

Appendix B

Workers Compensation Glossary of Terms

This section of terms is taken from The Workers Compensation Insurance Organizations a voluntary association of authorized or licensed rating, advisory, or data service organizations that collect workers compensation insurance information in one or more states.

GLOSSARY

OF

TERMS

GLOSSARY

INTRODUCTION TO THE GLOSSARY

This glossary defines terms that are not all insurance related, but are commonly used in the business and data reporting environment. The terms have been defined in a simplified and nontechnical manner.

The definitions are not intended to and should not be used as the "legal" definitions of the terms. For example: Permanent Partial – this definition may vary by state.

The purpose of the glossary is to acquaint the reader with easy-to-understand definitions of workers' compensation terms.

Acronyms and abbreviations found in the Acronyms and Abbreviations section of this manual are defined in this glossary.

In an effort to keep the definitions simple, many of the terms in this glossary have been defined in greater detail throughout this manual; e.g., unit reports.

GLOSSARY

A

AAA –

see definition for American Academy of Actuaries

AAI –

see definition for Alliance of American Insurers

AASCIF –

see definition for American Association of State Compensation Insurance Funds

ACAS –

see definition for Associate of Casualty Actuarial Society

ACCCT –

see definition for American Cooperative Council on Compensation Technology

ACORD™ –

see definition for Association for Cooperative Operations Research & Development

Accident Date

the month, day and year on which the injury occurred. For cumulative injuries or disease injuries there may not be an actual accident date. In these cases the accident date may be the last date of exposure or last day of policy.

Accident Year –

the year in which the injury occurred

Accident State –

a state or foreign location that identifies where the accident took place or where a disease was first contracted.

Accredited Standards Committee (ASC) –

see definition for National Committee for Information Technology Standards

Actuary –

an individual who computes statistics relating to insurance, such as pricing and reserving.

Add (A)/Change (C)/Delete (D) –

a correction procedure in which an update type

code indicates that the correction is being done to add (A), change (C) or delete (D) exposure or claim information on unit stat data. The use of A, C, or D is not allowed in all jurisdictions.

Address Record –

a portion of data that identifies the address information of the insured.

Adjusting and Other –

a new term for Unallocated Loss Adjustment Expense. See definition for Unallocated Loss Adjustment Expense.

Adjuster –

an individual representing the insurance company in discussions to reach agreement on the loss amount. (Sometimes called a claim representative or claim adjuster.)

Admiralty –

refers to the laws governing shipping, transportation, and fishing.

ADQIP –

see definition for Aggregate Data Quality Incentive Program (NCCI's)

Advisory Organization –

an organization that provides advisory rules and rates for the Insurance Industry.

Advisory Statistical Work Group (ASWG) –

Originally, ASWG referred to the group analyzing workers' comp statistical data collection. (See section on ASWG). 'ASWG' is now used to describe:

- 250-byte unit report format
- 250-byte unit report requirements - unit report form
- the Advisory Statistical Work Group

Agent –

an independent business person engaged in the activity of soliciting insurance coverage for one or more insurance companies.

Aggregate Data Quality Incentive Program (ADQIP) –

an NCCI program that rewards companies for filing aggregate (financial) data early, or fines for late or erroneous filings.

Aggregate Financial Data – see Financial data.

Aggregate Limit –

the maximum amount an insurer will pay for all claims covered by a policy during a policy period.

Aggregate Reports –

reports that aggregate data for all insurers reporting to a statistical agent in a state. There are three types of statistical data that may be aggregated:

1. Financial Data
2. Unit Report Data
3. Claim Information Data

AIA –

see definition for American Insurance Association

AIDM –

see definition for Associate Insurance Data Manager

ALAE –

see definition for Allocated Loss Adjustment Expense

Alliance of American Insurers (AAI) –

a National Insurance Trade Association of Property and Casualty member companies. Provides input on critical legislative and regulatory issues.

Allocated Loss Adjustment Expense (ALAE) –

an accumulation of expenses incurred in investigating and settling claims that are directly assignable to specific claims. Examples include: legal fees, adjusting fees, court costs, medical costs, containment expenses, services required by law or insurance regulation.

Allocated Loss Adjustment Expense – Incurred –

a specific expense in whole dollars incurred, including paid and outstanding by an insurance company, when handling a claim that can be directly allocated to that particular claim.

Allocated Loss Adjustment Expense – Paid –

a specific expense in whole dollars paid by an insurance company when handling a claim that can be directly allocated to that particular claim.

Alpha (A) –

a field that contains only alphabetical characters. Data field is to be left-justified and right blank-filled.

Alphanumeric (AN) –

a field that contains alphabetic and numeric characters. Data field is to be left-justified and right blank-filled.

‘Alternative workers’ compensation coverage’ –

this is commercial insurance purchased on the voluntary market. The policy may consist of any combination of life, disability, accident, health or other insurance, provided that the coverage insures without limitation or exclusion any of the workers' compensation benefits as defined in the law of the state.

A.M. Best Company –

a company that rates insurance companies based on their financial condition and operating performance

AMCOMP –

see definition for The American Society of Workers' Compensation Professionals, Inc.

American (National) Standard Code for Information Interchange (ASCII) –

a table of values used for data transmission by minicomputers and personal computers.

American Academy of Actuaries (AAA) –

is the organization representing the entire U.S. actuarial profession. It serves the public and the actuarial profession both nationally and internationally through: (1) establishing, maintaining, and enforcing high professional standards of actuarial qualification, practice and conduct; (2) assisting in the formation of public policy by providing independent and objective information, analysis, and education; (3) advancing the actuarial profession with other organizations representing actuaries; and (4) increasing the public's recognition of the actuarial profession's value.

American Association of State Compensation Insurance Funds (AASCIF) –

an organization whose members are the state compensation insurance funds and the Workers' Compensation Boards and Commissions of Canada.

American Cooperative Council on Compensation Technology (ACCCT) –

a workers' compensation joint venture that shares ideas and technology and, jointly develops software programs and systems with the goal of operating more effectively and efficiently.

American Insurance Association (AIA) –

a property and casualty insurance trade organization. Provides constructive solutions to issues facing the insurance industry.

American National Standards Institute (ANSI) –

encourages the use of US standards internationally and the adoption of international standards as national standards.

American Society of Workers' Comp Professionals, Inc. (AMCOMP) –

a not-for-profit corporation dedicated to the improvement of professional excellence in the multi-disciplined field of workers' compensation.

Anniversary Rating Date (ARD) –

a term used in the experience rating process. In general terms, the anniversary rating date is normally the effective date of the policy.

Annual Statement –

a detailed financial statement required to be reported by each insurer to the insurance department in its state of domicile. The annual statement includes a balance sheet, income statement, reinsurance information, and a breakdown of loss payments and reserves by line of business and accident year.

ANSI –

see definition for American National Standards Institute

Antitrust laws –

laws that prohibit companies from working as a group to set prices, restrict supplies, stop competition in the marketplace.

APP –

see definition for Application

Application (APP) –

a statement of information sent to an insurance company made by the insured or his agent to obtain an insurance policy.

ARD –

see definition for Anniversary Rating Date

ARAP –

see definition for assigned Risk Adjustment Program

Assigned Risk Adjustment Program (ARAP) –

an additional adjustment to the experience

modification factor, used in states to adjust premium for assigned risk policies.

ARP –

see definition for Assigned Risk Plan

ASC (Accredited Standards Committee) –

see definition for National Committee for Information Technology Standards

ASCII –

see definition for American Standard Code for Information Interchange

Assigned Risk –

an insured who is unable to acquire coverage in the regular (voluntary) market, and has been assigned to a company that will provide coverage.

Assigned Risk Plan (ARP) –

an involuntary plan where a risk obtains insurance that is not available on the voluntary insurance market. Insurance is handled by a pool (Assigned Risk Pools) or assigned to insurers for which participation is mandatory. Under an assigned risk plan, the Plan Administrator assigns the account to licensed insurers and the insurers issue their own policies and retain the experience of the risk as direct business.

(ACORD™) –

Association for Cooperative Operations Research & Development a non-profit standards developer for the insurance industry, a resource for information about object technology, EDI, XML and electronic commerce in the United States and other nations.

Associate Insurance Data Manager (AIDM) –

to achieve the AIDM designation requires passage of four IDMA examinations.

Associate of Casualty Actuarial Society (ACAS) –

an individual who has passed at least the first seven, but not all, of the examinations of the Casualty Actuarial Society, and has attained an Associateship status.

Assumed –

to accept the risk from the ceding insurer

ASWG –

see definition for Advisory Statistical Work Group

ASWG Committee –

see definition for Advisory Statistical Work Group

ASWG Unit Submission Code –

a code that indicates that the unit statistical data being reported in the ASWG format (see ASWG).

Audit –

an examination of the insured's books and records to determine actual payroll (exposure) for the purpose of computing premium. Audits are a requirement for workers' compensation.

AWW –

see definition for Average Weekly Wage

Average Weekly Wage (AWW) –

an average of an injured employee's weekly earnings over a period of time.

B

Basic Manual –

a manual published by NCCI that contains the underwriting rules and rates for workers' compensation insurance. Other DCOs publish similar manuals under different titles.

BBS –

see definition for Bulletin Board Services

BBS –

see definition for Bulletin Board Systems

BEEP –

see definition for Bureau Entry & Edit Package (ACCCT's)

Benefits –

monetary payments and other services provided by the insurer.

Binder –

a legal agreement issued by an agent or company to provide temporary insurance coverage until a policy can be written.

Book of Business –

total amount of insurance on an insurer's books at a particular point in time.

Broker –

a licensed person or organization paid to look for insurance.

BSI 5/17 –

a form used by self-insured groups to report unit report data. Form BSI 5 is for reporting the premium information, and Form BSI 17 is for reporting loss information. BSI 5/17 reporting is unique, in that premium and losses are reported on separate forms. The primary use of each form is to obtain an experience modification.

Bulk Reserves –

an accumulated amount determined to provide for future loss of payments for known claims. These include case reserve inadequacies, additional case reserves, and claims that may reopen or other reserves not allocated to specific claims.

Bulk Self-Insured

Premium (5) & Loss (17) Forms – see definition for BSI 5/17

Bulletin Board Service (BBS) –

a communication medium to report data electronically by telephone, computer and modems.

Bulletin Board System (BBS, EBBS) –

a communicating computer equipped to provide informational messages, file storage, transfer and message exchange to dial-up data terminal or personal computer users.

Bureau –

an organization formed for checking rates, developing forms, rules and rates for a line of business. A bureau may be a department of the state or an independent entity.

A Bureau also collects and edits data.

The term 'Bureau' is often used to describe a rating bureau, audit bureau, advisory rating bureau, inspection bureau and Data Collection Organization, etc.

Bureau Entry and Edit Package (BEEP) –

a software package developed by ACCCT that permits insurance carriers and other reporting organizations to enter workers' compensation unit report information for transmission to any state insurance advisory and/or rating organization.

Bureau Rates –

refers to rates filed by a rating bureau (see bureau) and

approved by the insurance department for use in that state.

