,750	2,325	6,075
43	3,875	480	4,355	3,875	2,400	6,275
44	4,000	495	4,495	4,000	2,475	6,475
45	4,125	510	4,635	4,125	2,550	6,675
46	4,250	525	4,775	4,250	2,625	6,875
47	4,375	540	4,915	4,375	2,700	7,075
48	4,500	555	5,055	4,500	2,775	7,275
49	4,625	570	5,195	4,625	2,850	7,475
50	4,750	585	5,335	4,750	2,925	7,675
51	4,875	600	5,475	4,875	3,000	7,875
52	5,000	615	5,615	5,000	3,075	8,075
53	5,125	630	5,755	5,125	3,150	8,275
54	5,250	645	5,895	5,250	3,225	8,475
55	5,375	660	6,035	5,375	3,300	8,675

STATISTICAL CALL EDIT CRITERIA

OVERVIEW

The following are edit standards for the Policy Year Call #1, Calendar Year Expense Data Call #2, Net Large Deductible Policy Year Call #8, Gross Large Deductible Policy Year Call #9 and Assigned Risk Policy Year Call #12 which are subject to the DCRB's Aggregate Financial Call Incentive Program. The edit criteria are divided into three groups: Preliminary, Basic and Actuarial.

Preliminary Edits are applicable to all statistical Calls. Satisfactory compliance with these edits is a prerequisite to the Bureau's processing of a carrier's submission.

Basic Edits are designed to identify conditions that can only occur as the result of an error or omission and can be determined based upon a comparison of data elements from one or more statistical Calls.

Actuarial Edits include subjective edits that bring data accuracy into question but do not necessarily indicate that the data is incorrect. Upon investigation an adequate explanation for the observed conditions may be provided. Some of these edits will identify conditions that can only represent improperly reported data.

The edit descriptions are not all-inclusive; there may be other types of data problems which could result in the carrier filing a revision and incurring assessments.

PRELIMINARY EDITS

1. A completed Transmittal Letter must accompany each submission (original or revision) with all required information provided.

2. Carrier name must be shown on the reporting form. If reporting on a group basis, each carrier writing compensation must be listed individually on the reporting form. List only the names of those carriers which have direct business during at least one of the policy years for which data is required.

3. The reported data must be legible.

4. Amounts must be reported in whole dollars only. Count fifty cents and over as an extra dollar, and reject the cents if less than fifty.

5. Negative amounts must be enclosed with parentheses so that they may be handled properly in punching and tabulating operations.

6. A complete submission of the policy year call must include all seven pages and a copy of page 15 of the annual statement for every carrier included in the call. These seven pages include data pages 1 through 4 inclusive, the questionnaire page 5, the calendar year reconciliation report page 6 and the signature page 7. A complete submission of the calendar year expense data call must include all three pages. These

pages include data pages 1 and 2 inclusive and the reconciliation report page 3. A complete submission of the net and gross large deductible call must include all five pages. These pages include data pages 1 through 4 inclusive and the questionnaire page 5. A complete submission of the assigned risk policy year call must include all five pages. These pages include data pages 1 through 4 inclusive and the questionnaire page 5.

7. The DCRB form or a comparable company designed form in the DCRB format must be used. Acceptability of company designed forms will be determined based on the DCRB's ability to keypunch data in the reported format.

BASIC EDITS

Policy Year Call #1

1. For columns (1) through (22), the sum of lines (A) through (T) must equal line (X).

2. The sum of columns (4) through (6) must equal column (7) for all lines.

3. The sum of columns (9) through (10) must equal column (4) for all lines.

4. The sum of columns (11) through (12) must equal column (5) for all lines.

5. The sum of columns (13) through (14) must equal column (6) for all lines.

6. If the response to NOTE A on page 3 is "No" then:
   a.) The sum of columns (15) through (16) must equal column (11), and
   b.) The sum of columns (17) through (18) must equal column (12).

7. The sum of columns (19) and (20) must equal column (8) (mandatory reporting for Policy Years 1988 and subsequent).

8. The sum of columns (23) through (25) must equal column (26) for all lines.

9. For columns (1) through (26), line (Y) from the current Call must equal line (X) from the preceding Policy Year Call.

10. For all columns, line (Z) must equal line (X) minus line (Y).

11. For columns (1) through (26), lines (A) through (T), all data items should be non-negative. If negative amounts do appear, the reason must be addressed in question #2 of the Questionnaire.

