



Pennsylvania Compensation Rating Bureau

The Widener Building • 6th Floor

One South Penn Square • Philadelphia, PA 19107-3577 • (215) 568-2371 • FAX (215) 564-4328

March 6, 2001

To All Members of the Bureau:

Re: **FINANCIAL DATA INCENTIVE PROGRAM**

The Financial Data Incentive Program (FDIP) was originally released on January 31, 2001 with the caveat that the edits described in the January 31, 2001 version were consistent with the PCRB's review of a "Draft" of the 2000 Schedule "W." Since the January 31, 2001 mailing, the Pennsylvania Insurance Department released the 2000 Schedule "W" incorporating several administrative changes from our review of the Draft version of 2000 Schedule "W". Accordingly, some procedures as originally described in the most recent release of the FDIP were affected.

A summary of the changes required to comply with the 2000 Schedule "W" are provided in the document entitled "Annual Calls for Experience Update" included in this mailing. This update will be helpful in identifying changes in the March 6, 2001 version of the FDIP. It is each carrier's responsibility to read and understand the entire updated 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.

With approval of the Governing Board a Financial Data Incentive Program (FDIP) will apply to selected Pennsylvania financial data submissions of 2000 experience to be reported during 2001. This continues PCRB practice each year since the FDIP's initial implementation in 1996.

Consistent with last year's program, the FDIP for 2000 covers the following data submissions:

Policy Year Call No. 1
Reconciliation of Financial Calls and Schedule "W" Call No. 5
Net (As Written) Large Deductible Call No. 8
Gross (First Dollar) Large Deductible Call No. 9
Pennsylvania Special Schedule "W"

Some limited changes have been made to the FDIP in 2000 in the interest of clarity and to reflect mechanical changes in the Call forms to which the FDIP applies.

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

- For late reporting purposes Calls No. 1, 8 and 9 as a group will be treated as a single entity. Call No. 5 and Schedule "W" together 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, 5, 8 and 9 and Schedule “W” 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 FDIP 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 1999 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.

A complete updated copy of the 2000 FDIP is enclosed and may also be accessed via the Bureau’s internet website at www.pcrb.com.

Timothy L. Wisecarver
President

bp - FDIP “Contact”

**PENNSYLVANIA COMPENSATION RATING BUREAU
FINANCIAL DATA INCENTIVE PROGRAM
REVISION ISSUED MARCH 6, 2001**

I. INTRODUCTION

For calls received in 2001, the PCRB is applying the Financial Data Incentive Program (FDIP). This continues PCRB practice each year since the FDIP's initial implementation in 1996. 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 Pennsylvania Insurance Department. In addition, this program is intended to more equitably allocate costs to the PCRB associated with late or inaccurate data submission.

II. APPLICATION

The FDIP will apply to the following Financial Calls and the Schedule "W".

<u>Name</u>	<u>Due Date</u>
Policy Year Call #1	March 15, 2001
Net (As Written) Large Deductible Call #8	March 15, 2001
Gross (1st Dollar) Large Deductible Call #9	March 15, 2001
2000 Pennsylvania Schedule "W"	April 16, 2001
PA Reconciliation Report Call #5 Calendar Year 2000	April 16, 2001

For purposes of determining fees for late submission and resubmissions, Calls #1, #8, and #9 will be treated as a single entity. Similarly, Call #5 and Schedule "W" will be treated as a second, separate entity. For purposes of determining fees for data errors Calls #1, #5, #8, #9 and Schedule "W" will collectively be edited and treated as one entity.

III. GENERAL INFORMATION

Under the program, the PCRB will levy assessments on carriers for Financial Calls and Schedule W's that are not received with a postmarked date prior to or on the required due date. In instances where electronic submission is an acceptable method of reporting (Schedule "W" and Call #5 only) the transfer of data must occur 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 and Schedule W's. 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 PCRB based on the actual date received and not by the postmarked date.

ALL DATA SHOULD BE MAILED TO THE FOLLOWING ADDRESS:

Pennsylvania 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 carrier's 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 changes to contact person information. Copies of the Designation of Contact Person form can be secured at any time by contacting the Actuarial Department at (215) 568-2371 or visiting our web site at www.pcrb.com. 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. Instructions for Schedule "W" state that the data should be reported on the same basis as is used for reporting data on Bureau Call #1.

