

Workers' Compensation Claims Involving Medical Payments Only
and Claims Involving Indemnity Payments Report

Company Name and Address	FEIN:
	Reporting period:

MEDICAL ONLY CLAIMS (IC-2)

(A) Total number of **medical-only claims** on which payments were made during the reporting period: _____

(B) Total amount paid on **medical-only claims** during the reporting period: \$ _____

INDEMNITY CLAIMS (IC-327)

(C) Total number of **indemnity claims** on which payments (including any medical payments) were made during the reporting period: _____

(D) Total amount of **indemnity payments** (not including medical payments) during the reporting period: \$ _____

(E) Total amount of all **indemnity claims payments** (including medical payments on indemnity claims only.) \$ _____

Certification

State of _____ County of _____

I, _____, being duly sworn on oath, state that I have read the foregoing report which sets forth certain information relating to medical and indemnity payments made during the reporting period, that I know the contents, and that I certify the report is true and correct to the best of my knowledge.

Signature of Preparer _____ Print Name _____ Telephone _____

Email Address _____ Fax _____

SUBSCRIBED AND SWORN to before me on this _____ day of _____, _____

The ISIF assessment billing should be sent to:

Name: _____
Please Print

Title: _____

Address: _____

City, State, Zip

Phone: _____

Notary Public for

My commission expires:
