

**TRANSMITTAL LETTER
PENNSYLVANIA ACCIDENT YEAR CALL FOR COMPENSATION EXPERIENCE #7
VALUED AS OF DECEMBER 31, 2000**

1. DUE DATE: APRIL 2, 2001

2. CARRIER NAME: _____

3. FILING AS: GROUP INDIVIDUAL COMPANY

4. If filing as a group, list individual carrier names or NAIC carrier codes:

5. SUBMISSION TYPE: ORIGINAL CORRECTION

MAIL CALL AND TRANSMITTAL LETTER TO:

**PENNSYLVANIA COMPENSATION RATING BUREAU
THE WIDENER BUILDING, 6TH FLOOR
ONE SOUTH PENN SQUARE
PHILADELPHIA, PA 19107-3577
ATTN: ACTUARIAL DEPARTMENT**

PCRB USE ONLY

Date Received

Receipt Mailed

**PENNSYLVANIA COMPENSATION RATING BUREAU
RECEIPT OF CALL NOTIFICATION
PENNSYLVANIA ACCIDENT YEAR CALL FOR COMPENSATION EXPERIENCE #7
VALUED AS OF DECEMBER 31, 2000**

6. DUE DATE: APRIL 2, 2001

7. SUBMISSION TYPE: ORIGINAL CORRECTION

8. DATE RECEIVED AT P.C.R.B. _____ BY _____

9. MAIL RECEIPT TO (Indicate specific individual):

**PENNSYLVANIA COMPENSATION RATING BUREAU
 INDEMNITY LOSS DEVELOPMENT DATA BY ACCIDENT YEAR CALL #7
 INDEMNITY LOSSES VALUED AS OF 12/31/00**

CARRIER(S)* _____ **NAIC CARRIER CODE(S)** _____

SUBMITTED BY _____ **TITLE** _____

SIGNATURE _____ **STATE CODE** **PA(37)**

TELEPHONE _____ **DATE SUBMITTED** _____

Accident Year	CLOSED CLAIMS		OPEN CLAIMS		
	Number of Claims (1)	Paid Indemnity (2)	Number of Claims (3)	Paid Indemnity (4)	Case O/S Indemnity (5)
A) Prior to 1980					
B) 1980					
C) 1981					
D) 1982					
E) 1983					
F) 1984					
G) 1985					
H) 1986					
I) 1987					
J) 1988					
K) 1989					
L) 1990					
M) 1991					
N) 1992					
O) 1993					
P) 1994					
Q) 1995					
R) 1996					
S) 1997					
T) 1998					
U) 1999					
V) 2000					
X) Total @12/31/00 Sum (A) to (V)					
Y) Total @12/31/99 Sum (A) to (V) Last Year					
Z) Calendar Year 2000 Experience (X - Y)					

NOTE: Amount in Column (5) is to be case-basis outstanding estimates only. Bulk and IBNR reserves must be excluded from data presented on this form.

*If this is a group report, please list individually all carriers for which any experience is reported.

**PENNSYLVANIA COMPENSATION RATING BUREAU
 MEDICAL ON INDEMNITY LOSS DEVELOPMENT DATA BY ACCIDENT YEAR CALL #7
 MEDICAL ON INDEMNITY LOSSES VALUED AS OF 12/31/00**

CARRIER(S)* _____ **NAIC CARRIER CODE(S)** _____

SUBMITTED BY _____ **TITLE** _____

SIGNATURE _____ **STATE CODE** **PA(37)**

TELEPHONE _____ **DATE SUBMITTED** _____

Accident Year	CLOSED CLAIMS		OPEN CLAIMS		
	Number of Claims (6)	Paid Medical on Indemnity (7)	Number of Claims (8)	Paid Medical on Indemnity (9)	Case O/S Medical on Indemnity (10)
A) Prior to 1980					
B) 1980					
C) 1981					
D) 1982					
E) 1983					
F) 1984					
G) 1985					
H) 1986					
I) 1987					
J) 1988					
K) 1989					
L) 1990					
M) 1991					
N) 1992					
O) 1993					
P) 1994					
Q) 1995					
R) 1996					
S) 1997					
T) 1998					
U) 1999					
V) 2000					
X) Total @12/31/00 Sum (A) to (V)					
Y) Total @12/31/99 Sum (A) to (V) Last Year					
Z) Calendar Year 2000 Experience (X - Y)					

NOTE: Amount in Column (10) is to be case-basis outstanding estimates only. Bulk and IBNR reserves must be excluded from data presented on this form.

