December 1, 2009

VIA CERTIFIED MAIL

TO: Members of the Georgia Self-Insurers Guaranty Trust Fund

FROM: John P. Reale, Administrator

Attached please find a copy of the 2010 Member Information Update form. This form must be completed to retain self-insured status in Georgia and will be used to update our files and compute your company's assessment in 2010. A COPY OF YOUR COMPLETED FORM WILL BE FORWARDED TO THE STATE BOARD OF WORKERS' COMPENSATION UPON RECEIPT BY THIS OFFICE.

The 2010 Member Information Update form must be postmarked no later than MARCH 31, 2010. Failure to return your form as required will result in an automatic penalty of $50.00 for each day the form is delinquent or 10 percent of the assessment, whichever is greater. **Extensions will not be granted after MARCH 23, 2010. Facsimiles are not permitted.**

Return your completed form to:

Georgia Self-Insurers Guaranty Trust Fund
P. O. Box 7159
Atlanta, Georgia 30357-0159
OR
880 West Peachtree Street, N.W.
Atlanta, Georgia 30309

If you have any questions, please call us at (404) 872-6184. Thank you for your cooperation.

2464341/1
0708-16211

GEORGIA SELF-INSURERS GUARANTY TRUST FUND

2010 MEMBER INFORMATION UPDATE

December 1, 2009

VIA CERTIFIED MAIL

TO:

PLEASE PROVIDE THE FOLLOWING INFORMATION. SIGN AND RETURN THIS FORM TO:

GEORGIA SELF-INSURERS GUARANTY TRUST FUND
P. O. BOX 7159
ATLANTA, GEORGIA 30357-0159

OR

880 WEST PEACHTREE STREET NW
ATLANTA, GEORGIA 30309

The 2010 Member Information Update form must be postmarked no later than MARCH 31, 2010. Failure to return your form as required will result in an automatic penalty of $50.00 for each day the form is delinquent or ten percent (10%) of the assessment, whichever is greater. Extensions will not be granted after MARCH 23, 2010. Facsimiles are not permitted. ALL QUESTIONS MUST BE ANSWERED COMPLETELY. INCOMPLETE FORMS WILL BE CONSIDERED DELINQUENT.

1. **STATE THE COMPANY NAME IN WHICH YOUR SELF-INSURANCE IS REGISTERED. STATE THE NAME OF THE PERSON WHO IS OUR CONTACT PERSON AT THE MEMBER COMPANY, ALONG WITH HIS/HER ADDRESS AND TELEPHONE NUMBER.** (THE PERSON WHOSE NAME IS STATED HERE MUST BE AN EMPLOYEE OF THE MEMBER COMPANY.)

MEMBER COMPANY NAME		
SBWC ID #		FEIN:
CONTACT PERSON		
TITLE		
ADDRESS		
CITY, STATE, ZIP		
TELEPHONE NUMBER		
FACSIMILE NUMBER		
E-MAIL ADDRESS		

2. **STATE THE NAME OF THE THIRD-PARTY ADMINISTRATOR (TPA must be licensed in Georgia), ALONG WITH HIS/HER COMPANY, ADDRESS, AND TELEPHONE NUMBER. LIST ONE OFFICE ONLY.** If your program is self-administered, state the name, address and telephone number of the person at your company who is responsible for administering your claims. If your program is self-administered, the company named will be the same as the member company in Item 1. If you have a question regarding claim handling/administration, please contact the State Board of Worker's Compensation at **(404) 651-7839 or griffinc@sbwc.ga.gov**. Please refer to Board Rule 127. **PLEASE NOTE: If more than one location handles your claims, you must select one office as your designated office**.

CLAIMS COMPANY ______________________________

CLAIMS COMPANY FEIN ______________________________

CONTACT PERSON ______________________________

ADDRESS ______________________________

CITY, STATE, ZIP ______________________________

TELEPHONE **(toll-free number, if available)** ______________________________

FACSIMILE ______________________________

E-MAIL ADDRESS ______________________________

PLEASE ATTACH A COPY OF THE FOLLOWING:

1. **YOUR THIRD-PARTY ADMINISTRATOR'S CERTIFICATE OF ERRORS & OMISSIONS INSURANCE COVERAGE.**

2. **YOUR THIRD-PARTY ADMINISTRATOR'S GEORGIA TPA LICENSE .**

3. **IS YOUR COMPANY OR BUSINESS A SUBSIDIARY? ____ IF SO, NAME THE PARENT OR HOLDING COMPANY ALONG WITH ITS ADDRESS.**
If the member company (the company stated in Item 1) is a subsidiary of another company, type "yes" and state the name and address of the parent company.

