STATE OF CALIFORNIA

WOSHEF FUND FEE REPORT

DIR CHSWC 001 REV. 10/2025

DEPARTMENT OF INDUSTRIAL RELATIONS

COMMISSION ON HEALTH AND SAFETY AND WORKERS' COMPENSATION

CLEAR PRINT

- **LABOR CODE SECTION 6354.7 REQUIRES ALL WORKERS' COMPENSATION INSURERS TO FUND THE "WORKERS' OCCUPATIONAL SAFETY AND HEALTH EDUCATION FUND "BY PAYING AN ANNUAL FEE OF THE GREATER OF $100 OF A PERCENTAGE OF THEIR PAID WORKERS' COMPENSATION INDEMNITY AS REPORTED FOR THE PRIOR CALENDAR YEAR ON THE "DATA CALL FOR CALIFORNIA WORKERS' COMPENSATION EXPERIENCE" FILED WITH THE WORKERS' COMPENSATION INSURANCE RATING BUREAU (WCIRB) OF CALIFORNIA.**
- **PLEASE COMPLETE AND SUBMIT THIS REPORT FORM WITH THE REQUIRED FEES AND ATTACHMENTS TO THE E-MAIL ADDRESS LISTED BELOW. PAYMENT IS DUE ON OR BEFORE APRIL 1 EVERY YEAR.**

1. NAME OF INSURERS: List the parent insurance company name including the assigned WOSHEF company number and its subsidiaries that write workers' compensation insurance in California. For all insurance companies listed, attach a copy of each insurer's Certificate of Authority, issued by the California Department of Insurance to write workers' compensation insurance. (Attach an additional page if more companies need to be listed.)

2. COMPANY OFFICER: Name the person with the authority to establish the program to provide loss control consultation services in California and who authorizes the payment of fees into the Fund.

Certification

I certify the information provided is correct and valid.

Signature of Company Officer: _____ Date: _____

Print Name of Officer: _____

Title: _____

(The address below will only be used for all future correspondence from this office.)

Name of Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone No.: _____ Fax No.: _____

E-mail: _____

3. FEE CALCULATION: Indicate the total amount of Paid Indemnity as reported for the prior calendar year on the "Data Call for Direct California Workers' Compensation Insurance Rating Bureau of California (WCIRB) for the parent insurance company, and calculate fees due.

(Include a copy of the prior calendar year "Data Call" on this application)

Prior Calendar Year _____

Paid Indemnity: _____ X 0.000286 = * Fee $ 100.00

*Pay this amount or $100, whichever is greater

[Example - $43,060,531.00 (PI) x .000286 = $12,315.31(Fee)]

Payment: Make an electronic payment at our secure WOSHEF online payment via EFT or Credit/Debit Card or go to www.dir.ca.gov/chswc/woshef.html.

4. SUBMISSION: Please send this completed Fund Fee Report form with the "Data Calls", the Certificate(s) of Authority, and payment confirmation, if applicable, to WOSHEF e-mail at WOSHEF@dir.ca.gov before April 1 every year:

If you have any questions regarding this fee or report process, call us at (510) 622-3959 or send your inquiries to WOSHEF e-mail at WOSHEF@dir.ca.gov.