GENERAL INFORMATION – FORM WC-701

The form WC-701 is used to report to the Agency payment of weekly compensation benefits made to the employee. Attorney fees, rehabilitation costs, medical expenses, etc. should not be reported on the form. Burial expenses must be reported by the employer on form WC-106 or a receipt of payment will be requested.

The filing number should always be #1 the first time the form WC-701 is submitted for a claim, and then increase sequentially for subsequent filings.

It is critical that all subsequent filings contain the **exact** SSN and DOI that were reported on the first filing. If this information was previously reported in error, the correction(s) should be clearly marked on the form.

Friend of the Court payments should not be reported to the Agency.

All Agency orders have a nine digit number written in the upper right hand corner consisting of the mailed date and a three digit sequential number. All forms WC-701 that are filed pursuant to an award (basis of payment anything other than "A") should have the order number included in the space provided below section D.

Redemption amounts should not be reported on a form WC-701. If the redemption involves a claim which is in payment status, the system will automatically terminate the weekly payments assuming that the weekly rate, date of injury and carrier listed on the redemption order match the information reported on the latest form WC-701. If not, a form WC-701 must be filed closing out the weekly payments. A form WC-701 must also be filed if partial benefits are being paid at the time of the redemption.

Lump sum advance payment amounts should not be reported on a form WC-701. If the advance payment order results in a reduction or termination of the weekly rate, a form WC-701 must be filed showing the rate change or termination.

In February of each year, the Agency runs a program which summarizes the payment status of open claims. The Open Claim Validation Report is sent to each carrier or service company listing all claims. This report should be used to verify that all claims on the report are still in payment status and that the Benefit Type, Compensation Rate and effective dates are correct. If not, the appropriate forms WC-701 should be filed. If partial benefits are being paid, the employee worked less than a 5 day work week, or the compensation rate is in error, a form WC-701 must be filed.

Forms WC-701 which are filed to report payment of accrued benefits as a result of an order or agreement which cover multiple benefit periods should have the Report of Accrued Benefits worksheet (or a similar format) attached and include all available information: basis, benefit type, special payment, weekly rate, from and through dates and total amounts paid for each payment period. Interest payments, when applicable, should be reported on a separate line from the accrued benefit period(s) and include the special payment code, through date and total interest payment only.

FILING INSTRUCTIONS FOR FORM WC-701

PART A

This section must be completed when filing the form WC-701. Extreme care should be taken to ensure that all subsequent filings contain the same correct SSN and DOI.

- #1 Social Security Number: 9 digit numeric.
- #2 Date of Injury: Must be complete date (mm/dd/yyyy).
- #3 Employee Name: Employee's last name, first name and middle initial.
- #4 Date of Birth: Must be complete date (mm/dd/yyyy).
- #5 Date of Death: If employee is deceased, enter complete date (mm/dd/yyyy).
- #6-9 Employee Address: Complete mailing address of employee.
- #10 Employer Name: Enter complete business name of employer, d.b.a., etc.
- #11 Federal ID Number: Enter 9 digit Federal ID number used by the employer listed in #10.
- #12 Injury Location Code: This should be left blank. It is an internal three digit location code that is assigned and used by Agency staff only.
- #13-16 Employer Address: Complete address of employer, including number, street, city, state and ZIP Code.
- #17 Carrier or Self-Insured Name: Enter complete name of carrier or self-insured employer. A service company name should not be reported in this field.
- #18 NAIC or Self-Insured Number: Carriers should report their 5 digit NAIC number and 4 digit group code, and self-insureds should report their 8 digit self-insured ID number.
- #19 Self-Insurer's Service Company Name: Enter the name of the service company handling the claim.
- #20 Service Company ID Number: The 3 digit service company ID number assigned by the Agency must be reported if a service company name is listed in #19.
- #21 ZIP Code of Issuing Office: ZIP Code of carrier, self-insurer or service company filing the form. The ZIP Code will be used to identify the mailing address of the appropriate office where correspondence should be sent.
- #22 Carrier or Self-Insured Claim Number: Submitter's claim or file number, if applicable. This number will appear on all system generated correspondence.

- #23 Date Carrier Received Notice of Injury: This information is required on all voluntary payment claims to determine promptness of payment.
- #24 Date First Payment Made: The date the first check was sent out on this claim. This date is required on all voluntary payment claims to determine promptness of payment. If the employer is continuing to pay wages while the compensability issue is being resolved or benefits are being coordinated under a wage continuation plan, the date first payment made should be the same as the from date in Part D.

PART B

This section must be completed when filing the form WC-701.

- #25 Nature of Injury: Provide a brief description of the injury or disease. If desired, the codes from the list of filing codes may be entered in addition to the description.
- #26 Part of Body: Provide a brief description of the part of body affected by the injury or disease. If desired, the codes from the list of filing codes may be entered in addition to the description.
- #27 Average Weekly Wage: Total weekly wages from place of injury, excluding fringes.
- #28 Discontinued Fringes: Weekly fringe benefits that are not continuing during the disability period.
- #29 Second Employer AWW: Total wages from second employer, if applicable.
- #30 Second Employer Discontinued Fringes: Discontinued fringes from second employer, if applicable.
- #31 Tax Filing Status on Date of Injury: Employee's tax filing status at the time of injury using the federal income tax eligibility criteria. The status does not change during the life of the claim.
- #32 Last Day Worked: Last day preceding the current disability period for which the employee received full wages.
- #33 Number of Days in Work Week: Number of days the employee is regularly scheduled to work per week. If the employee works less than a 5 day week, we are unable to calculate the total amount paid. Therefore, if any of these claims are in open payment status at the end of the year, a form WC-701 must be filed reporting the amount of compensation paid during the year. All payments made for dates of injury on and after May 11, 1999 must be calculated on a 7 day work week per Rule 408.31a.
- #34 Number of Dependents: Number of dependents, not including the employee.

PART C

This section must be completed when filing the form WC-701. The information should always pertain to the latest payment period reported on the form.

- #35 Reason for Filing: The appropriate code must be entered on all filings:
 - A Commencing Benefits: Used whenever benefits are commencing and continuing. In Part D, complete the basis of payment, benefit type, special payment (if applicable), weekly rate, and from date.
 - B Change in Weekly Rate: Used whenever there is a change in the current rate and benefits are continuing. In Part D, complete the entire first line (except for the termination reason) in order to close out the old rate, as well as the first half of the second line in order to report the new total weekly rate and from date. If benefits covered more than one calendar year, the from date on the first line should always be January 1 of the current year. When benefits are changing from partial to total, a wage statement showing the calculation of partial payments must also be attached to the form WC-701.
 - C Terminating Benefits: Used whenever benefits that were previously reported are now being terminated. In Part D, complete the entire first line showing the total payments made for the current calendar year only.
 - D Commencing and Terminating Benefits: Used whenever benefits that have never been previously reported are both commencing and terminating. Also used when TOTAL WEEKLY RATE in Part D is reduced to zero after applying adjustments "A" thru "G" (coordination of benefits) for more than 14 consecutive calendar days during the initial disability period see WC-701 example 5b. In Part D, complete the entire first line showing the total payments that were made.
 - E Reimbursement by a Fund: Used whenever the rate is staying the same but reimbursements are now being received from either the Silicosis, Dust Disease and Logging Industry Compensation Fund or the Vocationally Handicapped Provisions of the Second Injury Fund. In Part D, complete the entire first line to close out the rate and payment period (if payments covered multiple calendar years, use January 1 of the current calendar year) for which the carrier is responsible, as well as the first half of the second line in order to give us the new from date for which reimbursement takes effect.
 - F Reopening Claim: Used whenever a claim that had previously been in payment status is now reopening and benefits are continuing. In Part D, complete the basis of payment, benefit type, special payment (if applicable), weekly rate, and from date.
 - G Reopening and Closing Claim: Used whenever benefits are both commencing and terminating on a claim that had previously been in payment status. Also used when TOTAL WEEKLY RATE in Part D is reduced to zero after applying adjustments "A" thru "G" (coordination of benefits) for more than 14 consecutive calendar days during a subsequent disability period see WC-701 example 7b. In Part D, complete the entire first line showing the total payments that were made.

H – Yearly Report of Partial Payments: Used to report the amount of partial benefits that were paid on all claims which are in partial benefit status as of December 31. A wage statement should also be attached. This code should also be used when reporting yearly payments on any claim still in payment status at the end of the year in which the employee worked less than a 5 day work week. In Part D, complete the entire first line (except for the termination reason) in order to report the partial payments that were made during the previous calendar year (show the through date as close to December 31 as possible) as well as the first half of the second line using a from date one day after the through date. A partial payment worksheet must also be attached to the form.

I – Error on Previous Filing: Used whenever information was improperly reported on a previous form WC-701.

- #36 Weekly Compensation Base Rate: The base rate which is owed prior to taking into account any adjustment(s) specified in line 37.
- #37 Weekly Adjustments to Base Rate: This line should always be completed when the base rate in line 36 does not match the "total weekly rate" in Part D. Record the appropriate code(s) and weekly dollar amount(s). If the code is "A" thru "G" (coordination of benefits), the appropriate section in Part E should also be completed on the back of the form. If the code is "J" or "K," the order number must also be entered in the space provided below Part D. If the code is "R," rate reduction due to post injury wage earning capacity (PIWEC), Part F should also be completed on the back of the form.
- Weekly Amount Being Reimbursed by a Fund: Indicate the appropriate code(s) and weekly dollar amount(s) being reimbursed by the Silicosis, Dust Disease and Logging Industry Compensation Fund or the Vocationally Handicapped Provisions of the Second Injury Fund. Do not record any Compensation Supplement Fund payments (adjustment code of "I") or Second Injury differential benefits (adjustment code of "L"). These amounts should be reported in #37. Also, do not report any reimbursements received as a result of the 70% or Dual Employment provisions. This information will be provided to us by the Second Injury Fund.

PART D

This section must be completed as follows when filing the form WC-701 on a claim.

BASIS OF PAYMENT:

Indicate the appropriate code from the list of WC-701 Filing Codes. When a claim is being paid pursuant to any type of order, including a voluntary payment form (WC-115), include the order number in the space provided below Part D.

BENEFIT TYPE:

Indicate the appropriate code from the list of WC-701 Filing Codes. This information is always necessary unless a Special Payment type code is present. Also, the first filing reporting a specific loss benefit type "C" should include a copy of the amputation chart signed by the physician or affidavit of vision loss, whichever applies. The number of loss weeks and effective date of loss should be completed below Part D.

When the benefit type is "D" (permanent total), there must be an adjustment code of "L" (SIF differential benefits) and an amount reported in #37.

When the benefit type is "W" (rate with post injury wage earning capacity), there must be an adjustment code of "R" and an amount reported in #37.

SPECIAL PAYMENT:

This code is only necessary when the payment period is pursuant to an award. When interest is being reported, the through date should reflect the date that the accrued benefits were paid.

TOTAL WEEKLY RATE:

This should reflect the amount the employee actually receives per week and should equal the base rate in line 36 plus or minus any adjustments reported in line 37.

The weekly rate should be left blank when the benefit type is "B" (partial wage loss).

FROM DATE:

The effective date for the payment period. Do not include the waiting week for the initial disability period unless benefits were paid for those dates. If benefits covered more than one calendar year, the from date should be January 1 of the current year. This field may be left blank when special payment code is "B" (interest).

THROUGH DATE:

The ending date (current calendar year only) of the rate/benefit type or the payment termination date, whichever applies. If a special payment code of "B" (interest) is being reported, the through date should reflect the date accrued benefits were paid.

TOTAL AMOUNT PAID:

Indicate the total amount paid to the employee for the payment period. This field is required whenever a through date is present. If an overpayment was made but not recouped, the amount actually paid to the employee should be reflected. If partial benefits are being terminated, the total amount paid must be entered in Part D.

YEAR PAID:

Indicate the year the total amount was paid for the payment period reported on the form.

TERMINATION REASON:

When the reason for filing is "C," "D," or "G," (all terminating benefits), the termination reason code is required. Whenever partial benefits are being terminated, a partial payment worksheet must be attached. If the termination reason is "E" (claimant deceased), a death certificate must be attached.

BELOW PART D

ORDER #:

If payments are being made pursuant to an award or voluntary payment form (WC-115), provide the 9 digit order number that is located in the upper right hand corner of all orders mailed out by the Agency.

SPECIFIC LOSS:

If the benefit type code is "C" (specific loss), enter the exact number of specific loss weeks as well as the effective date of the loss. An amputation chart (WC-728) or vision affidavit, whichever is applicable, should also be attached.

OTHER FILING CODES:

If any of the codes used on the form refer to "Other," the exact reason must be listed here.

- #39 Authorized Signature: The signature of an individual authorized to file this form.
- #40 Person Handling Claim: Print the name of the individual who is handling the claim.
- Telephone Number: Enter the telephone number, including extension, of the individual listed in #40 who is handling the claim.
- #42 Date: Enter the date the form was prepared.