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____

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4. **LIST THE SUBSIDIARIES OF THE MEMBER COMPANY (NAMED IN ITEM 1) WHICH ARE COVERED BY ITS SELF-INSURANCE PROGRAM AND ARE PRESENTLY DOING BUSINESS IN GEORGIA.** List the subsidiaries of the member company (the company stated in Item 1) along with the primary address of each subsidiary. List only the subsidiaries doing business in Georgia which are covered under the member company's self-insurance. Do not list divisions of the member company. Do not list individual locations of the member company.

NAME OF SUBSIDIARIES	ADDRESS, CITY, STATE, ZIP

5. **LIST THE AFFILIATES OF THE MEMBER COMPANY (NAMED IN ITEM 1) WHICH ARE COVERED BY ITS SELF-INSURANCE PROGRAM AND ARE PRESENTLY DOING BUSINESS IN GEORGIA.** List the affiliates of the member company (the company stated in item 1) along with the primary address of each affiliate. List only the affiliates doing business in Georgia which are covered under the member company's self-insurance. Do not list divisions of the member company. Do not list individual locations of the member company. (In order for an affiliate to be included in the member company's self-insurance, there must be 51% common ownership with the member company.)

NAMES OF AFFILIATES	ADDRESS, CITY, STATE, ZIP

6. **IF YOUR COMPANY IS DOING BUSINESS IN GEORGIA, USING NAMES OTHER THAN THOSE LISTED IN YOUR RESPONSES TO ANY PREVIOUS QUESTIONS, PLEASE LIST THOSE COMPANIES.**

If your company is doing business in Georgia using a trade name, the name of a division, etc., list those names. Your response to this question will be used in determining coverage at the State Board of Workers' Compensation.

TRADE NAME OR DBA	ADDRESS, CITY, STATE, ZIP

7. **IF YOUR COMPANY OPERATES FRANCHISES, WHICH ARE <u>COVERED BY ITS SELF-INSURANCE PROGRAM</u> AND ARE PRESENTLY DOING BUSINESS IN GEORGIA, PLEASE LIST THE NAME AND ADDRESS OF EACH FRANCHISE LOCATION**.

NAME OF FRANCHISE	ADDRESS

ITEMS 8 THROUGH 26 MUST INCLUDE 12 MONTHS OF DATA

In order for your company to be assessed in 2010, you must provide twelve months of data for items 8 through 26. If your company was not self-insured for all of 2009, you must contact the insurance carrier with which you were insured prior to commencing your self-insurance to determine what was paid on your company's behalf in 2009 and add it to what was paid while self-insured.

8. **AVERAGE NUMBER OF EMPLOYEES IN GEORGIA IN 2009**
State the average number of total employees in Georgia in 2009 (self-insured only) including the employees of a subsidiary and/or affiliate of the company which were covered by your self-insurance.

____

9. **AVERAGE PROJECTED NUMBER OF EMPLOYEES IN GEORGIA IN 2010**
State the projected average number of total employees in Georgia in 2010 (self-insured only).

____

10. **AVERAGE NUMBER OF EMPLOYEES OUTSIDE GEORGIA IN 2009**
State the average total number of out-of-state employees of the member company who were not located in Georgia in 2009 and not self-insured in Georgia.

____

11. **AVERAGE PROJECTED NUMBER OF EMPLOYEES OUTSIDE GEORGIA IN 2010**
State the projected average total number of out-of-state employees of the member company not located in Georgia in 2010 and not self-insured in Georgia.

____

12. **GEORGIA PAYROLL IN 2009**
State the payroll of the Georgia employees covered by self-insurance in 2009. Please include the W-2 earnings of the GA employees covered by self-insurance in 2009.

$ ____________________

13. **ESTIMATED GEORGIA PAYROLL IN 2010**
State the estimated payroll of the employees which will be covered by self-insurance in Georgia in 2010.

$ ____________________

14. **TOTAL MEDICAL PAID IN GEORGIA IN 2009** (regardless of date of injury)
State the **total** amount of all medical payments made by or on your company's behalf to Georgia employees or medical providers in 2009, regardless of the date of injury. The response to this item should include medical payments made in conjunction with both lost time and medical only claims. **(Exclude from the above amount any claims for which you have executed agreements with the SITF for full reimbursement and/or are currently receiving 100% reimbursement from the excess carrier.)**

$ ____________________

PLEASE NOTE: THE ACCURACY OF YOUR RESPONSE TO THIS QUESTION CAN SIGNIFICANTLY AFFECT YOUR SECURITY REQUIREMENTS.

