Form SI-7 Rev. 7/01/2006	ARKANSAS WORKERS' COMPENSATION COMMISSION **SELF-INSURANCE DIVISION** 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3783 / 1-800-622-4472	**SI-7**
Authority: AWCC Rule 099.05		

Do Not complete this form.

2006 **2006**

LOSS SUMMARY DATA REPORT

This report is to include only payments made
during the calendar year ending December 31, 2006

SELF-INSURER: _____ **FEIN** _____

ADDRESS: _____

_____

CITY ST ZIP: _____

This form is presented here for information purposes only.

SELF INSURER ADMINISTRATOR	**SELF INSURER CLAIMS OFFICER**
NAME: _____	**NAME:** _____
ADDRESS: _____	**ADDRESS:** _____
PHONE: _____	**PHONE** _____

TOTAL NUMBER OF EMPLOYEES: _____ **TOTAL NUMBER OF ARK. EMPLOYEES** _____

Non-Filed-M.O. - Cases involving accepted medical only claims not individually filed with the Commission, but are reported via the Monthly Medical Only Report (Form M). All Non-Filed M.O. cases are to be totaled and reported on Line 1 below.

Filed-Death - Death claims filed with the Commission. These are to be listed individually on Form SI-7-A, totaled, and reported on Line 2.

Filed-All Other - All cases, excluding Death, that are filed with the Commission. These are to be listed individually on Form SI-7-A, totaled and reported on Line 3.

This form is generated by the Self-Insurance Division pre-printed with certain information specific to the self-insurer.

Complete the Following Items:	**# OF CASES**	**INDEMNITY PAYMENTS**	**MEDICAL PAYMENTS**	**EXPENSE PAYMENTS**	**RESERVES PENDING**
1 NON-FILED-M.O.	_____	$_____	$_____	$_____	$_____
2 FILED-DEATH	_____	$_____	$_____	$_____	$_____
3 FILED-All OTHER	_____	$_____	$_____	$_____	$_____
4 TOTALS	_____	$_____	$_____	$_____	
				ALL PAYMENTS	**ALL RESERVES**
5 GRAND TOTALS				$_____	$_____

Detailed instructions for the completion of this report are available at www.awcc.state.ar.us/lsdr_instructions.pdf

I hereby certify that the information stated in this report is correct to the best of my knowledge and belief.

_____

SIGNATURE **DATE**

For Arkansas Workers' Compensation Use Only

S-I Entry Date **S-I Cancel Date**

Audited by _____ **Date**_____

_____

TITLE & COMPANY **PHONE**