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING #

PARIA										
	curity Number	2. Date	e of Injury	3. Employee Name (Last	, First, MI)	4. Date	of Birth	5. Date	5. Date of Death	
6. Employee	Street Address				7. City	8. State	•	9. ZIP (Code	
10. Employe	r Name					11. Fed	eral ID Number	12. Inju	iry Location Code	
									N/A	
13. Employe	r Street Address				14. City	15. Stat	e	16. ZIP	Code	
17. Carrier o	r Self-Insured Na	me			<u> </u>	18. NAI	C or Self-Insured	Number		
19. Self-Insu	ırer's Service Con	npany Name				20. Ser	vice Company ID	Number		
21. ZIP Code	e of Issuing Office	22. Car	rrier or Self-Insure	ed Claim Number	23. Date Carrier Received Noti	ce of Injury	24. Date	e First Paymer	nt Made	
PART B		<u>"</u>			l		<u> </u>			
25. Nature of	f Injury				26. Part of Body					
27. Average	Weekly Wage		28. Discontinu	ued Fringes	29. Second Employer A.W.W	<i>I</i> .	30. Second Emp	oloyer Disconti	nued Fringes	
\$ \$					\$		\$			
31. Tax Filing	g Status on Date	of Injury	32. Last Day	Worked	33. Number of Days in Work	Dependents				
PART C										
35. Reason f	for Filing				36. Weekly Compensation Ba	ase Rate				
					\$					
37. Weekly A	Adjustments to Ba									
					\$		\$			
			ınd (Not reported							
	.\$		\$_		\$		\$_			
PART D										
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	,	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON	
IF BASIS C	DF PAYMENT	IS OTHER	THAN "A" (VO	LUNTARY PAYMEN	T) OR LINE 37 IS EQUA	L TO "J" OR	"K," ENTER	ORDER#		
			-		EKS AND EFF					
					ASE BE SPECIFIC					
	Maki	ng a false o			purpose of obtaining on, or both, and denial			n result in		
		THIS IS TO C	ERTIFY THA	T A COPY OF THIS FO	RM HAS BEEN MAILED C	R GIVEN TO	THE EMPLO	YEE		
39. Authorize	ed signature			40. Person Handling Claim	(Please print)	41. Telephon	ne Number	42.	Date	
						1				

PART E - COORDINATION OF BENEFITS

	PENSION	WAGE CONTINUATION	DISABILITY INSURANCE	SELF INSURANCE	OTHER			
A. WEEKLY BENEFIT AMOUNT								
3. 80% AFTER-TAX AMOUNT OF (A)								
	x 1.25	x 1.25	x 1.25	x 1.25	x 1.25			
C. 100% AFTER-TAX AMOUNT								
D. FICA TAX ¹								
E. STATE INCOME TAX ¹								
F. % EMPLOYER CONTRIBUTION								
G. INCOME TO BE COORDINATED ²								
¹ Does not apply in all cases. If applicable, include the year of injury. ² Line G = (Line C + D + E) x Line F. (This figure shape)	nould appear in Part C	Line 37, with the appropriate adju	ustment code)					
SOCIAL SECURITY This section a A. MONTHLY SOCIAL SECURITY OLD AGE RE			INIY. (Enter net benef	it with code "B" in Part C, Lin	ie 37)			
B. WEEKLY SOCIAL SECURITY OLD AGE RET								
C. 50% OF LINE B								
D. 50% OF BASE RATE (Found in Box 36)								
E. IS DATE OF INJURY ON OR AFTER 12/19/1:	_ □YES [□NO						
IF NO – COORDINATE AMOUNT IN LINE C								
IF YES – WERE SOCIAL SECURITY OLD AG	E RETIREMENT BEN	EFITS BEING PAID ON THE DA	TE OF INJURY?	_ □YES [□NO			
IF NO – COORDINATE AMOUNT IN LIN								
IF YES – COORDINATE THE LOWEST	AMOUNT FOUND IN I	LINE C OR D						
UNEMPLOYMENT COMPENSATION	ON			T				
A. NUMBER OF WEEKS AWARDED								
B. BEGINNING DATE OF UNEMPLOYMENT CO	OMPENSATION							
D. TOTAL WEEKLY UNEMPLOYMENT COMPE	NSATION BENEFITS	(Enter with code "D" in Part C, Lin	e 37)					
C. SCHEDULED EXPIRATION DATE	NSATION BENEFITS	<u>, </u>	·	CAPACITY (PIWI	EC)			
A. AVERAGE WEEKLY WAGE (On front, Line 27	7)							
B. 80% AFTER-TAX AMOUNT OF LINE A (See	calc program or rate ch	narts)						
C. 100% AFTER-TAX AMOUNT (Line B multiplie	d by 1.25)							
D. GROSS WEEKLY POST INJURY WAGE EAR	NING CAPACITY (PIV	VEC) AMOUNT						
E. DIFFERENCE BETWEEN 100% AFTER-TAX If the calculation in line E is less than or equal								
F. 80% of Line E (Line E multiplied by .8) ³								
G. AMOUNT OF ADJUSTMENT FOR PIWEC (B This figure should appear on front, Part C, Lin- If the adjustment calculation shows an amount	e 37, with appropriate	adjustment code R.	pplied.					
³ For injury dates on or after 12/19/11, the weekly b				ı				

LARA is an equal opportunity employer/program. Auxiliary aids, services and	Authority:	Workers' Disability Compensation Act, R408.31(6a-d)
other reasonable accommodations are available upon request to individuals	Completion:	Mandatory
with disabilities.	Penalty:	Workers' Disability Compensation Act, 418.631; 418.801

WC-701 FILING CODES

LINE 31 - TAX FILING STATUS

- A. Single
- B. Single/Head of Household
- C. Married/Filing Joint
- D. Married/Filing Separate

LINE 35 - REASON FOR FILING

- A. Commencing Benefits F. Reopening Claim
- B. Change in Weekly Rate
 C. Terminating Benefits
 G. Reopening and Closing Claim
 H. Yearly Report of Partial Payments
- D. Commencing and Terminating Benefits I. Error on Previous Filing
- E. Reimbursement by a Fund

LINE 37 - WEEKLY ADJUSTMENTS TO BASE RATE

- A. Wage Continuation Offset (-)

 B. Social Security Coordination (-)

 C. Pension Offset (-)

 D. Unemployment Offset (-)

 E. Disability Insurance Offset (-)

 J. Advance Payment (-)

 K. 30% Appeal Adjustment (-)

 L. SIF Differential Benefits (+)

 M. Double Compensation (+)

 N. Third Party Offset (-)
- F. Self Insurance Offset (-)
 G. Other Benefit Coordination (-)
 O. 2 Years Continuous Disability (+)
 P. Recoupment of Overpayment (-)
- H. Age 65 Reduction (-) Q. Other
- I. Compensation Supplement (+) R. Post Injury Wage Earning Capacity (PIWEC) (-)

LINE 38 - REIMBURSEMENT BY A FUND*

- A. Silicosis, Dust Disease & Logging Industry Compensation Fund
- B. Self-Insurers' Security Fund
- C. SIF/Vocationally Handicapped Provisions
- D. Other

*Do not report reimbursements received as a result of the 70% or dual employment provisions. This information will be provided to the agency by the Second Injury Fund.

PART D - BASIS OF PAYMENT

- A. Voluntary Payment D. Stipulated Award B. Open Award E. Compromise
- C. Closed Award F. Form 115 Voluntary Pay

PART D – BENEFIT TYPE

- A. General Disability E. Death B. Partial Wage Loss F. Other
- C. Specific Loss W. Rate with Post Injury Wage Earning Capacity (PIWEC)
- D. Permanent Total

PART D - SPECIAL PAYMENT

- A. Accrued Benefits C. 30% Appeal Adjustment
- B. Interest D. Other

PART D - TERMINATION REASON

- A. Returned to Work With No Wage Loss E. Claimant Deceased (attach death certificate)
- B. Recovered from Disability F. Closing Out Weekly Due to Redemption
- C. Award Reversed G. Closing Out Weekly Due to Advance Payment
 - End of Specific Loss H. Other

REPORT OF ACCRUED BENEFITS

SS#	DOI	Employee Name	
Order #	Basis Payment Code	Year Paid	

Benefit Type	Special Payment	Adjusted Rate	From	Through	Total	Variable Rate Factors
						DepsBase Amt \$ Adjustment Code \$ Adjustment Code \$
						DepsBase Amt \$ Adjustment Code \$ Adjustment Code \$
						DepsBase Amt \$ Adjustment Code \$ Adjustment Code \$
						DepsBase Amt \$ Adjustment Code \$ Adjustment Code \$
						DepsBase Amt \$ Adjustment Code \$ Adjustment Code \$
						DepsBase Amt \$ Adjustment Code \$ Adjustment Code \$
						DepsBase Amt \$ Adjustment Code \$ Adjustment Code \$
						DepsBase Amt \$ Adjustment Code \$ Adjustment Code \$

Basis of Payment Benefit Type Special Payment

A = Voluntary Payment A = General Disability A = Accrued Benefits
B = Open Award B = Partial Wage Loss B = Interest

C = Closed Award C = Specific Loss C = 30% Appeal Adjustment

D = Stipulated Award D = Permanent Total D = Other

W= Rate with Post Injury Wage Earning Capacity (PIWEC)

Weekly Adjustments to Base Rate

Wage Continuation Offset Advance Payment J = Social Security Coordination 30% Appeal Adjustment B = K = C = Pension Offset L = SIF Differential Benefits D = Unemployment Offset M= **Double Compensation** E = Disability Insurance Offset N = Third-Party Offset

F = Self-Insurance Offset O = 2-Years Continuous Disability
G = Other Benefit Coordination P = Recoupment of Overpayment Q

H = Age 65 Reduction Q = Other

I = Compensation Supplement R = Post Injury Wage Earning Capacity (PIWEC)

NATURE OF INJURY CODES

Code	Description	Code	Description
300	Abrasions	540	Depression
183	Abscess	200	Electric shock, electrocution
281	Aluminosis - aluminum exposure	274	Emphysema
100	Amputation or enucleation (loss of an eye)	240	Environmental heat (does not include sunburn)
272	Anemia	260	Epicondylitis
282	Anthracosis - coal dust	995	Epilepsy
152	Anthrax	184	Erythema, toxic
540	Anxiety	530	Eye diseases
283	Asbestosis - asbestos fibers	210	Fracture
110	Asphyxia	220	Freezing (includes frostbite)
572	Asthma	260	Ganglion cyst
274	Asthma, toxic (systemic poisoning)	276	Gastro-enteritis
552	Benign and unspecified tumor	276	Gastro-intestinal diseases
590	Bites, human and non-toxic animal	273	Hay fever, toxic (systemic poisoning)
300	Blisters	230	Hearing loss or impairment
272	Blood diseases (includes purpura)	991	Heart attack
183	Boils	991	Heart conditions
572	Bronchitis	240	Heatstroke
274	Bronchitis, toxic (systemic poisoning)	320	Hemorrhoids (circulatory system)
153	Brucellosis	330	Hepatitis (serum & infective)
160	Bruise	250	Hernia, rupture
130	Burn (chemical)	190	Herniated disc
120	Burn or scald (heat)	159	Herpes
260	Bursitis	991	Hypertension
284	Byssinosis - cotton dust	150	Infective or parasitic disease, unspecified
551	Cancer	572	Influenza
183	Carbuncles	274	Influenza, toxic (systemic poisoning)
562	Carpal tunnel	294	Ionizing radiation - Isotopes
310	Cartilage, torn	293	Ionizing radiation - X-Ray
183	Cellulitis	530	Iritis
561	Central nervous system	260	Joints, inflammation or irritation
561	Cerebral palsy	170	Laceration
	Cerebrovascular & other circulatory		
510	conditions	551	Leukemia
159	Chicken pox	184	Lichen
276	Colitis	530	Loss of vision
520	Complications peculiar to medical care (toxic or non-toxic)	551	Malignant tumor
140	Concussion (brain, cerebral)	159	Measles
154	Conjunctivitis (non-toxic)	540	Mental disorders
530	Conjunctivitis, chemical	292	Microwave, radiation effects
160	Contusion	561	Migraine
083	COVID-19	995	Miscarriage
160	Crush	400	Multiple injuries
170	Cut	159	Mumps
950	Damage to prosthetic devices (includes eyeglasses, false teeth, etc.)	260	Muscles, inflammation or irritation