BWC –

see definition for Bureau of Workers' Compensation (Ohio)

Byte –

eight (8) bits (a binary digit is a basic binary unit for storing data, it can either be 0 (zero) or 1 (one)) treated as a unit and representing a character.

C

"C" Report or Correction Report –

a unit report used to correct any type of error or information on a previously filed unit report.

"Comp" –

short for workers' compensation.

'C' Report –

see definition for Correction Report

Calendar Year –

the year in which premiums and losses are booked.

Calendar Year (CY) Report –

a report submitted by companies to jurisdictions pertaining to financial data that provides detail information on the analysis of state(s) and countrywide trends.

Calendar Year Expense (CYE) Report –

a report submitted by companies to jurisdictions pertaining to financial data that is used to substantiate the expenses included in the rate filings.

Calendar Year Reconciliation (CYR) Report –

a report used to reconcile data reported on Line 16 of Page 15 of the Annual Statement with the data reported on aggregate financial calls.

Calendar-Accident Year Assigned Risk (CAYAR) Report –

a report that is the same as CAY, but only contains data of insureds in the involuntary market.

Calendar-Accident Year Capitated Medical (CAYCM) Report –

a report that is the same as CAY, but only contains data from insureds with capitated medical policies.

Calendar-Accident Year Expense (CAYE) Report –

a report that is used to substantiate the expenses included in the rate filings.

Calendar-Accident Year Report (CAY) –

a report that aggregates losses from accidents that occurred during a particular year regardless of when the losses were recorded or reported. For example, if an accident occurred on 12/31/99 but was not reported until 1/5/2000, the Calendar-Accident Year would be 1999.

California Workers' Compensation Institute (CWCI) –

an organization of insurers and self-insured employers conducting and communicating research and analysis to improve the operation of the California Workers' Compensation System.

Calls –

a term used for the request of data by an insurance department, DCO or others. For example, Policy Year "Call".

Cancelled Flat –

a policy that is terminated as of the policy effective date.

Cancellation –

a termination, by either the insured or company, of an insurance policy before its expiration date.

There are three types of cancellations. They are:

Flat – termination of the insurance back to the effective date of coverage without a premium charge.

Mid-Term – Pro Rata – termination where the premium is adjusted for the time the coverage was in effect. Cancellation at the request of an insurer is usually on a pro rata basis.

Mid-Term – Short Rate – termination at the request of the insured prior to the expiration date. Therefore, if cancelled by insured, an increased charge is made to cover expenses.

CAOM –

see definition for Compensation Advisory Organization

of Michigan

California Insurance Guarantee Association (CIGA) –
if a carrier becomes insolvent in California, this organization settles unpaid claims and assesses each other carrier its proportional share.

Capitated (Contract) Medical –
an arrangement/contract with an organization where the care of injured employees is administered by a managed care organization including when the provider is reimbursed on a percovered individual, rather than per specific treatment basis.

Card Serial Number –
a number assigned, usually sequential, to the unit report.

Carrier –
an insurance company that ‘carries’ the insurance coverage.

Carrier Code (Insurer) Number –
a 5-digit numeric code identifying the reporting company (for most states).

Carrier of Last Resort –
the insurance company designated to accept a risk after the risk has been refused coverage by all other insurance companies.

CAS –
see definition for Casualty Actuarial Society

Case –
another name for a claim.

Case Reserve –
an accumulated amount that an insurer’s claim professional determines is appropriate to value the unpaid portion of a claim or a group of claims.

Casualty Actuarial Society (CAS) –
an international research, examination and membership organization for actuaries in property and casualty insurance. It also administers a series of examinations leading to Associate status and then to Fellowship.

Catastrophe –
an accident/occurrence that results in two or more claimants being injured.

Catastrophe Number –
a sequential number for two or more claims resulting from the same occurrence, beginning with 01 for the first occurrence, 02 for the second occurrence, etc., and is usually assigned by the Data Collection Organization or the insurance company.

CAY –
see definition for Calendar Accident Year (Report)

CAYAR –
see definition for Calendar Accident Year Assigned Risk (Report)

CAYCM –
see definition for Calendar Accident Year Capitated Medical (Report)

CAYE –
see definition for Calendar Accident-Year Expense (Report)

CBA –
see definition for Cost-Benefit Analysis

CCIA –
see definition for Colorado Compensation Insurance Authority

CCO –
see definition for Coordinated Care Organization

CEO –
see definition for Chief Executive Officer

CEP –
see definition for Company Edit Package

Cede or Ceded –
to pass on to another insurance company all or part of the insurance written by the insurer.

Certificate Number –
a number used to identify a risk covered under a master policy.

Certified Insurance Data Manager (CIDM) –
to achieve CIDM designation requires completion of the four IDMA study courses plus additional course work from one of four recognized professional/programs; e.g., CPCU.

CFO – see definition for Chief Financial Officer	a code that indicates whether a claim is opened, closed, reopened or resolved.
Charter Property and Casualty Underwriters (CPCU) – an organization of more than 28,000 insurance professionals. All members have passed examinations and fulfilled other requirements.	Claimant's Attorney Fees – a whole dollar amount of paid plus outstanding reserves for claimant's legal representation during the settlement of the claim.
Chief Executive Officer (CEO) – a title normally given to the highest ranking officer of a company.	Claims Missing From Subsequent List – a listing that contains claims that were open on a prior report but were not reported on a subsequent report. This list is applicable to Massachusetts only.
Chief Financial Officer (CFO) – a title normally given to the highest ranking financial/accounting officer of a company.	Classification (Class) Code – a numeric code corresponding to the classification assigned to the insured according to the rules of the manual for workers' compensation or the statistical classification code defined by the rating organization.
Chief Information Officer (CIO) – a title normally given to the highest ranking information technology officer of a company.	Client-Server – a common form of a system in which software is split between server tasks and client tasks. A client sends a request to a server, according to some rules, asking for information or action, and the server responds. For example, it is like a customer (client) who sends an order (request) to a supplier (server) who sends the goods (response).
Chief Operating Officer (COO) – a title normally given to the second highest ranking officer of a company.	Closed Claim – a claim that has been settled with all payments having been made and one which has no case reserve.
CIDM – see definition for Certified Insurance Data Manager	Closed No Payment (CNP) – a claim that has been settled with no payments made.
CIGA – see definition for California Insurance Guarantee Association	Closed Without Payment – a claim that has been settled with no payments made.
CIO – see definition for Chief Information Officer	CNP – see definition for Closed No Payment or Closed Without Payment
Circulars – a term used to describe newsletters, bulletins, guidelines, etc., in the insurance industry.	Colorado Compensation Insurance Authority (CCIA) – a quasi-public authority, self-supporting state fund. CCIA is the carrier of last resort in Colorado.
Claim – a demand by an individual or corporation to recover under an insurance policy for a loss.	Commissioner of Insurance – a state official charged with enforcement of the laws pertaining to insurance. Can be called Superintendent or Director of Insurance.
Claimant – a person who submits a claim to an insurance company for a loss.	
Claim Number – an alphanumeric code that uniquely identifies the claim.	
Claim Status –	

COMP –

see definition for Workers' Compensation. Short for Workers Compensation

Company Code –

see definition for Carrier Code

Company Edit Package (CEP) –

a general term that refers to the software and associated tools that assist the companies in editing and sometimes reporting the data.

Company Use Only Codes –

a special code designated for use within a company's own system to identify certain information.

Compensable –

a term used to describe a loss where an employee is entitled to compensation due to a work related injury.

Compensation Advisory Organization of Michigan (CAOM) –

an organization that captures and compiles workers' compensation data for the state of Michigan.

Competitive State Fund –

refers to a fund established by a state to write Workers' Compensation that also competes with private insurers.

Compilation Report –

a report that aggregates data and is normally used in a state that has multiple rating organizations or statistical agents.

CompSource Oklahoma (CSO) –

CompSource (CSO) is self-supporting and administered by a President/CEO. Formerly known as The Oklahoma State Insurance Fund (SIF).

Compulsory Insurance –

a type of insurance that is required for every insured by state or federal statute. Workers' compensation is compulsory in most states.

Contingent Mod –

a term used to describe an experience modification factor that has been produced from incomplete information. This mod, while temporary, is contingent upon the completion of the missing data,

i.e., company went bankrupt.

Contract Medical –

an agreement between an insurance company and doctor(s) that states that for a sum of money the doctor(s) will provide medical service for treatment of injuries sustained by the employees of a particular account insured by the insurance company.

Control List –

a listing of unit statistical reports produced by various DCOs, usually produced near the time of policy audit to assist carriers in identifying those unit reports that will become due. Timing and content vary by DCO.

COO –

see definition for Chief Operating Officer

Coordinated Care Organization (CCO) –

an organization licensed and certified to provide medical services to an injured worker.

Correction Report or "C" Report –

a unit report that is required to correct any type of error on a previously filed unit report.

Correction Sequence Number (Indicator) –

the number that corresponds to the number of correction reports submitted within a particular report level.

Correction Type –

the code that indicates the type of correction report being submitted.

Cost Benefit Analysis (CBA) –

a process used to compute whether the implementation of a procedure, development of a project, etc. is cost-justified, i.e., benefits outweigh the cost.

Countrywide Standard Earned Premium at Uniform Reporting Level –

a total premium that would have been earned if the rates were identical to each of the defined premium sizes for all states.

CPCU –

see definition for Chartered Property and Casualty Underwriters

Critical Value (CV) –

a term used to identify criteria for correcting potential errors; e.g., payroll amounts over \$100,000. Also a term used in the ratemaking process where the amount is used to limit losses in a given state.

'CRITS' –

see definition for Letters of Criticism

CSO –

CompSource (CSO) is self-supporting and administered by a President/CEO. Formerly known as The Oklahoma State Insurance Fund (SIF).

Cumulative Injury –

an injury which results in a disability or death and is not traceable to a definite compensable accident occurring during the employee's present or past employment.

CV –

see definition for Critical Value

CWCI –

see definition for California Workers' Compensation Institute

CWP –

see definition for Closed Without Payment

CY –

see definition for Calendar Year (Report)

CYE –

see definition for Calendar Year Expense (Report)

CYR –

see definition for Calendar Year Reconciliation (Report)

D

DASD –

see definition for Direct Access Storage Device

Data Collection Agency (DCA) –

see definition for Data Collection Organization.

Data Collection Organization (DCO) –

an organization that collects information. Organization can be a bureau, jurisdiction or

statistical agent.

Data Processing (DP) –

an old term that referred to the information technology area in a company.

Data Provider –

a company that reports data/information to a DCO.

Data Provider Code –

this is the 5-digit code corresponding to the originator of the transmission (data) or confirmation. If an insurer is the originator, then it is the 5-digit carrier code. If a DCO is the originator, then it is a 5-digit code consisting of 000 + the 2-digit state code of the DCO or 000XX for entities other than states.

Data Receiver Code –

this is the 5-digit code corresponding to the recipient of the transmission (data) or confirmation. If an insurer is the recipient, then it is the 5-digit carrier code. If a DCO is the recipient, then it is a 5-digit code consisting of 000 + the 2-digit state code of the DCO or 000XX for entities other than states.