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 or Schedule "W". 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.* In instances where an electronic submission is an acceptable method of reporting (Schedule "W" and Call #5 only) the transfer of data must occur prior to or on the required due date.* The PCRB 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 with return receipt, signed and returned Bureau Transmittal letter, or electronic mail receipts transmitted by the Bureau, etc.) to support its case in the event of a carrier appeal.

2. Assessments -- Original Submissions

Calls #1, #8 & #9 will be grouped as a single entity, as will Call #5 and Schedule "W" 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 a Call or Schedule "W" will be subject to a \$100 fee per entity (Any of Calls #1, #8 and/or #9 counting as one entity and Call #5 and Schedule W 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 PCRB, 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. Call #5, whether submitted via a hardcopy format or electronic mail without all eight pages completed will be considered late and subject to the same late fee of \$50 per day per entity. Schedule W's received without the appropriate attachments when submitting electronically or the accompanying diskette when submitted in paper format 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 the 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

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 Schedule W's and are prerequisites to the PCRB's 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, reconciliation pages, and Schedule "W". 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, or if the carrier advises the Bureau that they are continuing to work on resolving a failed edit(s), the carrier will continue to be assessed from the date of receipt of the Bureau's previous failed edit inquiry letter. In the latter case, as previously noted, the Bureau will not initiate additional interim contacts with the 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.

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. For a response to be considered satisfactory, a carrier should describe the relevant factors that caused the condition in question. Asserting the accuracy of the reported data without written detail will not be considered a satisfactory response. Explanations that merely identify the source of the error without correcting the error condition will not be considered acceptable.

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 PCRB (and possibly by telephone, e-mail or fax) and advised of the error condition. The PCRB will mail the letter certified mail with a return receipt allowing the PCRB 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 or electronically transmitted 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.

The Bureau may require resubmission by the carrier of experience for the prior calendar year period to be consistent with changes or corrections in response to basic and/or actuarial edit criteria which are reflected in the most recent experience. When such resubmission is required the Bureau's request shall be of like standing with any other correction and/or explanation required under terms of the FDIP.

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 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 2001 processing of 2000 data, a carrier's 1999 Direct Written Premiums will be used to determine the maximum allowable assessment.

VI. 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.

VII. APPEAL PROCEDURES

A. Appeal

Carriers will have 31 days after receipt of the PCRB'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:

Pennsylvania 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 PCRB 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, et cetera.

Appeals will be reviewed by PCRB staff and management, and carriers will be advised in writing of the PCRB's final decision in appeals within 31 days after the carrier's receipt of the acknowledgment by the PCRB. In the event that a carrier remains dissatisfied with the PCRB's final decision, the carrier has 31 days after the receipt of the PCRB's final decision letter to request a hearing in the matter before the PCRB's Governing Board. The carrier's original appeal and the PCRB's final decision letter will be submitted to the Governing Board for review, and the carrier and PCRB 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 PCRB receives notice that the carrier wishes to appeal a final decision to the Governing Board.

B. Acknowledgment

The PCRB will send a letter acknowledging the appeal of an assessment within 14 days of receipt by the Bureau. All appeals of assessments must be in writing and sent to:

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

C. Response

Within 31 days of acknowledgment, the PCRB 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.

VIII. 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 or 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.

**PENNSYLVANIA COMPENSATION RATING BUREAU
FINANCIAL DATA ERROR ASSESSMENT SCHEDULE**
Effective for December 31, 2000 Calls

