WORKERS COMPENSATION EXPERIENCE RATING FOR CLIENT COMPANIES OF EMPLOYEE LEASING ARRANGEMENTS

NV-361 Form (Nevada Only)

Provide the date of submission in Item 1 along with indication if this form is an Original (O) or Replacement (R) of a previously submitted form. Provide the name and Risk ID of the Employee Leasing Company in Item 2. Provide the name, address, and FEIN Number of the client company in Item 3.

Item 1—Submission Date:	Original/Replacement:
Item 2—Employee Leasing Company Ri Employee Leasing Company Ri	
Item 3—Client Risk Name:	Client Risk ID:
Client Address:	
Client City/State:	Client FEIN #:
	CLIENT COMPANY'S REPORTED DATA WAS DEVELOPED: ne Employee Leasing Company named in Item 2.
1. Client Company Effective Date:	
2. Client Company Expiration Date:	
3. Policy Number:	
4. Carrier Code:	
5. Carrier Name:	
6. Exposure State:	
7. Master Policy Effective Date:	

	Ex	xposure			Loss	
(1)	(2)	(3)	(4)	(5)	(6) Accident	(7) Claim
Class Code	Payroll	Rate	Premium	Claim Number	Date	Class Code

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(Ed. 2018)

	E	xposure			Loss	
(1)	(2)	(3)	(4)	(5)	(6) Accident	(7) Claim
Class Code	Payroll	Rate	Premium	Claim Number	Date	Class Code
				-		
				┨ ┣────		
				┥ ┝────		
				┨ ┣────		

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

We herby 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 completin	g the form:		
Telephone Number:			

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