Data Standards Committee (DSC) –

a committee formed by IDMA to review/study insurance data standards.

Date of Injury –

see definition for Accident Date

DBA –

see definition for Doing Business As

DCA –

see definition for Data Collection Agency

DCI –

see definition for Detailed Claim Information

DCO –

see definition for Data Collection Organization

Death Benefits –

indemnity benefits paid to a survivor of a worker whose injury resulted in death.

Dec Page –

see definition for Declaration Page

DCRB –

see definition for Delaware Compensation Rating

Bureau

of Delaware.

Declaration Page (Dec Page) –

a page (usually the first page) of an insurance policy that displays the coverage carried by the insured. The Declaration Page is now called the Policy Information Page.

Deductible Amount Aggregate –

a maximum loss amount for all claims to be paid by the insured.

Deductible Amount Per Claim/Accident –

the loss amount by claim/accident to be paid by the insured.

Deductible Percent –

the whole percent of the deductible to be paid by the insured.

Deductible Program –

deductible coding is made up of five deductible elements and two statistical codes.

Elements:

Deductible Type

Deductible Percent

Deductible Amount Per Claim/Accident

Deductible Amount Aggregate

Deductible Code (Loss)

Deductible Reimbursement –

the whole dollar amount of reimbursement received by the data provider by which the reported gross is to be reduced in order to conform to state requirements for net experience rating.

Deductible Type –

the 2-segment 2-digit code that identifies the type of deductible being reported.

Deductibles –

a clause in an insurance policy that relieves the insurer of responsibility in dollars, percentage of the total or percentage of the loss, before paying the loss.

Defense and Cost Containment Expense –

a new term for Allocated Loss Adjustment Expense. See definition for Allocated Loss Adjustment Expense.

Delaware Compensation Rating Bureau –

the authorized data collection organization for the state

Delinquent Listing –

a listing that alerts the insurers of the unit reports that have not been received by the DCO. It is usually produced in the 21 st month after policy effective date.

Department of Insurance (DOI) –

an area within a state's government charged with regulating the business of insurance.

Designated Statistical Reporting (DSR) –

refer to the reporting of premium on financial calls. Premium is reported before the application of company deviations.

Deposit Premium –

the premium deposit (usually first month estimated premium) paid by the insured when an application is made for an insurance policy.

Detailed Claim Information (DCI) –

an NCCI program that captures detailed claim data on indemnity losses on a sampling basis. The state of Texas has a detailed claim program that is NOT on a sampling basis.

Deviation(s) –

usually refers to using a rate other than the bureau rate. Each state has specific rules for deviations.

Direct Premium –

premium collected by the insurer from policyholders, before reinsurance premiums are deducted.

Direct Written Premium (DWP) –

a premium amount as reported on Line 16 of Page 15 of the Annual Statement.

Direct Written Premium Report (DWP) –

a report that is usually used to determine bureau assessments and pool participation.

Direct-Access Storage Device (DASD) –

an IBM mainframe terminology for a disk drive in contrast with a tape drive.

Disability –

a physical or mental impairment that limits

one or more of an individual's major life activities.

Disease B –

a disease arising out of and in the course of employment, not an ordinary disease of life to which the general public is exposed outside of the employment.

Dividend –

a return of premium, calculated after policy expiration, based on the over-all performance of the insurance company or of a group of insureds.

Division of Insurance (DOI) –

see definition for Department of Insurance

DNQ –

see definition for Do Not Qualify

Do Not Qualify (DNQ) –

a term used when an account does not qualify for experience rating.

DOI –

see definition for Department or Division of Insurance

Doing Business As (DBA) –

a phrase used to identify the insured's business trade name; e.g., Sammy Smith, DBA Bully Bulldozers, Inc.

DP –

see definition for Data Processing

D-Ratio –

a factor used in experience rating. It is the ratio of smaller losses (under \$2,000), plus the discounted value of large losses, compared to the total losses that might be expected of an insured in a particular type of business.

DSC –

see definition for Data Standards Committee

DSR –

see definition for Designated Statistical Reporting

DWP –

see definition for Direct Written Premium (Report)

E**E-MAIL –**

see definition for Electronic Mail

Earned Premium –

a portion of the premium allocated to the expired portion of the policy. For example, a policy effective 1 / 1 /2000 to 1/1/2001 for \$1200 has an earned premium of \$100 as of 2/1/2000. It should be noted that there are formulas for determining earned premium.

EBCDIC –

see definition for Extended Binary Coded Decimal Interchange Code

EDI –

see definition for Electronic Data Interchange

EDI Committee –

a group composed of representatives of each member of the WCIO.

Effective Date –

a date that identifies when a transaction becomes effective. For Workers' Compensation insurance purposes this is normally the policy effective date.

EL –

see definition for Employers' Liability

Electronic Data Interchange (EDI) –

a general term used to describe the method by which carriers submit data to DCOs via magnetic tape, diskette, BBS, internet or other electronic transmissions.

Electronic Data Submission (Electronic Submission) –

a method by which companies submit data to DCOs via magnetic tape, diskette, BBS, internet, or other electronic transmissions.

Electronic Mail (E-Mail) –

a term that describes mail that is sent through a computer (PC).

E-Mod –

an acronym for experience modification. See definition for Experience Modification.

Employee Leasing Company –

see definition Professional for Employer Organization (PEO)

Employer's Attorney Fees –

a whole dollar amount of paid plus outstanding reserves for an employer's legal representation during the litigation of the claim.

Employers' Liability (EL) –

a coverage for the liability of employers for damage resulting from injuries by accident or disease sustained by employees in the course and scope of employment, but not covered, under the workers' compensation laws who choose to sue the employer denying benefits payable under the workers' compensation laws.

Employment Status–

a code that identifies an injured worker's employment status as of the date the claim was first reported to the insurer. For example: regular, part-time employee, etc. This information is captured on detailed claim reports and individual case/claim reports.

Endorsement –

a change to an insurance policy made by using a form containing the language for change.

EPO –

see definition for Exclusive Provider Organization

ERM14 –

see definition for Experience Rating Modification – Change of Ownership Form

ERM6 –

see definition for Experience Rating Modification Form

Error Listing –

a listing that alerts insurers of errors on the data reported to DCOs.

Estimated –

a general calculation of size. The term is usually used to describe premium, payroll, losses, etc.

Excess Policy –

a policy that provides coverage when a loss amount equals or exceeds a predefined amount.

Exclusion –

certain causes and conditions listed in the policy, which are not covered.

Exclusive Provider Organization (EPO) –

a coverage for services only from network providers.

Exclusive State Fund(s) –

Also referred to as monopolistic state funds. An entity that insures all of the employers (there may be few exceptions) in a state. An example of an exclusive state fund is the Ohio Bureau of Workers' Compensation (BWC). The private market is not allowed to compete with the BWC. It should be noted that even in a state with an exclusive state fund, employers may be self-insured and not use the fund.

Ex-Med (Excluding Medical) –

for data reporting, refers to files, reports or exhibits that excludes data for medical payments.

Expense Constant –

a charge applied to all policies to cover company expenses associated with issuing a policy.

Experience –

a term used to identify an insured's payroll and loss activity for a given period.

Experience Modification (E-Mod, X-Mod) –

a factor used to modify the computed premium based on an insured's payroll and loss record. The modification factor is determined by comparing actual losses to expected losses, and can be a debit (>1.00) or a credit (<1.00).

Experience Rating –

a term given to the procedure of comparing the insured's previous payroll and loss data over a three-year period to develop an experience modification. In developing a January 2000 modification, the data normally used is as follows:

YearReport

98 1st

97 2nd

96 3rd

Experience Rating Modification Factor (E-Mod)

– see definition for Experience Modification

Experience Rating Modification – Change of Ownership Form (ERM14) –

a form used to report change of ownership, merger, etc. for experience rating purposes.

Experience Rating Modification Form (ERM6) –

a form used by self-insured groups to report unit report data. In most jurisdictions, ERM6 has been replaced with the ASWG Unit Report. Primary use of this form was to obtain an experience modification.

Experience Rating Status –

a code that indicates the status of the experience modification, final, not final or not applicable.

Expiration Date –

a date that identifies when a transaction ends. For workers compensation insurance purposes, this is normally the policy expiration date.

Exposure –

the basis against which losses are compared; i.e., the payroll or other measure of risk, by class.

Exposure Amount –

a whole dollar amount for each payroll classification assigned to the policy. Exposure amount is normally on a payroll basis. Exceptions include: per capita, seat surcharge.

Exposure Coverage (ACT) Code –

a code that identifies the type of exposure coverage.

Exposure Record/Section –

a portion of the unit report that identifies the *Exposure Information*- classification(s), audited payrolls, carrier rating values, premium amount, employer's liability, experience modification, and miscellaneous premiums and credits.

Exposure State –

a state in which coverage has been provided for the classifications and corresponding exposures, if any, and to which the payrolls of injured workers have been assigned.

Extended Binary Coded Decimal Interchange Code (EBCDIC) – an IBM proprietary 8-bit code for data communications.**Extensible Markup Language (XML) –**

a data format that enables delivery of information for applications on the internet, intranet and extranet.

'External data set identifier' –

for a tape, cartridge or diskette. This is a label that is firmly glued to the tape, cartridge or diskette.

F**'F' Classes or Codes –**

see definition for Federal Classifications or Codes

'F' Classification (Federal Classification) –

a classification that is covered under the USL&HW Act.

Fellow of Casualty Actuarial Society (FCAS) –

a designation earned by passing a series of Casualty Actuarial Society examinations.

FCAS –

see definition for Fellow of Casualty Actuarial Society

FCIP –

see definition for Financial Calls Incentive Program (Minn)

FCOD –

see definition for Financial Calls on Diskette® (NCCI's) software

FCRD –

see definition for Financial Call Reporting by Diskette (Minn)

FDRA –

see Financial Data Reporting Application (FDRA) - an Internet-based system that allows carriers to enter, edit and submit Forms, Calls and Schedule W (for the Pennsylvania/Delaware Rating Bureau). The FDRA also includes product demo information.

FDIP –

see Financial Data Incentive Program for the Pennsylvania/Delaware Rating Bureau. Financial Data Incentive Program (FDIP) - Pennsylvania/Delaware Rating Bureau's program that rewards companies for filing financial data early, or fines for late or erroneous filings.

Federal Coal Mine Health and Safety Act (FCMHSA) – an act that provided benefits to coal miners.

Federal Employers' Liability Act (FELA) – a law that establishes benefits for certain employees, e.g., those engaged in interstate commerce by rail. An act that gives employees of interstate rail carriers an action in negligence against their employers.

Federal Employer Identification Number (FEIN) – a Federal Employer Identification Number of the insured.

FEIN – see definition for Federal Employer Identification Number

FELA – see definition for Federal Employer's Liability Act

Field(s) – a length of a data element within a format. For example: 2-digit code is referred to as a 2- digit "field".

File-and-Use States – states where insurers must file rate charges with the regulators, but don't have to wait for approval to put them into effect.

File Transfer Protocol (FTP) – a client-server protocol that allows a user on one computer to transfer files to and from another computer over a network.

