DIVISION OF WORKERS' COMPENSATION

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

SELF-INSURER'S REPORT OF COMPENSATION PAYMENTS

For Year Ending

This form must be **completed and returned** on or before March 31 to:

MISSOURI DIVISION OF WORKERS' COMPENSATION
P.O. BOX 58
JEFFERSON CITY, MO 65102-0058

SECTION I

Official Name of Self-Insured Entity	Federal Employer Identification No.
Corporate Address	Month and Date of Fiscal Year End

During the Calendar Year Closed January 1 thru December 31,

Compensation Paid	Medical Paid	Total Paid
$	$	$

SECTION II

Name, address, telephone number of service company which handled injury payments if used or of person processing such payments if self-administered.

Service Company Name		
Address	Address	Address
Telephone Number	Telephone Number	Telephone Number

SECTION III

Name, address, telephone number of person to be contacted in self-insured company (entity), responsible for annual reports and other matters pertaining to maintaining self-insured authority.

Name	Title	Telephone Number	
Address	City	State	ZIP Code

Name of parent company, **if a subsidiary:**

Is the self-insured entity or any parent company, currently under bankruptcy protection or considering filing for bankruptcy protection? ☐ Yes ☐ No If "Yes," attach a statement with details regarding the bankruptcy action.

An authorized self-insurer, being duly sworn, state that the foregoing is a full and correct report of the information required in this statement.

Signature	Official Capacity	Date

Notary Public Embosser Seal	State		County (or) City of
	Subscribed and sworn before me, this Day of Year		**USE RUBBER STAMP IN CLEAR AREA BELOW.**
	Notary Public Signature	My Commission Expires	
	Notary Public Name (Typed or Printed)		