GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Employment Services

VIINCENT C. GRAY
MAYOR

LISA M.MALLORY
DIRECTOR

OFFICE OF WORKERS' COMPENSATION

August 30, 2013

Dear Workers' Compensation Insurer:

The purpose of this correspondence is to provide official notification of the

District of Columbia Workers' Compensation Program – Fiscal Year 2014
"PREMIUM SURCHARGE FOR WORKERS' COMPENSATION POLICIES."

Attachment A explains the formula used to calculate the premium surcharge. Effective October 1, 2013 through September 30, 2014, **the rate is 2.05 percent.**

For your immediate reference, **Attachments B and C** contain the schedule and format for remitting premium surcharge payments to the D.C. Department of Employment Services, Office of the Chief Financial Officer at 4058 Minnesota Avenue, NE – 5th Floor, Suite 5700, Washington, D.C. 20019.

If you have any questions or concerns, I can be reached by e-mail at Malcolm.luis-harper@dc.gov or 202-671-1000.

Sincerely,

Malcolm J. Luis-Harper
Associate Director
Department of Employment Services
Office of Workers' Compensation

Attachments

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Employment Services

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FISCAL YEAR 2014 PREMIUM SURCHARGE RATE

(Formula Used to Calculate the Premium Surcharge)

Computation Factors

Total Fiscal Year 2012 Reported Losses (Self Insurers and Insurance Carriers) = $114,936,168.41
Total Fiscal Year 2012 Reported Losses (Carriers Only) = $88,208,520.20
Fiscal Year 2014 Special Fund Assessment = $3,800,000.00
2012 Paid Workers' Compensation Insurance Premiums = $142,129,750.00

Computations

1. Determine Insurance Carriers' Proportion of the Total Paid Losses for the Preceding Fiscal Year.

Insurance Carriers Paid Losses divided by Total Paid Losses =
Insurance Carriers Proportion:

Divided by $88,208,520.20 divided by $114,936,168.41 = .7675

2. Determine the Dollar Amount of the Special Fund to be Collected through the Employer Insurance Premium Surcharge.

Special Fund Assessment x Insurance Carrier Proportion of Total Paid Losses =
Amount to be Collected through Insurance Premium Surcharge:

$3,800,000.00 x .7675 = $2,916,500.00

3. Determine Premium Surcharge Rate.

Amount to be collected divided by the Preceding Year's Paid Workers' Compensation Insurance Premiums = Premium Surcharge Rate:

$2,916.500.00 divided by $142,129,750.00
=
PREMIUM SURCHARGE RATE
[OCTOBER 1, 2013 THROUGH SEPTEMBER 30, 2014]

.0205 or 2.05 Percent

Attachment A

4058 Minnesota Avenue, N.E. • 3rd Floor • Washington, D.C. 20019 • Office: 202.671.1000 • Fax: 202.671.1929

Premium Surcharge Procedures

At the end of each fiscal quarter, insurers must submit an amount equal to the premium surcharge collected from policyholders during that quarter. The payment shall be submitted no later than 30 days after the end of each quarter.

The following table illustrates the due dates for the periods covered in each quarter:

Quarter Covered	Period	Due By
First Quarter	October 1 – December 31	January 31
Second Quarter	January 1 – March 13	April 30
Third Quarter	April 1 – June 30	July 31
Fourth Quarter	July 1 – September 30	October 31

Checks shall be made payable to the DC Treasurer and transmitted with the "Quarterly Premium Surcharge Payment Form."

Checks [along with the Quarterly Premium Surcharge Payment Form] are to be submitted to:

DC Department of Employment Services
Office of the Chief Financial Officer
4058 Minnesota Avenue, NE – 5th Floor, Suite 5700
Washington, D.C. 20019
(202) 671-1400

A copy of the form must also be submitted to:

DC Department of Employment Services
Office of Workers' Compensation
P.O. Box 56098
Washington, D.C. 20011
ATTN: Insurance Unit
(202) 671-1000

Note: The Quarterly Premium Surcharge Payment Form may be reproduced or downloaded from the DOES website. The website address is www.does.dc.gov.

Attachment B

QUARTERLY PREMIUM SURCHARGE PAYMENT FORM

Insurer Name_____
Address_____
City_____ **State**_____ **Zip Code**_____

Insurer NCCI Number_____

Date of Report	Quarter Ending Date	Dollar Amount Submitted

_____
CERTIFYING OFFICIAL (Type Name)

_____ _____
CERTIFYING OFFICIAL (Signature) **DATE**

_____
TITLE

_____
TELEPHONE NUMBER

Mail Form and Check to:
D.C. Department of Employment Services
Office of the Chief Financial Officer
4058 Minnesota Avenue, NE - 5th Floor, Suite 5700
Washington, D.C. 20019
(Telephone: 202-671-1400)

Submit a Copy of the Form to:
D.C. Department of Employment Services
Office of Workers' Compensation
Post Office Box 56098, Insurance Unit
Washington, D.C. 20011
(FAX: 202-671-1929)

(1) Checks are payable to the *D.C. Treasurer*.
(2) This form may be reproduced or downloaded from the DOES website. The website address **is** **www.does.dc.gov** .