

SERFF Tracking Number: UTCX-125839226 State: Arkansas
First Filing Company: Utica Mutual Insurance Company, ... State Tracking Number: EFT \$50
Company Tracking Number: WC AR09968CGF01
TOI: 16.0 Workers Compensation Sub-TOI: 16.0004 Standard WC
Product Name: Workers Compensation
Project Name/Number: Workers Compensation/WC AR09968CGF01

Filing at a Glance

Companies: Utica Mutual Insurance Company, Graphic Arts Mutual Insurance Company
Product Name: Workers Compensation SERFF Tr Num: UTCX-125839226 State: Arkansas
TOI: 16.0 Workers Compensation SERFF Status: Closed State Tr Num: EFT \$50
Sub-TOI: 16.0004 Standard WC Co Tr Num: WC AR09968CGF01 State Status: Fees verified and received
Filing Type: Form Co Status: Reviewer(s): Betty Montesi, Carol Stiffler
Author: SPI UticaNational Disposition Date: 10/01/2008
Date Submitted: 09/30/2008 Disposition Status: Approved
Effective Date Requested (New): 01/01/2009 Effective Date (New): 01/01/2009
Effective Date Requested (Renewal): Effective Date (Renewal):
State Filing Description:

General Information

Project Name: Workers Compensation Status of Filing in Domicile:
Project Number: WC AR09968CGF01 Domicile Status Comments:
Reference Organization: Reference Number:
Reference Title: Advisory Org. Circular:
Filing Status Changed: 10/01/2008
State Status Changed: 10/01/2008 Deemer Date:
Corresponding Filing Tracking Number:
Filing Description:

With this filing we are revising our Workers Compensation/Employers Liability Policy Declaration Page (Manual and Automated) to remove West Virginia as a monopolistic state. We have also amended our Supplementary Dec Page to comply with our new policy administration system by making state specific fields variable information rather than hard coded.

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Company and Contact

Filing Contact Information

Tina Cirelli, Senior State Filings Coordinator tina.cirelli@uticanational.com
 180 Genesee Street (315) 734-2129 [Phone]
 New Hartford, NY 13413 (315) 734-2252[FAX]

Filing Company Information

| | | |
|--------------------------------|----------------------------|-----------------------------|
| Utica Mutual Insurance Company | CoCode: 25976 | State of Domicile: New York |
| 180 Genesee Street | Group Code: 201 | Company Type: |
| New Hartford, NY 13413 | Group Name: Utica National | State ID Number: |
| (315) 734-2000 ext. [Phone] | Insurance Group | |
| | FEIN Number: 15-0476880 | |
| | ----- | |

| | | |
|---------------------------------------|----------------------------|-----------------------------|
| Graphic Arts Mutual Insurance Company | CoCode: 25984 | State of Domicile: New York |
| 180 Genesee Street | Group Code: 201 | Company Type: |
| New Hartford, NY 13413 | Group Name: Utica National | State ID Number: |
| (315) 734-2000 ext. [Phone] | Insurance Group | |
| | FEIN Number: 13-5274760 | |
| | ----- | |

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---------------------------------------|---------|----------------|---------------|
| Utica Mutual Insurance Company | \$50.00 | 09/30/2008 | 22834030 |
| Graphic Arts Mutual Insurance Company | \$0.00 | 09/30/2008 | |

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Product Name: Workers Compensation
Project Name/Number: Workers Compensation/WC AR09968CGF01

Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|----------|----------------|------------|----------------|
| Approved | Carol Stiffler | 10/01/2008 | 10/01/2008 |

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Disposition

Disposition Date: 10/01/2008
Effective Date (New): 01/01/2009
Effective Date (Renewal):
Status: Approved
Comment:

Rate data does NOT apply to filing.

