

SELF-INSURER'S REPORT
DUE MARCH 1st

Calendar Year: _____

Company: _____

1. Total Workers' Compensation Benefits paid for the reporting period: _____

(a) Indemnity: \$ _____

(b) Medical: \$ _____

(c) Other: \$ _____

(d) Total: \$ _____

2. Assessment due [line (d) x .01]: \$ _____

3. Claims for which benefits were paid for this reporting period. (this may be included on a separate form provided that all the information requested is present):

Name	Date of Injury	State File Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Certification:

I certify that the information identified above, and submitted, is true and accurate.

Signature _____ Date _____

Name: _____ Telephone: _____

Title: _____ Email: _____

Group Address: _____ Company Address: _____

