

NC2745 Form—Workers Compensation Experience Rating for Former Clients of Labor Contactors

General Instructions:

- A separate NC2745 Form is required for each state and policy year
- The data reported on this form must match the data reported on the corresponding unit report
- Complete payroll and properly valued losses for all years in the experience rating period must be resubmitted prior to each renewal rating effective date
- Each form submitted must be completed and signed by the carrier of record for the policy period during which the reported data was developed

Form Instructions:

Item #	Field Name	Definition/Reporting Requirements
1	Previous Labor Contractor Risk Name	The legal entity name of the previous labor contractor.
1	Previous Labor Contractor Risk ID	The nine-digit number that NCCI assigned to the Risk Name entered in Item 1.
2	Client Company Risk Name	The legal entity name of the former client company.
2	Client Company Risk ID	The nine-digit number that NCCI assigned to the Risk Name entered in Item 2.
3	New Labor Contractor Risk Name	If client has entered into a leasing agreement with a new labor contractor, enter the legal entity name of the new labor contractor.
3	New Labor Contractor Risk ID	If client has entered into a leasing agreement with a new labor contractor, enter the nine-digit number that NCCI assigned to the Risk Name entered in Item 3.
FOR THE PERIOD DURING WHICH THE REPORTED DATA WAS DEVELOPED: (Left Side of Form)		
4-1	Effective Date	The Effective Date of the policy containing the client's information corresponding to the Risk Name entered in Item 1.
4-2	Policy Number	The Policy Number of the policy containing the client's information corresponding to the Risk Name entered in Item 1. Provide the entire Policy Number without dashes or punctuation.
4-3	Carrier Code and Name	The Carrier Code and Name that issued the policy containing the client's information corresponding to the Risk Name entered in Item 1.
4-4	Exposure State	The Exposure State for the client company experience from the policy information corresponding to the Risk Name entered in Item 1.

Item #	Field Name	Definition/Reporting Requirements
FOR THE CURRENT PERIOD: (Right Side of Form)		
4-1	Effective Date	The Effective Date of the policy containing the client company information corresponding to the Risk Name entered in Item 2.
4-2	Policy Number	The Policy Number of the policy containing the client company information corresponding to the Risk Name entered in Item 2. Provide the entire Policy Number without dashes or punctuation.
4-3	Carrier Code and Name	The Carrier Code and Name that issued the policy containing the client company information corresponding to the Risk Name entered in Item 2.
EXPOSURE COLUMNS		
(1)	Class Code	The Classification Code that corresponds to the client company experience. The Classification Code must have been reported on the previous labor contractor's unit report for the Policy Number entered in item 4-2.
(2)	Payroll	The portion of the Exposure Amount that corresponds to the client company Classification Code entered in column (1). Round to the nearest whole dollar. The sum of the Exposure Amount for the Classification Code reported for the client company must be equal to or less than the Exposure Amount for the Classification Code reported on the employee leasing company unit report.
(3)	Rate	The Manual/Charged Rate that corresponds to the separated employers' Classification Code entered in column (1).
LOSS COLUMNS		
(4)	Claim Number	The unique Claim Number for each loss associated with the Client Risk Name entered in Item 2. Claims may not be grouped for reporting purposes.
(5)	Accident Date	The Accident Date that corresponds to the client company Claim Number entered in column (4).
(6)	Injury Type	The Injury Type code must correspond to the client company Claim Number entered in column (4). Refer to the Statistical Plan for coding values.
(7)	Open/Closed	The claim status of the claim for the client company Claim Number reported in column (4). Enter "O" for Open or "F" for Closed.
(8)	Claim Class Code	The Classification Code for the injured worker that corresponds to the client company Claim Number reported in column (4).
(9)	Indemnity	The actual loss amount (including reserves) for the indemnity portion of the claim that corresponds to the client company Claim Number entered in column (4). Losses must be valued and reported in accordance with the Statistical Plan . Round to the nearest whole dollar.

Item #	Field Name	Definition/Reporting Requirements
(10)	Medical	The actual loss amount (including reserves) for the medical portion of the claim that corresponds to the client company Claim Number entered in column (4). Losses must be valued and reported in accordance with the Statistical Plan . Round to the nearest whole dollar.
(11)	Actual Incurred Losses	The sum of columns (9) and (10). Round to the nearest whole dollar.
(12)	Loss Cov. Act Code	The Loss Coverage Act Code that identifies the type of Act benefits that apply to the client company Claim Number entered in column (4). Refer to the Statistical Plan for coding values.
(13)	Cat. No.	The Catastrophe Number is reported as part of the client company Claim Number entered in column (4). The Catastrophe Number must be reported in accordance with the Statistical Plan .

NC2745 Form—Required Signature

The form must be signed by the insurance company that provided coverage for the period the reported data was developed. The individual completing the form must provide the following:

Field Name	Instructions
Insurance Carrier	The carrier name of the policy containing the client company information.
Signature	Signature of the individual completing the form.
Title	Title of the individual completing the form.
Date	Date (MM/DD/YYYY) that the form was signed.
Name of Person Completing the Form:	Printed name of the individual completing the form.
Telephone No.	The telephone number of the individual completing the form.