Financial Call Incentive Program (FCIP) – a program of the Minnesota Workers' Compensation Insurers Association, Inc., that encourages the filing of financial data on a timely and accurate basis. The program applies to Policy Year Call, Policy Year Large Deductible Call, Calendar-Accident Year Call and Calendar-Accident Large Deductible Call.

Financial Call Reporting by Diskette (FCRD) – Minnesota's program for reporting financial data on diskette. It should be noted that there are specific rules that should be followed when using FCRD.

Financial Calls on Diskette® (FCOD) – software
an NCCI program for reporting certain financial data on diskette™.

Financial Data – a group of financial reports required by the different data collection agencies.

Fine List Final – a report that alerts the insurers of the unit reports not reported, reported late and subject to fines.

Fine List Original – a report that alerts the insurers of unit reports not reported or reported late and that may have appeared on overdue/delinquent lists.

First Report – a first reporting of audited payroll, premium and loss data to be filed as of the initial valuation date which is eighteen (18) months after the policy effective date.

First Report of Injury (FROI) – a report prepared by the employer or other parties that describes the events and injuries. May be called by other names, e.g., Employer's Report of Work-Related Accident/Occupational Disease.

Follow-up List Quality – a listing that alerts insurers that errors appearing on a previous error listing have not been corrected.

Fraud – intentional lying or concealment by policyholders to obtain payment of an insurance claim that would otherwise not be paid.

Fraudulent Claim Indicator – an indicator that identifies the involvement of fraud in the claim.

FROI – see definition for First Report of Injury

FTP – see definition for File Transfer Protocol

G

Garbage In - Garbage Out (GIGO) – a slang term for poor quality data going into a system, resulting in poor quality data going out from a system.

GIGO –

see definition for Garbage In-Garbage Out

Governing Class –

a classification, other than a standard exception classification (salespersons, clerical employees, etc.), to which the largest amount of payroll is assigned.

Graphic User Interface (GUI) –

a use of pictures to represent input and output of a program. For example, the program displays icons on the screen and the user controls it by using a mouse.

GUI –

see definition for Graphic User Interface

Grouped Claims –

a procedure where the insurer may opt to combine certain claims by classification and type of injury for reporting purposes.

‘Guaranteed Cost’ –

a premium charged on a prospective basis, fixed or adjustable, but never on the basis of loss experience.

Guaranty Fund –

the mechanism by which solvent insurers bail out the policyholders of companies that fail.

H

HC –

see definition for Hard Copy

Hard Copy (HC) –

a paper copy of a data type which is submitted and processed through a data entry system.

HCFA –

see definition for Health Care Financing Administration

Header Record –

a portion of data that identifies the key *Policy Information* (policy number, carrier, effective/expiration date) *Report No.* and *Type* of report (correction type, number of report), *Policy Conditions* and *Deductibles*.

Health Care Financing Administration (HCFA) –

an organization that administers Medicare, Medicaid and children’s health insurance programs.

Health Insurance Portability and Accountability Act –

a federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. The act also gives Health and Human Services the authority to mandate the use of standards for the electronic exchange of health care data.

Health Maintenance Organization (HMO) –

an entity that provides, offers or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium. Under the Federal HMO Act, an entity must have three characteristics to call itself an HMO:

1. an organized system for providing health care or otherwise assuring health care delivery in a geographic area;
2. an agreed-upon set of basic and supplemental health maintenance and treatment services;
3. a voluntarily-enrolled group of people.

HIPAA –

see definition for Health Insurance Portability and Accountability Act

HMO –

see definition for Health Maintenance Organization

HTTP –

see definition for Hypertext Transfer Protocol

Hypertext Transfer Protocol (http) –

the client server rules used on the world wide web for the exchange of documents.

I

IAIABC –

see definition for International Association of Industrial Accident Boards and Commissions

IBNR –

see definition for Incurred But Not Reported

ICD Codes –

see definition for International Classification of Disease Codes

ICRB –

see definition for Indiana Compensation Rating Bureau

ICRs –
see definition for Individual Case/Claim Reports

IDMA –
see definition for Insurance Data Management Association

IDMS –
see definition for Integrated Database Management System

IEE –
see definition for Insurance Expense Exhibit

If Any –
a term used to indicate that coverage exists "if any" exposure/premium develops for a specific classification or state.

IIA –
see definition for Insurance Institute of America

Impairment Percentage –
a formula to provide an objective, fair and consistent method for evaluating the level of permanent impairment.

Import –
a process to bring data into a computer system from an external source.

Incurred But Not Reported (IBNR) –
loss amounts that are liabilities of an insurer, but which are not yet reported to a statistical agent or rating organization, nor recorded on the company's books.

Incurred Indemnity –
a whole dollar amount of compensation, including all paid and outstanding reserve benefits due an employee as a result of a work-related injury.

Incurred losses –
losses occurring within a fixed period, whether or not adjusted or paid during the same period.

Incurred Medical –
the whole dollar amount of hospital, physician and other medical benefits, including all paid and outstanding reserve benefits.

IND(s) –
see definition for Independent State Rating

Organization(s)

Indemnity –
the compensation paid an injured worker due to a work-related injury.

Independent State Rating Organizations (INDs) –
the following data collection organizations are considered independent state rating organizations.

- Workers' Compensation Insurance Rating Bureau of California
- Delaware Compensation Rating Bureau, Inc.
- Indiana Compensation Rating Bureau
- Workers' Compensation Insurance Rating and Inspection Bureau of Massachusetts
- Compensation Advisory Organization of Michigan
- Minnesota Workers' Compensation Insurers, Inc.
- New Jersey Compensation Rating and Inspection Bureau
- New York Compensation Insurance Rating Board
- North Carolina Rate Bureau
- Pennsylvania Compensation Rating Bureau
- Wisconsin Compensation Rating Bureau

Indiana Compensation Rating Bureau (ICRB) –
a private, non-profit unincorporated association of all insurance companies licensed to write workers' compensation insurance in the state of Indiana.

Indicator –
as used in data reporting, an indicator is not a code but rather a 'yes or no' type of identification. For example: Attorney involvement; yes (y) or no (n).

Individual Case or Claim Report (ICR) –
a detailed report on an individual claim which contains specific information pertaining to the claimant and the reserve calculation. The ICR is usually filed concurrently with the submission of the unit report. Reporting requirements vary with each jurisdiction.

Individual Practice Association (IPA) –
a network of physicians who will provide medical service to non-network patients covered by insurance.

Individual Risk Rating –
is the procedure an underwriter uses for classifying and rating any risk which presents

unique or unusual conditions, exposures or hazards for which he feels a commercial lines manual classification or rate is not appropriate.

Information Page –

usually the first page of the policy contract that contains information about the insured and the insured's coverage; e.g., name and address of insured.

Information System (IS) –

a general term used to describe programming/system development areas.

Information Technology (IT) –

a general term used to describe programming/system development areas.

Injured Workers' Insurance Fund of Maryland (IWIF)

–

an independent entity created by state statute. IWIF is entirely self supporting and the market of last resort.

Injury Description Code –

a 6-digit segment that represents the part of body, nature of injury and cause of accident for a given claim.

Injury Type –

a code that identifies under which provision of the law benefits are paid or are expected to be paid.

Insurance –

a contractual relationship that exists when one party (the insurer) assumes a risk faced by another party (insured) in return for consideration (premium).

Insurance Commissioner –

see definition for Commissioner of Insurance

Insurance Company –

an organization chartered under state or provincial laws to act as an insurer.

Insurance Data Management Association (IDMA) –

a not-for-profit, independent professional association of insurance data managers.

Insurance Expense Exhibit (IEE) –

a requirement of the National Association of Insurance Commissioners (NAIC). The data is used to conduct a review of general and loss adjustment expenses by line of business.

Insurance Institute of America (IIA) –

a non-profit organization that offers education, certification, publications and research reports to businesses and individuals in risk management and property and liability insurance.

Insurance Services Office, Inc. (ISO) –

an organization that provides information, including statistics, underwriting and claims information, actuarial analyses, policy language, and consulting and technical services in connection with 18 lines of property/casualty insurance.

Insured –

a person or business (an employer) with whom an insurance contract is made.

Insured Address –

the street address, city, state and zip code of the insured.

Insured Name –

the name of the person or business (employer) with whom an insurance contract is made.

Insurer –

an organization that underwrites or covers an employer (insured) for workers' compensation insurance.

Insurer Code –

see definition for Carrier Code

Integrated Database Management System (IDMS) –

a network management system developed in 1972. It is a management system for integrating a database of pictures and alphanumeric data.

International Association of Industrial Accident Boards And Commissions (IAIABC) –

an organization where workers' compensation specialists from a number of disciplines interact. Government officials and regulators, business and labor leaders, medical providers, law firms, insurance carriers, rehabilitation and safety experts all make up the IAIABC.

International Classification of Disease Codes (ICD Codes) –

a list of diseases and conditions developed by and used by Physicians and hospitals to classify illness, injury or disease of patients.

Interstate –

an interstate account is an employer who operates in more than one state. Interstate rating is subject to different rules and is not applicable to all states. It also references the type of experience modification factor that has been developed for an insured.

Intrastate –

an intrastate account usually refers to an employer operating in only one state. It also references the type of experience modification factor that has been developed for an insured.

IPA –

see definition for Individual Practice Association

IS –

see definition for Information System

ISO –

see definition for Insurance Services Office, Inc.

IT –

see definition for Information Technology

IWIF –

see definition for Injured Workers' Insurance Fund (of Maryland)

J**Joint Coverage Claim –**

is a claim for which it has been determined by adjudication that the coverage furnished by other than the one policy for which the experience is being reported is pertinent to a division of the total incurred loss.

Joint Underwriting Association (JUA) –

an entity that allows a limited number of insurers to service certain risks on behalf of all insurers. Servicing carriers write the business on behalf of the JUA, usually on JUA policies, and are not required to retain any of these risks as direct written business. The JUA administrator distributes the collective experience of all policies written by servicing carriers to all insurers writing that particular line of insurance in the state.

Jones Act -

the federal act which provides for the covering of ships' crews under a Workers' Compensation plan.

JUA –

see definition for Joint Underwriting Association

Julian date –

for data reporting, the Julian date is the last two digits of the year and numerical day of the year. For example, 1/1/2002 = 02001.

Jurisdiction –

the limit or territory within which a state or regulatory body's authority may be exercised. Used to refer to a state requirement or applicability, when used, it is not necessarily referring to a DCO.

Jurisdiction State –

the state code of the governing jurisdiction that will administer the claim and whose statutes will apply to the claim adjustment process when that state is different from the exposure state.

K**KEMI –**

see definition for Kentucky Employers' Mutual Insurance

Kentucky Employer's Mutual Insurance (KEMI) –

a non-profit, independent, self-supporting, de -jure municipal corporation and a political subdivision of the Commonwealth of Kentucky. KEMI is a fully competitive state fund and the market of last resort.

L**LAE –**

see definition for Loss Adjustment Expense

LAN –

see definition for Local Area Network

Large Deductible –

a large deductible is usually defined as \$100,000 or more per claim or per accident that is the responsibility of the insured. Coverage is provided when this deductible is met.

Last Page Number –

the last page number of multi-page hard copy unit reports.

Legal Nature of Insured Code –

a two-digit numeric code that identifies the legal nature of the insured, e.g., partnership, corporation, etc.

Legal Nature of Entity Code –

see Legal Nature of Insured code.

Letter of Authority (LOA) –

a term usually associated with the experience rating process. It is a document that allows one rating organization to release data to another rating organization, insurer, broker or agent.

Letter of Transmittal –

a form used by the insurer when submitting data on hard copy to the rating organization. A letter of Transmittal is sometimes used with electronic reporting.

Letter of Criticism (Crits) –

a letter of “criticism” is issued by some rating organizations when a discrepancy or error in rates or other calculations is found. Criticisms are used by some DCOs instead of error reports to request a correction to an error or to notify the insurer of a possible problem or request additional information.

Liability Over –

refers to a particular Employers Liability coverage situation where a third party, who is being sued by an employee, in turn sues the employer. Any damages incurred by the employer are classified as ‘liability over’, and are in addition to compensation payments made to the injured employee.

Link Data –

a set of data fields used to connect/match records to a policy, claim, etc.

LOA –

see definition for Letter of Authority

Local Area Network (LAN) –

a data communication network that allows easy interconnections of terminals, computers, etc.

Loss

a result of a claim for indemnity, medical costs or damages under the terms of a policy.

Loss Adjustment Expense (LAE) –

an expense incurred to investigate and litigate claims, but not the cost of the claim itself.

Loss Adjustment Expense (LAE) Report –

a report that is used to determine the loss adjustment expense portion that is to be included in the manual rate.

Loss Conditions –

a loss condition is made of the following 5 segments:

- Act
- Type of Loss
- Type of Recovery
- Type of Coverage
- Type of Settlement

Loss Constant –

a fixed amount added to the premium to offset losses considered too small to be recorded in the experience.

Loss Cost –

a dollar amount of loss per unit of exposure

Loss Coverage –

a basis under which the loss is covered by the policy. Loss coverage codes are usually used to describe the liability.

Loss Conversion Factor –

a term used in retrospective rating. It is a factor applied to the loss formula to give the insurer the funds needed to handle the investigation of the claim.

Loss Cost Multiplier –

a factor applied to a loss cost to develop a premium rate.

Loss Development Factor –

a factor that gives the insurer additional money to allow for the subsequent development of incurred but not reported (IBNR) and to reimburse for claim reported late to the insurer. Was introduced to address the effect of inflation on losses.

Loss Limitation –

a term used in ratemaking and retrospective rating. Limit the amount of large losses.

Loss Ratio –

incurred losses divided by earned premiums. a percentage of each premium dollar an insurer spends on claims.

Loss Record/Section –

a portion of the data that identifies the **Loss Information** reported during the policy term. It contains required and optional claim information

(claim number, accident date, indemnity and medical amounts, class code, injury code, status, etc.).

Loss reserves –
see reserves

Louisiana Workers' Compensation Corporation (LWCC) –
a private, non-profit mutual insurance corporation. LWCC is a competitive fund and the market of last resort.

Lump Sum –
for data reporting, is a claims settled by agreement of the insurer and claimant that the claimant will accept a specified amount of a specific award or benefit.

Lump Sum Indicator –
an indicator that identifies a lump sum agreement for the claim.

LWCC –
see definition for Louisiana Workers' Compensation Corporation

M

MAAA –
see definition for Member of the American Academy of Actuaries

Magnetic Tape Reporting –
a type of medium for reporting data.

Maine Employers Mutual Insurance Company (MEMIC) –
a private, taxable corporation that guarantees a workers' compensation market for all employers doing business in Maine.

Managed Care Organization (MCO) –
a general term describing associations, members, etc., providing health care, research, advice, etc. See Managed Health Care.

Managed Health Care –
a process that combines quality improvement, analysis, efficiency and accountability for health care systems and delivery. This is accomplished by:

- analyzing the process and results of medical

treatment

- developing and communicating guidelines
- building networks of doctors, hospitals and other health care providers
- seeking continuous quality improvement
- coordinating roles among the complex network of payers, providers and patients.

Management Information System (MIS) –
a name given to a company's internal system that provides data needed to manage the company's operations; e.g., number of policies per state.

Managing General Agent (MGA) –
an agent that has the right to bind coverage for an insured without prior approval.

Manual Premium –
premium obtained by applying classification manual rates to their respective exposures.

Manual Rate –
a charge per unit of exposure for each classification.

Maritime coverage –
is a term used to indicate coverage for marine shipping.

Maximum Medical Improvement –
the maximum level of medical improvement of an injured workers condition.

McCarran-Ferguson –
a federal law in which Congress declared that states would continue to regulate the insurance business.

MCO –
see definition for Managed Care Organization

Medical –
an amount paid or expected to be paid for the treatment of a workplace injury.

Medical Only(s) (MOs) –
an amount paid or expected to be paid for the treatment of a workplace injury that does not result in lost time from work or permanent disability.

MEM –
see definition for Missouri Employers Mutual

Member of the American Academy of Actuaries (MAAA) – see definition for American Academy of Actuaries

MEMIC –
see definition for Maine Employers Mutual Insurance Company

Merit Rating –
a process that applies prospective experience rating, retrospective experience rating and many other loss-based rating program that may be available in various states.

MGA –
see definition for Managing General Agent

Minimum Premium –
the lowest amount of money (premium) that the insured will pay for the coverage being provided.

Minnesota Workers' Compensation Insurers Association, Inc. –
the authorized data collection organization for the state of Minnesota.

MIS –
see definition for Management Information System

Missing First Reports List –
a listing that alerts insurers of the first unit reports that have not been received by the Worker's Compensation Rating and Inspection Bureau of Massachusetts.

Missouri Employers Mutual (MEM) –
a non-profit, mutual insurance company. MEM is a competitive fund.

MO(s) –
see definition for Medical Only(s)

Mod –
short for experience modification. See definition for Experience Modification.

Mod Effective Date –
the mod effective date is reported only when different from the policy effective date. If the anniversary rating date is different from the policy effective date, then the mod effective date may equal the anniversary rating date.

Modified Premium –
a premium charge derived from applying the experience modification factors to the manual premium.

Monopolistic State Fund(s) (MSFs) –
a self-supporting direct seller of workers' compensation insurance policies, who is the only provider of workers' compensation insurance in a particular jurisdiction. For example, the Ohio Bureau of Worker's Compensation Insurance (BWC) handles the state of Ohio. Monopolistic state funds are usually called exclusive state funds.

MSF –
see definition for Monopolistic State Fund(s)

Mutual Insurance Company –
a company that does not issue stock and is owned by its policy holders. Also known as a non-stock company.

MWCIA –
see definition for Minnesota Workers' Compensation Insurers Association, Inc.

N

N/A –
see definition for Not Applicable

NAIC –
see definition for National Association of Insurance Commissioners

NAICS –
see definition for North American Industry Classification System

NAII –
see definition for National Association of Independent Insurers

Name Record –
a portion of data that identifies the name information of the insured.

NAPEO –
see definition for National Association of Professional Employer Organizations

National Association of Independent Insurers (NAII)

–

a non-profit property and casualty trade association.

National Association of Insurance Commissioners (NAIC) –

an organization of the commissioners, directors, superintendents, or other officials who, by law, are charged with the principal responsibility of supervising the business of insurance within each state, territory or insular possession of the United States.

National Association of Professional Employer Organizations (NAPEO) –

an organization of professional employee leasing companies.

National Committee for Information Technology Standards (NCITS) –

a committee that produces market-driven voluntary consensus standards in the areas of multimedia, databases, security and programming language.

National Council on Compensation Insurance, Inc. (NCCI) –

a shared-services organization committed to the collection, management, and distribution of information that serves and adds value to the workers' compensation industry and all of its stakeholders.

NCCI –

see definition for National Council on Compensation Insurance, Inc.

NCITS –

see definition for National Committee for Information Technology Standards

NCRB –

see definition for North Carolina Rating Bureau

Net –

direct plus assumed minus ceded.

Net Investment Income –

is the revenue obtained from the investment of unearned premium and loss reserves.

New Jersey Compensation Rating and Inspection Bureau –

the authorized data collection organization for the state of New Jersey.

New York Compensation Insurance Rating Board –

the authorized data collection organization for the state of New York.

New York Financial Call Information System –

New York's program for reporting financial data on diskette.

NJCRI –

see definition for New Jersey Compensation Rating and Inspection Bureau

North Carolina Rating Bureau –

the authorized data collection organization for the state of North Carolina.

NOA –

see definition for Notice of Assignment

NOC –

see definition for Not Otherwise Classified

No Payroll Developed (NPD) –

at the time of audit, the state or classification that was covered on the policy with payroll/premium, developed no payroll.

No Payroll Expended (NPE) –

see definition for "No Payroll Developed"

Nonappropriated Fund Instrumentalities Act -

an act to make the provisions of the Longshoremen's and Harbor Workers' Compensation Act applicable to certain civilian employees of nonappropriated fund instrumentalities of the Armed Forces, and for other purposes.

Non-Compensable –

a term used for a claim or loss for which the injured worker is not entitled to compensation under Worker's Compensation laws.

Non-exclusive State Funds –

a self-supporting fund that can compete with the private market and may be the carrier of last resort. Some funds are non-profit and compete. Lately, some of the newer funds operate as a mutual insurance corporation.

Non-rated Policy -

for workers' compensation data reporting, refers to a policy that does not qualify for a rating plan (see rated policy). This is usually a policy with a small premium amount.

North American Industry Classification System (NAICS) –

a system that replaced the Standard Industrial Classification System (SIC codes) in 1997. It provides common industry definitions for Canada, Mexico and the United States.

Not Applicable (N/A) –

wherever a field or record is indicated as "Not Applicable," this means that the field or record is "Not Required" or "Not Allowed" in the jurisdiction(s) [rating organization(s)/bureau(s)/data collection organization(s)]. A field or record that is "Not Allowed" will be edited for compliance in some DCOs.

Not Otherwise Classified (NOC) –

a catch-all term used to indicate a business, that can not otherwise be more accurately described by the general classification descriptions.

Notice of Assignment –

a notification that a risk has been assigned to an insurer under an assigned risk program.

Notice of Fines –

a listing that alerts the insurers of unit reports not reported, or reported late, which will be subject to fines by Minnesota.

Notice of Loss –

see 'First Report of Injury'

NPD –

see definition for No Payroll Developed

NPE –

see definition for No Payroll Expended

Number of Claims –

a total of claims that have been grouped by a specific classification. Most companies no longer group claims but rather report them on an individual basis by claim number and accident date.

Numeric (N) –

field contains only numeric characters. Data field is to be right-justified and left-zero-filled.

NYFCIS –

see definition for New York Financial Call Information System

NYCIRB –

see definition for New York Compensation Insurance Rating Board

O**"Off The Record" –**

a term used to signify that the person(s) does not want the information being communicated to be attributed to them; i.e., Confidential.

Occupation Description –

an 18-digit alphanumeric narrative description of the regular occupation of the claimant.

Occupational Disease –

a type of condition that does not result from a specific accident covered under the workers' compensation laws. The condition is caused by repeated exposure overtime to risks inherent in a particular type of employment; e.g., fumes, chemicals, etc. Laws vary by state.

'Occupational Hazard' –

a condition in an occupation that increases the risk of an accident and sickness.

Occupational Safety and Health Act –

a federal law to ensure worker and workplace safety. The law also created the Occupational Safety and Health Administration (OSHA).

Occupational Safety and Health Administration (OSHA) –

a division of the Department of Labor that oversees the administration of the Occupational Safety and Health Act. It enforces standards in all 50 states.

‘Oil and other Mineral over Water’ –

refers to the state or federal acts on the transporting of oil and other mineral over water.

Open Claim –

a claim that has not been settled or on which payments are still being made. Sometimes referred to as an outstanding claim.

Open Competition States –

states where insurance companies can set new rates without prior approval, although the state’s commissioner can disallow the rates if they are not reasonable and adequate and are discriminatory.

Optional –

wherever a field or record is indicated as “Optional,” the field or record is not required to be reported to the jurisdiction(s) [rating organization(s)/bureau(s)/data collection organization(s)] indicated. Optional elements may be edited, captured or ignored by the DCO(s) if reported.

OSHA –

see definition for Occupational Safety and Health Administration

Outer Continental Shelf Lands Act –

An Act to provide among other things that the Longshoremen's and Harbor Workers' Compensation Act be extended to employees working on the Outer Continental Shelf in the exploration and the development of natural resources.

Outstanding Claim –

see definition for Open Claim

Overdue Report –

a listing that alerts insurers of the unit reports that have not been received by the DCOs. Also referred to as the Delinquent Listing.

Overdue Subsequent Reports –

a listing that alerts the insurers of subsequent unit reports that have not been received by the DCOs. It is produced on the same schedule as the Overdue/Delinquent listing for 1st reports.

P

Page Number –

the page number of multi-page hard copy unit reports.

Paid Indemnity –

a whole dollar amount of compensation paid due to disability or inability to work. Also includes compensation paid to a deceased prior to death, burial expenses, survivor benefits, claimant’s attorney fees, vocational rehabilitation benefits, payments to the state and employer’s liability losses and expenses.

Paid Medical –

a whole dollar amount of paid physician, hospital or other medical treatment as of the loss valuation date.

Payroll –

an exposure basis for most Workers’ Compensation Classifications; refers to wages paid to employees.

Payroll Audit –

see definition for "Audit"

PCRB –

see definition for Pennsylvania Compensation Rating Bureau

Pending File Number –

a number that identifies the unit report in the rating organization’s system that the insurer wants to replace.

Pending Initial Rating (PIR) –

a procedure that is used when an account is close to qualifying for experience rating and the data will have to be linked.

Pension Tables –

are tables to be used to determine benefits to be paid to the injured worker, dependents, etc. Sometimes these tables can be found in the DCO’s statistical plan.

Pennsylvania Compensation Rating Bureau –

the authorized data collection organization for the state of Pennsylvania.

PEO –

see definition for Professional Employer Organization

Per Capita –

a measure of exposure where the base is the number of units other than payroll.

Permanent Partial Disability –

an injury that, although permanent; e.g., loss of arm, results in partial disability.

Permanent Total Disability –

an injury that has left the worker permanently disabled and unable to return to work.

PICS –

see definition for Policy Issue Capture System (NCCI's)

PIF –

see definition for Policies-in-Force

PIR –

see definition for Pending Initial Rating

POC –

see definition for Proof of Coverage

Policies-in-Force (PIF)–

a number of policies that are active at a point in time. Companies maintain these figures on a state and countrywide basis.

Policy –

a written contract of insurance.

Policy Conditions –

an indicator that identifies whether the policy and/or unit has any of the following conditions: Coded: Y = Yes N = No
Three-Year Fixed Rate Indicator Multi-state Policy Indicator Interstate Rated Indicator Estimated Exposure Indicator Retrospective Rated Indicator Canceled Mid-Term Indicator Managed Care Organization Indicator

Policy Count –

a total of all policies written on a direct basis, including USL&HW, coal mine, assigned risk, etc.

Policy Effective Date –

the month, day and year upon which the policy became effective.

Policy Expiration Date –

the month, day and year upon which the policy expired.

Policy Information Page –

see definition for Information Page

Policy Issue Capture System (PICS) (NCCI's) –
NCCI's policy database.

Policy Number –

the number that uniquely identifies the policy.

Policy Period –

the length of time between the policy effective date and policy expiration date.

Policy Surcharge Factor –

Second Injury Fund, Uninsured Employers Fund, and Plan Surcharge for Rejected Voluntary Coverage.

Policy Type ID Code –

the code that corresponds to the Type of Coverage, Plan Indicator and Non-Standard Indicator provisions of the policy.

Policy Verification Report –

a report that alerts the insurers of unit reports that are expected to be filed with the DCOs. This listing is issued in the 14th month for Minnesota, and in the 13th month for New York, Pennsylvania and Delaware.

Policy Year –

the year of the effective date of the policy.

Policy Year Assigned Risk (PYAR) Report –

a report that aggregates data by policy year for assigned risks.

Policy Year Capitated Medical (PYCM) Report –

a report that aggregates data by policy year for capitated medical only.

Policy Year Federal (PYF) Report –

a report that aggregates data by policy year for federal (F) classifications only.

Policy Year Large Deductible (PYLD) Report –

a report that is used to perform premium level analysis, test rate adequacy and reserve level changes for large deductible policies.

Policy Year Report (PY) –

a report that aggregates data by policy year from policies written in that year, regardless of when the accident occurred or when the loss was reported.

Pool –

insurance companies that have joined together for the purpose of sharing the risks. Term is mostly associated with the involuntary market; e.g., Assigned Risk Pool.

PPO –

see definition for Preferred Provider Organization

Pre-ASWG –

statistical reporting requirements that were required prior to implementation of the expanded ASWG data elements and format. Pre-ASWG filing requirements were for policies effective prior to 1-1-96 (for most states).

Pre-delinquent Report –

a listing that alerts the insurers of unit reports that are expected to be filed with the DCOs. Also known as the Pre-notification Listing.

Preferred Provider Organization (PPO) –

a program that establishes contracts with providers of medical care. Providers under such contracts are referred to as preferred providers. A PPO arrangement can be insured or self-funded. Providers may be, but are not necessarily, paid on a discounted fee-for-service basis.

Preliminary Fine List-Quality –

a listing that alerts insurers of unit reports that contain errors for which corrections have not been received.

Preliminary Modification –

a temporary experience modification factor that is issued to an insured until such time that the rates are approved in a given state.

Premium –

a money amount to be paid for coverage on an insurance policy.

Premium Amount –

by Extension of Payroll:
 $(\text{Payroll} \times \text{manual rate}) \div 100$

Other premium:

As defined by the classification/statistical code or DCO statistical plan.

Premium by Size of Policy (PSP) Report –

a report used to determine premium discounts by

state.

Premium Deviation –

means to depart from the standard premium. There are many types of premium deviations.

Premium Discount (Amount) –

a discount in the price of an insurance policy attributable to proportionally lower expense costs for larger policies.

Premium Written –

the total premium on all policies written by an insurer during a specified period of time regardless of what portions have been earned.

Previous and Revised –

a reporting procedure requiring that both last report and revised data be submitted. These data segments are indicated by a **P** (previous) or **R** (revised) as shown in the *Update Type*. These indicators are used for correction reports and subsequent reports. Certain rating bureaus require Previous and Revised; they will not accept Add (A), Change (C) or Delete (D).

Prior Approval State –

states where insurance companies must file proposed rate changes with state regulators, and gain approval before the proposed rates can go into effect.

Professional Employer Organization (PEO) –

another name for an employee leasing company. It is a company that provides integrated human resource administration and risk management to its clients, including workers' compensation insurance arrangements. The PEO is legally the employer of record or co-employer for its clients' employees.

Program for Submission of California Aggregate Data (SCAD) – see definition for SCAD**Proof of Coverage (POC) –**

a process that is utilized by various rating organizations or states to verify the employer is covered for workers' compensation.

Protocol –

a set of formal rules describing how to transmit data.

PSP –

see definition for Premium by Size of Policy

Pure Premium –

a premium necessary to cover the expected loss for a policy. Some states define pure premium as containing no provision for expenses, profit, and contingencies; others include loss adjustment expenses as part of the definition.

PY –

see definition for Policy Year (Report)

PYAR –

see definition for Policy Year Assigned Risk (Report)

PYCM –

see definition for Policy Year Capitated Medical (Report)

PYF –

see definition for Policy Year Federal (Classification Report)

PYLD –

see definition for Policy Year Large Deductible (Report)

Q**QC –**

see definition for Quality Control

QDWP –

see definition for Quarterly Direct Written Premium (Report)

Quality Control (QC) –

a term that collectively describes the efforts of a DCO, insurers, etc., to ensure that the data reported and collected is of the highest quality.

Quarterly Direct Written Premium (QDWP) Report –

is cumulative and is used to analyze the direct written premium in the voluntary market and to determine bureau assessments and pool participation.

Queries –

are issued by rating organizations when a discrepancy or error in rates or other calculations are found. Queries are used by some DCOs instead of error reports to request a correction to an error.

R**"Retros" –**

see definition for Retrospective Ratings

'R' Report –

see definition for Replacement Report

Rate –

a cost for insurance for a unit of exposure, by classification (usually \$100 of payroll).

Rate Deviations –

a factor that an insurer applies to premiums or pure premiums filed by a statistical agent and/or approved by the department of insurance to determine the rates it will charge its policyholders.

Rate Effective Date –

a rate effective date is reported only when different from the policy effective date.

Rated Policy –

for workers' compensation data reporting, refers to a policy that qualifies for an experience rating plan, merit rating, schedule rating or other types of rating plans.

Rating Organization –

an entity, other than a single insurer, that assists insurers by compiling and furnishing loss or expense statistics and recommending, making or filing rates, forms or supplementary rate information.

Ratemaking –

a process used by the DCOs for determining the rates for a given state and classification.

Record Layout –

an older term that refers to the positions in the format of the data type. It was used to describe key punch card format.

Record of Transmittal –

an electronically filed "letter of transmittal".

Recovery –

a money amount received by an insurance company from a reinsurer or injury fund or by subrogation.

Redundant Code –

a same value that is reported more than once.

Reinstatement –

is the resumption of coverage under a policy that has lapsed. A provision is usually made for reinstating the policy to its original amount. Depending on policy conditions, it may be done automatically, either with or without premium consideration, or it may be done at the request of the insured.

Reinsurance –

insurance of all or part of one insurer's risk by a second insurer, who accepts the risk in exchange for a percentage of the original premium. Reinsurance is usually classified as assumed or ceded. Assumed is to accept all or part of another company's liability or risk; ceded is to transfer all or part of the liability to another company.

