

COMMONWEALTH OF KENTUCKY

Kentucky Department of Insurance • Financial Standards and Examinations Division
 P.O. Box 517 • Frankfort, KY 40602-0517 • 502-564-6082 • FAX 502-564-4604

Business Name of Self Insured: _____

Contact Person or Responsible Party: _____

Date: _____

Address: _____

PLEASE CHECK BELOW THE APPROPRIATE QUARTER BEING SUBMITTED:

City, State, Zip: _____

1 ST - due April 10 <input type="checkbox"/>	2 ND - due July 10 <input type="checkbox"/>	3 RD – due Oct 10 <input type="checkbox"/>	4 TH – due Jan 10 <input type="checkbox"/>
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Phone Number: _____

Email: _____

MOTOR VEHICLE SELF-INSURED QUARTERLY REPORT CLAIMS FORM

Name of Payee	Date of Loss	Type of Claim (mark with an X)			Amount Paid	Date Paid	Adjusting Company	Status (Open or Closed)	Amount Paid on Open Claim
		BI	PIP	PD					