



# Individual

## RETROSPECTIVE RATING PLAN AGREEMENT

*Please complete all blanks.*

<b>Company Name</b>			<b>Retro ID number</b> (to be determined by L&I if first enrollment)
<b>Company mailing address and location</b>			<b>Unified Business Identifier</b> (UBI number)
<b>City</b>	<b>State</b>	<b>Zip Code+4</b>	<b>L&amp;I Account number</b> – including all related sub-accounts
<b>Company contact name</b> (please print)			<b>Enrollment period beginning</b> (first day of calendar quarter)
<b>Company contact phone and FAX number</b> (including area code)			<b>Authorized outside representative</b> (third party administrator), if any
<b>Company contact e-mail address</b>			<b>Company web site</b> (optional)

If known or from prior plan years:      **Standard Premium** \$       **Size Group**       **Hazard Group**

Refer to *WAC 296-17B-300* for limitations on plan choices and loss limits. Please contact Retrospective Rating staff if you need assistance.

**Plan type** (check one):      **Loss Based**       **Premium Based**       See WAC 296-17B-440

**Minimum Loss Ratio** (up to 4 digits – between 0.0000 and 0.6000): \_\_\_\_ . \_\_\_\_ \_\_\_\_ \_\_\_\_      See WAC 296-17B-910 – 990

**Maximum Loss Ratio** (up to 4 digits – between 0.3000 and 1.6000): \_\_\_\_ . \_\_\_\_ \_\_\_\_ \_\_\_\_      See WAC 296-17B-910 – 990

**Single Loss Limit:**      \$120,000       \$250,000       \$500,000   
 (choose one)      \$1,000,000       Unlimited/No limit       See WAC 296-17B-300(1) and (3a)

**Our claims mail should be sent to** (choose one):      Company address       Third Party Administrator

Documents and reports will be sent in electronic format, unless printed documents are specifically requested. Please check the box if you prefer to receive retro reports and correspondence in printed/paper format:

**As owner, partner or corporate officer of the business listed above, I am agreeing to enroll in the Retrospective Rating program, with the plan choices listed above.**

If these choices do not meet the requirements of *WAC 296-17B-300*, L&I staff will notify you.

Upon acceptance by L&I, I understand and agree that:

- This agreement will be in effect for the twelve month coverage period listed above and the related subsequent adjustments required by *WAC 296-17B-400*.
- In order to reenroll, I must submit a new application each year, stating my plan choices for the coming year, and that this application is due no later than the fifteenth day of the month prior to the start of the coverage period.
- My company will maintain our industrial insurance accounts in good standing, and will be current on any money owed L&I at the time of enrollment and reenrollment.
- We will comply with L&I laws, rules and regulations.
- My company is responsible for any additional premium assessed for the coverage periods enrolled.

**This agreement cannot be changed without the express written consent of L&I and is in effect through the coverage period selected above.**

**TO BE COMPLETED BY EMPLOYER**

<b>Employer's Name and Title</b> (please print legibly)	
<b>Employer's Authorized Signature</b>	<b>Date Signed</b>

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