Reinsurance Pools (Facilities) –

are entities created to allow all insurers to cede the experience of certain risks to a pool. The pool administrator distributes the collective experience of all ceded policies to all insurers writing that particular line of insurance in the state. Policies ceded to the pool are direct written risks that the insurer does not want to retain as voluntary business.

Reissue –

a policy that replaces a previously issued policy.

Rejects –

a transaction or unit statistical report that is not entered into the processing system. The transaction or unit report is usually missing a key field, e.g., policy number, state, etc. The errors are usually referred to as fatal errors.

Remuneration –

the basis for calculating workers' compensation premium. Remuneration is primarily payroll, but may also include other forms of employee compensation.

Renewal –

a policy that has been continued past the original expiration date by the same insurer.

Replace –

a policy that replaces a previously issued policy due to changes.

Replacement Report Indicator ('R' Report) –

indicates that a unit report should "replace" what the rating organization has in its system.

Report Card –

a performance report produced by the NCCI that grades an insurers reporting performance by data type.

Report Number –

a number code that corresponds to the report level based on the loss valuation date.

Report Level –

see definition for Report Number

Request for Bid (RFB) –

a letter with attached specifications detailing a service and requesting a bid on the service.

Request for Information (RFI) –

a request that solicits input on a process or project. May or may not request a bid.

Request for Proposal (RFP) –

a request for bids that indicates the specification for a project.

Request for Quote (RFQ) –

usually refers to the process whereby data is provided for certain questions, e.g., purchasing insurance online and a price or quote is received from the company.

Reserved for Bureau Use –

reserved for DCO use.

Reserved for Carrier Use –

companies may use this space for internal purposes.

Reserves –

insurer funds set aside to meet future obligations.

Residual Market (RM) –

a term used to describe the various types of insurance that is written on a non-voluntary basis. Collectively includes pools, assigned risk, joint underwriting associations, etc.

Residual Market Application Processing SystemSM (RMAPSSM)–

NCCI's online residual market application processing system.

Resolved claim –

a resolved claim is any case where an agreement between the parties has been reached, or where an award or judgement has been entered, reciting the specific terms of future indemnity payments but for which the final payment has not been made.

Retrospective Rating (Retros) –

a plan or program in which the premium is adjusted after the expiration of the policy based on taking into consideration the insured's actual losses and expenses.

RFB –

see definition for Request For Bid

RFI –

see definition for Request for Information

RFP –

see definition for Request For Proposal

RFQ –

see definition for Request For Quote

RIMS –

see definition for Risk and Insurance Management Society

Risk –

a term to describe the insured or account.

Risk and Insurance Management Society (RIMS) –

an organization that serves nearly 4500 businesses with risk management responsibilities throughout the United States and Canada. It provides products, services and information to manage all forms of business risks.

RISK ID –

see definition for Risk Identification Number

Risk Identification Number (Risk ID) –

the Number assigned to the risk by the rating organization issuing the experience rating.

RM –

see definition for Residual Market

RMAPSSM

see definition for Residual Market Application Processing System (NCCI's)

S**'S' Claims –**

a closed death claim compromised over the sole question of applicability of the workers compensation laws of California.

SCAD - EDI –

California's program for validating and reporting financial data on diskette or by modem.

SCAD (Program for Submission of California Aggregate Date) –

a program instituted by the Worker's Compensation Insurance Rating Bureau of California that encourages the filing of financial data on a timely and accurate basis. The program applies to quarterly and annual calendar year and accident year calls, the annual expense call and the annual aggregate indemnity and medical cost call.

Sched Z –

see definition for Schedule Z

Schedule Rating –

a plan, that alters the premium based on attributes that are not reflected in the experience of individual employers (insureds).

Schedule Rating Premium (SRP) Report –

a report used to validate premium data reported on other reports. Compilation of the premium data is used in analyzing competitive markets.

Schedule Z (Sched Z) –

a Schedule Z (Sched Z) is a report by:

- Classification Code
- Report Number (1-5 normally)
- Injury Code – on some Sched Zs, this field has a dual purpose and may be called a transaction code, where the first position of the transaction code is a 1, indicating losses. Therefore, medical only claim would be shown as transaction 16.
- Policy/Claim Count
- Exposure/Indemnity
- Manual Premium/Medical
- Standard Premium

Depending upon the DCO, the Sched Z may contain less or more information. The format can be

different by DCO. There is not a standard format utilized by the DCOs for the production of Sched Z data.

SCIF –

see definition for State Compensation Insurance Fund

Seat Surcharge –

an additional amount (surcharge) of premium that applies to the passenger seats on the aircraft.

Second Injury Fund (SIF) –

a trust established to reimburse insurers when a subsequent injury is caused by or made substantially greater due to the combined effects of physical impairment or previous accident, disease or congenital condition.

Self-Insurance –

a system whereby an employer sets aside an amount of money to pay for any loss that occurs.

Self-Insurance Groups (SIGs) –

see definition for Self-Insured Funds

Self-Insured Funds (SIFs) –

an organization of members or affiliates, usually in a common industry, that pay a fee to cover their workers' compensation losses. Self-insured funds should not be confused with insureds that pay for their own losses and are not insured.

Self-rating point -

The point when a risk becomes self-rated. In experience rating, the amount of expected losses necessary for a risk's own experience to solely determine its experience modification. However, under Revised Experience Rating Plan (RERP), the concept of self-rating no longer exists. Self-rating point is also used to limit the losses considered in experience rating to 10% and 20% of the self-rating point for single and multiple claims, respectively. Under RERP the State Reference Point limits losses for experience rating.

SF(s) –

see definition for State Fund(s)

SFM –

see definition for State Fund Mutual (Insurance Company of Minnesota)

Short-term Coverage –

insurance coverage that last less than one year.

SIC –

see definition for Standard Industry Classification

SIF –

see definition for Second Injury Fund

SIF –

see definition for State Insurance Fund (of Oklahoma)

SIF(s) –

see definition for Self-Insured Fund(s)

SIG(s) –

see definition for Self-Insured Group(s)

SIIS –

see definition for State Industrial Insurance System (of Nevada)

Social Security Number (SSN) –

the claimant's social security number on individually-reported claims.

Split Unit –

a unit report that is split to reflect an anniversary rating date that is different from the policy effective date.

SRP –

see definition for Schedule Rating Premium (Report)

SSN –

see definition for Social Security Number

Standard at Company Level –

is the accumulated earned premium for accounts after applying company deviations, schedule rating experience rating modification, company expense constants, company premium discounts, company loss constants, and merit etc.

Standard Industry Classification (SIC) –

a coding system that provided common industry definitions for classifying industries. It was replaced in 1997 with the North American Industry Classification System (NAICS).

Standard Premium –

an amount charged if there are no discounts or surcharges applicable to the policy.

STAT - short for statistical; e.g., stat agent, stat plan, stat codes, etc. – see definition for statistical agent, statistical plan, etc.

Stat Report –
see definition for ‘Unit Report’

State Code or State Number –
a 2-digit code that identifies the state, territory or province. The numeric code was assigned when there were 48 states in the U. S. Once Alaska and Hawaii became states, the numbering was no longer alphabetical by state; e.g., Alaska = 54; not 02. The postal abbreviation, 2- position alpha code, is also used.

State Compensation Insurance Fund (SCIF) –
a self-supporting fund that competes with the private market and is the market of last resort in California.

State Effective Date –
the endorsement effective date, if the state coverage was endorsed mid-term.

State Fund Mutual of Minnesota (SFM) –
an independent self-supporting state fund that operates like a mutual insurance company in Minnesota.

State Funds (SFs) –
organizations that are either exclusive state funds or non-exclusive state funds. See definitions for exclusive and non-exclusive state funds.

State Industrial Insurance System of Nevada (SIIS) –
a discontinued name for the Employers Insurance Company of Nevada.

State Insurance Fund of Oklahoma (SIF) –
a self-supporting fund that competes with the private market, and is the market of last resort in Oklahoma.

Statewide Average Weekly Wage (SAWW) -
a computation used to determine compensation benefit amounts. See Average Weekly Wage.

State Workers’ Insurance Fund of Pennsylvania (SWIF) –
a self-supporting fund that competes with the private market, and is the market of last resort in Pennsylvania.

Statistical Agent (Stat Agent) –
an organization, usually appointed by the states' insurance commissioner, that collects and consolidates insurance company data.

Statistical Code (Stat Code) –
a 4-digit code, captured in the classification code field, that identifies special premium programs, charges, discounts, etc.

Statistical Plan (Stat Plan) –
a manual of rules, guidelines and instructions for the reporting of workers' compensation data. Most statistical plans are filed with the states.

Stock Company –
a company owned by its shareholders.

Submission File –
a group of data formatted into a file according to standards. Submission files are usually created to transmit data to a jurisdiction, but may also be used to transfer data between workstations or from an external system to a software entry or edit package.

Subrogation –
a process by which losses incurred by an insurer due to the injury of an employee are reimbursed either in part or in whole by a third party deemed responsible in part or in whole for the injury.

Subsequent Report –
a unit statistical report submitted on a predetermined schedule after the first report. Subsequent unit statistical reports are valued at 12-month intervals after the first report.

Summary Reporting –
the reporting of data after applying changes; e.g., credits, debits, etc., at a given time.

Supplemental Loss Report Form –
a reporting form that used to update loss information as of the valuation date or as a correction report to change loss information previously submitted on unit statistical reports.

Surcharge –
a sum added to the usual premium to cover a specific type of coverage, e.g., terrorist insurance surcharge. Surcharges are used in many lines of insurance.

SWIF –

see definition for State Workers' Insurance Fund (of Pennsylvania)

T**Tax Factor (Tax Multiplier) –**

a factor applied in retrospective rating to a premium to cover state premium taxes.

Temporary Injury –

an injury that keeps the employee out of work, but that is reasonably expected to be cured or materially improved such that the employee can return to some employment.

Temporary Partial Disability –

an injured worker's status prior to maximum medical improvement is reached during which the worker can perform some work.

Term –

an indicator for the period covered by the policy.

Temporary Total Disability –

an injured worker's status prior to maximum medical improvement is reached during which the worker is unable to perform any work.

Third-Party Administrator (TPA) –

an organization hired to perform one or more of the business functions of another company.

Terrorism Risk Insurance Act – TRIA

Requires property and casualty insurers doing business in the United States to offer coverage for incidents of international terrorism; and reinsures a large percentage of that insured risk.

Total Allocated Loss Adjustment Expense – Incurred –

the total of the incurred expense amounts that are used to adjust claims that are reported for the state within the policy period. In the case of corrections and subsequent reports, this must be the revised total.

Total Allocated Loss Adjustment Expense – Paid –

the total of the paid expense amounts that are used to adjust claims that are reported for the state within the policy period. In the case of corrections and subsequent reports, this must be the revised total.

Total Claimant's Attorney Fees –

the total of the incurred claimant's attorney fees reported for the state within the policy period. In the case of corrections and subsequent reports, this must be the revised total.

Total Employer's Attorney Fees –

the total of the incurred employer's attorney fees reported for the state within the policy period. In the case of corrections and subsequent reports, this must be the revised total.

Total Incurred Indemnity –

the total of the incurred indemnity amounts for the state within the policy period. In the case of corrections and subsequent reports, this must be the revised total.

