

STAFF REVIEW

Date: _____

Name of Company: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____ E-Mail: _____

TITLE	NAME	TOTAL YEARS OF CLAIMS EXPERIENCE	TENURE WITH CURRENT COMPANY	NO. OF LOST TIME CASES (ALL ACCOUNTS)	NO. OF MEDICAL ONLY CASES (ALL ACCOUNTS)	NO. OF CLAIMS OTHER THAN COMP
BRANCH / CLAIM MANAGER E-MAIL PHONE NO.						
SUPERVISOR E-MAIL PHONE NO.						
ADJUSTER E-MAIL PHONE NO.						
ADJUSTER E-MAIL PHONE NO.						
ADJUSTER E-MAIL PHONE NO.						
ADJUSTER E-MAIL PHONE NO.						

Washington Fraud Warning: "It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits."



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