KWCFC – 02
REVISED 3-2014
COMMONWEALTH OF KENTUCKY

KENTUCKY WORKERS' COMPENSATION
INDIVIDUAL SELF-INSURERS
QUARTERLY
PREMIUMS REPORT
(KRS 342.122)

☐ **Original Filing**

☐ **Amended Filing**

Name of Company

Address (Number, Street, Post Office Box) ☐ Address Change

City State Zip Code

Report for Quarter Year

*** Federal Employer's ID Number (FEIN)**

Contact Person (Person Preparing Report) ☐ Contact Change

Name:

Title:

Phone Number : **( ) -**

Email Address:

*** Mandatory Field for Proper Credit**

Please complete report in accordance with instructions on reverse side. Report and payment must be received in the office of the Funding Commission, or postmarked by the **United States Postal Service** no later than 30 days following the end of the calendar quarter reporting period. Make check payable to and mail report and check to:

Kentucky Workers' Compensation Funding Commission
#42 Millcreek Park, P.O. Box 1128, Frankfort, Kentucky 40602-1128

	(A) All Employers Special Fund Assessments	(B) Additional Assessments Severance or Processing of Coal
(1) Total Annual Calculated Premium	$	$
(2) Quarterly Premium [Line (1) ÷ 4]	$	$
(3) Assessment Rate (Enter Correct Rate).	X .____	X .____
(4) Assessments Due [Line (2) x Line (3)]	$	$

(5) Total Assessment Due [Add Columns (A) and (B), Line (4)]	$
(6) Adjustment From Previous Reports **[Attach Explanation]**	$
(7) **TOTAL AMOUNT DUE [(5) ± (6)] (See Payment Info Below)**	$

IMPORTANT PAYMENT INFORMATION: In order to properly credit your account, each reporting entity MUST submit a separate check per individual quarterly filing equal to the amount computed on line 7 above.

The undersigned certifies that this return has been examined and is, to the best of the undersigned's knowledge and belief, a true, correct and complete report made in good faith.

President or Other Authorized Representative Title Date