

**NOTIFICATION OF COVERAGE
MULTI-STATE RETROSPECTIVE RATING PLAN**

NAME OF INSURED _____

CARRIER _____

POLICY NUMBER(S) _____ PLAN EFFECTIVE DATE _____

States to Which Plan Applies	Estimated Annual Standard Premium	Class Code Number*	If information above differs by state, then record only difference in these column.		
			Name of Insured by State	Policy Number	Effective Date

* Show class which produces the largest amount of estimated premium.

This Plan shall apply in any other states where available to any operations conducted during the rating period unless specified in Item 6.

1. Type of Retrospective Rating Plan (circle one)
 - A. Standard Retrospective Rating Plan
 - B. Large Risk Alternative Rating Option

2. Indicate Selection
 - A. Minimum Premium Factor _____
 - B. Maximum Premium Factor _____
 - C. Loss Conversion Factor _____
 - D. Tax Multiplier _____

3. Term of Plan (circle one)
 - A. 1 Year or 3 Year
 - B. Wrap-up Construction Project (enter details)

4. Loss Limitation Selected (if applicable) _____

5. Do Retrospective Development Factors apply? Yes No

6. Indicate any Exceptions or Special Conditions that apply to the Plan elected by this insured:

This Notification of Coverage is based on the insured's election to be subject to the Retrospective Rating Plan and the carrier's acceptance of the election having been executed and retained in the carrier's file.

Signature of Insured

Date Signed

Signature of Carrier Representative