NATURE OF INJURY CODES

Code	Description	Code	Description
562	Nerves and peripheral ganglia (includes Bell's Palsy)	560	Nervous system, conditions of, unspecified
540	Derangement, internal	540	Neurosis
185	Dermatitis, allergenic or contact	900	No injury or illness
180	Dermatitis, unspecified	999	Nonclassifiable
190	Dislocation & dislocated disc	990	Occupational disease (not elsewhere classified)
110	Drowning	159	Other infective diseases
151	Dysentery, amebiasis	995	Other injury, not elsewhere classified
500	Effects of changes in atmospheric pressure (equilibrium)	273	Sinusitis, toxic (systemic poisoning)
287	Other pneumoconiosis and related diseases	189	Skin conditions, unspecified
184	Other skin conditions	170	Sliver
279	Other toxic effects on one system only	273	Smoke inhalation
190	Pinched nerve (back only)	310	Sprains
310	Pinched nerve (other than back)	310	Strains
280	Pneumoconiosis & related diseases, unspecified	110	Strangulation
289	Pneumoconiosis with tuberculosis	540	Stress
572	Pneumonia	510	Stroke
274	Pneumonia, toxic (systemic poisoning)	110	Suffocation
274	Pneumonitis	291	Sunburn, etc. (non-ionizing radiation)
280	Pneumothorax	240	Sunstroke
270	Poisoning, systemic, unspecified	580	Symptoms & ill-defined conditions (e.g., fainting)
271	Poisoning, toxic material	260	Tendinitis
183	Primary Infections of the skin	260	Tendons, inflammation or irritation
184	Pruritus	260	Tenosynovitis, stenosing
170	Puncture	156	Tetanus
290	Radiation effects, unspecified	275	Toxic hepatitis
570	Respiratory System, conditions of, unspecified	157	Tuberculosis
581	Rhinitis	550	Tumor, neoplasm, unspecified
273	Rhinitis, toxic (systemic poisoning)	571	Upper respiratory
310	Rotator cuff tear	510	Varicose veins
300	Scratches	295	Welder's flash (eyes only)
285	Siderosis - metallic dust	310	Whiplash
286	Silicosis – silica dust		
* Whe	en two codes are listed, the first represents na	ature of inju	ry and the second is part of body

PART OF BODY CODES

Abdomen (include internal organs); Hernia, inguinal 520 Ankle 310 Arm(s), above wrist, unspecified 318 Arm, not elsewhere classified 319 Arm, not elsewhere classified 310 Arteries; Blood; Circulatory system; Heart; Veins 420 Back (include back muscles); Coccyx; Lumbar; Sacrum; Spinal cord; Spine 311 Biceps; Humerus; Triceps; Upper arm 820 Bladder; Excretory system; Intestines; Kidneys 800 Body system, unspecified 830 Bones; Joints; Muscles; Musculo-skeletal system; Tendons 110 Brain; Concussion 430 Berastbone; Chest (internal organs); Pectorals; Ribs; Sternum; Thorax 440 Buttocks; Hips; Pelvic organs; Pelvis 200 Cervical; Neck 141 Cheek; Chin; Jaw; Mandible 450 Clavicle; Deltoid; Scapula; Shoulder(s) 810 Digestive system 121 Ear(s), internal 122 Ear(s), internal 123 Elfow; Olecranon 134 Face, multiple parts 149 Face, not elsewhere classified; Forehead 140 Face, unspecified 151 Fibula; Lower leg; Tibia 150 Fibula; Lower leg; Tibia 150 Fibula; Lower leg; Tibia	Code	Description	Code	Description
South Sout	410	Abdomen (include internal organs); Hernia,	350	Finantin(s)
310 Arm(s), above wrist, unspecified 318 Arm, multiple 319 Arm, not elsewhere classified 310 Arteries; Blood; Circulatory system; Heart; Veins 311 Arm, include back muscles); Coccyx; Lumbar; Sacrum; Spinal cord; Spine 311 Biceps; Humerus; Triceps; Upper arm 312 Bladder; Excretory system; Intestines; Kidneys 313 Bones, Joints; Muscles; Musculo-skeletal system; Tendons 314 Brain; Concussion 315 Forearm; Radius; Ulna 317 Hand & Finger(s) 318 Hand (not wrist or fingers); Metacarpal 319 Head, multiple 310 Head, unspecified 311 Head, unspecified 312 Leg(s) (above ankle), unspecified 313 Leg(s) (above ankle), unspecified 314 Lips; Mouth (includes sense of taste, excludes teeth); Throat; Tongue 315 Forearm; Radius; Ulna 317 Hand & Finger(s) 318 Hand (not wrist or fingers); Metacarpal 310 Leg(s) (above ankle), unspecified 311 Leg(s) (above ankle), unspecified 312 Leg(s) (above ankle), unspecified 313 Leg(s) (above ankle), unspecified 314 Lips; Mouth (includes sense of taste, excludes teeth); Throat; Tongue 319 Leg(s) (above ankle), unspecified 310 Leg	410		330	i ingerup(s)
318 Arm, multiple 397 Hand & Finger(s) 330 Hand (not wrist or fingers); Metacarpal Arm, not elsewhere classified Arteries; Blood; Circulatory system; Heart; Veins 198 Head, multiple 198 He				
319 Arm, not elsewhere classified Arteries; Blood; Circulatory system; Heart; Veins 420 Back (include back muscles); Coccyx; Lumbar; Sacrum; Spinal cord; Spine 311 Biceps; Humerus; Triceps; Upper arm Bladder; Excretory system; Intestines; Kidneys 800 Body system, unspecified 830 Brones; Joints; Muscles; Musculo-skeletal system; Tendons 110 Brain; Concussion 430 Breastbone; Chest (internal organs); Pectorals; Ribs; Sternum; Thorax 440 Buttocks; Hips; Pelvic organs; Pelvis 200 Cervical; Neck 141 Cheek; Chin; Jaw; Mandible 450 Clavicle; Deltoid; Scapula; Shoulder(s) 810 Digestive system 121 Ear(s), external 122 Ear(s), internal 123 Elow; Olecranon 144 Elibow; Olecranon 145 Face, multiple parts 146 Scalp 150 Leg(s) (above ankle), unspecified 151 Leg, multiple 151 Leg, soleve ankle), unspecified 151 Leg, multiple 152 Leg(s) (above ankle), unspecified 153 Knee; Patella 154 Leg(s) (above ankle), unspecified 151 Leg(s) (above ankle), unspecified 151 Leg(s) (above ankle), unspecified 152 Leg(s) (above ankle), unspecified 153 Knee; Patella 165 Leg(s) (above ankle), unspecified 165 Leg(s) (above		Arm(s), above wrist, unspecified	315	Forearm; Radius; Ulna
Arteries; Blood; Circulatory system; Heart; Veins Back (include back muscles); Coccyx; Lumbar; Sacrum; Spinal cord; Spine 311 Biceps; Humerus; Triceps; Upper arm Bladder; Excretory system; Intestines; Kidneys Bones; Joints; Muscles; Musculo-skeletal system; Tendons Brain; Concussion Braastbone; Chest (internal organs); Pectorals; Ribs; Sternum; Thorax 440 Buttocks; Hips; Pelvic organs; Pelvis 200 Cervical; Neck 141 Cheek; Chin; Jaw; Mandible 450 Clavicle; Deltoid; Scapula; Shoulder(s) 810 Digestive system 121 Ear(s), external 122 Ear(s), inspecified 313 Elbow; Olecranon 840 Epilepsy; Nervous system 149 Face, unspecified 140 Face, unspecified 141 Femur; Thigh 151 Head, multiple 160 Head, unspecified 160 Leg(s) (above ankle), unspecified 161 Leg(s) (above ankle), unspecified 161 Leg(s) (above ankle), unspecified 162 Leg, multiple 161 Leg(s) (above ankle), unspecified 162 Leg, multiple 163 Leg, multiple 164 Lips; Mouth (includes sense of taste, excludes teeth); Throat; Tongue 164 Lips; Mouth (includes sense of taste, excludes teeth); Throat; Tongue 165 Lower extremities, multiple 165 Sealp 160 Skull	318	,	397	
Veins Back (include back muscles); Coccyx; Lumbar; Sacrum; Spinal cord; Spine Biceps; Humerus; Triceps; Upper arm Biadder; Excretory system; Intestines; Kidneys Body system, unspecified Bones; Joints; Muscles; Musculo-skeletal system; Tendons Brain; Concussion Brain; Concussion Brain; Concussion Brain; Concussion Brain; Concussion Brain; Concussion Buttocks; Hips; Pelvic organs; Pelvis Cervical; Neck Cheek; Chin; Jaw; Mandible Clavicle; Deltoid; Scapula; Shoulder(s) Bit Ear(s), external 121 Ear(s), external 122 Ear(s), internal 123 Ejbow; Olecranon Brain; Concussion Brain; Concussion 144 Lips; Mouth (includes sense of taste, excludes teeth); Throat; Tongue 519 Leg, not elsewhere classified Lips; Mouth (includes sense of taste, excludes teeth); Throat; Tongue 520 Lower extremities, multiple 530 Lower extremities, unspecified 850 Lungs; Respiratory system Multiple parts (use when more than one major body part has been affected) Nasal passages; Nose (includes sense of smell); Sinus Nonclassifiable (insufficient information to identify affected part) 120 Ear(s), unspecified 131 Elbow; Olecranon 141 Teeth 150 Scalp 150 Scalp 160 Skull 170 Teeth 170 Teeth 180 Other body systems 150 Scalp 1	319	,	330	Hand (not wrist or fingers); Metacarpal
Lumbar; Sacrum; Spinal cord; Spine 311 Biceps; Humerus; Triceps; Upper arm 820 Bladder; Excretory system; Intestines; Kidneys 800 Body system, unspecified 830 Bones; Joints; Muscles; Musculo-skeletal system; Tendons 110 Brain; Concussion 430 Breastbone; Chest (internal organs); Pectorals; Ribs; Sternum; Thorax 440 Buttocks; Hips; Pelvic organs; Pelvis 200 Cervical; Neck 141 Cheek; Chin; Jaw; Mandible 450 Clavicle; Deltoid; Scapula; Shoulder(s) 810 Digestive system 121 Ear(s), external 122 Ear(s), internal 123 Ear(s), unspecified 840 Epilepsy; Nervous system 141 Face, not elsewhere classified 511 Leg(s) (above ankle), unspecified 518 Leg, multiple 519 Leg, not elsewhere classified 519 Lower extremities, multiple 520 Lower extremities, unspecified 530 Lungs; Respiratory system 640 Multiple parts (use when more than one major body part has been affected) 700 Multiple parts (use when more than one major body part has been affected) 146 Masal passages; Nose (includes sense of smell); Sinus 150 Scalp 160 Skull 147 Teeth 150 Scalp 160 Skull 147 Teeth 150 Scyelid; Optic nerves; Vision 151 Face, not elsewhere classified; Forehead 140 Face, not elsewhere classified; Forehead 151 Femur; Thigh 150 Leg(s) (above ankle), unspecified 511 Leg(s) (above ankle), unspecified 5110 Leg(s) (above ankle), unspecified 5110 Leg(s) (above ankle), unspecified 5110 Leg(s) (above ankle), unspecified 512 Leg, multiple 518 Leg, multiple 519 Leg, not elsewhere classified 510 Leg(s) (above ankle), unspecified 510 Leg(s) (above ankle), unspecified 5110 Leg(s) (above ankle), unspecified 512 Leg, multiple 512 Leg, multiple 513 Knee; Patella 510 Leg(s) (above ankle), unspecified	801	Veins	198	Head, multiple
Bladder; Excretory system; Intestines; Kidneys		Lumbar; Sacrum; Spinal cord; Spine	100	•
S20 Kidneys Kidneys S10 Leg(s) (above ankle), unspecified S18 Leg, multiple S19 Leg, not elsewhere classified S18 Leg, multiple S19 Leg, not elsewhere classified S18 Leg, multiple Leg, not elsewhere classified S19 Leg, not elsewhere classified S18 Leg, multiple Leg, not elsewhere classified Lips; Mouth (includes sense of taste, excludes teeth); Throat; Tongue Lower extremities, multiple S18 Leg, multiple Leg, not elsewhere classified Leg, multiple S19 Lower extremities, multiple S18 Leg, multiple S19 Lower extremities, multiple S19 Lower extremities, multiple S19 Lower extremities, multiple S19 Lower extremities, unspecified S19	311		513	Knee; Patella
Bones; Joints; Muscles; Musculo-skeletal system; Tendons	820		510	Leg(s) (above ankle), unspecified
System; Tendons Signature	800	Body system, unspecified	518	Leg, multiple
110 Brain; Concussion 120 Breastbone; Chest (internal organs); Pectorals; Ribs; Sternum; Thorax 120 Cervical; Neck 121 Cheek; Chin; Jaw; Mandible 122 Ear(s), external 124 Ear(s), internal 120 Ear(s), unspecified 120 Ear(s), unspecified 120 Ear(s), unspecified 121 Eye(s); Eyelid; Optic nerves; Vision 122 Face, not elsewhere classified; Forehead 124 Face, unspecified 125 Fibula; Lower leg; Tibia 126 Breastbone; Chest (internal organs); Petvis 127 Extremities, multiple 128 Lower extremities, unspecified 129 Lower extremities, unspecified 120 Lower extremities, unspecified	830		519	Leg, not elsewhere classified
440 Buttocks; Hips; Pelvic organs; Pelvis 200 Cervical; Neck 141 Cheek; Chin; Jaw; Mandible 450 Clavicle; Deltoid; Scapula; Shoulder(s) 810 Digestive system 121 Ear(s), external 124 Ear(s), internal 120 Ear(s), unspecified 313 Elbow; Olecranon 840 Epilepsy; Nervous system 130 Eye(s); Eyelid; Optic nerves; Vision 148 Face, multiple parts 149 Face, not elsewhere classified; Forehead 140 Face, unspecified 310 Digestive system 311 Ewitter and the state of th	110	Brain; Concussion	144	
200 Cervical; Neck 141 Cheek; Chin; Jaw; Mandible 450 Clavicle; Deltoid; Scapula; Shoulder(s) 810 Digestive system 121 Ear(s), external 122 Ear(s), internal 120 Ear(s), unspecified 313 Elbow; Olecranon 840 Epilepsy; Nervous system 140 Ear(s), Eyelid; Optic nerves; Vision 141 Teeth 142 Face, multiple parts 144 Face, multiple parts 145 Trunk, multiple 149 Face, not elsewhere classified; Forehead 140 Face, unspecified 151 Femur; Thigh 151 Fibula; Lower leg; Tibia 850 Lungs; Respiratory system 700 Multiple parts (use when more than one major body part has been affected) 146 Nasal passages; Nose (includes sense of smell); Sinus 999 Nonclassifiable (insufficient information to identify affected part) 880 Other body systems 150 Scalp 160 Skull 147 Teeth 147 Teeth 148 Face, multiple parts 149 Trunk, multiple 149 Face, not elsewhere classified; Forehead 140 Face, unspecified 398 Upper extremities, multiple 300 Upper extremities, unspecified 320 Wrist	430		598	Lower extremities, multiple
141 Cheek; Chin; Jaw; Mandible 450 Clavicle; Deltoid; Scapula; Shoulder(s) 810 Digestive system 810 Ear(s), external 124 Ear(s), internal 120 Ear(s), unspecified 313 Elbow; Olecranon 840 Epilepsy; Nervous system 130 Eye(s); Eyelid; Optic nerves; Vision 148 Face, multiple parts 149 Face, not elsewhere classified; Forehead 140 Face, unspecified 511 Femur; Thigh 515 Fibula; Lower leg; Tibia 700 Multiple parts (use when more than one major body part has been affected) 146 Nasal passages; Nose (includes sense of smell); Sinus 999 Nonclassifiable (insufficient information to identify affected part) 880 Other body systems 150 Scalp 160 Skull 147 Teeth 540 Toe(s) 550 Toetip(s) 498 Trunk, multiple 400 Trunk, unspecified 398 Upper extremities, multiple 300 Upper extremities, unspecified 320 Wrist	440	Buttocks; Hips; Pelvic organs; Pelvis	500	Lower extremities, unspecified
The Cheek; Chin; Jaw; Mandible 450 Clavicle; Deltoid; Scapula; Shoulder(s) 810 Digestive system 121 Ear(s), external 122 Ear(s), internal 120 Ear(s), unspecified 313 Elbow; Olecranon 840 Epilepsy; Nervous system 130 Eye(s); Eyelid; Optic nerves; Vision 148 Face, multiple parts 140 Face, unspecified 140 Face, unspecified 151 Femur; Thigh 151 Fibula; Lower leg; Tibia 700 major body part has been affected) 146 Nasal passages; Nose (includes sense of smell); Sinus 999 Nonclassifiable (insufficient information to identify affected part) 880 Other body systems 150 Scalp 160 Skull 177 Teeth 187 Toe(s) 188 Trunk, multiple 188 Trunk, multiple 188 Trunk, unspecified 398 Upper extremities, multiple 300 Upper extremities, unspecified 320 Wrist	200	Cervical; Neck	850	
450 Clavicle; Deitold; Scapula; Snoulder(s) 810 Digestive system 121 Ear(s), external 122 Ear(s), internal 120 Ear(s), unspecified 313 Elbow; Olecranon 840 Epilepsy; Nervous system 130 Eye(s); Eyelid; Optic nerves; Vision 148 Face, multiple parts 149 Face, not elsewhere classified; Forehead 140 Face, unspecified 511 Femur; Thigh 515 Fibula; Lower leg; Tibia 140 Samell); Sinus 999 Nonclassifiable (insufficient information to identify affected part) 880 Other body systems 150 Scalp 160 Skull 177 Teeth 187 Toe(s) 188 Trunk, multiple 188 Trunk, unspecified 189 Trunk, unspecified 189 Trunk, unspecified 189 Trunk, unspecified 180 Skull 199 Toe(s) 199 Nonclassifiable (insufficient information to identify affected part)	141	Cheek; Chin; Jaw; Mandible	700	
121 Ear(s), external 880 Other body systems 124 Ear(s), internal 150 Scalp 160 Skull 160 Skull 170 Ear(s), unspecified 160 Skull 170 Ear(s), unspecified 170 Ear(s), unspecified 180 Epilepsy; Nervous system 180 Epilepsy; Nervous system 180 Eye(s); Eyelid; Optic nerves; Vision 180	450	Clavicle; Deltoid; Scapula; Shoulder(s)	146	
124Ear(s), internal150Scalp120Ear(s), unspecified160Skull313Elbow; Olecranon147Teeth840Epilepsy; Nervous system540Toe(s)130Eye(s); Eyelid; Optic nerves; Vision550Toetip(s)148Face, multiple parts498Trunk, multiple149Face, not elsewhere classified; Forehead400Trunk, unspecified140Face, unspecified398Upper extremities, multiple511Femur; Thigh300Upper extremities, unspecified515Fibula; Lower leg; Tibia320Wrist	810	Digestive system	999	
120 Ear(s), unspecified 313 Elbow; Olecranon 840 Epilepsy; Nervous system 130 Eye(s); Eyelid; Optic nerves; Vision 148 Face, multiple parts 149 Face, not elsewhere classified; Forehead 140 Face, unspecified 511 Femur; Thigh 515 Fibula; Lower leg; Tibia 160 Skull 147 Teeth 540 Toe(s) 550 Toetip(s) 498 Trunk, multiple 400 Trunk, unspecified 398 Upper extremities, multiple 300 Upper extremities, unspecified 320 Wrist	121	Ear(s), external	880	Other body systems
313 Elbow; Olecranon 840 Epilepsy; Nervous system 130 Eye(s); Eyelid; Optic nerves; Vision 148 Face, multiple parts 149 Face, not elsewhere classified; Forehead 140 Face, unspecified 511 Femur; Thigh 515 Fibula; Lower leg; Tibia 147 Teeth 540 Toe(s) 550 Toetip(s) 498 Trunk, multiple 400 Trunk, unspecified 398 Upper extremities, multiple 300 Upper extremities, unspecified 320 Wrist	124	Ear(s), internal	150	Scalp
840 Epilepsy; Nervous system 130 Eye(s); Eyelid; Optic nerves; Vision 148 Face, multiple parts 149 Face, not elsewhere classified; Forehead 140 Face, unspecified 511 Femur; Thigh 515 Fibula; Lower leg; Tibia 540 Toe(s) 550 Toetip(s) 498 Trunk, multiple 400 Trunk, unspecified 398 Upper extremities, multiple 300 Upper extremities, unspecified 320 Wrist	120	Ear(s), unspecified	160	Skull
130 Eye(s); Eyelid; Optic nerves; Vision 148 Face, multiple parts 149 Face, not elsewhere classified; Forehead 140 Face, unspecified 511 Femur; Thigh 515 Fibula; Lower leg; Tibia 550 Toetip(s) 498 Trunk, multiple 400 Trunk, unspecified 398 Upper extremities, multiple 300 Upper extremities, unspecified 320 Wrist	313	Elbow; Olecranon	147	Teeth
148Face, multiple parts498Trunk, multiple149Face, not elsewhere classified; Forehead400Trunk, unspecified140Face, unspecified398Upper extremities, multiple511Femur; Thigh300Upper extremities, unspecified515Fibula; Lower leg; Tibia320Wrist	840	Epilepsy; Nervous system	540	Toe(s)
149Face, not elsewhere classified; Forehead400Trunk, unspecified140Face, unspecified398Upper extremities, multiple511Femur; Thigh300Upper extremities, unspecified515Fibula; Lower leg; Tibia320Wrist	130	Eye(s); Eyelid; Optic nerves; Vision	550	Toetip(s)
140Face, unspecified398Upper extremities, multiple511Femur; Thigh300Upper extremities, unspecified515Fibula; Lower leg; Tibia320Wrist	148		498	Trunk, multiple
511 Femur; Thigh 515 Fibula; Lower leg; Tibia 300 Upper extremities, unspecified 320 Wrist	149	Face, not elsewhere classified; Forehead	400	Trunk, unspecified
515 Fibula; Lower leg; Tibia 320 Wrist		Face, unspecified		Upper extremities, multiple
340 Finger(s)			320	Wrist
	340	Finger(s)		

List of Form WC-701 Examples

EXAMPLE#	FILING REASON	DESCRIPTION
1	А	Commencing benefits (no adjustments to base rate)
2	А	Commencing benefits (with adjustments to base rate)
3	В	Change in weekly rate due to decrease in dependents
4	С	Terminating benefits
5a	D	Commencing and terminating benefits
<mark>5b</mark>	D	Commencing and terminating benefits – reduced to zero more than 14 days
6	F	Reopening claim
7a	G	Reopening and closing claim
<mark>7</mark> b	G	Reopening and closing claim - reduced to zero more than 14 days
8	Н	Yearly report of partial payments
9	В	Commencing benefits as the result of an open award
10	Е	Reporting a compromised payment
11	D	Change in weekly rate due to reporting of P&T differential benefits
12	А	Rate with post injury wage earning capacity (PIWEC)
13	А	Old-age social security benefits being paid on DOI occurring after 12/19/11
14	А	Old-age social security benefits not being paid on DOI occurring after 12/19/11
15	А	Old-age social security benefits being paid or subsequently paid on DOI occurring before 12/19/11

EXAMPLE #1 - Filing Reason "A" Commencing benefits (no adjustments to base rate)

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING #	1

				P.O. Box 3001	6, Lansii	ng, MI 48909					
PART A 1. Social Sec 1111-22-3			ate of Injury 01/2007	3. Employee Name (Last Doe, John R.	t, First, MI)			te of Birth 04/1950	5.	5. Date of Death	
	Street Address h Elm Stre	et			7. City Lansin	g	8. Sta	te		9. ZIP Code 48910	
10. Employer Smith's /	_{Name} Auto Repai	ir						11. Federal ID Number 138-1111111			Location Code
	Street Address outh Baker				14. City Lansin	15. State			16. ZIP Code 48915		
	Self-Insured Na tates Insur		npany					AIC or Self-Insu	red Number		
19. Self-Insu	er's Service Cor	mpany Name					20. Se	ervice Company	ID Number		
21. ZIP Code 48912	of Issuing Office		Carrier or Self-Insure 2345-1	ed Claim Number	23. Date 0	arrier Received Notice 2007	ce of Injury		Date First Pa /07/2007	t Payment Made	
PART B 25. Nature of	Iniury	•			26. Part	of Body					
Sprain (3	310)				Ankle	(520)					
27. Average \ \$450	Weekly Wage .00		28. Discontinu \$ 0.00		s 29. Second Employer A.W.W.			30. Second Employer Discontinued Fringes \$			
31. Tax Filing	Status on Date	of Injury	32. Last Day \ 02/01/20		33. Number of Days in Work Wee			ek 34. Number of Dependents 3			
PART C 35. Reason fo	- Filia -		1		20 1//22	kly Compensation Ba	na Data				
A	or Filling					кіу Сотпрепѕаціот ва 310.14	ise Kale				
	djustments to Ba				I				_		
-	\$ \$		\$_ \$		\$			-	\$ \$		
			Fund (Not reported			_ *					
-	_	-				\$			\$		
PART D			_								
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH		TOTAL AMOUNT PAI	D YEAR I	PAID	TERMINATION REASON
Α	Α		\$ 310.14	02/02/2007	,						
				DLUNTARY PAYMEN ER NUMBER OF WE							
F ANY FIL	ING CODES	ON THIS F	ORM REPRES	SENT "OTHER," PLEA	ASE BE S	PECIFIC					
	Makin	g a false o		statement for the pe or civil prosecution					n result i	in	
		THIS IS TO	CERTIFY THAT	TA COPY OF THIS FO	ORM HAS E	BEEN MAILED O	R GIVEN T	O THE EMPI	OYEE		
39. Authorize	d signature			40. Person Handling Claim Jane Smith	n (Please print	·)	•	one Number		42. D	ate 12/2007
				Jane Jillii			517-999	1-3333		02/	12/2001

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

EXAMPLE #2 - Filing Reason "A" Commencing benefits (with adjustments to base rate)