12. For any policy year [lines (A) through (T)], where incurred losses are reported in column (7), there must be corresponding premium reported in columns (1), (2) and (3).

13. For policy years in which the reporting of the incurred indemnity claim count is mandatory, (1981 and subsequent), the amount reported in column (8) must be greater than zero, if indemnity losses are reported in either column (9) or (11).

14. If there are no indemnity losses reported in columns (9) or (11), then the incurred indemnity claim count [column (8)] should be zero.

15. For policy years 1988 and subsequent, the following conditions must hold:
    A. If the amount reported in column (19) is greater than zero, then column (9) must be greater than zero. (If there are closed claims, there should be associated paid indemnity amounts.)
    B. If column (9) equals zero, then column (19) must equal zero. (If there is no paid indemnity, there should be no closed claims.)
    C. If column (20) is greater than zero, then column (11) should be greater than zero. (If there are open claims, there must be case indemnity reserves.)
    D. If column (20) is equal to zero, then column (11) should equal zero unless only bulk reserves are being reported. If there are no open claims, then there should be no indemnity case reserves.
    E. Column (21) must be less than or equal to column (9)
    F. Column (22) must be less than or equal to column (10)

16. The questionnaire must be completed.

17. The response to Note A on page 3 must be accurately checked either “Yes” or “No”.

Calendar Year Expense Data Call #2

1. The sum of lines (3A) through (3D) must equal line (3E).

2. The sum of lines (2) and (3E) must equal line (4).

3. For lines (6A) through (11), where expenses are reported, there must be corresponding allocation codes.

4. Line (13) must be completed in accordance with the instructions.

Net #8 and Gross #9 Large Deductible Policy Year Calls

1. For columns (1) through (26), the sum of lines (N) through (T) must equal line (X).

2. The sum of columns (4) through (6) must equal column (7) for all lines.

3. The sum of columns (9) through (10) must equal column (4) for all lines.

4. The sum of columns (11) through (12) must equal column (5) for all lines.

5. The sum of columns (13) through (14) must equal column (6) for all lines.

6. If the response to NOTE A on page 3 is "No" then:
   a.) The sum of columns (15) through (16) must equal column (11), and
   b.) The sum of columns (17) through (18) must equal column (12).

7. The sum of columns (19) and (20) must equal column (8).

8. For columns (1) through (26), line (Y) from the current Call must equal line (X) from the preceding Policy Year Call.

9. For all columns, line (Z) must equal line (X) minus line (Y).

10. For columns (1) through (26), lines (N) through (T), all data items should be non-negative. If negative amounts do appear, the reason must be addressed in question #2 of the Questionnaire.

11. For any policy year, [lines (N) through (T)], where incurred losses are reported in column (7), there must be corresponding premium reported in columns (1), (2) and (3).

12. For all policy years, the amount reported in column (8) must be greater than zero, if indemnity losses are reported in either column (9) or (11).

13. If there are no indemnity losses reported in columns (9) or (11), then the incurred indemnity claim count [column (8)] should be zero.

14. For all policy years the following conditions must hold:
   A. If the amount reported in column (19) is greater than zero, then column (9) must be greater than zero. (If there are closed claims, there should be associated paid indemnity amounts.)
   B. If column (9) equals zero, then column (19) must equal zero. (If there is no paid indemnity, there should be no closed claims.)
   C. If column (20) is greater than zero, then column (11) should be greater than zero. (If there are open claims, there must be indemnity case reserves.)
   D. If column (20) is equal to zero, then column (11) should equal zero unless only bulk reserves are being reported. If there are no open claims, then there should be no indemnity case reserves.
   E. Column (21) must be less than or equal to column (9)
   F. Column (22) must be less than or equal to column (10)

15. The questionnaire must be completed.

16. The response to Note A on page 3 must be accurately checked either "Yes" or "No".

Assigned Risk Policy Year Call #12

1. For columns (1) through (26), the sum of lines (A) through (D) must equal line (X).

2. The sum of columns (4) through (6) must equal column (7) for all lines.

3. The sum of columns (9) through (10) must equal column (4) for all lines.

4. The sum of columns (11) through (12) must equal column (5) for all lines.

5. The sum of columns (13) through (14) must equal column (6) for all lines.

6. If the response to NOTE A on page 3 is "No" then:
   a.) The sum of columns (15) through (16) must equal column (11), and
   b.) The sum of columns (17) through (18) must equal column (12).

