SELF-INSURED INJURY REPORT FOR 2009

THE INDUSTRIAL COMMISSION OF ARIZONA

This report is subject to verification by ICA auditors

Self-Insured Name:

Page **To**

Period covered: **To**

INSTRUCTIONS ON SEPARATE PAGE

(fill in the bolded cells)

CLAIMS $5,000 AND OVER

(fill in the bolded cells)

(B) Name/Date of Injury/ Nature of Injury Indemnity Includes Vocational Rehabilitation Indicate with a (Y) or (N) List all claims alphabetically by: Last Name					(C) MEDICAL		(D) INDEMNITY		(E)	(F) Total
					(fill in the bolded cells)		*(fill in the bolded cells)*			
Column A				Column B	Column C	Column D	Column E	Column F	Column G	Total Columns (C+D+E+F-G)
Last Name	First Name	DOI	Nature of Injury	Claim #	Paid	Outstanding	Paid	Outstanding	SUBROGATIONS & RECOVERIES	Total Amount Incurred
										-
										-
										-
										-
										-
										-
										-
										-
(G) Total Claims $5000 and over					-	-	-	-	-	-

(H) Check total (If row G and row H do not equal, mathematical error has occurred) -

	Column C	Column D	Column E	Column F	Column G	Total Columns (C+D+E+F-
(I) Claims $1,999 or less Medical only						-
(J) Claims $4,999 or less Medical and/or Indemnity:						-
(K) Total all claims:	-	-	-	-	-	-

(L) Check total (If row K and row L do not equal, mathematical error has occurred) -

I certify this report is a true and complete for the period stated.

Officer Signature:

Officer Name:

Officer Title:

Date of Officer Signature:

Name and Title of Person completing this form if different than above:

Date Form Completed:

Primary Email Address:

Alternative Email Address:

FAX Number:

Primary Phone Number:

Alternative Phone Number:

NAME OF TPA:

Phone Number of TPA:

TPA FAX Number: