



**OFFICE OF COMMISSIONER OF INSURANCE**

COMMISSIONER OF INSURANCE • INDUSTRIAL LOAN COMMISSIONER • SAFETY FIRE COMMISSIONER

**Ralph T. Hudgens, Commissioner**

2 Martin Luther King Jr., Dr. Suite - 904, West Tower, Atlanta, GA 30334

PHONE 404-656-4449



[www.oci.ga.gov](http://www.oci.ga.gov)

**DISCLOSURE STATEMENT**

For Experience Rating Notification By Workers' Compensation Carriers

**PROPERTY & CASUALTY  
GID-063-PC MAY2016  
(same as GID-63)**

The attached  
  
Disclosure Statement  
  
printed on the letterhead of the  
  
Workers' Compensation Carrier  
  
shall be used  
  
for experience rating notification  
  
to insured policyholders.

!!! Do **NOT** use this page as part of the Disclosure Statement notification !!!



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**DISCLOSURE STATEMENT**  
For Experience Rating Notification By Workers' Compensation Carriers

**PROPERTY & CASUALTY**  
**GID-063-PC MAY2016**  
(same as GID-63)

**GEORGIA FORM GID-63**  
**DISCLOSURE STATEMENT FOR EXPERIENCE RATING NOTIFICATION**

[ DATE OF MAILING ]

[ POLICY HOLDER ]

[ CARRIER'S RETURN ADDRESS ]

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Attached, **as required by Georgia Law**, is a copy of the loss experience to be used in experience rating your workers compensation policy. The experience rating can cause your premiums to increase or decrease depending on the frequency and severity of losses.

**In accordance with the O.C.G.A. Section 34-9-136**, please review the attached statement, sign below and return this form to our office. If you do not sign and return this form within 30 days from the mailing date, the date will be deemed correct for the purpose of calculating your experience rating modification factor and final premium. Your failure to respond shall not affect nor waive any of your rights to a future appeal.

If you find an error in the attached material, please contact our office immediately at the indicated address: \_\_\_\_\_.

**SIGN THE APPLICABLE STATEMENT BELOW AND RETURN REQUIRED STATEMENT**

[    ] I have reviewed the attached payroll and claims information and find it to be accurate. An insurance company representative has explained that this information may affect the premium charged for Workers' Compensation Insurance Coverage for my business.

\_\_\_\_\_  
SIGNATURE and TITLE (Authorized Representative of the Employer)

[    ] I have reviewed the attached payroll and claims information. According to my records, the information is inaccurate. I have attached a copy of my records which I believe to be correct and a statement explaining the differences. I understand that if you, the insurance company, do not respond to me within 60 days of the date on your statement, you are agreeing with me that my records are correct and you will change your records accordingly.

\_\_\_\_\_  
SIGNATURE and TITLE (Authorized Representative of the Employer)

NOTE: Return By Date \_\_\_\_\_