Lab 400

STATE OF NEW HAMPSHIRE
Department of Labor
Concord, NH 03301
WORKERS' COMPENSATION SELF-INSURANCE
QUESTIONNAIRE

Name of Self-Insurer _____

Address _____

Contact Name: _____ Fed. ID # _____

Email: _____ Telephone: _____

The following information is supplied for Labor Department use. List only amounts you PAID in workers' compensation benefits under NEW HAMPSHIRE LAW for calendar year _____ or your fiscal year that ended in calendar year _____.

Period covered: From _____ 20 _____ through _____ 20 _____

1. 281-A: 23 Medical, Hospital and Remedial Care $ _____

2. 281-A: 25 Vocational Rehabilitation _____

3. 281-A: 26 Compensation for Death

   (a) Dependent Benefits $ _____

   (b) Burial Expenses $ _____

   Total (a) & (b) $ _____

4. 281-A: 28 Compensation for Total Disability $ _____
(Statutory payments only, please exclude supplemental sick leave benefits)

5. 281-A: 29 Adjusted Total Disability (If any) $ _____

6. 281-A: 31 Compensation for Temporary Partial Disability $ _____

7. 281-A: 32 Scheduled Permanent Impairment Awards $ _____

8. 281-A: 37 Lump Sum Payments $ _____

   TOTAL (1 through 8) $ _____

(Signed)

_____
Title

_____
Date