State of New Jersey
Department of Banking and Insurance
(FORM 291A)

Supplementary Statement by _____ _____
(Name of employer) (Address)

Outstanding Death or Disability Claims, as of the last closing date _____2_____

Include all accidents occurring prior to above date which resulted in death or in disability exceeding seven days unless final payment has been made prior to said date in accordance with award or agreement approved by the Workers' Compensation Bureau, or the right to recovery is barred by limitation of statute.

- This statement is to be rendered in all cases. If there are no claims of any kind write "NONE".
- Total the Final Column.

Name of Injured or Deceased	Date of Accident	Weekly Compensation	Nature of Injury	Number of Dependents and Ages of each (Fatal Cases Only)	Year of Birth (when injury is permanent)	Probable Future Duration in Weeks	Estimated Total Future Payments