

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.

1. What is the present status of this case?

2. Send WKC-13 showing all dates of disability and all amounts paid to date.

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

WC86H (R. 02/2006)