

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

WC CLAIM NO: 9999-999999
INJURY DATE: 05/01/85
EMPLOYEE: SAMPLE-SIMPLES, SAMPLE
EMPLOYER: SAMPLE EMPLOYER INC
INSURER NO:

IF YOU CALL OR WRITE US
PLEASE USE WC CLAIM NO.

Our computation of the permanent partial disability is attached. Let us know immediately, if you do not make payment as shown.

If there is no temporary disability printed on the attached sheet or if temporary disability is incomplete, please send Form WKC-13 giving the date of disability and the amounts paid. If the temporary disability is not available then the accrual of PPD may not be correct.

This worksheet is final. When the final payment is made, send a final Form WKC-13.

Department of Workforce Development
Division of Worker's Compensation

CVRF

CVRF (R. 08/2001)