TEST INSURER 2
C/O TEST INSURER 2
123 JENNIFER ST
MADISON WI 53703

WC CLAIM NO:	9999-999999	IF YOU CALL OR WRITE US
INJURY DATE:	01/01/98	PLEASE USE WC CLAIM NO.
EMPLOYEE:	SIMPLES-SAMPLER, TESTER SAMPLE	
EMPLOYER:	SAMPLE EMPLOYER	
INSURER NO:		

Additional information is needed to process this claim. Please answer the question(s) below. Your reply can be made directly on this form unless a separate report has been requested.

What permanent disability is conceded? Is payment being made?

This information will assist in bringing this claim to a conclusion.

Failure to submit this required report within 30 days will result in a surcharge of $100 under sec. 102.35(1), Wis. Stats.

Department of Workforce Development
Worker's Compensation Division

WC86C (R. 02/2006)