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING #	1

				P.O. Box 3001	6, Lansin	g, MI 48909					
	PART A 2. Date of Injury 3. Employee Name (Last, First, MI) 1.11-22-3333 02/01/2007 Doe, John R.							te of Birth 04/1950		5. Date	of Death
	Street Address th Elm Stre	et		1	7. City Lansing		8. Sta	te		9. ZIP C	
10. Employer Smith's	_{r Name} Auto Repai	r						ederal ID Nu 111111		12. Injui	y Location Code
	r Street Address South Baker	Street			14. City Lansing		15. St MI	ate		16. ZIP	Code
United S	r Self-Insured Nar States Insur- rer's Service Con	ance Comp	pany				999	AIC or Self-I 999999 ervice Comp			
21. ZIP Code 48912	e of Issuing Office		arrier or Self-Insure 345-1	ed Claim Number	23. Date Ca	rrier Received Notic	e of Injury			First Paymen /2007	Made
PART B 25. Nature of Sprain (3	310)				26. Part o	(520)					
\$ 450			28. Discontinu \$ 0.00 32. Last Day \		29. Second Employer A.W.W.			30. Second Employer Discontinued Fringes			ued Fringes
C C	g Status on Date	of Injury	02/01/20		33. Number of Days in Work Week 7 34. Number of Dependents 3						
-	Adjustments to Ba		\$		\$ 3	y Compensation Ba			\$		
					\$\$ \$				\$		
-	_	-	und (Not reported	on Line 37)		\$			\$_		
PART D BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH		TOTAL AMOUNT I		YEAR PAID	TERMINATION REASON
Α	А		\$0.00	02/02/2007							
F BENEFI	T TYPE IS "C	" (SPECIFIC	LOSS), ENT	DLUNTARY PAYMEN ER NUMBER OF WE SENT "OTHER," PLEA	EKS	AND EFF					
	Makin	g a false or		statement for the proof or civil prosecution					can re	esult in	
		THIS IS TO C	CERTIFY THAT	TA COPY OF THIS FO		EEN MAILED OI					
39. Authorize	ed signature			40. Person Handling Claim Jane Smith	. Person Handling Claim (Please print) ane Smith						Date /12/2007

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

	PENSION	WAGE CONTINUATION	DISABILITY INSURANCE	SELF INSURANCE	OTHER
A. WEEKLY BENEFIT AMOUNT		\$ 450.00			
B. 80% AFTER-TAX AMOUNT OF (A)		\$ 310.14			
	x 1.25	x 1.25	x 1.25	x 1.25	x 1.25
C. 100% AFTER-TAX AMOUNT		\$ 387.68			
D. FICA TAX ¹					
E. STATE INCOME TAX ¹					
F. % EMPLOYER CONTRIBUTION		100%			
G. INCOME TO BE COORDINATED ²		\$ 387.68			
¹ Does not apply in all cases. If applicable, include the year of injury. ² Line G = (Line C + D + E) x Line F. (This figure			•	of the agency's rate tables	
SOCIAL SECURITY This section A. MONTHLY SOCIAL SECURITY OLD AGE			only. (Enter net ben	efit with code "B" in Part C,	Line 37)
B. WEEKLY SOCIAL SECURITY OLD AGE R					
C. 50% OF LINE B	LTIKLINLINT AMOONT	(Line A divided by 4.33)			
D. 50% OF BASE RATE (Found in Box 36)					
E. IS DATE OF INJURY ON OR AFTER 12/19	/442			DVEC	
				□YES	□NO
IF NO – COORDINATE AMOUNT IN LINE	Ü				
IF YES – WERE SOCIAL SECURITY OLD				□YES	□NO

	COMPENS	

IF NO – COORDINATE AMOUNT IN LINE C

IF YES – COORDINATE THE LOWEST AMOUNT FOUND IN LINE C OR D

A. NUMBER OF WEEKS AWARDED	
B. BEGINNING DATE OF UNEMPLOYMENT COMPENSATION	
C. SCHEDULED EXPIRATION DATE	
D. TOTAL WEEKLY UNEMPLOYMENT COMPENSATION BENEFITS (Enter with code "D" in Part C, Line 37)	

PART F – RATE ADJUSTMENT³ FOR POST INJURY WAGE EARNING CAPACITY (PIWEC)

(MCL 418.301(8) & 401(6))

A.	AVERAGE WEEKLY WAGE (On front, Line 27)	
В.	80% AFTER-TAX AMOUNT OF LINE A (See calc program or rate charts)	
C.	100% AFTER-TAX AMOUNT (Line B multiplied by 1.25)	
D.	GROSS WEEKLY POST INJURY WAGE EARNING CAPACITY (PIWEC) AMOUNT	
E.	DIFFERENCE BETWEEN 100% AFTER-TAX AMOUNT AND PIWEC (Line C minus Line D) If the calculation in line E is less than or equal to \$0, report base rate as adjustment amount in G.	
F.	80% of Line E (Line E multiplied by .8) ³	
G.	AMOUNT OF ADJUSTMENT FOR PIWEC (Base rate from front, Line 36, minus Line F) This figure should appear on front, Part C, Line 37, with appropriate adjustment code R. If the adjustment calculation shows an amount that is less than or equal to \$0, no adjustment can be applied.	
³ F	for injury dates on or after 12/19/11, the weekly benefit rate payable is 80% of the difference between the injured employee's after	er-tax average weekly wage before the

³ For injury dates on or after 12/19/11, the weekly benefit rate payable is 80% of the difference between the injured employee's after-tax average weekly wage before the personal injury and the employee's wage earning capacity after the personal injury but not more than the maximum weekly rate determined under section 355.

LARA is an equal opportunity employer/program. Auxiliary aids, services and	Authority:	Workers' Disability Compensation Act, R408.31(6a-d)
other reasonable accommodations are available upon request to individuals	Completion:	Mandatory
with disabilities.	Penalty:	Workers' Disability Compensation Act, 418.631; 418.801

EXAMPLE #3 - Filing Reason "B" Change in weekly rate

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING	#	1

				P.O. Box 3001	o, Lans	alig, ivii 40909					
PART A 1. Social Sec 1111-22-3			te of Injury 01/2007	3. Employee Name (Last Doe, John R.	, First, MI)			te of Birth	<u> </u>	5. Date	e of Death
6. Employee	Street Address h Elm Stre		31/2007	Doc, John IV.	7. City Lansi	na	8. Sta	State		9. ZIP 489	
10. Employer Name Smith's Auto Repair						<u> </u>	11. F	ederal ID N			ury Location Code
13. Employer	Street Address				14. City Lansi	na	15. S MI			16. ZIF	N/A Code 15
17. Carrier or Self-Insured Name United States Insurance Company						-3		AIC or Self			
	er's Service Cor		. ,				20. S	ervice Com	pany ID I	Number	
21. ZIP Code 48912	of Issuing Office		arrier or Self-Insure 2345-1	ed Claim Number		Carrier Received Notice /2007	ce of Injury			First Payme /2007	nt Made
PART B 25. Nature of						rt of Body					
Sprain (3	Weekly Wage		28. Discontinu	ued Fringes		e (520) cond Employer A.W.W		30. Sec	Second Employer Discontinued Fringes		
	.00 Status on Date	of Injury	\$ 0.00 32. Last Day \	Worked 33. Number of Days in Work Weel			Week				
C			02/01/20	07	7			3			
35. Reason fo	or Filing				36. W	eekly Compensation Ba	ise Rate				
A Wookly A	djustments to Ba	non Poto			\$	310.14					
	\$		\$_			\$			\$_		
	\$		\$_		\$			_	\$		
38. Weekly A	mount Being Re	imbursed by a F	fund (Not reported	on Line 37)							
PART D											
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH		TOTA AMOUNT	AL PAID	YEAR PAIL	TERMINATIO REASON
Α	Α		\$ 310.14	02/02/2007							
F BENEFI	T TYPE IS "O	C" (SPECIFIC S ON THIS F	C LOSS), ENT	DLUNTARY PAYMEN ER NUMBER OF WE SENT "OTHER," PLEA	EEKS ASE BE	AND EFF SPECIFIC	FECTIVE D	ATE OF	LOSS		
	Makin	ig a false o		statement for the po or civil prosecution					can re	esult in	
		THIS IS TO	CERTIFY THAT	A COPY OF THIS FO			R GIVEN T	O THE E	MPLOY	ÆE	
				40. Person Handling Claim Jane Smith	(Please pr	nt)	41. Telephone Number 517-999-9999				. Date 2/12/2007

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

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING	#	2

PART A				P.O. Box 30010	6, Lar	nsing, MI 48909				
	curity Number		e of Injury 11/2007	3. Employee Name (Last, Doe, John R.	First, M	l)		4. Date of Birth 09/04/1950		of Death
	Street Address th Elm Stre	et			7. City Lans		8. Stat	е	9. ZIP (4891	
10. Employe Smith's	^{r Name} Auto Repai	ir						deral ID Numbe	r 12. Inju	ry Location Code
13. Employer Street Address 34310 South Baker Street					14. Cit Lans		15. Sta	ate	16. ZIP 4891	Code
	r Self-Insured Na States Insur		pany					IC or Self-Insui	ed Number	
19. Self-Insu	rer's Service Cor	mpany Name					20. Se	rvice Company	ID Number	
21. ZIP Code 48912	e of Issuing Office		rrier or Self-Insure 345-1	d Claim Number		ate Carrier Received Notice of Ir 03/2007	njury		ate First Paymer 07/2007	t Made
PART B		1						•		
25. Nature of Sprain (3						Part of Body kle (520)				
•	Weekly Wage		28. Discontinu			29. Second Employer A.W.W. 30. Second Employer Discont			nued Fringes	
\$ 450	0.00 g Status on Date	of Injury	\$ 0.00 32. Last Day V		\$ \$ 33. Number of Days in Work Week 34. Number of Dependents					
С	g Clarac en Date	o,u,	02/01/200		7 2					
PART C										
35. Reason f	for Filing				36. \	Weekly Compensation Base Ra	ite			
В					:	\$ 303.95				
	Adjustments to Ba		\$			\$			\$	
	\$		\$_		\$\$\$\$					
38. Weekly A	Amount Being Re	imbursed by a Fu	und (Not reported o	on Line 37)		\$\$				
PART D										
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH		TOTAL AMOUNT PAIL	YEAR PAID	TERMINATION REASON
А	Α		\$ 310.14	02/02/2007		03/12/2007		\$ 1,727.92	2 2007	
Α	Α		\$ 303.95	03/13/2007						
IF BASIS (OF PAYMEN	T IS OTHER	THAN "A" (VO	LUNTARY PAYMEN	T) OR	LINE 37 IS EQUAL TO	"J" OR	"K," ENTER	R ORDER #_	
IF BENEFI	T TYPE IS "(C" (SPECIFIC	LOSS), ENTI	ER NUMBER OF WE	EKS_	AND E	FFECT	IVE DATE	OF LOSS	
IF ANY FIL	ING CODES	ON THIS FO	ORM REPRES	ENT "OTHER," PLEA	ASE B	E SPECIFIC				
	Makir	ıg a false oı				e of obtaining or den oth, and denial of bei		enefits car	n result in	
						10 DEEN MAIL ED OD ON				

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE								
39. Authorized signature	thorized signature 40. Person Handling Claim (Please print) 41. Telephone Number 42. Date							
	Jane Smith	517-999-9999	0315/007					

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

EXAMPLE #4 - Filing Reason "C" Terminating benefits

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING	#	1

				P.O. BOX 3001	o, Lansing	j, ivii 40909					
1. Social Sec 1111-22-3	curity Number		e of Injury 01/2007	3. Employee Name (Last Doe, John R.	, First, MI)			te of Birth 04/1950	5.	. Date o	f Death
6. Employee	Street Address th Elm Stre		7172001	Doc, John K.	7. City Lansing		8. Sta			ZIP Co	
10. Employer								ederal ID Numbe	er 1		/ Location Code
	r Street Address outh Bake			14. City Lansing		15. St	ate		16. ZIP Code 48915		
	Self-Insured Na States Insur	rance Com	pany				18. NAIC or Self-Insured Number 999999999				
19. Self-Insu	rer's Service Cor	mpany Name					20. Se	ervice Company	ID Number		
21. ZIP Code 48912	of Issuing Office		arrier or Self-Insure 2345-1	d Claim Number	23. Date Carr 02/03/20	ier Received Notice 107	e of Injury		0ate First Pa 07/2007		Made
PART B					1000 11						
25. Nature of Sprain (3					26. Part of Ankle (•					
_	Weekly Wage		28. Discontinu	· ·		Employer A.W.W		30. Second E	mployer Di	scontin	ued Fringes
\$ 450 31. Tax Filing C	g Status on Date	of Injury	\$ 0.00 32. Last Day V 02/01/200	Vorked	33. Numbe 7	r of Days in Work \	Veek	\$ 34. Number of	of Depender	nts	
PART C								1			
35. Reason f	or Filing				36. Weekly	Compensation Ba	se Rate				
37. Weekly A	adjustments to Ba										
	\$		\$_	\$ \$				\$			
38. Weekly A	Ψ mount Being Re	eimbursed by a Fi	Ψ und (Not reported o	on Line 37)		Ψ			Ψ		
						\$			\$		
PART D		1	1	1							
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH		TOTAL AMOUNT PAIL	YEAR	PAID	TERMINATION REASON
Α	Α		\$ 310.14	02/02/2007							
IF BASIS C	F PAYMEN	T IS OTHER	THAN "A" (VC	LUNTARY PAYMEN	IT) OR LINE	37 IS EQUAL	. TO "J" OF	R "K," ENTEI	R ORDEI	R #	
IF BENEFI	T TYPE IS "(C" (SPECIFIC	C LOSS), ENT	ER NUMBER OF WE	EKS	AN	ID EFFECT	TIVE DATE	OF LOSS	S	
IF ANY FIL	ING CODES	ON THIS FO	ORM REPRES	SENT "OTHER," PLE	ASE BE SPI	ECIFIC					
	Makir	ng a false oi		statement for the por civil prosecution					n result	in	
		THIS IS TO (CERTIFY THAT	A COPY OF THIS FO	ORM HAS BE	EN MAILED OI	R GIVEN TO	O THE EMPL	OYEE		
39. Authorize	ed signature			40. Person Handling Claim	(Please print)		41. Telepho	one Number		42. E	ate

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

517-999-9999

02/12/2007

Jane Smith

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

1. Social Sec 111-22-3	urity Number		e of Injury 01/2007	3. Employee Name (Las Doe, John R.	t, First, MI)		te of Birth 04/1950	5. Date	of Death	
	Street Address h Elm Stre	et		<u>l</u>	7. City Lansing	8. Sta	te	9. ZIP C		
10. Employer Smith's	Name Auto Repa	ir			3		ederal ID Number	12. Injur	y Location Code	
	Street Address outh Bake				14. City Lansing	15. St	15. State MI		16. ZIP Code 48915	
	Self-Insured Natates Insur	ance Com	pany		<u> </u>		AIC or Self-Insured	Number		
19. Self-Insu	er's Service Co	mpany Name				20. Se	ervice Company ID	Number		
21. ZIP Code 48912	of Issuing Office		arrier or Self-Insure 2345-1	ed Claim Number	23. Date Carrier Received N 02/03/2007	lotice of Injury		First Payment 7/2007	Made	
PART B		I			1		l			
25. Nature of Sprain (3					26. Part of Body Ankle (520)					
. ,	Weekly Wage		28. Discontinu	ied Fringes	29. Second Employer A.W	/.W.	30. Second Emp	loyer Discontin	ued Fringes	
\$ 450			\$ 0.00		\$		\$			
31. Tax Filing	Status on Date	of Injury	32. Last Day V 04/04/200		33. Number of Days in Wo	ork Week	34. Number of D	ependents		
PART C 35. Reason for	or Filing				36. Weekly Compensation	Base Rate				
C	or r illing				\$ 310.14	1 Bado Rato				
37. Weekly A	djustments to Ba									
	\$		\$_		\$		\$_			
	\$		\$_		\$ \$		\$_			
So. Weekly A	mount being Ke	illibuised by a F	una (Noi reportea i	on Line or)						
	\$	_	\$_		\$		\$_			
PART D		ı	T	1	<u> </u>			T	ı	
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROU	GH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATIO REASON	
Α	Α		\$ 310.14	02/02/2007	04/06/2	007	\$ 2,835.57	2007	А	
BASIS C	F PAYMEN	T IS OTHER	THAN "A" (VC	DLUNTARY PAYMEN	IT) OR LINE 37 IS EQU	IAL TO "J" OF	R "K," ENTER (ORDER #_		
BENEFI	TTYPE IS "(C" (SPECIFIC	C LOSS), ENT	ER NUMBER OF WI	EEKS	AND EFFECT	ΓΙVE DATE OF	LOSS		
ANY FIL	ING CODES	ON THIS F	ORM REPRES	SENT "OTHER," PLE	ASE BE SPECIFIC					
	Makir	ng a false o			ourpose of obtaining on nor both, and denial			esult in		
		THIS IS TO		•	ORM HAS BEEN MAILED			YEE		
	d aignatura			40. Person Handling Claim			one Number		Date	
Authorize	d Signature			40. I CISOTI Hariding Claim	i (Flease pillit)	41. Telepric	one number	42.	Date	

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

EXAMPLE #5a – Filing Reason "D" Commencing and terminating benefits

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING #	1

				P.O. Box 3001	o, Lansing, ivii 489	109				
PART A										
1. Social Second 111-22-3	curity Number 3333		e of Injury 01/2007	3. Employee Name (Last Doe, John R.	, First, MI)		ate of Birth 04/1950	5. Date	of Death	
	Street Address th Elm Stre	et			7. City Lansing	8. St MI	ate	9. ZIP C 4891		
10. Employe Smith's	er Name Auto Repa	ir			1		ederal ID Number	12. Injur	y Location Code N/A	
	er Street Address South Bake				14. City Lansing	15. S MI	15. State MI		16. ZIP Code 48915	
	or Self-Insured Na States Insu	rance Com	pany				IAIC or Self-Insure	d Number		
19. Self-Insu	urer's Service Co	mpany Name	<u> </u>			20. 8	Service Company I	O Number		
21. ZIP Code 48912	e of Issuing Offic		arrier or Self-Insure 345-1	d Claim Number	23. Date Carrier Received 02/03/2007	Notice of Injury		te First Payment	Made	
PART B 25. Nature o	f Injury				26. Part of Body					
Burn (12					Arm (310)					
_	Weekly Wage		28. Discontinu	•	29. Second Employer A.	.W.W.		nployer Discontin	ued Fringes	
\$ 450 31. Tax Filin C	0.00 g Status on Date	of Injury	\$ 0.00 32. Last Day V 02/01/200	Vorked	\$ 33. Number of Days in V	Vork Week	34. Number of	Dependents		
PART C			02/01/200		<u> </u>		1			
35. Reason	for Filing				36. Weekly Compensati	on Base Rate				
D					\$ 310.14					
	Adjustments to B		¢		¢		•			
	- Ψ _\$		\$		\$ \$		\$			
38. Weekly A	Amount Being Re	eimbursed by a F	und (Not reported o	on Line 37)						
	\$		\$_		\$		\$			
PART D										
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THRO	DUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON	
Α	А		\$ 310.14	02/02/2007	03/12/	/2007	\$ 1,727.92	2007	А	
F BASIS (OF PAYMEN	T IS OTHER	THAN "A" (VC	LUNTARY PAYMEN	T) OR LINE 37 IS EQ	UAL TO "J" O	R "K," ENTER	ORDER #_		
F BENEFI	IT TYPE IS "	C" (SPECIFIC	C LOSS), ENT	ER NUMBER OF WE	EKS	_AND EFFEC	TIVE DATE C	F LOSS		
F ANY FIL	LING CODES	ON THIS FO	ORM REPRES	ENT "OTHER," PLE	ASE BE SPECIFIC					
	Makii	ng a false oi	r fraudulent s criminal d	statement for the por civil prosecution	urpose of obtaining n, or both, and deni	g or denying al of benefits	benefits can s.	result in		
		THIS IS TO 0	CERTIFY THAT	A COPY OF THIS FC	PRM HAS BEEN MAILE	D OR GIVEN T	O THE EMPLO	DYEE		
00 1 1 1			1	40. D 11 II' Ola'	(DI	1 44 T L L		10	D - 1 -	

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

41. Telephone Number

517-999-9999

42. Date 03/13/2007

40. Person Handling Claim (Please print)

Jane Smith

EXAMPLE #5b – Filing Reason "D"

Commencing and Terminating benefits - reduced to zero more than 14 days

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING #	1

PART A	I 0 D.1.	(1.2 m)	Lo Farabasa Nasa (last	First MIX	Labor	(C C D'all	I s Date	(D II	
1. Social Security Number 111-22-3333	2. Date of 01/09		3. Employee Name (Last Doe, John R.	, First, MI)		te of Birth 04/1950	5. Date of	of Death	
6. Employee Street Address 123 North Elm Street				7. City Lansing	8. Sta	ate	9. ZIP C 48910		
10. Employer Name Smith's Auto Repair						ederal ID Number	12. Injur	y Location Code N/A	
13. Employer Street Address 34310 South Baker Stre	et			14. City Lansing	15. St MI	tate	16. ZIP (Code	
17. Carrier or Self-Insured Name United States Insurance	Compa	anv			_	AIC or Self-Insure	d Number		
19. Self-Insurer's Service Company N					20. Se	ervice Company IE	Number		
21. ZIP Code of Issuing Office 48912	er or Self-Insure 45-1	d Claim Number	23. Date Carrier Received Noti 01/11/2017	ice of Injury		e First Payment 7/2017	Made		
PART B						•			
25. Nature of Injury Sprain (310)				26. Part of Body Ankle (520)					
27. Average Weekly Wage		28. Discontinu	ů .	29. Second Employer A.W.W	٧.	30. Second Em	ployer Discontin	ued Fringes	
\$ 450.00 31. Tax Filing Status on Date of Injur C	у	\$ 0.00 32. Last Day W 01/09/201	Vorked	\$ 33. Number of Days in Work 7	Week	\$ 34. Number of I	Dependents		
PART C									
35. Reason for Filing				36. Weekly Compensation Base Rate					
D				\$ 310.14					
37. Weekly Adjustments to Base Rat A \$ 387.68		\$_		\$		\$			
\$		\$		\$					
38. Weekly Amount Being Reimburse				•		Φ.			
\$		Φ		\$		\$			
PART D	-0141	TOTAL				TOTAL	<u> </u>	TERMINIATION	
	ECIAL MENT V	TOTAL WEEKLY RATE	FROM	THROUGH		TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON	
A A		\$0.00	01/10/2017	01/24/20	17	\$0.00	2017	Н	
F BASIS OF PAYMENT IS C									
F BENEFIT TYPE IS "C" (SF									
F ANY FILING CODES ON T								nan 14 day	
Making a fa	alse or fi			urpose of obtaining or n, or both, and denial o			result in		
THIS	IS TO CE	RTIFY THAT	A COPY OF THIS FO	PRM HAS BEEN MAILED C	OR GIVEN T	O THE EMPLO	YEE		

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

41. Telephone Number

517-999-9999

42. Date

02/12/2017

40. Person Handling Claim (Please print)

Jane Smith

	PENSION	WAGE CONTINUATION	DISABILITY INSURANCE	SELF INSURANCE	OTHER
A. WEEKLY BENEFIT AMOUNT		\$ 450.00			
B. 80% AFTER-TAX AMOUNT OF (A)		\$ 310.14			
	x 1.25	x 1.25	x 1.25	x 1.25	x 1.25
C. 100% AFTER-TAX AMOUNT		\$ 387.68			
D. FICA TAX ¹					
E. STATE INCOME TAX ¹					
*. % EMPLOYER CONTRIBUTION		100%			
Does not apply in all cases. If applicable, include year of injury. Line G = (Line C + D + E) x Line F. (This figure)	e should appear in Part C	\$ 387.68 state income tax using the figure, Line 37, with the appropriate a	djustment code)		
G. INCOME TO BE COORDINATED ² Does not apply in all cases. If applicable, including year of injury. Line G = (Line C + D + E) x Line F. (This figure)	e should appear in Part C	\$ 387.68 state income tax using the figure, Line 37, with the appropriate a	djustment code)		
G. INCOME TO BE COORDINATED ² Those not apply in all cases. If applicable, included year of injury. Line G = (Line C + D + E) x Line F. (This figure) SOCIAL SECURITY This section	e should appear in Part C n applies to old a g	\$ 387.68 state income tax using the figure, Line 37, with the appropriate a	djustment code)		
G. INCOME TO BE COORDINATED ² Those not apply in all cases. If applicable, including year of injury. Line G = (Line C + D + E) x Line F. (This figure SOCIAL SECURITY This section A. MONTHLY SOCIAL SECURITY OLD AGE	e should appear in Part C n applies to old a d ERETIREMENT AMOUN	\$ 387.68 state income tax using the figure, Line 37, with the appropriate a ge retirement benefits	djustment code)		· ·
F. % EMPLOYER CONTRIBUTION G. INCOME TO BE COORDINATED ² ¹ Does not apply in all cases. If applicable, inclutive year of injury. ² Line G = (Line C + D + E) x Line F. (This figur SOCIAL SECURITY This section A. MONTHLY SOCIAL SECURITY OLD AGE B. WEEKLY SOCIAL SECURITY OLD AGE FOR SOME OF LINE B	e should appear in Part C n applies to old a d ERETIREMENT AMOUN	\$ 387.68 state income tax using the figure, Line 37, with the appropriate a ge retirement benefits	djustment code)		· ·
G. INCOME TO BE COORDINATED ² Does not apply in all cases. If applicable, include year of injury. Line G = (Line C + D + E) x Line F. (This figure SOCIAL SECURITY This section A. MONTHLY SOCIAL SECURITY OLD AGE B. WEEKLY SOCIAL SECURITY OLD AGE FOR SOME OF LINE B.	e should appear in Part C n applies to old a d ERETIREMENT AMOUN	\$ 387.68 state income tax using the figure, Line 37, with the appropriate a ge retirement benefits	djustment code)		· ·
G. INCOME TO BE COORDINATED ² Those not apply in all cases. If applicable, incluting year of injury. Line G = (Line C + D + E) x Line F. (This figure SOCIAL SECURITY This section A. MONTHLY SOCIAL SECURITY OLD AGE FOR	e should appear in Part Con applies to old agence RETIREMENT AMOUNT	\$ 387.68 state income tax using the figure, Line 37, with the appropriate a ge retirement benefits	djustment code)		· ·
G. INCOME TO BE COORDINATED ² Does not apply in all cases. If applicable, including year of injury. Line G = (Line C + D + E) x Line F. (This figur) SOCIAL SECURITY This section MONTHLY SOCIAL SECURITY OLD AGE B. WEEKLY SOCIAL SECURITY OLD AGE FOR SOME OF LINE B D. 50% OF BASE RATE (Found in Box 36)	e should appear in Part Con applies to old agence RETIREMENT AMOUNT RETIREMENT AMOUNT 9/11?	\$ 387.68 state income tax using the figure, Line 37, with the appropriate a ge retirement benefits	djustment code)	efit with code "B" in Part C, L	_ine 37)
G. INCOME TO BE COORDINATED ² Does not apply in all cases. If applicable, include year of injury. Line G = (Line C + D + E) x Line F. (This figur) SOCIAL SECURITY This section A. MONTHLY SOCIAL SECURITY OLD AGE FOR SOCIAL	e should appear in Part Con applies to old age RETIREMENT AMOUNT RETIREMENT AMOUNT 9/11?	\$ 387.68 state income tax using the figure. Line 37, with the appropriate a ge retirement benefits (Line A divided by 4.33)	djustment code) Only. (Enter net bender	efit with code "B" in Part C, L	_ine 37)
Does not apply in all cases. If applicable, include year of injury. Line G = (Line C + D + E) x Line F. (This figur SOCIAL SECURITY This section A. MONTHLY SOCIAL SECURITY OLD AGE B. WEEKLY SOCIAL SECURITY OLD AGE B. 50% OF LINE B D. 50% OF BASE RATE (Found in Box 36) E. IS DATE OF INJURY ON OR AFTER 12/1 IF NO – COORDINATE AMOUNT IN LINE	e should appear in Part Con applies to old age RETIREMENT AMOUNT 9/11? CO AGE RETIREMENT BEI	\$ 387.68 state income tax using the figure. Line 37, with the appropriate a ge retirement benefits (Line A divided by 4.33)	djustment code) Only. (Enter net bender	efit with code "B" in Part C, L	Line 37)

