

Bill Date: 04/01/2016

**THE COMMONWEALTH OF MASSACHUSETTS**  
**Department of Industrial Accidents**  
**Assessment Processing**  
**P.O. Box 3732**  
**Boston, MA 02241-3732**  
**ASSESSMENT FOR QUARTER ENDING 03/31/2016**

Invoice: 848434  
Form 050

XXXX INSURANCE COM  
XXXX STREET  
  
BOSTON, MA 02114

Company License # XXXX

**THIS BILL IS DUE ON : 05/02/2016**

**A FINE OF \$250 OR 5% OF BALANCE, WHICHEVER IS GREATER,  
WILL BE ASSESSED ON OUTSTANDING BALANCES NOT RECEIVED BY DUE DATE.**

**PRIVATE EMPLOYERS**

<input type="checkbox"/> Total Standard Premiums for Assessed Insured					
<input type="checkbox"/> Assessments Collected (Amount Due)					
<input type="checkbox"/> # Employers Assessed					
Massachusetts Industrial Accidents Private Trust Fund	\$0.00	X	.78624	=	\$0.00
Massachusetts Industrial Accidents Special Fund	\$0.00	X	.21376	=	\$0.00

[Upload supporting documentation](#)

**This form must be completed and submitted to the Department of Industrial Accidents by the above due date. If no workers' compensation insurance was written in the quarter please fill in 0's and complete in the portion below. If late a fine of \$250 or 5% of the amount due, which ever is greater, will be assessed.**

Checking this box qualifies as an electronic signature. By checking this box you hereby certify under the pains and penalties of perjury that all laws of the Commonwealth governing assessments and regulations thereof have been complied with and observed, and that all information is, to the best of your knowledge, correct.

All assessment forms, must be signed by a **Manager or above.**

<input type="checkbox"/> Name	<input type="text"/>	<input type="checkbox"/> Title	<input type="text"/>
<input type="checkbox"/> E-mail Address	<input type="text"/>	<input type="checkbox"/> Phone No	<input type="text"/>
<input type="checkbox"/> Preparer's Name	<input type="text"/>	<input type="checkbox"/> Preparer's E-mail	<input type="text"/>
Date	15-APR-2016		

Enter any changes to your mailing address and/or contact information in the fields provided below

Address / Contact Line 1

Address / Contact Line 2

City, State & Zip code

The DIA does not accept aggregated reporting information. Information is mandatory for each company licensed to write workers compensation insurance in the Commonwealth of Massachusetts. Incomplete forms will be considered to be delinquent and subject to a 5% fine. Please visit [www.mass.gov/dia](http://www.mass.gov/dia).

**[CLICK HERE FOR DIA HISTORICAL RATES](#)**

**THE COMMONWEALTH OF MASSACHUSETTS/DIA'S TAX ID IS 046002284**

Please do not press the SUBMIT FORM button more than once