

**ILLINOIS WORKERS' COMPENSATION COMMISSION  
RATE ADJUSTMENT FUND AND SECOND INJURY FUND  
ASSESSMENT TRANSMITTAL FORM  
FOR 01/01/2022 – 06/30/2022  
ASSESSMENT IS DUE BY SEPTEMBER 15, 2022\*  
\*NOTE ADDRESS CHANGE BELOW  
\*The Online Reporting System is now Operational.  
Register and Submit your assessment online.**

Company Name: \_\_\_\_\_  
Contact Person: \_\_\_\_\_  
Address 1: \_\_\_\_\_  
Address 2: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Email/Phone: \_\_\_\_\_

**SECTION 1. ASSESSMENT CALCULATION**

Please submit a separate sheet for each subsidiary or division reported

|   |  |                          |
|---|--|--------------------------|
| <b>FEIN CODE:</b>   | <b>Company Name:</b>   |                          |
| <small>FOR LINE A), Include ALL compensation payments made under the Illinois Workers' Compensation Act, whether by lump sum settlement or weekly/monthly compensation payments. Do not include hospital, surgical, or rehabilitation payments. For Insurance Companies, <u>do not subtract</u> Subrogation, and/or Reinsurance recoveries. For Self-Insured Companies, <u>do not subtract</u> Subrogation and/or Excess Workers' Compensation recoveries. If no compensation payments were made, enter 0 (zero) on Line A. Complete Section II, and return the form on or before the due date of September 15, 2022.</small> |  |                          |
| <b>A)</b>   | <b>Total Gross compensation paid from 01/01/2022 through 06/30/2022:</b> | \$ _____                 |
| <b>B)</b>   | <b>Rate Adjustment Fund (RAF) assessment rate: (this year is 0.625%)</b> | <b><u>X 0.00625</u></b>  |
| <b>C)</b>   | <b>RAF amount due (Line A x Line B):</b>                                 | \$ _____                 |
| <b>D)</b>   | <b>Second Injury Fund (SIF) assessment rate: (this year is 0.0625%)</b>  | <b><u>X 0.000625</u></b> |
| <b>E)</b>   | <b>SIF amount due (Line A x Line D):</b>                                 | \$ _____                 |
| <b>F)</b>   | <b>Total amount due (Line C + Line E):</b>                               | \$ _____                 |

Make assessment checks payable to:  
**Illinois Workers' Compensation Commission**

Mail checks to\*:  
**\*Please note the address has changed**  
**Illinois Workers' Compensation Commission**  
**Attn: Fiscal Office**  
**69 W. Washington St., Suite 900**  
**Chicago, IL 60602**

Disclosure of this information is required under Section 7(f) of 820 ILCS 305/7(f). Failure to provide information will result in a delinquency notice with penalties being issued.

## SECTION II. AFFIDAVIT

*An officer of the company must complete this section, and the signature must be notarized.*

I, \_\_\_\_\_, being duly sworn on oath, depose and state that I have read this notice of assessment,  
Name  
that I am acquainted with the affairs of the employer, and that the representations and statements herein  
set forth are true in substance and fact.

By:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Company

\_\_\_\_\_  
Company telephone and fax numbers

\_\_\_\_\_  
Email address

Subscribed and sworn to before me at \_\_\_\_\_

City, State

this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_.

\_\_\_\_\_  
Notary Public