Total Incurred Medical –

the total of the incurred medical amounts reported for the state within the policy period. In the case of corrections and subsequent reports, this must be the revised total.

Total Modified Premium –

the total subject premium multiplied by the experience modification factor.

Total Number of Claims –

the total number of claims reported for the state within the policy period. In the case of corrections and subsequent reports, this must be the revised total.

Total Paid Indemnity –

the total of the paid indemnity amounts reported for the state within the policy period. In the case of corrections and subsequent reports, this must be the revised total.

Total Paid Medical –

the total of the paid medical amounts reported for the state within the policy period. In the case of corrections and subsequent reports, this must be the revised total.

Total Standard Exposure –

the sum of all payroll exposures.

Total Standard Premium –

the sum of all premium dollars excluding premium discount and retrospective rating adjustments, both subject and not subject to experience modifications, as defined by the individual jurisdiction's statistical plan.

Total Subject Premium's –

the sum of premium amounts subject to experience modification, as defined by the individual jurisdiction Statistical Plan Manual.

Totals Record/Section –

there are two types of total records – exposure and loss totals. The *Exposure Totals* provide total standard exposure and total standard premium. The *Loss Totals* provide number of claims, total paid/incurred indemnity and medical.

TPA –

see definition for Third Party Administrators

Transactional Reporting –

the reporting of data as the activity occurs.

Transmission –

a term used in data reporting indicating the communication of data between entities, usually electronically.

Transmittal –

a record or form used for control, balancing and communication on data submissions.

TRIA –

see Terrorism Risk Insurance Act
Terrorism Risk Insurance Act (TRIA) - requires property and casualty insurers doing business in the United States to offer coverage for incidents of international terrorism; and reinsures a large percentage of that insured risk.

Truncation –

to shorten a data element by dropping one or more digits or characters.

Turnaround Documents –

documents/listings that allow the company to correct the data on the document and return to the jurisdiction.

Twenty-four Hour Coverage –

generally means coverage for all medical services, whether work related or not, under one policy or

program. It sometimes refers to the combined administration of workers' compensation and general disability claims.

Type of Rate Data Code

A code in WCRATE that determines the applicable markets' rate used in pricing the premium.

U**U/R –**

see definition for Unit Report

ULAE –

see definition for Unallocated Loss Adjustment Expense

Unallocated Loss Adjustment Expense (ULAE) –

an expense pertaining to handling claims that cannot be specifically attributable to a claim.

Underwriter –

a person who selects risks for insurance and determines the terms and premium for which the insurance company will accept the account.

Underwriting –

the process of selecting applicants for insurance and classifying them according to the degrees of insurability so that the appropriate premium rates may be charged.

Unearned Premium –

the portion of the premium that applies to the unexpired period of the policy.

Unit –

short for Unit Report. See definition for Unit Report.

Unit Card –

see definition for Unit Report

Unit Report (UR) –

form submitted by companies for reporting workers' compensation insurance statistical data. It includes policy level detail regarding exposures, classifications and premiums; and losses at an individual employer level, by state. Unit reports are submitted on hard copy or by electronic transmission.

Unit Report Control (URC) –

the acronym URC is usually associated with NCCI's Unit Report Control System. However, most of the independent rating organizations have a unit report control system. Unit report control systems produce listings advising the insurer that a unit report is due or is late.

Unit Report Expected Report –

a report that alerts insurers of the unit reports that are expected to be filed with Minnesota, which is issued in the 18th month after the policy effective date.

Unit Report Quality (URQ) –

the acronym URQ is usually associated with NCCI's Unit Report Quality system. However, most of the independent rating organizations have a unit report quality system. Unit report quality systems unit advise the insurer of the types of errors found on the unit report.

Unit Stat –

Short for Unit Statistical Plan Data. See definition for Unit Report.

Unit Statistical Plan Manual –

a manual published by bureaus, data collection organizations and states that contains rules and procedures for the submission of data.

Unit Statistical Report (USR) – see definition for Unit Report**United States Longshoreman and Harbor Workers**

(**USL&HW or USL&H**) – identifies employee covered under the federal USL&HW Act. These employees include those working in loading, unloading, repairing, or building vessels. The USL&HW Act provides for a payment schedule of compensation to USL&HW employee different from that provided under most state worker's compensation laws.

Unity Mod –

a term used to describe an experience modification factor of 1.00.

Update Type –

a code that identifies the activity of an exposure record. Coding is the same as Update Type under the Exposure Information Section. Used on subsequent and correction reports only.

URC –

see definition for Unit Report Control

URQ –

see definition for Unit Report Quality

USL & HW or USL&H –

see definition for United States Longshore and Harbor Workers

USR –

see definition for Unit Report

V**Validate –**

a process of extended checking of data. The phrase 'Data has been validated' means the data has been checked and corrected if necessary.

Valuation Date –

the date at which losses are valued. Valuation dates begin on the 18th month after policy effective date for the 1st valuation and revalued at 12-month intervals thereafter.

Virtual Storage Access Method (VSAM) – an IBM disk file storage scheme.**'Voc Rehab' –**

Short for Vocational Rehabilitation

Voc Rehab Education (Training) Expense –

direct training costs, including, but not limited to, tuition, books, tools, transportation, and additional living expenses.

Voc Rehab Evaluation Expense –

the expense of evaluation, testing and counseling (provided by either the insurer's own personnel or outside vendors), including those expenses associated with a claimant for which no training or educational program was conducted.

Voc Rehab Maintenance Expense –

when an employee is determined to be medically eligible and chooses to participate in a vocational rehabilitation program, he or she may receive a maintenance allowance (dollar amount).

Vocational Rehabilitation –

a program to assist injured workers in their return to work. It can be in the form of education, training, job placement, etc.

Vocational Rehabilitation Indicator –

indicates the inclusion of vocational rehabilitation costs in the losses.

VOL –

short for Voluntary Insurance. See definition for Voluntary Insurance

Voluntary Compensation –

an endorsement to the standard workers' compensation insurance policy that extends coverage to employees not required to be Policy which extend required to be covered under the state's statutory workers' compensation provisions.

Voluntary Insurance (VOL) –

a term where an insurance company freely agrees to insure a risk, using its' own rules, rates and forms.

VR -

Vocational Rehabilitation

VSAM –

see definition for Virtual Storage Access Method

W

Wage Loss –

temporary disability benefits that may be paid when an employee returns to work at less than full earnings.

WAN –

see definition for Wide Area Network

WC –

see definition for Workers' Compensation

WCCDCI –

see definition for Workers' Compensation Detailed Claim Information (Electronic Format for DCI Data)

WCCDCI –

WCIO's electronic format for reporting Detailed Claim Information.

WCCNTL –

see definition for Workers' Compensation Control (Electronic Format for the Control of Unit Report Data)

WCCNTL –

WCIO's electronic format for reporting unit report data control listings; e.g. Pre-delinquent, Delinquent, etc.

WCDM –

see definition for Workers' Compensation Data Monitoring

WCESTAT –

WCIO's electronic format for reporting unit report errors.

WCF –

see definition for Workers' Compensation Fund (of Utah)

WCIO –

see definition for Workers' Compensation Insurance Organizations

WCIRB –

a non-profit statistical agent designated by the California Department of Insurance, whose members consist of all insurance companies licensed to write workers' compensation insurance in the state of California.

WCNOA –

WCIO's electronic format for reporting notices of assignment.

WCPOLS –

see definition for Workers' Compensation Policies (Electronic Format for Policy Data)

WCPOLS –

WCIO's electronic format for reporting policy, endorsement, cancellation and reinstatement data.

WCRATE –

see definition for Workers' Compensation Rate (Electronic Format for Rates)

WCRATE –

WCIO's electronic format for communicating rates.

WCRATING –

WCIO's electronic format for reporting experience and merit rating data.

WCRB –

see definition for Wisconsin Compensation Rating Bureau

WCRI –

see definition for Workers' Compensation Research Institute

WCSTAT –

see definition for Workers' Compensation Statistical (Electronic Format for Unit Report Data)

WCSTAT –

WCIO's electronic format for reporting unit report and Individual Case/Claim Report data.

Weekly Wage –

an injured employee's weekly earnings.

Wide Area Network (WAN) –

a network extending over distances.

Wisconsin Compensation Rating Bureau –

the authorized data collection organization for the state of Wisconsin.

Workers Compensation Insurance Organizations (WCIO) –

a voluntary association of statutorily authorized or licensed rating, advisory or data services organizations that collect Workers' Compensation insurance information in one or more states.

Workers' Compensation Statistical Plan – see definition for Statistical Plan

Workers' Compensation Rating and Inspection Bureau of Massachusetts –

the authorized data collection organization for the state of Massachusetts.

Workers' Compensation (WC) –

The NAIC Statistical Handbook, Section 23, defines workers' compensation as:

"Insurance that employers are required (in most states and for most [employmentemployers](#)) to provide to cover employees against loss of income and/or

medical expenses that result from job-related injury, disease or death."

Workers' Compensation Data Monitoring (WCDM) –

a program applicable to certain states to monitor the quality of workers' compensation data.

Workers' Compensation Data Specifications Manual –

a manual published and administered by the WCIO of electronic specifications that provides standardized formats for exchanging information on electronically, including policy, unit report and individual case report (ICR) submission requirements.

Workers' Compensation Fund of Utah (WCF) –

a self-supporting non-profit mutual insurance company, and the market of last resort in Utah.

Workers' Compensation Insurance –

coverage to insure the employer's responsibilities for work-related injuries, including occupational diseases.

Workers Compensation Research Institute (WCRI) –

an organization of insurers and Data Collection Organizations conducting research and analysis for the improvement of the workers' compensation system.

Workers' Compensation Unit Report – see definition for Unit Report

Workforce Safety and Insurance (WSI) -

an exclusive, premium-financed, no-fault insurance system covering workplace injuries, illnesses and deaths. (North Dakota)

WSI -

see definition for Workforce Safety and Insurance.

'Write' –

to insure, underwrite, or accept an application for insurance.

Written Premium –

the entire amount of premium written during a period regardless of whether the premiums are earned or unearned. See Premium Written.

World Wide Web (WWW) –

a term used to indicate the client-server hypertext distributed information retrieval system which originated from the CERN High-Energy Physics

Laboratories in Geneva, Switzerland.

Wrap-up –

a policy that covers a large construction, erection or demolition project.

WWW –

see definition for World Wide Web

X**XML –**

see definition for Extensible Markup Language

X-Mod –

short for experience modification. See definition for Experience Modification

Y**Year 2000 (Y2K) –**

a common name for all the difficulties the turn of the century may bring to computer users. This was due to most programs storing only the last two digits of the year.

Y2K –

see definition for Year 2000

Z**ZIP Code –**

Zoning Improvement Plan Code.

MISCELLANEOUS**120-Byte –**

an electronic format for Pre-ASWG Unit Report Data (120 positions).

250-Byte Full –

an electronic format for the ASWG Unit Report Data (250 positions).

250-Byte Interim –

an electronic format for PreG Unit Report Data reported in the new ASWG format (250 positions)