

MAILING LABEL IDENTIFYING
INSURANCE CARRIER

I. Carrier Identification

If missing OR incorrect above.

Insurance Carrier FEIN _____ Insurance Carrier SCWCC Code No. _____

Insurance Carrier Name: _____

II. Reporting Contact Address

The address shown above is the correct contact for completion of this form.

OR

Future editions of this form should be sent to the following address:

III. Statistical Report

Submitted by _____
Preparer's Name Telephone

Total minor medical claims filed during calendar year: _____

Total medical costs paid during calendar year: _____

File this form with the Accident Reporting Division on or before April 1 according to R.67-412. Only one report per carrier will be accepted.