Workers' Compensation Annual Report
Self-Insured (Current/Previous)
January 1, 2002 through December 31, 2002

Name: _____
Address: _____
_____
_____
Contact: _____
Phone: _____
Self-Insured (Renewal Date/Discontinue Date): _____

I certify that the total indemnity/compensation and medical payments made during the Calendar Year ending December 31, 2002 are as follows:

Name:_____ Title:_____

Phone Number:_____ Fax Number:_____
E-Mail Address: _____

Indemnity/Compensation	**$**_____
Medical	**$**_____
Total Medical/Indemnity	**$**_____

The amount of these payments will be used to determine the Second Injury Fund/Workers' Compensation assessments for your company. The information contained in this report is subject to audit by the Second Injury Fund. Please provide us with a payment register; or a loss run, that reconciles to the above reported paid losses.

Any questions concerning this report should be directed to Julie Bernard at (860) 702-3173.

Please return this completed report by April 1, 2003, to: **Office of the Treasurer**
Second Injury Fund
Attn: Julie Bernard
55 Elm Street, 5th Floor
Hartford, CT 06106