TPRS Workers Compensation Survey

PLEASE FAX COMPLETED FORM TO 202-833-2027 or MAIL TO P.O. Box 34602, WASHINGTON, DC 20043-4602

Plan Enrollee: ______________________________

Patient: ______________________________ Plan ID No: ____________________________

If you have an accepted workers compensation case with the federal Department of Labor's Office of Workers Compensation Programs ("OWCP"), please provide us with your OWCP Case Number.

Your 9-digit OWCP Case Number: ________________________________

The date of your accident, injury, or illness: _________________________

If you have an accepted workers compensation case with any agency or carrier other than OWCP, please provide us with the following information:

The date of your accident, injury, or illness: _________________________

The workers compensation claim number: __________________________

________________________________ __________________________

Name of Contact/Adjustor Phone Number

____

Name of Company/Carrier

____

Mailing Address

____

City, State, Zip Code

Please check here ___ if you did not file a workers compensation claim and explain why below.

<table>
<tr><td colspan="2">Name of Responder:</td><td>Date:</td></tr>
<tr><td>Email</td><td>Tel.</td><td>Best time to call:</td></tr>
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