TEST INSURER 2
C/O TEST INSURER 2
RM C100
201 E WASHINGTON AVE
MADISON WI 53703

WC CLAIM NO:	9999-999999	IF YOU CALL OR WRITE US
INJURY DATE:	05/01/85	PLEASE USE WC CLAIM NO.
EMPLOYEE:	SAMPLE-SIMPLES, SAMPLE	
EMPLOYER:	SAMPLE EMPLOYER INC	
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.

Reply to our letter of 01/01/2016.

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

WC86F (R. 11/2004)