

**NOTICE OF COMPENSATION PAYMENTS**  
 Michigan Department of Energy, Labor & Economic Growth  
 Workers' Compensation Agency  
 P.O. Box 30016, Lansing, MI 48909

FILING # \_\_\_\_\_

**PART A**

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth	5. Date of Death
6. Employee Street Address			7. City	8. State
10. Employer Name			11. Federal ID Number	12. Injury Location Code <b>N/A</b>
13. Employer Street Address		14. City	15. State	16. ZIP Code
17. Carrier or Self-Insured Name			18. NAIC or Self-Insured Number	
19. Service Company/TPA Name (if applicable)			20. Service Company/TPA ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made

**PART B**

25. Nature of Injury		26. Part of Body	
27. Average Weekly Wage \$ _____	28. Discontinued Fringes \$ _____	29. Second Employer A.W.W. \$ _____	30. Second Employer Discontinued Fringes \$ _____
31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents

**PART C**

35. Reason for Filing	36. Weekly Compensation Base Rate \$ _____		
37. Weekly Adjustments to Base Rate			
_____ \$ _____	_____ \$ _____	_____ \$ _____	_____ \$ _____
_____ \$ _____	_____ \$ _____	_____ \$ _____	_____ \$ _____
38. Weekly Amount Being Reimbursed by a Fund (Not reported on line 37)			
_____ \$ _____	_____ \$ _____	_____ \$ _____	_____ \$ _____

**PART D**

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER # \_\_\_\_\_  
 IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS \_\_\_\_\_ AND EFFECTIVE DATE OF LOSS \_\_\_\_/\_\_\_\_/\_\_\_\_  
 IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC \_\_\_\_\_

***Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.***

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE			
39. Authorized signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date

**NOTICE TO EMPLOYEE:** IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN SPACE 40.

