

**ASSESSMENT REPORT 2012
FOR INSURANCE COMPANIES, SELF-INSURERS & GROUP FUNDS**

STATE OF ALABAMA
DEPARTMENT OF LABOR
WORKERS' COMPENSATION DIVISION
649 Monroe Street
Montgomery, Alabama 36131
Telephone: (334) 242-2868 Toll Free 1-800-528-5166

COMPANY NAME
CONTACT PERSON
MAILING ADDRESS
PHYSICAL ADDRESS
CITY ST ZIP
EMAIL:

NCCI#:
FEIN#:
SI#:
GSI#:
TELEPHONE#:

SUBSIDIARIES OF SELF INSURED COMPANIES:

PLEASE MAKE ALL CHANGES TO ABOVE INFORMATION IF NECESSARY and INCLUDE YOUR EMAIL & TELEPHONE

In accordance with the Alabama Workers' Compensation Law, Title 25, Code of Alabama, 1975, as last amended, this report is to be filed with the State of Alabama on or before the first day of March each year. The total expenses reported will be used in the calculation of your 2012 assessment. **DO NOT include negative amounts.**

DO NOT DEDUCT SUBROGATION OR REINSURANCE/EXCESS RECOVERABLES

Compensation Paid:	\$ _____
Medical Paid:	\$ _____
Attorney Fees Paid:	\$ _____
Administrative Expenses Paid:	\$ _____
Court Settlements:	\$ _____
TOTAL LOSSES:	\$ _____

CERTIFICATION

**UNDER PENALTY OF PERJURY, I, _____, being duly sworn, depose, affirm, and
PRINT YOUR NAME**

verify that the foregoing is a true and correct report of workers' compensation payments made in accordance with the Alabama Workers' Compensation Law, as last amended. I further verify and affirm that this report constitutes a true and correct report of payments made by all operations with the state. I understand that the monetary figures and sums certain contained therein will be used to compute the workers' compensation assessment due and payable to the Alabama Workers' Compensation Administrative Trust Fund. I further verify and affirm that I am a duly appointed official of Company:

_____ in the capacity of _____ and that I am duly qualified and authorized to sign this report.
Printed Name Corporate Title

Title

Signature

Sworn to and subscribed before me this _____ day of _____, 2012. _____

Notary Public