

Jim Doyle
Governor

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Division Administrator



State of Wisconsin
Department of Workforce Development

WORKER'S COMPENSATION
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October 6, 2003

TEST INSURER 1
C/O TEST INSURER 1
ONE MAIN ST
MADISON WI 53703

WC CLAIM NO: 9999-999999
INJURY DATE: 05/01/98
EMPLOYEE: SIMPLE, SAMPLE
EMPLOYER: SAMPLE EMPLOYER INC
INSURER NO: 094CBD6S8646

IF YOU CALL OR WRITE US
PLEASE USE WC CLAIM NO.

This is our second request for this information.

Our calculations of the disability amounts due and paid to date for this claim are shown below. Please pay the balance due promptly and confirm that your payment has been made by sending us an amended Supplementary Report, WKC-13, within 30 days of the date of this letter. If you disagree with our calculation of the amount due and have paid a different amount, please explain the basis for your payment on the amended WKC-13.

Failure to respond to this request within 30 days may result in sanctions by the Division under ss. 102.28(2)(c) or 102.31(3), Wis. Stats., or by the Office of the Commissioner of Insurance, under s. 601.64 Wis. Stats., or both.

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WC77A (R. 2/2/98)