7. The sum of columns (19) and (20) must equal column (8).

8. The sum of columns (23) through (25) must equal column (26) for all lines.

9. For columns (1) through (26), line (Y) from the current Call must equal line (X) from the preceding Policy Year Call.

10. For all columns, line (Z) must equal line (X) minus line (Y).

11. For columns (1) through (26), lines (A) through (D), all data items should be non-negative. If negative amounts do appear, the reason must be addressed in question #2 of the Questionnaire.

12. For any policy year [lines (A) through (D)], where incurred losses are reported in column (7), there must be corresponding premium reported in columns (1), (2) and (3).

13. For all policy years, the incurred indemnity claim count reported in column (8) must be greater than zero, if indemnity losses are reported in either column (9) or (11).

14. If there are no indemnity losses reported in columns (9) or (11), then the incurred indemnity claim count [column (8)] should be zero.

15. For all policy years, the following conditions must hold:
   A. If the amount reported in column (19) is greater than zero, then column (9) must be greater than zero. (If there are closed claims, there should be associated paid indemnity amounts.)
   B. If column (9) equals zero, then column (19) must equal zero. (If there is no paid indemnity, there should be no closed claims.)
   C. If column (20) is greater than zero, then column (11) should be greater than zero. (If there are open claims, there must be indemnity case reserves.)

D. If column (20) is equal to zero, then column (11) should equal zero unless only bulk reserves are being reported. If there are no open claims, then there should be no indemnity case reserves.
E. Column (21) must be less than or equal to column (9)
F. Column (22) must be less than or equal to column (10)

16. The questionnaire must be completed.

17. The response to Note A on page 3 must be accurately checked either "Yes" or "No".

ACTUARIAL EDITS

All items on calls 1, 2, 8, 9 and 12 will be checked for reasonableness. Specific examples include:

Policy Year Call #1

1. The relationship between Standard Earned Premium at DSR Level and Standard Earned Premium at Company Level should be consistent with each company's filed deviations and/or loss cost multiplier(s).

2. For columns (9) and (10), paid losses, lines (A) through (S) will be checked when the losses on the current Call for a specific policy year are less than the losses on the preceding Policy Year Call for the same policy year. Any decreases must be explained on the questionnaire on page 5.

3. For columns (1), (2), (3) and (7) line T should not equal line Z.

4. The entries on page 6, the Calendar Year Reconciliation Report will be verified, this data must be pulled correctly from Calls #1, #3, #8, #9 and page 15. Any differences greater than $1,000 and less than ($1,000) must be explained. These explanations will be reviewed for reasonableness.

Calendar Year Expense Data Call #2

1. The entries on page 3, the Calendar Year Reconciliation Report will be verified, this data must be pulled correctly from Calls #1, #2 and page 15. Any differences greater than $1,000 and less than ($1,000) must be explained. These explanations will be reviewed for reasonableness.

2. Line 5C should equal Call #9, Line Z, Column 1, minus Call #8, Line Z, Column 1.

3. Line 5D should equal Call #9, Line Z, Column 3, minus Call #8, Line Z, Column 3.

4. All expense items should match the corresponding expense items on page 15.

Net #8 and Gross #9 Large Deductible Policy Year Calls

1. The relationship between Standard Earned Premium at DCRB DSR Level and Standard Earned Premium at Company Level should be consistent with each company's filed deviations and/or loss cost multiplier. (Gross Large Deductible Policy Year Call #9 only)

2. For columns (9) and (10), paid losses, lines (A) through (S) will be checked when the losses on the current Call for a specific policy year are less than the losses on the preceding Policy Year Call for the same policy year. Please explain any decreases on the questionnaire on page 5.

3. All data entries on the Net Large Deductible Call should be less than the corresponding data entries on the Gross Large Deductible Call.

Assigned Risk Policy Year Call #12

1. Standard Earned Premium at DSR Level should equal Standard Earned Premium at Company Level.

2. For columns (9) and (10), paid losses, lines (A) through (S) will be checked when the losses on the current Call for a specific policy year are less than the losses on the preceding Policy Year Call for the same policy year. Please explain any decreases on the questionnaire on page 5.

3. For columns (1), (2), (3) and (7) line T should not equal line Z.

4. Policy Year entries in lines (A) - (D) should be less than or equal to the corresponding entries on Call #1.