

**TRANSMITTAL LETTER
DELAWARE WORKERS COMPENSATION DEDUCTIBLE EXPERIENCE BY POLICY YEAR CALL #6
VALUED AS OF DECEMBER 31, 2000**

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

5. SUBMISSION TYPE: ORIGINAL CORRECTION

MAIL CALL AND TRANSMITTAL LETTER TO:

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

DCRB USE ONLY
Date Received

Receipt Mailed

**DELAWARE COMPENSATION RATING BUREAU, INC.
RECEIPT OF CALL NOTIFICATION
DELAWARE WORKERS COMPENSATION DEDUCTIBLE EXPERIENCE BY POLICY YEAR CALL #6
VALUED AS OF DECEMBER 31, 2000**

6. DUE DATE: MARCH 15, 2001
7. SUBMISSION TYPE: ORIGINAL CORRECTION
8. DATE RECEIVED AT D.C.R.B. _____ BY _____
9. MAIL RECEIPT TO (Indicate specific individual):

DELAWARE COMPENSATION RATING BUREAU

**Workers' Compensation Small Deductible Call for Experience #6 by Policy Year
As of December 31, 2000**

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

SUBMITTED BY _____ TITLE _____

SIGNATURE _____ STATE CODE DE(07)

TELEPHONE _____ DATE SUBMITTED _____

If you wrote deductible experience in period shown below, indicate deductible level(s) at which you had business:

| Policy Year | Small Deductible Premium Credit | Incurred Indemnity Claim Count ** | Incurred Losses Recovered Under Deductible | | |
|-------------|---------------------------------|-----------------------------------|--|---------|-------|
| | | | Indemnity | Medical | Total |
| 1996 | | | | | |
| 1997 | | | | | |
| 1998 | | | | | |
| 1999 | | | | | |
| 2000 | | | | | |

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

** This claim count should only include all claims for which the indemnity payment has been completely recovered under a deductible program.