Overall Rate Information for Multiple Company Filings

| | |
|---|--------|
| Overall Percentage Rate Indicated For This Filing | 0.000% |
| Overall Percentage Rate Impact For This Filing | 0.000% |
| Effect of Rate Filing-Written Premium Change For This Program | \$0 |
| Effect of Rate Filing - Number of Policyholders Affected | 0 |

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 TOI: 16.0 Workers Compensation Sub-TOI: 16.0004 Standard WC
 Product Name: Workers Compensation
 Project Name/Number: Workers Compensation/WC AR09968CGF01

| Item Type | Item Name | Item Status | Public Access |
|---------------------|--|-------------|---------------|
| Supporting Document | Uniform Transmittal Document-Property & Casualty | Approved | Yes |
| Form | Workers Comp Dec Page (Automated) | Approved | Yes |
| Form | Workers Comp Dec Page (Manual) | Approved | Yes |
| Form | WC Supplementary Dec Page | Approved | Yes |

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 TOI: 16.0 Workers Compensation Sub-TOI: 16.0004 Standard WC
 Product Name: Workers Compensation
 Project Name/Number: Workers Compensation/WC AR09968CGF01

Form Schedule

| Review Status | Form Name | Form # | Edition Date | Form Type Action | Action Specific Data | Readability | Attachment |
|---------------|-----------------------------------|---------------|--------------|--|---|-------------|------------|
| Approved | Workers Comp Dec Page (Automated) | 8-D-WC | Ed. 08-2008 | Declaration Replaced s/Schedule | Replaced Form #:0.00 8-D-WC Previous Filing #: | 8-D- | WC.PDF |
| Approved | Workers Comp Dec Page (Manual) | 8-D-WC | Ed. 08-2008 | Declaration Replaced s/Schedule | Replaced Form #:0.00 8-D-WC Previous Filing #: | 8-D- | WC.PDF |
| Approved | WC Supplementary Dec Page | 8-D-WC (Supp) | Ed. 08-2008 | Election/Re Replaced jection/Sup plemental Application s | Replaced Form #:0.00 8-D-WC (Supp) Previous Filing #: | 8-D-WC | (Supp).PDF |



Issuing Company:

A MEMBER OF UTICA NATIONAL INSURANCE GROUP

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

Information Page

Policy Number:

1. The Insured and Mailing Address:

Prior Policy Number:

Producer:

Entity of Insured:

Producer Number:

Other workplaces not shown above:

Insured's I.D. Number:

NCCI Company Number:

Risk I.D. Number:

2. The policy period is from _____ to _____ 12:01 AM Standard Time at the insured's mailing address.

3. A. Workers Compensation Insurance: Part One of the policy applies to the Workers Compensation Law of the states listed here:

B. Employers Liability Insurance: Part Two of the policy applies to work in each state listed in Item 3.A. The limits of our liability under Part Two are:

| | | |
|---------------------------|----|---------------|
| Bodily Injury by Accident | \$ | Each Accident |
| Bodily Injury by Disease | \$ | Policy Limit |
| Bodily Injury by Disease | \$ | Each Employee |

C. Other States Insurance: Part Three of the policy applies to the states, if any, listed here:

All States except those listed in Item 3.A., ND, OH, WA, WY

D. This policy includes these endorsements and schedules:

4. The premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All information required below is subject to verification and change by audit.

| <input type="checkbox"/> See Extension of Information Page Classifications | Code No. | Premium Basis Total est. Annual Remuneration | Rate Per \$100 of Remuneration | Estimated Annual Premium |
|--|----------|--|--------------------------------|--------------------------|
| | | | | |

| | | |
|--|--|-------------------------------------|
| Minimum Premium: \$ If indicated below, interim adjustments of premium shall be made | Expense Constant Total Estimated Annual Premium Deposit Premium | \$ \$ \$ |
|--|--|-------------------------------------|

Issuing Office:

Date of Issue:

Countersigned by _____



Issuing Company:

A MEMBER OF UTICA NATIONAL INSURANCE GROUP

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

Information Page

Policy Number:

