

STATE OF KANSAS
DEPARTMENT OF LABOR
Division of Workers Compensation

ANNUAL LOSS PAYMENT REPORTING FORM K-WC 92 (REV. 1-98)

April 26, 2007

19232

ATTN:

This is to certify that during the period January 01, 2006, through December 31, 2006, the following benefit payments were made pursuant to the Workers Compensation Act.

REPORT THE FOLLOWING:

Total of all weekly compensation payments; travel and per diem for medical examination and/or treatment; lump sum payments; compromise settlements; hospital, appliance, and medical payments; vocational rehabilitation; and, death and funeral benefits paid during said period as follows:

DO NOT INCLUDE ATTORNEY FEES AND/OR OTHER EXPENSES AND ASSESSMENTS.

KANSAS DIRECT LOSSES PAID 2006 CALENDAR YEAR	\$ _____
PLUS All Deductibles on Workers Compensation policies	\$ _____
LESS Any Amount Included But Not Covered By Kansas	\$ _____
Workers Compensation Act:	
A. U.S. Longshoreman's Act	\$ _____
B. Coverage B (Employer's Liability)	\$ _____
NET ASSESSMENT BASE	\$ _____

SIGNED THIS _____ DAY OF _____

BY: _____

TITLE: _____

Telephone Number: _____

NOTICE: INSURANCE COMPANIES MUST INCLUDE WITH THIS STATEMENT A COPY OF THE ANNUAL STATEMENT, SPECIAL EXHIBIT OF PREMIUMS AND LOSSES – BUSINESS IN KANSAS DURING THE YEAR, 2006, FROM THE ANNUAL REPORT FILED WITH THE KANSAS INSURANCE DEPARTMENT

ON OR BEFORE MARCH 15, 2007 return the completed statements to:

Kansas Dept. of Labor, Division of Workers Compensation

800 S.W. Jackson Street, Suite 600, Topeka, Kansas 66612-1227

phone 785-296-3606 * fax 785-296-0839 * toll free 1-800-332-0353 * workerscomp@dol.ks.gov * www.dol.ks.gov