**Tommy G. Thompson**
Governor

**Linda Stewart**
Secretary

**Gregory Krohm**
Division Administrator

**WORKER'S COMPENSATION**
201 East Washington Avenue
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
FAX: (608) 267-0394
http://www.dwd.state.wi.us/wc/

**State of Wisconsin**
**Department of Workforce Development**

April 14, 1997 INS Letter 373

To: Worker's Compensation Carriers

From: Gregory Krohm, Administrator

Subject: 10-DAY NOTICE TO RESPOND TO REQUEST FOR MAILING ADDRESS INFORMATION FOR CLAIMS-RELATED CORRESPONDENCE

***Purpose:*** This is the Division's second request for mailing address information for worker's compensation claims related correspondence, required under s. 102.31(3), Wisconsin Statutes. Our first request was sent via INS Letter 364, dated March 10, 1997. The Division will take enforcement action for continued failure to comply with this request.

***Action Required:*** Please complete the enclosed form and promptly return it to the Division at the address above, or fax it to (608) 267-0394. Questions about this request may be directed to Lee Shorey, Director, Bureau of Claims Management (608) 267-9407.

***Penalties:*** We have not received from you the address information we requested in our previous correspondence. Failure to provide the requested address information by April 25, 1997 will result in immediate referral to the Commissioner of Insurance with a request to take effective enforcement measures, as provided under sec. 601.64 of the Wisconsin Statutes.

The information requested is essential for the Division to effectively carry out our claims management responsibilities toward you and other customers. Until we receive a response to this survey we will continue to use the address on this letter for Wisconsin claims related correspondence. Please give this request your immediate attention.

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## INSURANCE CARRIER ADDRESS AND INFORMATION REQUEST

**Carrier Name: (Label)** **NAIC #__________**

Complete the request for information below regarding your designated mailing address. This address will be used to address mail for claims handling purposes by the Division.

**Designated Mailing Name and Address:**________________________________________

______________________________________________________________________

______________________________________________________________________

Contact Name: ____________________________Phone: ( )_____ _______ext:_______

Fax: ( )______ _______ Internet E-mail______________

| | YES | NO |
|---|---|---|
| Do you request more than one claims handling address? | _____ | _____ |

If yes, please indicate them on the reverse side or separate sheet and explain specifically how the multiple claims handling addresses are determined, for example, geographical location of worker, location of employer, TPA, etc. If you use a TPA, list the addresses for Wisconsin claims and indicate how the TPA decides what address to use if the TPA uses multiple addresses.

Person completing this request:______________________________________

Phone: ( )_____ _______ Fax: ( )______ _______ Internet E-mail______________

## ADDITIONAL ADDRESS INFORMATION

**Additional Claims Handling Name and Address:** ______________________________

______________________________________________________________________

Contact Name: ______________________________Phone: (     )_____ _______ ext._____

Fax: (     )______ _______ Internet E-mail_______________

**Additional Claims Handling Name and Address:** ______________________________

______________________________________________________________________

Contact Name: ______________________________Phone: (     )_____ _______ ext._____

Fax: (     )______ _______ Internet E-mail_______________

**Additional Claims Handling Name and Address:** ______________________________

______________________________________________________________________

Contact Name: ______________________________Phone: (     )_____ _______ ext._____

Fax: (     )______ _______ Internet E-mail_______________

**Additional Claims Handling Name and Address:** ______________________________

______________________________________________________________________

Contact Name: ______________________________Phone: (     )_____ _______ ext._____

Fax: (     )______ _______ Internet E-mail_______________

**EXPLANATION FOR USE OF MULTIPLE CLAIMS HANDLING ADDRESSES:**

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