1. The Insured and Mailing Address:

Prior Policy Number:

Producer:

Entity of Insured:

Producer Number:

Other workplaces not shown above:

Insured's I.D. Number:

NCCI Company Number:

Risk I.D. Number:

2. The policy period is from _____ to 12:01 AM Standard Time at the insured's mailing address.

3. A. Workers Compensation Insurance: Part One of the policy applies to the Workers Compensation Law of the states listed here:

B. Employers Liability Insurance: Part Two of the policy applies to work in each state listed in Item 3.A. The limits of our liability under Part Two are:

| | | |
|---------------------------|----|---------------|
| Bodily Injury by Accident | \$ | Each Accident |
| Bodily Injury by Disease | \$ | Policy Limit |
| Bodily Injury by Disease | \$ | Each Employee |

C. Other States Insurance: Part Three of the policy applies to the states, if any, listed here:

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D. This policy includes these endorsements and schedules:

4. The premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All information required below is subject to verification and change by audit.

| <input type="checkbox"/> See Extension of Information Page Classifications | Code No. | Premium Basis Total est. Annual Remuneration | Rate Per \$100 of Remuneration | Estimated Annual Premium |
|--|----------|--|--------------------------------|--------------------------|
| | | | | |

| | | |
|--|--|-------------------------------------|
| Minimum Premium: \$ If indicated below, interim adjustments of premium shall be made | Expense Constant Total Estimated Annual Premium Deposit Premium | \$ \$ \$ |
|--|--|-------------------------------------|

Issuing Office:

Date of Issue:

Countersigned by _____

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY
EXTENSION OF INFORMATION PAGE**

Item 4. Continued

Page:

NCCI Company Number:

Policy Number:

| Classifications | Code No. | Premium Basis Total Est. Annual Remuneration | Rate Per \$100 of Remuneration | Estimated Annual Premium |
|------------------------|-----------------|---|---|---|
| | | | | |

| | | | |
|---------------------------------|---|-------------------------------|----------------------------|
| <i>SERFF Tracking Number:</i> | <i>UTCX-125839226</i> | <i>State:</i> | <i>Arkansas</i> |
| <i>First Filing Company:</i> | <i>Utica Mutual Insurance Company, ...</i> | <i>State Tracking Number:</i> | <i>EFT \$50</i> |
| <i>Company Tracking Number:</i> | <i>WC AR09968CGF01</i> | | |
| <i>TOI:</i> | <i>16.0 Workers Compensation</i> | <i>Sub-TOI:</i> | <i>16.0004 Standard WC</i> |
| <i>Product Name:</i> | <i>Workers Compensation</i> | | |
| <i>Project Name/Number:</i> | <i>Workers Compensation/WC AR09968CGF01</i> | | |

Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Satisfied -Name: Uniform Transmittal Document-
Property & Casualty

Review Status:

Approved

10/01/2008

Comments:

Attachments:

AR - NAIC P&C TRANSMITTAL DOCUMENT.PDF

AR - NAIC FORM FILING SCHEDULE.PDF

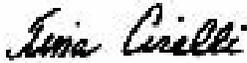
Property & Casualty Transmittal Document

| | | | | | |
|---|---|--------------|--|------------------|--|
| 1. Reserved for Insurance Dept. Use Only | 2. Insurance Department Use only a. Date the filing is received: b. Analyst: c. Disposition: d. Date of disposition of the filing: e. Effective date of filing: <table style="width: 100%; border: none;"> <tr> <td style="width: 60%; border: none;">New Business</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Renewal Business</td> <td style="border: none;"></td> </tr> </table> f. State Filing #: g. SERFF Filing #: h. Subject Codes | New Business | | Renewal Business | |
| New Business | | | | | |
| Renewal Business | | | | | |

| | | | | |
|---------------------------------------|---------------------|---------------|---------------|----------------|
| 3. Group Name | Group NAIC # | | | |
| Utica National Insurance Group | 0201 | | | |
| 4. Company Name(s) | Domicile | NAIC # | FEIN # | State # |
| Utica Mutual Insurance Company | NY | 25976 | 15-0476880 | |
| Graphic Arts Mutual Insurance Company | NY | 25984 | 13-5274760 | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| | |
|-----------------------------------|-----------------|
| 5. Company Tracking Number | WC AR09968CGF01 |
|-----------------------------------|-----------------|

Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

| | | | | | |
|-----------|--|----------------------------------|--|--------------|--------------------------------|
| 6. | Name and address | Title | Telephone #s | FAX # | e-mail |
| | Tina D. Cirelli 180 Genesee Street New Hartford NY 13413 | Senior State Filings Coordinator | 800-274-1914 Ext. 2129 | 315-734-2252 | tina.cirelli@uticanational.com |
| 7. | Signature of authorized filer | |  | | |
| 8. | Please print name of authorized filer | | Tina D. Cirelli | | |

Filing Information (see General Instructions for descriptions of these fields)

| | | |
|------------|---|--|
| 9. | Type of Insurance (TOI) | 16.0 Workers Compensation |
| 10. | Sub-Type of Insurance (Sub-TOI) | 16.0004 Standard WC |
| 11. | State Specific Product code(s) (if applicable) [See State Specific Requirements] | |
| 12. | Company Program Title (Marketing Title) | Revised Dec Page |
| 13. | Filing Type | <input type="checkbox"/> Rate/Loss Cost <input type="checkbox"/> Rules <input type="checkbox"/> Rates/Rules <input checked="" type="checkbox"/> Forms <input type="checkbox"/> Combination Rates/Rules/Forms <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other (give description) |
| 14. | Effective Date(s) Requested | New: 01/01/2009 Renewal: 01/01/2009 |
| 15. | Reference Filing? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 16. | Reference Organization (if applicable) | |
| 17. | Reference Organization # & Title | |
| 18. | Company's Date of Filing | 09/30/2008 |
| 19. | Status of filing in domicile | <input type="checkbox"/> Not Filed <input checked="" type="checkbox"/> Pending <input type="checkbox"/> Authorized <input type="checkbox"/> Disapproved |

FORM FILING SCHEDULE

(This form must be provided **ONLY** when making a filing that includes forms)
 (Do **not** refer to the body of the filing for the forms listing, unless allowed by state.)

| | | |
|-----------|--|-----------------|
| 1. | This filing transmittal is part of Company Tracking # | WC AR09968CGF01 |
|-----------|--|-----------------|

| | | |
|-----------|---|-----|
| 2. | This filing corresponds to rate/rule filing number (Company tracking number of rate/rule filing, if applicable) | N/A |
|-----------|---|-----|

| 3. | Form Name /Description/Synopsis | Form # Include edition date | Replacement Or Withdrawn? | If replacement, give form # it replaces | Previous state filing number, if required by state |
|----|--------------------------------------|--------------------------------|---|---|--|
| 01 | Workers Comp Dec Page (Automated) | 8-D-WC Ed. 08-2008 | <input type="checkbox"/> New <input checked="" type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn | 8-D-WC Ed. 04-1999 | |
| 02 | Workers Comp Dec Page (Manual) | 8-D-WC Ed. 08-2008 | <input type="checkbox"/> New <input checked="" type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn | 8-D-WC Ed. 04-1999 | |
| 03 | WC Supplementary Dec Page | 8-D-WC (Supp) Ed. 08-2008 | <input type="checkbox"/> New <input checked="" type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn | 8-D-WC (Supp) Ed. 10-1997 | |
| 04 | | | <input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn | | |
| 05 | | | <input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn | | |
| 06 | | | <input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn | | |
| 07 | | | <input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn | | |
| 08 | | | <input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn | | |
| 09 | | | <input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn | | |
| 10 | | | <input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn | | |
| 11 | | | <input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn | | |