Texas Department of Insurance
Workers' Compensation Insurance

Schedule Rating Plan Information Sheet

Group Name: _____ **Group #:**_____

TDI use only

Link # _____

Company Name	NAIC #	1/1/2002 Relativities Adoption Date	Does Company Use Schedule Rating (Yes or No)	Schedule Rating Plan Change * (Y - Change) (N – No Change)	TDI #
_____	_____	___/___/_____	_____	_____	_____
_____	_____	___/___/_____	_____	_____	_____
_____	_____	___/___/_____	_____	_____	_____
_____	_____	___/___/_____	_____	_____	_____
_____	_____	___/___/_____	_____	_____	_____
_____	_____	___/___/_____	_____	_____	_____
_____	_____	___/___/_____	_____	_____	_____
_____	_____	___/___/_____	_____	_____	_____
_____	_____	___/___/_____	_____	_____	_____
_____	_____	___/___/_____	_____	_____	_____
_____	_____	___/___/_____	_____	_____	_____
_____	_____	___/___/_____	_____	_____	_____

** If "yes," submit a copy of the new schedule rating plan. If "no," submit a copy of the current schedule rating plan.*

Schedule Rating Plan Certification

I, _____, am an officer of the _____ and in that capacity, I certify that all the information contained above is complete, correct, and true to the best of my knowledge and belief.

_____
Officer's Signature

_____
Officer's Title