ENCLOSURE A

Form SI-08 Rev. 10/05

Employer Name:_____

Loss Experience Report for Calendar Year(s):_____

Social Security Number	Employee Last Name	Employee First Name	Injury Date	NCCI Body Part and/or Nature of Injury Code	Indicator	OWC Agency Claim Number	Indemnity Paid as of 12/31/YR	Medical Paid as of 12/31/YR	Vocational Rehab. Paid as of 12/31/YR	Indemnity Reserve as of 12/31/YR	Medical Reserve as of 12/31/YR	Vocational Rehab. Reserve as of 12/31/YR	SIR

*** Please Total Each Individual Year**