

**WORKERS COMPENSATION EXPERIENCE RATING FOR FORMER CLIENTS OF LABOR CONTRACTORS**

**VA1271 Form**  
(Virginia Only)

(Ed. 2018)

Provide the termination date in Item 1. Provide name of previous labor contractor in Item 2. Provide name, address, and FEIN of client company in Item 3. If the client company has entered into a professional employer service arrangement with a new professional employer organization, provide the name of the new professional employer organization in Item 4.

Item 1—Termination Date:			
Item 2—Previous Labor Contractor Risk Name:		Previous Labor Contractor Risk ID:	
Item 3—Client Company Risk Name:		Client Company Risk ID:	
Client Company Address:		Client Company FEIN Number:	
Item 4—New Labor Contractor Risk Name:		New Labor Contractor Risk ID:	

**Item 5—Policy Information**

Enter data for the policy written for the labor contractor named in Item 2, for the period during which the reported data was developed:

1. Effective Date:		4. Carrier Code and Name:	
2. Expiration Date:		5. Exposure State:	
3. Policy Number:			

Exposure			Loss									
(1) Class Code	(2) Payroll	(3) Rate	(4) Claim No.	(5) Accident Date	(6) Injury Type	(7) Open/ Closed	(8) Claim Class Code	(9) Indemnity	(10) Medical	(11) Actual Incurred Losses	(12) Loss Cov. Act Code	(13) Cat. No.

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**This document must be signed by the insurance company that provided coverage for the period the reported data was developed.**

We hereby certify that the information given in this report is correct to the best of our knowledge and belief.

Insurance Carrier

Signature

Title

Date

Name of person completing the form:

\_\_\_\_\_

Telephone Number:

\_\_\_\_\_