15. **TOTAL INDEMNITY PAID IN GEORGIA IN 2009** (regardless of date of injury)
State the **total** amount of all indemnity payments made by or on your company's behalf to Georgia employees in 2009, regardless of the date of injury. The response to this item should include indemnity payments made in conjunction with lost time and indemnity only claims as well as any settlements. **(Exclude from the above amount any claims for which you have executed agreements with the SITF for full reimbursement and/or are currently receiving 100% reimbursement from the excess carrier.)**

$ ____________________

PLEASE NOTE: THE ACCURACY OF YOUR RESPONSE TO THIS QUESTION CAN SIGNIFICANTLY AFFECT YOUR SECURITY REQUIREMENTS.

16. **TOTAL OUTSTANDING (NET) RESERVES FOR ALL SELF- INSURED CLAIMS IN GEORGIA AS OF 12/31/2009** (regardless of date of injury)
State the **total** outstanding reserves for all Georgia employees as of 12/31/09. The response to this item should include both medical and indemnity reserves. **Exclude from the above amount any self-insured claims for which you have executed agreements with the SITF for full reimbursement and/or are currently receiving 100% reimbursement from the excess carrier. Please note, any cases that have been accepted by SITF or Excess should be reserved at their corresponding amount. For instance, if SITF or Excess fully reimburses a claim, the reserves should be set at $0. Likewise, if SITF or Excess reimburses a claim 50%, the reserves should be reduced by 50%.**

$ ____________________

PLEASE NOTE: THE ACCURACY OF YOUR RESPONSE TO THIS QUESTION CAN SIGNIFICANTLY AFFECT YOUR SECURITY REQUIREMENTS.

PLEASE NOTE: ATTACH A LOSS RUN BY CLAIMANT NOTING THE INDIVIDUAL RESERVE FOR ALL OPEN CLAIMS AS OF 12/31/09. PLEASE INCLUDE THE FOLLOWING ON THE LOSS RUN: CLAIMANT'S NAME, THE LAST FOUR DIGITS OF THE CLAIMANT'S SOCIAL SECURITY NUMBER, DATE OF INJURY, TYPE OF INJURY, MEDICAL PAID TO DATE, INDEMNITY PAID TO DATE, AND UNPAID MEDICAL AND INDEMNITY RESERVES.

17. **PLEASE ATTACH A LIST OF ALL CLAIMS DESIGNATED TO BE CATASTROPHIC ALONG WITH THEIR RESPECTIVE RESERVES.**

18. **PLEASE ADVISE HOW YOUR RESERVES ARE FUNDED AND WHETHER YOUR COMPANY HAS A CAPTIVE**.

___ **Yes**, we have a captive. Reserves are funded as follows: ____________________________________

____

____

___ **No**, we do not have a captive.

PLEASE NOTE: IN THE EVENT OF THE MEMBER COMPANY'S BANKRUPTCY, YOUR CAPTIVE MUST AGREE TO REIMBURSE THE GSIGTF FOR PAYMENTS MADE BY THE FUND ACCORDING TO THE SAME TERMS AS THE CAPTIVE WOULD HAVE REIMBURSED THE MEMBER COMPANY FOR PAYMENTS MADE ON ANY CLAIM.

19.

PLEASE FORWARD THIS TO YOUR CAPTIVE

CAPTIVE INSURANCE ENDORSEMENT:

IN THE EVENT OF THE BANKRUPTCY OR INSOLVENCY OF THE NAMED INSURED: If the Georgia Self-Insurers Guaranty Trust Fund is called upon to expend monies on behalf of the insolvent or bankrupt member in order to pay workers' compensation benefits, medical expenses, or other costs pursuant to O.C.G.A. 34-9-1, et seq., we will reimburse the Georgia Self-Insurers Guaranty Trust Fund for those amounts paid on behalf of the insolvent or bankrupt member per your agreement with this employer. The Georgia Self-Insurers Guaranty Trust Fund will be treated as the insured for purposes of reimbursement pursuant to this endorsement and payments made by the bankrupt insolvent named insured will be credited towards the retention for the benefit of the Georgia Self-Insurers Guaranty Trust Fund.

If you have any questions, please contact us at (404) 872-6184 or the State Board of Workers' Compensation at (404) 656-4893.

20.

ALSO, DOES YOUR COMPANY HAVE AN ANNUAL ACTUARIAL STUDY OF RESERVES?

☐ **Yes**, we have an annual actuarial study of reserves. The cost is ___________________________

☐ **No**, we do not have an annual actuarial study of reserves.

21. **TOTAL NUMBER OF OPEN MEDICAL ONLY CLAIMS COVERED BY SELF-INSURANCE IN GEORGIA AS OF 12/31/2009** ____________________

22. **TOTAL NUMBER OF OPEN INDEMNITY CLAIMS COVERED BY SELF-INSURANCE IN GEORGIA AS OF 12/31/2009** ____________________

23. **NUMBER OF INJURIES OF ALL KINDS IN GEORGIA IN 2009**
State the total number of reported injuries including medical only and lost time claims ____________________

24. **NUMBER OF DEATHS IN GEORGIA IN 2009** ____________________

25. **NUMBER OF DISMEMBERMENTS IN GEORGIA IN 2009** ____________________

26. **NUMBER OF INJURIES IN GEORGIA IN 2009 WHICH ALLOWED AN EMPLOYEE TO COLLECT WEEKLY INDEMNITY BENEFITS, *including*: TEMPORARY TOTAL, TEMPORARY PARTIAL, PERMANENT PARTIAL, AND PERMANENT TOTAL**. ____________________

27. Please attach a **written** explanation of any variance of 20% or more in the total medical, indemnity, and/or reserve data that you reported on last year's Update Form, when compared to what you are reporting on this year's Update Form. If you are unable to provide specifics related to the variance, please summarize the reason for the variance to the best of your knowledge, pointing out any significant claims that contributed to the variance. **NOTE: the accuracy of your response to this question can significantly affect your security requirements**.

28. **PLEASE ADVISE WHO IS RESPONSIBLE FOR NOTIFYING YOUR EXCESS CARRIER AND/OR THE SITF OF CLAIMS ELIGIBLE FOR REIMBURSEMENT.**

COMPANY NAME ____________________

CONTACT PERSON ____________________

ADDRESS ____________________

CITY, STATE, ZIP ____________________

TELEPHONE NUMBER ____________________

FACSIMILE NUMBER ____________________

E-MAIL ADDRESS ____________________

29. **WAS THERE A CHANGE IN OWNERSHIP OF YOUR COMPANY LAST YEAR OR DID YOU BUY OR SELL SUBSIDIARY COMPANIES LAST YEAR? IF SO, PLEASE EXPLAIN.**

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30. **NAME, ADDRESS AND TELEPHONE NUMBER OF THE PERSON COMPLETING THIS FORM.**

State the name, address and telephone number of the person we should contact if there are questions about your responses on this form. The person named does not have to be an employee of the member company.

NAME ______________________________

ADDRESS ______________________________

CITY, STATE, ZIP ______________________________

TELEPHONE NUMBER ______________________________

FACSIMILE NUMBER ______________________________

E-MAIL ADDRESS ______________________________

31. **ENCLOSE AN ORIGINAL BOUND COPY OF YOUR MOST RECENT AUDITED FINANCIAL STATEMENTS.**

Each employer is required to furnish a copy of their full audit to us each year. <u>If we do not have a copy of your most recent audit on file, please attach a copy of your audited financial statement for the recently completed calendar year with the update form or, if not yet available, please advise when same is produced. If you are on a fiscal year, please advise when your most recent fiscal year will be completed and when your financial statement for the said year will be available.</u> (We prefer to receive original bound copies of your financial statements or annual report, instead of photocopies.) **<u>DO NOT</u> DELAY SENDING YOUR UPDATE FORM BECAUSE AUDITED FINANCIAL STATEMENTS ARE NOT AVAILABLE. THE FINANCIAL STATEMENTS MAY BE SENT UNDER SEPARATE COVER.** If it is necessary to submit financial statements separately from the update form, you are required to forward the enclosed affidavit entitled "Certification of Financial Statements" (#34) which is to be executed by the owner, a partner, or a corporate officer, preferably the President or CFO, of the member company.

(continued on following page)

Please note that the State Board of Workers' Compensation may rely on the information contained herein; therefore, the attached affidavit requires an officer of the member company, preferably the President or the CFO, to certify that the most recent audited financials statements are attached, and that there are no material changes in the member's financial status between the previous and current year. As a member of the self-insurance program, you are required to notify the Georgia Self-Insurers Guaranty Trust Fund and the State Board of Workers' Compensation if any material changes do occur in said financial statements status

☐ **If your most recent audited financial statements are *not* available, please check the box and state the date of their availability here**: _____________

☐ **Please advise when your most recent fiscal year will be completed here**: _________________

32. **ENCLOSE A COPY OF THE CERTIFICATE OF INSURANCE ASSOCIATED WITH YOUR EXCESS INSURANCE COVERAGE.**

You are required to furnish a copy of the certificate of insurance for the excess policy currently in place which includes the effective date, expiration date, specific retention level, workers' compensation limits, the insurance company that issued the policy, and companies covered by the policy. The certificate must state the policy is a specific excess workers' compensation policy. <u>If we already have a copy of your current certificate of insurance, you do not need to include a copy with your update form.</u> <u>DO NOT</u> DELAY SENDING YOUR UPDATE FORM BECAUSE PROOF OF EXCESS INSURANCE IS NOT AVAILABLE. PROOF OF EXCESS INSURANCE MAY BE SENT UNDER SEPARATE COVER. (FOR ADDITIONAL INFORMATION, PLEASE REFER TO OUR WEB SITE www.gaguaranty.com.

33. **IF A CAPTIVE INSURANCE COMPANY IS USED TO FUND ANY PART OF THE SELF-INSURANCE LIABILITY OF THE EMPLOYER, PLEASE PROVIDE A COPY OF THE MOST RECENT CERTIFIED FINANCIAL STATEMENT OF THE CAPTIVE AS WELL AS THE FOLLOWING INFORMATION REGARDING THE CAPTIVE MANAGER.**

NAME ______________________________

ADDRESS ______________________________

____

TELEPHONE ______________________________

DOMICILE ______________________________

34. **DIRECTORS AND OFFICERS INSURANCE COVERAGE**

You are required to provide the following information, if applicable:

INSURED'S NAME	
LIMITS OF COVERAGE	
ISSUING COMPANY	
POLICY	

35. **CERTIFICATION BY THE MEMBER COMPANY**:

The update form must be signed by the owner, partner, or corporate officer, preferably the President or CFO, of the member company. It cannot be signed by your third-party administrator. In addition, the signature must be notarized and where applicable, the corporate seal must be used.

The undersigned, after being duly sworn does hereby depose and state under oath, and certify under penalty of law, that I am thoroughly familiar with the operation and affairs of the above-named company; that I have read and studied the statements above, attachments, ***including the most recent audited financial statements, if currently available***, and exhibits, and know the contents thereof; that I am authorized by said company to execute and submit the foregoing information with all attachments ***including the most recent audited financial statements, if currently available,*** exhibits and supporting documents, as well as to individually execute this affidavit. I hereby certify that after a thorough and diligent search, that said statements and representations contained herein, together with all supporting attachments ***including the most recent audited financial statements, if currently available***, exhibits and documents are true and correct to the best of my knowledge, information and belief.

SUBSCRIBED AND SEALED THIS ___________ DAY OF ______________________________, 2010.

____

SIGNATURE OF OWNER, PARTNER, OR CORPORATE OFFICER
(PRESIDENT OR CFO) AS AFFIANT

____

TYPED NAME AND OFFICIAL POSITION

Attest (If a Corporation)

____

Signature of Corporate Secretary

____

Name of Corporate Secretary (Typed or Printed)

(PLACE CORPORATE SEAL HERE)

SWORN TO AND SUBSCRIBED BEFORE ME BY ABOVE
AFFIANT, THIS THE DATE SHOWN ABOVE:

____

SIGNATURE OF NOTARY PUBLIC

ADDRESS AND TELEPHONE NUMBER OF NOTARY PUBLIC:

____

____

____

MY COMMISSION EXPIRES ___________________
(SEAL OF NOTARY PUBLIC HERE)

36. **CERTIFICATION BY CLAIMS COMPANY, ADJUSTER OR THIRD PARTY ADMINISTRATOR**

If a claims company, adjuster or third party administrator provided information regarding claims, payments and reserves which were used in the preparation of this form, the claims company, adjuster or third party administrator must certify the data provided herein.

PLEASE ATTACH A BRIEF DESCRIPTION OF YOUR RESERVING METHODOLOGY OR FORMULAS USED TO REACH THE RESERVE FIGURES YOU ARE CERTIFYING, SPECIFICALLY OUTLINING HOW OFTEN RESERVES ARE ADJUSTED, WHAT INPUT THE SELF-INSURED EMPLOYER PROVIDED, *if any*, AS WELL AS ANY OTHER INFORMATION YOU BELIEVE TO BE PERTINENT TO YOUR RESERVING PRACTICES.

I hereby certify that after a thorough and diligent search, that the information provided in this form regarding claims, payments and reserves are true and correct to the best of my knowledge.

SUBSCRIBED THIS ___________ DAY OF _____________________________, 2010.

_____________________________________ _____________________________________

SIGNATURE OF DESIGNATED OFFICIAL OF THE ADJUSTER, CLAIMS COMPANY OR THIRD PARTY ADMINISTRATOR

TYPED NAME AND OFFICIAL POSITION OF THE DESIGNATED OFFICIAL OF THE ADJUSTER, CLAIMS COMPANY OR THIRD PARTY ADMINISTRATOR

NAME OF THE ADJUSTER, CLAIMS COMPANY OR THIRD PARTY ADMINISTRATOR'S PLACE OF BUSINESS

____

SWORN TO AND SUBSCRIBED BEFORE ME BY ABOVE AFFIANT, THIS THE DATE SHOWN ABOVE:

____

SIGNATURE OF NOTARY PUBLIC

ADDRESS AND TELEPHONE NUMBER OF NOTARY PUBLIC:

____

____

____

____

MY COMMISSION EXPIRES __________________

(SEAL OF NOTARY PUBLIC HERE)

37. **CERTIFICATION BY MEMBER COMPANY SUBMITTING FINANCIAL STATEMENTS *SEPARATE FROM* THE UPDATE FORM:**

This certification must be signed by the owner, partner, or corporate officer, preferably the President or CFO, of the member company. In addition, the signature must be notarized and where applicable, the corporate seal must be used.

The undersigned, after being duly sworn does hereby depose and state under oath, and certify under penalty of law, that I am thoroughly familiar with the operation and affairs of the above-named company; that I am authorized by said company to execute and submit, ***under separate cover***, the most recent audited financial statements as well as to individually execute this affidavit.

SUBSCRIBED AND SEALED THIS ___________ DAY OF _____________________________, 2010.

____

SIGNATURE OF OWNER, PARTNER, OR CORPORATE OFFICER (PRESIDENT OR CFO) AS AFFIANT

____

TYPED NAME AND OFFICIAL POSITION

Attest (If a Corporation)

____

Signature of Corporate Secretary

____

Name of Corporate Secretary (Typed or Printed)

(PLACE CORPORATE SEAL HERE)

SWORN TO AND SUBSCRIBED BEFORE ME BY ABOVE AFFIANT, THIS THE DATE SHOWN ABOVE:

____

SIGNATURE OF NOTARY PUBLIC

MY COMMISSION EXPIRES __________ _______

(SEAL OF NOTARY PUBLIC HERE)

ADDRESS AND TELEPHONE NUMBER OF NOTARY PUBLIC:

____

____

BEFORE YOU MAIL YOUR 2010 MEMBER INFORMATION UPDATE

* Please ensure you have responded to each item. **If any question is left unanswered, the form will be returned to you**.

* Regarding the submission of current financial statements, if you have **not** submitted a copy of your most recent audited financial statements, please send a copy with your update form. If your company's year ending date for the most current financial statements has not passed, resulting in your need to submit current financial statements at a later date, please complete questions numbered 28 and 34 regarding this latter submission to us.

* If we do not have a current certificate of insurance for your excess insurance policy, please include a copy with your update form.

* Do **not** send copies of your letter of credit, surety bond or OSHA reports.

IMPORTANT

FAILURE TO RETURN THIS FORM WITH A POSTMARK OF MARCH 31, 2010 OR BEFORE, WILL RESULT IN AN AUTOMATIC PENALTY OF $50.00 FOR EACH DAY THE FORM IS DELINQUENT OR 10 PERCENT OF THE ASSESSMENT, WHICHEVER IS GREATER. EXTENSIONS WILL NOT BE GRANTED AFTER MARCH 23, 2010.

DO NOT DELAY SENDING YOUR UPDATE FORM BY MARCH 31, 2010 BECAUSE YOUR FINANCIAL STATEMENTS AND/OR EXCESS CERTIFICATE ARE NOT AVAILABLE. YOUR FINANCIAL STATEMENTS AND EXCESS CERTIFICATE CAN BE SENT UNDER SEPARATE COVER.

FACSIMILES ARE NOT PERMITTED.