

Form SI-7
Rev. 7/01/2006
Authority:
AWCC Rule 099.05

ARKANSAS WORKERS' COMPENSATION COMMISSION
SELF-INSURANCE DIVISION
324 Spring Street, Little Rock, AR 72201
Mail: P. O. Box 950, Little Rock, AR 72203-0950
401-683-2783 / 1-800-632-4422

SI-7

2006

Do Not complete this
LOSS SUMMARY DATA REPORT
This report is to include only payments made
during the calendar year ending December 31, 2006
form.

2006

SELF-INSURER: _____ FEIN _____

ADDRESS: _____

CITY ST ZIP: _____

SELF INSURER ADMINISTRATOR SELF INSURER CLAIM OFFICER

NAME: _____ NAME: _____

ADDRESS: _____ ADDRESS: _____

PHONE: _____ PHONE: _____

TOTAL NUMBER OF EMPLOYEES: _____ TOTAL NUMBER OF ARK. EMPLOYEES _____

Non-Filed-M.O. - Cases involving accepted medical only claims not individually filed with the Commission, but are reported via the Monthly Medical Only Report (Form M). All Non-Filed M.O. cases are to be totaled and reported on Line 1 below.

Filed-Death - Death claims filed with the Commission. These are to be listed individually on Form SI-7-A, totaled, and reported on Line 2.

Filed-All Other - All cases, including Death, that are filed with the Commission. These are to be listed individually on Form SI-7-A, totaled, and reported on Line 3.

Complete the Following Items: # OF TYPE OF CASE CASES NON-MEDICAL PAYMENTS MEDICAL PAYMENTS EXPENSE PAYMENTS RESERVES PENDING

1 NON-FILED-M.O. _____ \$ _____

2 FILED-DEATH _____ \$ _____ \$ _____ \$ _____

3 FILED-All OTHER _____ \$ _____ \$ _____ \$ _____

4 TOTALS _____ \$ _____ \$ _____ \$ _____ ALL PAYMENTS ALL RESERVES

5 GRAND TOTALS _____ \$ _____ \$ _____

Detailed instructions for the completion of this report are available at www.awcc.state.ar.us/lscr_instructions.pdf

I hereby certify that the information stated in this report is correct to the best of my knowledge and belief.

For Arkansas Workers' Compensation Use Only
S-I Entry Date _____ S-I Cancel Date _____
Audited by _____ Date _____

insurer. _____ SIGNATURE _____ DATE _____

TITLE & COMPANY _____ PHONE _____