

## Experience Modification Subscription Form 205 (Rev. 11/2022)

### Instructions

#### Purpose of Form

WCIRB member insurers (Insurers) and registered Advisory Organizations in good standing with the California Department of Insurance (CDI) can use this form to subscribe to the Experience Modification Subscription product.

See California Insurance Code Sections 11750.1(e) and 11753 for information about Advisory Organizations. To become a registered Advisory Organization, contact the CDI directly.

#### Ordering Process

- Upon receipt of this form, the WCIRB will verify eligibility for the product. For Advisory Organizations, the WCIRB will contact the CDI.
- Once eligibility is verified, an invoice for the order will be generated and an *Indemnification Agreement* will be sent to the signatory(ies) designated in section H.
- For Insurers, if experience modification data for more than one company in the same NAIC group is requested in section D, the signatory(ies) designated in section H signing the *Indemnification Agreement* must have the authority to sign the contract on behalf of each company.
- Upon receipt of the signed Agreement and payment, the WCIRB will contact your designated Technical Contact in section F to begin the setup process.

#### Pricing

The Experience Modification Weekly File is \$2,500 per year and the Daily File is \$12,500 per year, prorated to the nearest month and billed on an annual basis. The Master File is provided upon initiating the subscription. Subscribers may order a Replacement Master File at any time for \$500. Payment is due in advance of service. No refunds will be issued upon cancellation.

#### Payment Method

The WCIRB must receive payment before processing the order. Indicate the payment method and corresponding authorization information in section G.

- Direct billing is available for WCIRB member insurers.
- The WCIRB accepts Visa® and Mastercard® or ACH. Authorize.Net will email an electronic invoice to the requester on behalf of WCIRB California and process the credit card or ACH payment.

#### Product Delivery

The Experience Modification Subscription product is delivered electronically on either a daily or weekly basis. See product documentation, [Experience Modification Subscription #DP2010](#), for additional information.

#### Form Completion

This form can be completed electronically or printed out and completed on hard copy. Electronic signatures are acceptable when a signature is required. This form may be emailed or mailed.

Email [contracts@wcirb.com](mailto:contracts@wcirb.com)

Mail WCIRB California  
Attention: WCIRB Legal  
1901 Harrison Street, 17th Floor  
Oakland, CA 94612

#### Questions/Additional Information

Call the WCIRB Contract Administrator at 415.778.7241 or email [contracts@wcirb.com](mailto:contracts@wcirb.com).

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All products and services are prepared by the WCIRB in the normal course of business pursuant to the regulations of the California Department of Insurance or for the benefit of the WCIRB's members. The WCIRB has made reasonable efforts to ensure the accuracy of the products and services.

You must make an independent assessment regarding the use of all WCIRB products and services based upon your particular facts and circumstances. The WCIRB cannot make such an assessment and shall not be liable for any damages, of any kind, whether direct, indirect, incidental, punitive or consequential, arising from the use, inability to use, or reliance upon WCIRB products and services.

**Experience Modification Subscription  
Form 205 (Rev. 11/2022)****A. Company Type**

Insurance Company

Advisory Organization

**B. Product Selection**

Weekly File

Daily File

Replacement Master File Only

**C. Primary Contact**

Name

Title

Company

Address (No P.O. Boxes)

City

State

Zip

Telephone

Email

**D. Insurer Information** (skip for Advisory Organization)

Insurers may elect to receive experience rating information for their own company or for one or more additional companies within their NAIC group. If requesting experience rating data for more than one company in the same NAIC group, the Legal Contact named in section E must have the authority to accept notice on behalf of each company in the designated group.

Please list the company(ies) in the box below.

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**E. Legal Contact**

The Legal Contact is a corporate officer or attorney of the Insurer or Advisory Organization who is authorized to accept legal notices on behalf of the Insurer or Advisory Organization.

☐ Same as Primary Contact in section C

Name

Title

Company Name

Address (No P.O. Boxes)

City

State

Zip

Telephone

Email

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### F. Technical Contact

The Technical Contact is an employee of the Insurer or Advisory Organization in the Information Technology Department who will be responsible for downloading and processing the file(s) and who has knowledge of the Insurer's or Advisory Organization's information technology capabilities.

Name

Title

Telephone

Email

### G. Payment Method

☐

#### 1. WCIRB Member Insurers Billing

I am authorized by the Insurer named in section D to request products. I understand that my company will be billed for the products ordered by this form.

Authorized by

Signature

Title

Date

☐

#### 2. Payment by Credit Card or ACH (see Instructions)

Please provide the following:

Name on Card

Email

**Do not enter any credit card number onto this form. Credit card payment will be processed directly via Authorize.Net.**

### H. Signatory(ies)

The Signatory must be an officer or attorney affiliated with the Insurer or Advisory Organization and who is authorized to sign the Agreement on behalf of the Insurer or Advisory Organization.

For Insurers, each insurer identified in section D must have an Insurer Signatory who is (1) an officer or attorney affiliated with the Insurer, (2) authorized to legally bind the Insurer, and (3) authorized to sign the *Indemnification Agreement* on behalf of the Insurer. If the Insurer Signatory does not have authority to sign the Agreement on behalf of all the insurers identified in section D, multiple signatories are required.

☐

Check this box if one Insurer Signatory is authorized to sign the Agreement on behalf of all the insurers identified in section D. If this box is not checked, please provide additional signatory(ies) for the remaining insurer(s) on the next page.

Name

Title

Company Name

Address (No P.O. Boxes)

City

State

Zip

Telephone

Email

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Please provide additional signatory(ies) below if the box in section H on the prior page is not checked.

Name	Title		
Company Name			
Address (No P.O. Boxes)	City	State	Zip
Telephone	Email		

  

Name	Title		
Company Name			
Address (No P.O. Boxes)	City	State	Zip
Telephone	Email		

  

Name	Title		
Company Name			
Address (No P.O. Boxes)	City	State	Zip
Telephone	Email		

  

Name	Title		
Company Name			
Address (No P.O. Boxes)	City	State	Zip
Telephone	Email		