

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.