WCRA
Workers' Compensation Reinsurance Association
Suite 1700 ✍ 400 Robert Street North ✍ St. Paul, MN 55101-2015 ✍ Phone: (651) 293-0999 ✍✍ www.wcra.biz

LOSS REPORTING FORM

INITIAL _____ **INTERIM** _____ **FINAL** _____ **WCRA CLAIM #** _____ **STAFF** _____

MEMBER _____ MEMBER CLAIM # _____
EMPLOYER _____ DATE OF LOSS _____
CLAIMANT _____ CITY, STATE, & ZIP _____
SOCIAL SECURITY # _____ OCCUPATION & CLASS CODE _____
DATE OF BIRTH _____ DATE OF DEATH _____

AVG WKLY WAGE $_____ INITIAL WKLY IND $_____ CURRENT WKLY IND $_____
CURRENT BENEFIT TYPE: ✍ TTD ✍ TPD ✍ PTD ✍ PPD ✍ DEPENDENCY
SS EFF DATE _____ INITIAL MONTHLY SS $_____ CURRENT MONTHLY SS $_____
OTHER GOVT BENEFITS $_____ PTD EFF DATE _____ RTW DATE _____

DETAILED DESCRIPTION OF ACCIDENT AND INJURY _____
_____
_____
DEPENDENCY STATUS AND DOB _____

PERMANENCY RATING _____ ✍ **ESTIMATED** ✍ **FINAL**

INDEMNITY PAID TO DATE

Perm/Temp Total **(no supps)**		Temp Partial	
Economic Recovery		Death Indemnity	
Impairment Comp.		Retraining	
Perm Partial		Other Indemnity	
		(include description)	

TOTAL PAID TO DATE		**OUTSTANDING/UNPAID RESERVE**	
Indemnity		Indemnity	
Medical		Medical	
Rehabilitation		Rehabilitation	
Recoveries (total)			
(do not include WCRA reimbursements or supplemental benefits)			
Net paid to date		Retention Limit	
(indemnity + medical + rehabilitation - recoveries)			

COMMENTS: (include medical, rehab, and work status; status of subrogation, contribution, and social security recovery)
_____
_____
_____

Contact name and title: _____ Date: _____
Address: _____
Phone # and e-mail address: _____