

**ILLINOIS WORKERS' COMPENSATION COMMISSION
 RATE ADJUSTMENT FUND AND SECOND INJURY FUND
 ASSESSMENT TRANSMITTAL FORM
 FOR 7/1/2014 – 12/31/2014
 ASSESSMENT IS DUE BY MARCH 15, 2015**

Company Name _____
Contact Person _____
Address _____
Address _____
City, State, Zip _____

SECTION 1. ASSESSMENT CALCULATION

Please submit a separate sheet for each company in your group

A) Total compensation paid from 7/1/2014 through 12/31/2014 for

NAIC Code _____ **Company Name** _____

Include ALL compensation payments made under the Illinois Workers' Compensation Act, whether by lump sum settlement or weekly compensation payments. Do not include hospital, surgical, or rehabilitation payments. Do not subtract subrogation recovery or refunds when calculating compensation payments. If **no** compensation payments were made, enter 0 (zero) on Line A, complete Section II, and return the form.

\$ _____

B) Rate Adjustment Fund (RAF) assessment rate:

X 0.00625

C) RAF amount due (Line A x Line B):

\$ _____

D) Second Injury Fund (SIF) assessment rate:

X 0.000625

E) SIF amount due (Line A x Line D):

\$ _____

F) Total amount due (Line C + Line E):

\$ _____

Make assessment checks payable to:
Illinois Workers' Compensation Commission

Mail checks to:
Illinois Workers' Compensation Commission
Attn: Fiscal Office
100 W. Randolph St., Suite 8-329
Chicago, IL 60601

SECTION II. AFFIDAVIT

An officer of the company must complete this section, and the signature must be notarized.

I, _____, being duly sworn on oath, depose and state that I have read this notice of
Name
assessment, that I am acquainted with the affairs of the employer, and that the representations and statements herein set forth are true in substance and fact.

By:

Signature

Title

Company

Company telephone and fax numbers

Email address

Subscribed and sworn to before me at _____
City, State

this _____ day of _____ 201 .

Notary Public