Business Day After Due Date	Flat Amount		Market Share Factor *	
	Daily	Cumulative	Daily	Cumulative
1	0	0	0	0
2	0	0	0	0
3	0	0	0	0
4	0	0	0	0
5	0	0	0	0
6	0	0	0	0
7	0	0	0	0
8	0	0	0	0
9	0	0	0	0
10	0	0	0	0
11	50	50	1,000	1,000
12	100	150	2,000	3,000
13	150	300	3,000	6,000
14	200	500	3,000	9,000
15	250	750	3,000	12,000
16	300	1,050	3,000	15,000
17	350	1,400	3,000	18,000
18	400	1,800	3,000	21,000
19	450	2,250	3,000	24,000
20	500	2,750	3,000	27,000
21	500	3,250	3,000	30,000
22	500	3,750	3,000	33,000
23	500	4,250	3,000	36,000
24	500	4,750	3,000	39,000
25	500	5,250	3,000	42,000
26	500	5,750	3,000	45,000
27	500	6,250	3,000	48,000
28	500	6,750	3,000	51,000
29	500	7,250	3,000	54,000
30	500	7,750	3,000	57,000
31	500	8,250	3,000	60,000
32	500	8,750	3,000	63,000
33	500	9,250	3,000	66,000
34	500	9,750	3,000	69,000
35	500	10,250	3,000	72,000
36	500	10,750	3,000	75,000
37	500	11,250	3,000	78,000
38	500	11,750	3,000	81,000
39	500	12,250	3,000	84,000
40	500	12,750	3,000	87,000
41	500	13,250	3,000	90,000
42	500	13,750	3,000	93,000
43	500	14,250	3,000	96,000
44	500	14,750	3,000	99,000
45	500	15,250	3,000	102,000
46	500	15,750	3,000	105,000
47	500	16,250	3,000	108,000
48	500	16,750	3,000	111,000
49	500	17,250	3,000	114,000
50	500	17,750	3,000	117,000
51	500	18,250	3,000	120,000
52	500	18,750	3,000	123,000
53	500	19,250	3,000	126,000
54	500	19,750	3,000	129,000
55	500	20,250	3,000	132,000

* 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.

**PENNSYLVANIA COMPENSATION RATING BUREAU
FINANCIAL DATA ERROR ASSESSMENT SCHEDULE**
Effective for December 31, 2000 Calls

Example: Market Share 1 %

Example: Market Share 5 %

Business Day After Due Date	Cumulative Assessment			Cumulative Assessment		
	Flat Amount	Market Share	Total Assessment	Flat Amount	Market Share	Total Assessment
1	0	0	0	0	0	0
2	0	0	0	0	0	0
3	0	0	0	0	0	0
4	0	0	0	0	0	0
5	0	0	0	0	0	0
6	0	0	0	0	0	0
7	0	0	0	0	0	0
8	0	0	0	0	0	0
9	0	0	0	0	0	0
10	0	0	0	0	0	0
11	50	10	60	50	50	100
12	150	30	180	150	150	300
13	300	60	360	300	300	600
14	500	90	590	500	450	950
15	750	120	870	750	600	1,350
16	1,050	150	1,200	1,050	750	1,800
17	1,400	180	1,580	1,400	900	2,300
18	1,800	210	2,010	1,800	1,050	2,850
19	2,250	240	2,490	2,250	1,200	3,450
20	2,750	270	3,020	2,750	1,350	4,100
21	3,250	300	3,550	3,250	1,500	4,750
22	3,750	330	4,080	3,750	1,650	5,400
23	4,250	360	4,610	4,250	1,800	6,050
24	4,750	390	5,140	4,750	1,950	6,700
25	5,250	420	5,670	5,250	2,100	7,350
26	5,750	450	6,200	5,750	2,250	8,000
27	6,250	480	6,730	6,250	2,400	8,650
28	6,750	510	7,260	6,750	2,550	9,300
29	7,250	540	7,790	7,250	2,700	9,950
30	7,750	570	8,320	7,750	2,850	10,600
31	8,250	600	8,850	8,250	3,000	11,250
32	8,750	630	9,380	8,750	3,150	11,900
33	9,250	660	9,910	9,250	3,300	12,550
34	9,750	690	10,440	9,750	3,450	13,200
35	10,250	720	10,970	10,250	3,600	13,850
36	10,750	750	11,500	10,750	3,750	14,500
37	11,250	780	12,030	11,250	3,900	15,150
38	11,750	810	12,560	11,750	4,050	15,800
39	12,250	840	13,090	12,250	4,200	16,450
40	12,750	870	13,620	12,750	4,350	17,100
41	13,250	900	14,150	13,250	4,500	17,750
42	13,750	930	14,680	13,750	4,650	18,400
43	14,250	960	15,210	14,250	4,800	19,050
44	14,750	990	15,740	14,750	4,950	19,700
45	15,250	1,020	16,270	15,250	5,100	20,350
46	15,750	1,050	16,800	15,750	5,250	21,000
47	16,250	1,080	17,330	16,250	5,400	21,650
48	16,750	1,110	17,860	16,750	5,550	22,300
49	17,250	1,140	18,390	17,250	5,700	22,950
50	17,750	1,170	18,920	17,750	5,850	23,600
51	18,250	1,200	19,450	18,250	6,000	24,250
52	18,750	1,230	19,980	18,750	6,150	24,900
53	19,250	1,260	20,510	19,250	6,300	25,550
54	19,750	1,290	21,040	19,750	6,450	26,200
55	20,250	1,320	21,570	20,250	6,600	26,850

STATISTICAL CALL EDIT CRITERIA

OVERVIEW

The following are edit standards for the Policy Year Call #1, Net Large Deductible Policy Year Call #8, Gross Large Deductible Policy Year Call #9, Schedule "W" and Reconciliation of the Pennsylvania Schedule "W" with Financial Calls #5 which are subject to the PCRB'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 Call (original or revision) with all required information provided. A completed cover page must accompany each electronic transmission of Schedule "W" (original or revision) with all the 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 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 Call #5 (The Calendar Year Reconciliation of the Pennsylvania Schedule "W" with the Financial Calls) must include all eight pages, whether submitted in hardcopy form or electronically. These eight pages include the calendar year reconciliation report, request for Schedule "W", comparison of Schedule "W" and Calls #1, #8 and #9 and the Statement of Consistency and Comparability Form. A complete electronic original submission of Schedule "W" consist of the cover page, questionnaire, considerations affecting data, and reporting template. A complete electronic resubmission of Schedule "W" consists of a cover page and reporting template. A complete hardcopy original submission of the Schedule "W" consists of the cover page, questionnaire, considerations affecting data, and Parts A through E in both paper and diskette form for original and resubmissions as required.

7. The PCRB form or a comparable company designed form in the PCRB format must be used. Acceptability of company designed forms will be determined based on the PCRB'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 (V) 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) and (10) must equal column (4) for all lines.
4. The sum of columns (11) and (12) must equal column (5) for all lines.
5. The sum of columns (13) and (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) and (16) must equal column (11), and
 - b.) The sum of columns (17) and (18) must equal column (12).
7. The sum of columns (19) and (20) must equal column (8) (mandatory reporting for Policy Years 1987 and subsequent).
8. For columns (1) through (22), 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 (22), lines (A) through (V), 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 (A) through (V)], where incurred losses are reported in column (7), there must be corresponding premium reported in columns (1), (2) and (3).
12. 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).
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 policy years 1987 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 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”.

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

1. For columns (1) through (22), the sum of lines (L) through (V) 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) and (10) must equal column (4) for all lines.
4. The sum of columns (11) and (12) must equal column (5) for all lines.
5. The sum of columns (13) and (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) and (16) must equal column (11), and
 - b.) The sum of columns (17) and (18) must equal column (12).

7. The sum of columns (19) and (20) must equal column (8).
8. For columns (1) through (22), 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 (22), lines (L) through (V), 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 (L) through (V)], 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”.

Reconciliation of the Pennsylvania Schedule “W” with Financial Calls (Call #5)

1. All differences reported on pages 1, 4, 5, 6 and 7 must be explained.
2. All entries should be pulled correctly from the Schedule “W” and Financial Calls #1, #8 and #9 onto pages 1, 4, 5, 6 and 7 of Call #5.

Schedule "W"

Edits #1 through #7 pertain to Parts A-1 through A-5

1. The sum of lines (1) and (2) must equal line (3).
2. Line (3) less line (4) must equal line (5).
3. The sum of lines (6A) through (6G) must equal line (6H).
4. The sum of lines (5) and (6H) must equal line (7).
5. For lines (9A) through (9H), column (1) + column (2) - column (3) must equal column (4).
6. For columns (1) through (4), the sum of line (9A) and (9B) must equal line (9C).
7. For columns (1) through (4), the sum of lines (9D) through (9G) must equal line (9H).

Edits #8 through #16 pertain to Parts B and C

8. For columns (3) through (23), line (7) must equal the sum of lines (1), (3) and (5).
9. For columns (3) through (24), line (8) must equal the sum of lines (2), (4) and (6).
10. For lines (1),(3),(5),(7),(9),(11),(13),(15), and (17), column (25) must equal the sum of columns (3) through (23).
11. For lines (2),(4),(6),(8),(10),(12),(14),(16), and (18), column (25) must equal the sum of columns (3) through (24).
12. For columns (3) through (23), line (11) should be less than or equal to line (9).
13. For columns (3) through (24), line (12) should be less than or equal to line (10).
14. For columns (3) through (24):
 - Part B-1, line (15) should equal Part C-1, line (15).
 - Part B-1, line (16) should equal Part C-1, line (16).
 - Part B-1, line (17) should equal Part C-1, line (17).
 - Part B-1, line (18) should equal Part C-1, line (18).
15. For columns (3) through (24), the sum of lines (10) and (14) should be greater than or equal to the sum of lines (9) and (13).
16. All values should be non-negative with the possible exception of lines (5) and (6).

Edits #17 through #29 pertain to Parts D-1 through E-2

17. For columns (3) through (12), line (7) must equal the sum of lines (1), (3) and (5).
18. For columns (3) through (13), line (8) must equal the sum of Lines (2), (4) and (6).
19. For lines (1),(3),(5),(7),(9),(11),(13),(15) and (17), column (14) must equal the sum of columns (3) through (12).
20. For lines (2),(4),(6),(8),(10),(12),(14),(16) and (18), column (14) must equal the sum of columns (3) through (13).
21. Lines (11) and (12) should be less than or equal to Lines (9) and (10), respectively, for all columns (3) through (13).
22. For columns (3) through (13), lines (15),(16),(17) and (18) of Part D-1 should equal the corresponding value on Part D-2.
23. For columns (3) through (13), lines (15),(16),(17) and (18) of Part E-1 should equal the corresponding value on Part E-2.
24. For columns (3) through (13), the sum of lines (10) and (14) should be greater than or equal to the sum of lines (9) and (13).
25. All values should be non-negative with the possible exception of lines (5) and (6).
26. For column (14), the difference of Part E-1 line (8) less line (7) and Part D-1 line (8) less line (7) must equal Part A-1, line (9F) column (4).
27. For column (14), the difference of Part E-2 line (8) less line (7) and Part D-2 line (8) less line (7) must equal Part A-1, line (9G), column (4).
28. For column (14), the difference of Part E-1 line (18) less line (17) and Part D-1 line (18) less line (17) must equal Part A-1, line (8B)
29. If Part A-1, line (8B) is greater than zero, data should appear on Part E-1 and/or Part E-2.

ACTUARIAL EDITS

All items on Calls #1, #5, #8 and #9 and Schedule “W” 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 (U) 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 (V) 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.

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

1. The relationship between Standard Earned Premium at PCR B DSR Level and Standard Earned Premium at Company Level should be consistent with each company’s filed deviations and/or loss cost multiplier.
2. For columns (9) and (10), paid losses, lines (A) through (U) 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.

Schedule “W”

1. For columns (3) through (24), Part C should be greater than Part B for lines (9) through (12).
2. For Parts B and C, columns (3) through (24), line (12) should be greater than or equal to line (11).
3. For columns (3) through (13) on Parts D-1 through E-2, line (12) should be greater than or equal to line (11).

4. Parts A-1 through A-5, lines 6A through 6G, adjustments which increased earned premiums such as loss cost multipliers should be shown as negative amounts. Adjustments which decreased earned premiums such as deviations, premium discounts, or credits for PA Certified Safety Committee Credit Program should be shown as positive amounts.
5. For columns (3) through (13), lines (1) through (18) on Part D-1 should be less than on Part E-1.
6. For columns (3) through (13), lines (1) through (18) on Part D-2 should be less than on Part E-2.