DEPARTMENT OF EMPLOYMENT SERVICES
OFFICE OF WORKERS' COMPENSATION
4058 MINNESOTA AVE. NE, SUITE 3802
WASHINGTON, DC 20019

PAGE_______ OF ________

QUARTER ENDING DATE: ________________

DATE OF REPORT: ______________________

INSURER NAME: _________________________________

____
CERTIFYING OFFICIAL (TYPE)

QUARTERLY REPORT OF BENEFIT PAYMENTS

ADDRESS: _______________________________________

____

____
CERTIFYING OFFICIAL (SIGNATURE)

____
TITLE

INSURER NCCI NUMBER: _________________________

____
TELEPHONE NUMBER

CLAIMANT NAME	SOCIAL SECURITY #	OWC #	INJURY DATE	EMPLOYER ID #	N/L *	MEDICAL PAYMENTS	COMPENSATION PAYMENTS	VOCATIONAL REHAB. PAYMENTS	TOTAL
				SUB TOTAL					
				TOTAL					

* NO=NO LOSS TIME L=LOSS TIME