

December 1, 2009

VIA CERTIFIED MAIL

TO: Employers Who Are No Longer Self-Insured

FROM: John P. Reale, Administrator

Attached please find a copy of your 2010 Member Information Update form. This form must be completed even though you are no longer self-insured since you will continue to be assessed until all self-insured claims are closed. Your completed form will be used to update our files and compute your assessment for 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, GA 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.

GEORGIA SELF-INSURERS GUARANTY TRUST FUND
2010 MEMBER INFORMATION UPDATE
(FOR EMPLOYERS WHO ARE NO LONGER SELF-INSURED)

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 named company, along with his/her address and telephone number. (The person whose name is stated here must be an employee of the named 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 Workers' 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 NUMBER	_____
	(toll-free number, if available)
FACSIMILE NUMBER	_____
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.

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

NAME OF SUBSIDIARIES

STREET ADDRESS, CITY STATE & ZIP CODE

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

NAMES OF AFFILIATES

STREET ADDRESS, CITY, STATE & ZIP CODE

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

If your company was doing business in Georgia while self-insured 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

STREET ADDRESS, CITY, STATE & ZIP CODE

7. **IF YOUR COMPANY OPERATED FRANCHISES DURING ITS PERIOD OF SELF-INSURANCE, PLEASE STATE THE NAME AND ADDRESS OF EACH OF THOSE FRANCHISE LOCATIONS.**

NAME OF FRANCHISE

ADDRESS

**ITEMS 8 THROUGH 25 MUST INCLUDE 12 MONTHS OF DATA
FOR OPEN CLAIMS WHICH OCCURRED DURING
THE PERIOD OF SELF-INSURANCE ONLY**

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 number of employees of a subsidiary and/or affiliate of the company which were covered by your self-insurance.

9. **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.

10. **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.

11. **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.

12. **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.

13. **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 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.

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

15. **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.

16.

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 insured 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.

17. **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.

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

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

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

21. 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.**

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

CLAIMS COMPANY _____

CONTACT PERSON _____

ADDRESS _____

CITY, STATE, ZIP _____

TELEPHONE NUMBER _____

FACSIMILE NUMBER _____

E-MAIL ADDRESS _____

23. **NUMBER OF GEORGIA DEATHS IN 2009** _____

24. **NUMBER OF GEORGIA DISMEMBERMENTS IN 2009** _____

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

26. SUPPLY THE FOLLOWING INFORMATION FOR THOSE GEORGIA CLAIMS WHICH OCCURRED WHILE YOU WERE SELF-INSURED (WHICH REMAIN OPEN AT THIS TIME).

CLAIM #1

NAME OF CLAIMANT _____
SOCIAL SECURITY NUMBER _____
DATE OF INJURY _____
TYPE OF INJURY _____
INDEMNITY PAID TO DATE \$ _____
MEDICAL PAID TO DATE \$ _____
UNPAID RESERVES \$ _____

CLAIM #2

NAME OF CLAIMANT _____
SOCIAL SECURITY NUMBER _____
DATE OF INJURY _____
TYPE OF INJURY _____
INDEMNITY PAID TO DATE \$ _____
MEDICAL PAID TO DATE \$ _____
UNPAID RESERVES \$ _____

CLAIM #3

NAME OF CLAIMANT _____
SOCIAL SECURITY NUMBER _____
DATE OF INJURY _____
TYPE OF INJURY _____
INDEMNITY PAID TO DATE \$ _____
MEDICAL PAID TO DATE \$ _____
UNPAID RESERVES \$ _____

CLAIM #4

NAME OF CLAIMANT _____
SOCIAL SECURITY NUMBER _____
DATE OF INJURY _____
TYPE OF INJURY _____
INDEMNITY PAID TO DATE \$ _____
MEDICAL PAID TO DATE \$ _____
UNPAID RESERVES \$ _____

CLAIM #5

NAME OF CLAIMANT _____
SOCIAL SECURITY NUMBER _____
DATE OF INJURY _____
TYPE OF INJURY _____
INDEMNITY PAID TO DATE \$ _____
MEDICAL PAID TO DATE \$ _____
UNPAID RESERVES \$ _____

CLAIM #6

NAME OF CLAIMANT _____
SOCIAL SECURITY NUMBER _____
DATE OF INJURY _____
TYPE OF INJURY _____
INDEMNITY PAID TO DATE \$ _____
MEDICAL PAID TO DATE \$ _____
UNPAID RESERVES \$ _____

CLAIM #7

NAME OF CLAIMANT _____
SOCIAL SECURITY NUMBER _____
DATE OF INJURY _____
TYPE OF INJURY _____
INDEMNITY PAID TO DATE \$ _____
MEDICAL PAID TO DATE \$ _____
UNPAID RESERVES \$ _____

CLAIM #8

NAME OF CLAIMANT _____
SOCIAL SECURITY NUMBER _____
DATE OF INJURY _____
TYPE OF INJURY _____
INDEMNITY PAID TO DATE \$ _____
MEDICAL PAID TO DATE \$ _____
UNPAID RESERVES \$ _____

CLAIM #9

NAME OF CLAIMANT _____
SOCIAL SECURITY NUMBER _____
DATE OF INJURY _____
TYPE OF INJURY _____
INDEMNITY PAID TO DATE \$ _____
MEDICAL PAID TO DATE \$ _____
UNPAID RESERVES \$ _____

CLAIM #10

NAME OF CLAIMANT _____
SOCIAL SECURITY NUMBER _____
DATE OF INJURY _____
TYPE OF INJURY _____
INDEMNITY PAID TO DATE \$ _____
MEDICAL PAID TO DATE \$ _____
UNPAID RESERVES \$ _____

**IF YOU HAVE MORE THAN TEN (10) OPEN CLAIMS, PLEASE ATTACH
ADDITIONAL PAGES TO THIS FORM.**

27. **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 _____

28. **ENCLOSE AN ORIGINAL BOUND COPY OF YOUR MOST RECENT AUDITED FINANCIAL STATEMENTS.** 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. DO NOT DELAY SENDING YOUR UPDATE FORM BECAUSE YOUR FINANCIAL STATEMENTS ARE NOT AVAILABLE. 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" (#30), which is to be executed by the owner, a partner or a corporate officer, preferably the President or CFO, of the member company.

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. 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 _____.

29. **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 NO. _____
DOMICILE _____

30. **DIRECTORS AND OFFICERS INSURANCE COVERAGE**

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

INSURED'S NAME: _____
LIMITS OF COVERAGE: _____
ISSUING COMPANY'S NAME: _____
POLICY NUMBER: _____

31. **CERTIFICATION:**

The update form must be signed by the owner, partner, or corporate officer, preferably the President or CFO, of the member company. It can not 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 statement, if currently available**, exhibits and supporting documents, as well as to individually execute this affidavit; and 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

(PLACE CORPORATE SEAL HERE)

Name of Corporate Secretary (Typed or Printed)

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)

32. 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)

33. **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, 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)

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 25 and 30 regarding this latter submission to us.

- * 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 ARE NOT AVAILABLE. YOUR FINANCIAL STATEMENTS CAN BE SENT UNDER SEPARATE COVER.

FACSIMILES ARE NOT PERMITTED.