



PROVIDER NOTIFICATION FORM

RELIAMAX INSURANCE COMPANY

WORKERS' COMPENSATION

EMPLOYEE NAME: _____

EMPLOYEE'S PHONE NUMBER: _____

EMPLOYER'S NAME: NORTHERN HILLS TRAINING CENTER

EMPLOYER'S PHONE NUMBER: 605-642-2785

INJURY: _____

DATE OF INJURY: _____

PAYER NAME, ADDRESS, AND PHONE:

RELIAMAX INSURANCE COMPANY

P.O Box 90910

SIOUX FALLS, SD 57109-0910

PHONE: 605-444-4800

FAX: 605-271-1940

POLICY NUMBER: **WC100-0000113-2011A**

POLICY TERM: **8/1/2012**