SELF-INSURED INJURY REPORT FOR 2010

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

Indemnity Includes Vocational Rehabilitation Indicate with a (Y) or (N) List all claims alphabetically by: Last Name						MEDICAL		INDEMNITY			Total
Column A					Column B	Column C	Column D	Column E	Column F	Column G	Total Columns (C+D+E+F-G)
Rehab Y/N	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:

TPA Name:

TPA Phone Number:

TPA FAX Number: