TRANSMITTAL LETTER
DELAWARE WORKERS COMPENSATION DEDUCTIBLE EXPERIENCE BY POLICY YEAR CALL #6
VALUED AS OF DECEMBER 31, 2001

1. DUE DATE: April 15, 2002

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, 2001

6. DUE DATE: April 15, 2002

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, 2001

NAIC

CARRIER(S) * _____ **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
1997					
1998					
1999					
2000					
2001					

* 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.