*If this is a group report, please list individually all carriers for which any experience is reported.

**PENNSYLVANIA COMPENSATION RATING BUREAU
 MEDICAL ONLY LOSS DEVELOPMENT DATA BY ACCIDENT YEAR CALL #7
 MEDICAL ONLY LOSSES VALUED AS OF 12/31/00**

NAIC
CARRIER(S)* _____ **CARRIER CODE(S)** _____

SUBMITTED BY _____ **TITLE** _____

SIGNATURE _____ **STATE CODE** **PA(37)**

TELEPHONE _____ **DATE SUBMITTED** _____

Accident Year	Number of Claims (11)	Medical Incurred (12)
A) Prior to 1980		
B) 1980		
C) 1981		
D) 1982		
E) 1983		
F) 1984		
G) 1985		
H) 1986		
I) 1987		
J) 1988		
K) 1989		
L) 1990		
M) 1991		
N) 1992		
O) 1993		
P) 1994		
Q) 1995		
R) 1996		
S) 1997		
T) 1998		
U) 1999		
V) 2000		
X) Total @12/31/00 Sum (A) to (V)		
Y) Total @12/31/99 Sum (A) to (V) Last Year		
Z) Calendar Year 2000 Experience (X - Y)		

NOTE: Amount in Column (12) should include paid plus case-basis outstanding estimates only. Bulk and IBNR reserves must be excluded from data presented on this form.

*If this is a group report, please list individually all carriers for which any experience is reported.

PENNSYLVANIA COMPENSATION RATING BUREAU
Call #7 - Reconciliation of the Policy Year Call With the Accident Year Call

NAIC
CARRIER CODE(S)

CARRIER(S)* _____

SUBMITTED BY _____ TITLE _____

SIGNATURE _____ STATE CODE PA(37)

TELEPHONE _____ DATE SUBMITTED _____

	Policy Year Call #1	Accident Year Call #7	Differences
Indemnity Claim Count			
#1-pg.2, line Z, column (8)			
#7-pg.1, line Z, columns (1)+(3)	_____	_____	_____
Closed Indemnity Claim Count			
#1-pg.4, line Z, column (19)			
#7-pg.1, line Z, column (1)	_____	_____	_____
Open Indemnity Claim Count			
#1-pg.4, line Z, column (20)			
#7-pg.1, line Z, column (3)	_____	_____	_____
Indemnity Paid			
#1-pg.2, line Z, column (9)			
#7-pg.1, line Z, columns (2)+(4)	_____	_____	_____
Indemnity Paid on Closed Claims			
#1-pg.4, line Z, column (21)			
#7-pg.1, line Z, column (2)	_____	_____	_____
Indemnity Case Outstanding			
** #1-pg.3, line Z, column (15) OR			
pg.2, line Z, column (11)			
#7-pg.1, line Z, column (5)	_____	_____	_____
Total Medical Case Incurred			
** #1-pg.2, line Z, column (10) +			
pg.3, line Z, column (17) OR			
pg.2, line Z, columns (10) + (12)			
#7-pg.2, line Z, columns (7)+(9)+(10)			
+ pg.3. line Z, column (12)	_____	_____	_____

***Reason for Differences

* If this is a group report, please list individually all carriers for which any experience is reported.
 ** If data is not reported on Page 3 of Policy Year Call #1, please use Page 2 data.
 *** If more space is needed to provide reasons for differences, please use reverse side or attach separate sheet.