WORKERS' COMPENSATION PREMIUM TAX REPORT

Submit completed report to:
OKLAHOMA WORKERS' COMPENSATION COMMISSION
Insurance Division
1915 N. Stiles Avenue
Oklahoma City, OK 73105
(405) 522-3222 or In-State Toll Free (855) 291-3612

In accordance with 85A O.S., §206, as a mutual or interinsurance association, stock company or other insurance carrier writing workers' compensation insurance on risks located in this state, you are asked to provide the following information to the Oklahoma Workers' Compensation Commission **NO LATER THAN** _____:

Name of Carrier:_____

Gross Direct Written Premium of Carrier Writing Workers' Compensation Insurance on Risks Located in Oklahoma for CALENDAR YEAR _____:

$_____.

This information will be used to determine the Oklahoma Option Insured Guaranty Fund assessment rate under 85A O.S., §208 to be collected by the Oklahoma Workers' Compensation Commission at the same time and in the same manner as insurance premium taxes under Title 36 of the Oklahoma Statutes for deposit into the Oklahoma Option Guaranty Fund.

Notice of the rate will be provided to each carrier and will be posted on the Commission's web site at www.wcc.ok.gov.

The undersigned hereby certifies, UNDER PENALTY OF PERJURY, that he/she executed this report of his/her free and voluntary will and as the duly authorized representative of the carrier named above, that the information and amounts herein contained reflect a true, accurate and complete statement.

Administrative Workers' Compensation Act, 85A O.S., §6(A)(1)(a): "Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for the purpose of: (1) obtaining any benefit or payment … shall be guilty of a felony."

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

Signed_____
Signature of Preparer **E-Mail Address**

By_____
Name and Title (PLEASE PRINT)

Telephone Number _____
Area Code and Number

Date _____

Direct questions regarding this form to the Oklahoma Workers' Compensation Commission at the address and telephone numbers listed above.

Revised 12-18-14