

TRANSMITTAL LETTER
WORKERS COMPENSATION LARGE CLAIM EXPERIENCE CALL #4
VALUED AS OF DECEMBER 31, 1999 AND DECEMBER 31, 2000

1. STATE: PENNSYLVANIA DELAWARE
2. DUE DATE: MARCH 15, 2001
3. CARRIER NAME: _____
4. FILING AS: GROUP INDIVIDUAL COMPANY
5. If filing as a group, list individual carrier names or NAIC carrier codes:

6. SUBMISSION TYPE: ORIGINAL CORRECTION

MAIL CALL AND TRANSMITTAL LETTER TO:

PENNSYLVANIA / DELAWARE COMPENSATION RATING BUREAU
THE WIDENER BUILDING, 6TH FLOOR
ONE SOUTH PENN SQUARE
PHILADELPHIA, PA 19107-3577
ATTN: ACTUARIAL DEPARTMENT

PCRB/DCRB USE ONLY
Date Received

Receipt Mailed

PENNSYLVANIA / DELAWARE COMPENSATION RATING BUREAU
RECEIPT OF CALL NOTIFICATION
WORKERS COMPENSATION LARGE CLAIM EXPERIENCE CALL #4
VALUED AS OF DECEMBER 31, 1999 AND DECEMBER 31, 2000

7. STATE: PENNSYLVANIA DELAWARE
8. DUE DATE: MARCH 15, 2001
9. SUBMISSION TYPE: ORIGINAL CORRECTION
10. DATE RECEIVED AT PCRB/DCRB _____ BY _____
11. MAIL RECEIPT TO (Indicate specific individual):

PENNSYLVANIA / DELAWARE COMPENSATION RATING BUREAU
Workers' Compensation Large Claim Call for Experience #4 By Policy Year

CARRIER(S) * _____ **NAIC CARRIER CODE(S)** _____

SUBMITTED BY _____ **TITLE** _____

SIGNATURE _____ **STATE CODE (check one)** PA(37) _____ DE(07) _____

TELEPHONE _____ **DATE SUBMITTED** _____

Losses Evaluated Prior to Taking Credit for Any Applicable Deductibles											
Policy Year (1)	Claim Number (2)	Valued as of 12/31/99				Valued as of 12/31/00				Deductible Amount (11)	Coverage Code (12)
		Indemnity		Medical		Indemnity		Medical			
		Paid (3)	Case Reserve (4)	Paid (5)	Case Reserve (6)	Paid (7)	Case Reserve (8)	Paid (9)	Case Reserve (10)		

* If this is a group report, list individually all carriers for which any experience is reported.