

## ANNUAL REPORT OF CLAIMS INVENTORY

### PART 2

For each individual underwriting company in an insurance group or client of a third-party administrator (whether an insurer, self-insured employer or CIGA), whose claims are administered at the adjusting location, complete the following (note: all information below is for the individual underwriting company or client. Do not duplicate information from Part 1):

<p><b>COMPANY NAME</b></p> <p>STREET ADDRESS</p> <p>CITY/STATE/ZIP</p> <p>Mailing address: P. O. BOX; CITY/STATE/ZIP</p> <p>Manager Name:</p> <p>Telephone:</p> <p>Fax No:</p> <p>E-Mail:</p>	<p><b>CHECK ONE:</b></p> <p><input type="checkbox"/> Insurance Company</p> <p><input type="checkbox"/> California Insurance Guarantee Assoc.</p> <p><input type="checkbox"/> Self-insured employer (private or public including joint powers authority)</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; width: 80%;">Type of Claim</th> <th style="text-align: right; width: 20%;">Number</th> </tr> </thead> <tbody> <tr> <td>• Indemnity</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>• Denied</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>• Medical Only</td> <td style="text-align: right;">_____</td> </tr> <tr> <td style="text-align: right;">Total</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>• Indemnity with payments</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>• Open claims (all yrs) end of 2005</td> <td style="text-align: right;">_____</td> </tr> </tbody> </table>	Type of Claim	Number	• Indemnity	_____	• Denied	_____	• Medical Only	_____	Total	_____	• Indemnity with payments	_____	• Open claims (all yrs) end of 2005	_____
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**Complete and attach additional sheets if necessary. The sum of the totals for claims of all entities reported for Part 2 must equal the total of claims reported for Part 1.**