PLEASE TYPE OR PRINT LEGIBLY. State Form 12386-b

CERTIFICATION FOR WORKER'S COMPENSATION CARRIERS

STATE OF ___________________________

COUNTY OF _________________________

I, ____________________________, hereby CERTIFY that I am ___________________________________
(Official Title)

of ____ and that I have knowledge of the
(Carrier)
workers' compensation records of Carrier. I further CERTIFY that the amount of **direct written premiums** issued by Carrier for Indiana Worker's Compensation Insurance in the calendar year **2016** totaled $__________.

I further CERTIFY that I have calculated Carrier's 2018 assessment for the Second Injury Fund by dividing the above number representing Carrier's Direct Written Premiums by 876,183,000 (which, in dollars represents the total direct written premiums for all worker's compensation carriers in Indiana in 2016), and then multiplying that figure by 5,189,679 (which, in dollars represents the amount for all carriers portion of the 2018 assessment for the Second Injury Fund). This calculation gave me ____________, which in dollars represents Carrier's total annual assessment.

_____I further CERTIFY that the enclosed sum of $_______________________ represents one half of Company's calculated assessment (only if total assessment is greater than $1,000), which is the first installment of the statutory assessment due by **January 31, 2018** and payable to the Worker's Compensation Board of Indiana for the Second Injury Fund. I agree to pay $____________ as payment of the second half of Company's assessment for 2018 *without notice* to the Board by **June 29, 2018**.

OR
_____I further CERTIFY that the enclosed sum of $______________ represents the entire assessment of Company.

PLEASE PAY ELECTRONICALLY VIA http://www.in.gov/wcb.

I hereby verify, subject to penalties of perjury, that the facts contained herein are true.

____________________________________ Signature	____________________________________ Date
____________________________________ Carrier Name	____________________________________ Federal ID Number
____________________________________ Telephone Number	____________________________________ E-mail Address
____________________________________ Mailing Address	____________________________________ City, State, Zip

***Please note that IC§22-3-3-13(j) requires each company subject to this assessment to provide to the Board the name, address, and E-mail address of a representative authorized to receive the notice of assessment.**