Insurer ______________________________

Preferred Worker Program
Quarterly Claim Cost Reimbursement Request

__________ Quarter __________ Year

Preferred Worker number	Claim status Nondis. or Disabling		Insurer claim number	Claimant name(s) (Alphabetical order, last, first)	Date of new injury	Date of hire for this job	Quarter/ Year of payment	Claim costs				
								Disability type		Disability benefits	Medical benefits	Total costs
	N	D						TTD	PPD			
	☐	☐						☐	☐			
	☐	☐						☐	☐			
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							Totals (Transfer to Page 1.):					