Workers' Benefit Fund Assessment
Corrections and Changes Notification

• Use this form to update your Workers' Benefit Fund assessment account*

Business name	Oregon Business Identification Number (BIN)

Corrections (enter corrected information)

Is this address to be used for forms only? ☐ Yes ☐ No

Business name			BIN
Mailing address			Federal Employer Identification Number (FEIN)
City	State	ZIP code	Telephone number

Changes in Status (check and complete all that apply)

DCBS use only
RC02 _____
RC06 _____
A/L
RC06 _____
RC02 _____
RC02 _____
RC05 _____

☐ 1. **No longer in business.** Effective date of closure: _____

☐ 2. **Still in business, but have no paid employees.** Effective date: _____

I maintain workers' compensation insurance coverage:

- ☐ Not for myself and/or corporate officers, but in case I hire employees.
- ☐ To cover myself and/or corporate officers exclusively; no employees.
- ☐ To cover volunteer workers exclusively.

☐ 3. **I no longer have workers' compensation insurance coverage:**

- ☐ I have canceled my workers' compensation insurance coverage.
  Effective date of cancellation: _____
- ☐ I will be canceling my workers' compensation insurance coverage.
  Effective date of cancellation: _____

☐ 4. **I now use leased employees only.** Effective date: _____

☐ 5. **Other.** Please explain: _____

*** Contact your insurance carrier to make any changes in name, partnership, corporate status, or changes in the number of personal elections taken.** Check with your insurance company to see if it will accept a copy of this form as notification of any changes or corrections to your insurance policy.

Note: Submitting this notice to the Workers' Compensation Division will affect **only** your Workers' Benefit Fund assessment account for purposes of reporting. It will **not** affect your workers' compensation insurance coverage or claims liability. You need to contact your insurance provider to notify it of the changes.

I understand that I am required to report and pay the Workers' Benefit Fund assessment at any time that the law requires or I choose to carry workers' compensation insurance coverage for myself or for any of my paid workers in Oregon.

X _____ _____
Signature Date

_____ _____
Print name Telephone number

Mail your completed form to:

WC Assessments Unit
DCBS/CSD/Financial Services
PO Box 14480
Salem OR 97309-0405