

ANNUAL REPORT OF CLAIMS INVENTORY

**TO: State of California, Department of Industrial Relations
 Division of Workers' Compensation, Audit Unit ~ Attn: ARI Desk
 2424 Arden Way, Suite 305
 Sacramento, CA 95825**

PART 1

COMPANY NAME STREET ADDRESS CITY/STATE/ZIP P. O. BOX CITY/STATE/ZIP Manager Name: Telephone: Fax No. E-Mail:	CHECK ONE: <input type="checkbox"/> Self-Administered Insurance Company or Group <input type="checkbox"/> Third-Party Administrator <input type="checkbox"/> Self-Administered Self-Insured Employer (private or public) <input type="checkbox"/> Self-Administered Joint Powers Authority <input type="checkbox"/> Combination of any of the following, but only if administered under the same local management. (Check two or more): <input type="checkbox"/> Self-Administered Insurance Company or Group <input type="checkbox"/> Self-Administered Self-Insured Employer <input type="checkbox"/> Third-Party Administrator
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Number of California workers' compensation claims reported at this location during the 2005 year:

Type of Claim	Number	Type of Claim	Number
• Indemnity	_____	• Indemnity with indemnity payments	_____
• Denied	_____	• Open claims (all years) end of year	_____
• Medical-only	_____	2005	_____
Total:	_____		

Signature	_____
Title:	_____
Date:	_____

NOTE: Insurer Groups (more than one underwriting company at the same location), third-party administrators, and combinations of the two must complete Part 2.

- Reports of Claims Inventory for each adjusting location of California workers' compensation claims are due by **April 1, 2006**.
- Failure to timely submit reports may subject you to penalty assessments of up to \$500 per location.