A.	NUMBER OF WEEKS AWARDED	
В.	BEGINNING DATE OF UNEMPLOYMENT COMPENSATION	
C.	SCHEDULED EXPIRATION DATE	
D.	TOTAL WEEKLY UNEMPLOYMENT COMPENSATION BENEFITS (Enter with code "D" in Part C. Line 37)	

PART F - RATE ADJUSTMENT³ FOR POST INJURY WAGE EARNING CAPACITY (PIWEC)

(MCL 418.301(8) & 401(6))

A.	AVERAGE WEEKLY WAGE (On front, Line 27)	
В.	80% AFTER-TAX AMOUNT OF LINE A (See calc program or rate charts)	
C.	100% AFTER-TAX AMOUNT (Line B multiplied by 1.25)	
D.	GROSS WEEKLY POST INJURY WAGE EARNING CAPACITY (PIWEC) AMOUNT	
E.	DIFFERENCE BETWEEN 100% AFTER-TAX AMOUNT AND PIWEC (Line C minus Line D) If the calculation in line E is less than or equal to \$0, report base rate as adjustment amount in G.	
F.	80% of Line E (Line E multiplied by .8) ³	
G.	AMOUNT OF ADJUSTMENT FOR PIWEC (Base rate from front, Line 36, minus Line F) This figure should appear on front, Part C, Line 37, with appropriate adjustment code R. If the adjustment calculation shows an amount that is less than or equal to \$0, no adjustment can be applied.	
³ F	for injury dates on or after 12/19/11, the weekly benefit rate payable is 80% of the difference between the injured employee's after	er-tax average weekly wage before the

personal injury and the employee's wage earning capacity after the personal injury but not more than the maximum weekly rate determined under section 355.

LARA is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.

Authority: Completion: Workers' Disability Compensation Act, R408.31(6a-d)

Mandatory

Penalty:

Workers' Disability Compensation Act, 418.631; 418.801

EXAMPLE #6 - Filing Reason "F" Reopening claim

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING #	1

1. Social Sec 111-22-3	curity Number 3333		e of Injury 01/2007	3. Employee Name (Last, First, MI) Doe, John R.			4. Date of Birth 09/04/1950)	5. Date o	f Death		
	Street Address th Elm Stre	et		l)	8. State MI		9. ZIP Code 48910				
10. Employe Smith's	r _{Name} Auto Repa	ir					11. Federal ID N 38-111111			/ Location Code N/A		
	r Street Address South Bake				14. City Lansing)	15. State MI		16. ZIP 0 48915			
United S	r Self-Insured Na States Insul	rance Com	pany				18. NAIC or Self 999999999999999999999999999999999999		Number			
19. Self-Insu	ırer's Service Co	mpany Name					20. Service Com	pany ID N	Number			
21. ZIP Code 48912	e of Issuing Offic		arrier or Self-Insure 2345-1	d Claim Number	23. Date Ca 02/03/2	arrier Received Notice of I 2007		24. Date 02/07	First Payment /2007	Made		
PART B 25. Nature o	f Injury	•			26. Part o	of Body						
Sprain (310)				Ankle	(520)						
-	Weekly Wage		28. Discontinu			29. Second Employer A.W.W.			30. Second Employer Discontinued Fringes			
\$ 450	0.00 g Status on Date	of Injury	\$ 0.00 32. Last Day V		\$ 33 Numb	per of Days in Work Week	\$ 34 Num	34. Number of Dependents				
C	g Glatus on Date	or injury	02/01/200		7				репаста			
PART C 35. Reason t	for Filing				36. Weel	dy Compensation Base R	ate					
D					\$ 3	10.14						
37. Weekly A	Adjustments to B		\$_		_	_\$		\$_				
	\$		\$					\$				
38. Weekly A			und (Not reported o			_\$		\$				
PART D						_ *						
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH	TOT/ AMOUNT		YEAR PAID	TERMINATIO REASON		
Α	А		\$ 310.14	02/02/200)7	03/12/2007	\$ 1,72	7.92	2007	Α		
F BASIS (OF PAYMEN	T IS OTHER	THAN "A" (VO	LUNTARY PAYME	ENT) OR LIN	E 37 IS EQUAL TO	"J" OR "K," EN	ITER C	RDER #			
						AND E						
F ANY FIL	LING CODES	ON THIS F	ORM REPRES	ENT "OTHER," PL	EASE BE SI	PECIFIC						

	THIS IS TO CERTIFY THA	T A COPY OF THIS FORM HAS BEEN MAILED O	R GIVEN TO THE EMPLOYEE	
39. Authorized signature		40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
		Jane Smith	517-999-9999	03/13/2007

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING #	2

				F.O. BOX 3001	io, Laiis	ing, ivii 46909					
PART A											
1. Social Se 111-22-	curity Number 3333		e of Injury 01/2007	3. Employee Name (Last, First, MI) Doe, John R.				4. Date of Birth 09/04/1950		e of Death	
' '	Street Address th Elm Stre				7. City Lansing				-	9. ZIP Code 48910	
10. Employe Smith's	er Name Auto Repa	ir					_	deral ID Numb 111111	er 12. In	ury Location Code N/A	
	er Street Address South Bake				14. City Lansir	ng	15. Sta	ate	16. ZI 489	P Code	
	or Self-Insured Na States Insu	ame rance Comp	pany		<u> </u>			IC or Self-Insu	red Number		
	ırer's Service Co	-					20. Se	rvice Company	/ ID Number		
21. ZIP Cod 48912	e of Issuing Offic		arrier or Self-Insure 345-1	d Claim Number	23. Date 02/03/	Carrier Received Notice of 2007	f Injury		Date First Payme 07/2007	nt Made	
PART B		•			1			•			
25. Nature o Sprain (t of Body e (520)					
	Weekly Wage		28. Discontinu			cond Employer A.W.W.	30. Second Employer Discontinued Fringes				
\$ 450	0.00 ig Status on Date	of Injury	\$ 0.00 32. Last Day \		\$ 33 Nur	mber of Days in Work Wee	\$ eek 34. Number of Dependents				
C				07	7	ibei oi bays iii work wee	žK	3	or Dependents		
PART C											
35. Reason	for Filing					ekly Compensation Base	Rate				
F Wookly	Adjustments to B	aca Pata			\$	310.14					
			\$			\$			\$		
	\$		\$_			\$			\$		
38. Weekly	Amount Being Re	eimbursed by a Fu	und (Not reported o	on Line 37)							
PART D	_Ψ		Ψ			Ψ			Ψ		
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH		TOTAL AMOUNT PAI	D YEAR PAII	TERMINATION REASON	
А	А		\$ 310.14	04/05/2007	,						
IF BASIS (OF PAYMEN	T IS OTHER	THAN "A" (VC	LUNTARY PAYMEN	NT) OR LI	NE 37 IS EQUAL TO	O "J" OR	"K," ENTE	R ORDER #		
IF BENEF	IT TYPE IS "	C" (SPECIFIC	C LOSS), ENT	ER NUMBER OF WI	EEKS	AND	EFFECT	IVE DATE	OF LOSS _		
IF ANY FII	LING CODES	S ON THIS FO	ORM REPRES	SENT "OTHER," PLE	ASE BE	SPECIFIC					
	Makii	ng a false or		statement for the por civil prosecution				enefits ca	n result in		
		T				-			0)/55		

THIS IS TO CERTIFY THA	T A COPY OF THIS FORM HAS BEEN MAILED O	R GIVEN TO THE EMPLOYEE	
39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	04/12/2007

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

EXAMPLE #7a – Filing Reason "G" Reopening and closing claim

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING:	#	1

03/13/2007

517-999-9999

PART A					-					
	curity Number		te of Injury 01/2007	3. Employee Name (Last, First, MI) Doe, John R.			e of Birth)4/1950	5. Dat	e of Death	
	Street Address th Elm Stre	et		•	7. City Lansing	8. Sta	te	_	9. ZIP Code 48910	
10. Employer Smith's A	Name Auto Repai	ir					ederal ID Number	12. In	ury Location Code N/A	
	Street Address outh Bakeı				14. City Lansing	15. St MI	ate	16. ZII 489	P Code	
	Self-Insured Na States Insur	ance Com	pany			_	AIC or Self-Insure	d Number		
19. Self-Insu	rer's Service Cor	mpany Name				20. Se	ervice Company II) Number		
21. ZIP Code 48912	of Issuing Office		arrier or Self-Insure 2345-1	d Claim Number	23. Date Carrier Received Noti 02/03/2007	ce of Injury		te First Payme 7/2007	ent Made	
PART B 25. Nature of					26. Part of Body					
Sprain (3	,			154	Ankle (520) 29. Second Employer A.W.W	,	L 00 0 15.	-lBi	C. JEC.	
\$ 450	Weekly Wage .00		28. Discontinu \$ 0.00	o .	\$	V.	\$ Second Em	ployer Discontinued Fringes		
	Status on Date	of Injury	32. Last Day V 02/01/200	Vorked	33. Number of Days in WorkWeek 7 34. Number of Days				ependents	
PART C 35. Reason for D 37. Weekly A	or Filing	ase Rate			36. Weekly Compensation B \$ 310.14	ase Rate				
	•		\$_		\$		\$			
					\$\$ \$		\$			
			und (Not reported o		\$		\$			
PART D										
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	1	TOTAL AMOUNT PAID	YEAR PAII	TERMINATION REASON	
Α	А		\$ 310.14	02/02/2007	03/12/200	07	\$ 1,727.92	2007	A	
F BASIS C	OF PAYMEN	T IS OTHER	THAN "A" (VC	LUNTARY PAYMEN	IT) OR LINE 37 IS EQUA	L TO "J" OF	R "K," ENTER	ORDER #		
F BENEFI	T TYPE IS "C	C" (SPECIFIC	C LOSS), ENT	ER NUMBER OF WE	EEKSAI	ND EFFECT	TIVE DATE O	FLOSS_		
F ANY FIL	ING CODES	ON THIS FO	ORM REPRES	SENT "OTHER," PLE	ASE BE SPECIFIC					
	Makin	ng a false oi			urpose of obtaining or n, or both, and denial c			result in		
		THIS IS TO (CERTIFY THAT	A COPY OF THIS FO	ORM HAS BEEN MAILED C	R GIVEN TO	O THE EMPLO	YEE		
39. Authorize	ed signature			40. Person Handling Claim	(Please print)	41. Telepho	one Number	42	2. Date	

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

Jane Smith

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING	#	2

1. Social Securi		2. Date	e of Injury	3. Employee Name (La	st, First, MI)		4. Date of Bir	th	5. Date of	of Death
111-22-33	333		1/2007	Doe, John R.				09/04/1950		
6. Employee St 123 North		et			7. City Lansin	g	8. State MI		9. ZIP Ci 4891(
10. Employer N Smith's Au	uto Repai	r			- 1		11. Federal II 38-1111		12. Injur	V Location Code
13. Employer S 34310 Sou		Street			14. City Lansin	g	15. State		16. ZIP 0 48915	Code
17. Carrier or S United Sta		me ance Comp	pany				18. NAIC or 9		Number	
19. Self-Insurer	's Service Con	npany Name					20. Service C	ompany ID	Number	
21. ZIP Code of 48912	f Issuing Office		rrier or Self-Insure 345-1	d Claim Number	23. Date 0	Carrier Received Notice of 1 2007	l Injury		First Payment 7/2007	Made
PART B										
25. Nature of In Sprain (31	0)					e (520)				
27. Average We			28. Discontinu	•		ond Employer A.W.W.	30. Second Employer Discontinued Fringes \$			
\$ 450.0 31. Tax Filing S		of Injury	\$ 0.00 32. Last Day V		\$ 33. Num	ber of Days in Work Week		lumber of D	ependents	
C			04/04/200)7	7	7 3				
PART C 35. Reason for	Filing				36. Wee	kly Compensation Base R	ate			
G					\$ 3	310.14				
37. Weekly Adj	ustments to Ba	se Rate	\$			\$		\$		
\$			\$_		·	\$\$ \$		\$_		
38. Weekly Am	ount Being Rei	mbursed by a Fu	und (Not reported o	on Line 37)		\$		\$		
		_		_						
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH		OTAL INT PAID	YEAR PAID	TERMINATIOI REASON
А	Α		\$ 310.14	04/05/200	7	04/20/2007	\$ 7	08.89	2007	А
F BASIS OF	PAYMEN	IS OTHER	THAN "A" (VC	LUNTARY PAYME	NT) OR LIN	NE 37 IS EQUAL TO	"J" OR "K,"	ENTER (ORDER #	
F BENEFIT	TYPE IS "C	" (SPECIFIC	LOSS), ENT	ER NUMBER OF W	/EEKS	AND E	FFECTIVE I	DATE OF	LOSS	
F ANY FILIN	NG CODES	ON THIS FO	ORM REPRES	ENT "OTHER," PLE	EASE BE S	PECIFIC				
				statement for the						

THIS IS TO CERTIFY THA	T A COPY OF THIS FORM HAS BEEN MAILED O	R GIVEN TO THE EMPLOYEE					
39. Authorized signature	39. Authorized signature 40. Person Handling Claim (Please print) 41. Telephone Number 42. Date						
	Jane Smith	517-999-9999	04/22/2007				

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

EXAMPLE #7b - Filing Reason "G"

Reopening and closing claim - benefits reduced to zero more than 14 days

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency
P.O. Box 30016 Lansing, MI 48909

FILING #	2

				P.O. Box 3001	6, Lans	ing, MI 48909				
PART A										
1. Social Sec 111-22-	curity Number 3333	2. Date 01/09	of Injury 9/2017	3. Employee Name (Last Doe, John R.	t, First, MI)			e of Birth 4/1950	5. Date of	of Death
6. Employee	Street Address th Elm Stre	et			7. City Lansin			е	9. ZIP C	
10. Employe	r Name Auto Repa	ir						deral ID Number	12. Injur	y Location Code
13. Employe	r Street Address South Baker				14. City Lansin	na	15. Sta		16. ZIP (Code
17. Carrier o	r Self-Insured Na		any			·9	18. NA	IC or Self-Insured		
	rer's Service Cor	-	, arry					rvice Company ID	Number	
21. ZIP Code 48912	e of Issuing Office		rier or Self-Insure	ed Claim Number	23. Date 0	Carrier Received Notice of I	Injury		e First Payment 7/2017	Made
PART B					•			•		
25. Nature o Sprain (of Body e (520)				
_	Weekly Wage		28. Discontinu		' '			30. Second Employer Discontinued Fringes		
\$ 450 31. Tax Filin C).00 g Status on Date	of Injury	\$ 0.00 32. Last Day \ 02/01/20	Worked		\$ \$ 33. Number of Days in Work Week 7 34. Number of Dependents				
PART C 35. Reason	for Filing					ekly Compensation Base R	ate			
37. Weekly	Adjustments to Ba									
A						\$				
20 \\/ = = -		eimbursed by a Fu		Line 27)		\$		\$		
So. Weekly /	_	-		on Line 37)		\$	_	\$		
PART D										
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH		TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
А	А		\$0.00	02/02/2007		02/16/2017		0.00	2017	Н
IF BASIS (OF PAYMEN	T IS OTHER	ΓHAN "A" (VC	DLUNTARY PAYMEN	IT) OR LI	NE 37 IS EQUAL TO	"J" OR	"K," ENTER	ORDER #_	
				ER NUMBER OF WE						
IF ANY FIL	ING CODES	ON THIS FO	RM REPRES	SENT "OTHER," PLE	ASE BE S	SPECIFIC Coordin	ation r	reduced to	0 more tl	nan 14 days
	Makin	g a false or		statement for the por civil prosecution				enefits can ı	esult in	
		TI IIO IO TO O						THE EMBLO	VEE	

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							
	Jane Smith	517-999-9999	02/12/2007				

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

	PENSION	WAGE CONTINUATION	DISABILITY INSURANCE	SELF INSURANCE	OTHER
A. WEEKLY BENEFIT AMOUNT		\$ 450.00			
B. 80% AFTER-TAX AMOUNT OF (A)		\$ 310.14			
	x 1.25	x 1.25	x 1.25	x 1.25	x 1.25
C. 100% AFTER-TAX AMOUNT		\$ 387.68			
D. FICA TAX ¹					
E. STATE INCOME TAX ¹					
F. % EMPLOYER CONTRIBUTION		100%			
G. INCOME TO BE COORDINATED ²		\$ 387.68			
			only. (Enter net bene	efit with code "B" in Part C,	Line 37)
	RETIREMENT AMOUN	Т	ONIY. (Enter net bene	efit with code "B" in Part C,	Line 37)
A. MONTHLY SOCIAL SECURITY OLD AGE B. WEEKLY SOCIAL SECURITY OLD AGE R	RETIREMENT AMOUN	Т	ONIY. (Enter net bene	efit with code "B" in Part C,	Line 37)
A. MONTHLY SOCIAL SECURITY OLD AGEB. WEEKLY SOCIAL SECURITY OLD AGE RC. 50% OF LINE B	RETIREMENT AMOUN	Т	ONIY. (Enter net bene	efit with code "B" in Part C,	Line 37)
 A. MONTHLY SOCIAL SECURITY OLD AGE B. WEEKLY SOCIAL SECURITY OLD AGE R C. 50% OF LINE B D. 50% OF BASE RATE (Found in Box 36) 	RETIREMENT AMOUN	Т	ONIY. (Enter net bene	efit with code "B" in Part C,	Line 37)
 A. MONTHLY SOCIAL SECURITY OLD AGE B. WEEKLY SOCIAL SECURITY OLD AGE R C. 50% OF LINE B D. 50% OF BASE RATE (Found in Box 36) 	RETIREMENT AMOUNT ETIREMENT AMOUNT //11?	Т	ONIY. (Enter net bene		
 A. MONTHLY SOCIAL SECURITY OLD AGE B. WEEKLY SOCIAL SECURITY OLD AGE R C. 50% OF LINE B D. 50% OF BASE RATE (Found in Box 36) E. IS DATE OF INJURY ON OR AFTER 12/19 	RETIREMENT AMOUNT ETIREMENT AMOUNT //11? C	T (Line A divided by 4.33)			
 A. MONTHLY SOCIAL SECURITY OLD AGE B. WEEKLY SOCIAL SECURITY OLD AGE R C. 50% OF LINE B D. 50% OF BASE RATE (Found in Box 36) E. IS DATE OF INJURY ON OR AFTER 12/19 IF NO – COORDINATE AMOUNT IN LINE 	RETIREMENT AMOUNT ETIREMENT AMOUNT //11? C AGE RETIREMENT BE	T (Line A divided by 4.33)		YES	□NO
 A. MONTHLY SOCIAL SECURITY OLD AGE B. WEEKLY SOCIAL SECURITY OLD AGE R C. 50% OF LINE B D. 50% OF BASE RATE (Found in Box 36) E. IS DATE OF INJURY ON OR AFTER 12/19 IF NO – COORDINATE AMOUNT IN LINE IF YES – WERE SOCIAL SECURITY OLD 	RETIREMENT AMOUNT OUT THE STATE OF THE STAT	T (Line A divided by 4.33) NEFITS BEING PAID ON THE DA		YES	□NO
A. MONTHLY SOCIAL SECURITY OLD AGE B. WEEKLY SOCIAL SECURITY OLD AGE R C. 50% OF LINE B D. 50% OF BASE RATE (Found in Box 36) E. IS DATE OF INJURY ON OR AFTER 12/19 IF NO – COORDINATE AMOUNT IN LINE IF YES – WERE SOCIAL SECURITY OLD IF NO – COORDINATE AMOUNT IN LINE IF YES – COORDINATE THE LOWES	RETIREMENT AMOUNT ETIREMENT AMOUNT //11? C AGE RETIREMENT BE LINE C ST AMOUNT FOUND IN	T (Line A divided by 4.33) NEFITS BEING PAID ON THE DA		YES	□NO
A. MONTHLY SOCIAL SECURITY OLD AGE B. WEEKLY SOCIAL SECURITY OLD AGE R C. 50% OF LINE B D. 50% OF BASE RATE (Found in Box 36) E. IS DATE OF INJURY ON OR AFTER 12/19 IF NO – COORDINATE AMOUNT IN LINE IF YES – WERE SOCIAL SECURITY OLD IF NO – COORDINATE AMOUNT IN L IF YES – COORDINATE THE LOWES UNEMPLOYMENT COMPENSAT	RETIREMENT AMOUNT ETIREMENT AMOUNT //11? C AGE RETIREMENT BE LINE C ST AMOUNT FOUND IN	T (Line A divided by 4.33) NEFITS BEING PAID ON THE DA		YES	□NO
A. MONTHLY SOCIAL SECURITY OLD AGE B. WEEKLY SOCIAL SECURITY OLD AGE R C. 50% OF LINE B D. 50% OF BASE RATE (Found in Box 36) E. IS DATE OF INJURY ON OR AFTER 12/19 IF NO – COORDINATE AMOUNT IN LINE IF YES – WERE SOCIAL SECURITY OLD IF NO – COORDINATE AMOUNT IN L IF YES – COORDINATE THE LOWES UNEMPLOYMENT COMPENSAT A. NUMBER OF WEEKS AWARDED	RETIREMENT AMOUNT ETIREMENT AMOUNT //11? C AGE RETIREMENT BE LINE C ET AMOUNT FOUND IN	T (Line A divided by 4.33) NEFITS BEING PAID ON THE DA		YES	□NO
 A. MONTHLY SOCIAL SECURITY OLD AGE B. WEEKLY SOCIAL SECURITY OLD AGE R C. 50% OF LINE B D. 50% OF BASE RATE (Found in Box 36) E. IS DATE OF INJURY ON OR AFTER 12/19 IF NO – COORDINATE AMOUNT IN LINE IF YES – WERE SOCIAL SECURITY OLD IF NO – COORDINATE AMOUNT IN LINE IF YES – COORDINATE THE LOWES 	RETIREMENT AMOUNT ETIREMENT AMOUNT //11? C AGE RETIREMENT BE LINE C ET AMOUNT FOUND IN	T (Line A divided by 4.33) NEFITS BEING PAID ON THE DA		YES	□NO

A.	NUMBER OF WEEKS AWARDED	
В.	BEGINNING DATE OF UNEMPLOYMENT COMPENSATION	
C.	SCHEDULED EXPIRATION DATE	
D.	TOTAL WEEKLY UNEMPLOYMENT COMPENSATION BENEFITS (Enter with code "D" in Part C. Line 37)	

PART F - RATE ADJUSTMENT³ FOR POST INJURY WAGE EARNING CAPACITY (PIWEC)

(MCL 418.301(8) & 401(6))

Α.	AVERAGE WEEKLY WAGE (On front, Line 27)								
В.	80% AFTER-TAX AMOUNT OF LINE A (See calc program or rate charts)								
C.	100% AFTER-TAX AMOUNT (Line B multiplied by 1.25)								
D.	GROSS WEEKLY POST INJURY WAGE EARNING CAPACITY (PIWEC) AMOUNT								
E.	DIFFERENCE BETWEEN 100% AFTER-TAX AMOUNT AND PIWEC (Line C minus Line D) If the calculation in line E is less than or equal to \$0, report base rate as adjustment amount in G.								
F.	80% of Line E (Line E multiplied by .8) ³								
G.	AMOUNT OF ADJUSTMENT FOR PIWEC (Base rate from front, Line 36, minus Line F) This figure should appear on front, Part C, Line 37, with appropriate adjustment code R. If the adjustment calculation shows an amount that is less than or equal to \$0, no adjustment can be applied.								
³ F	For injury dates on or after 12/19/11, the weekly benefit rate payable is 80% of the difference between the injured employee's after-tax average weekly wage before the								

personal injury and the employee's wage earning capacity after the personal injury but not more than the maximum weekly rate determined under section 355.

LARA is an equal opportunity employer/program. Auxiliary aids, services and	Authority:	Workers' Disability Compensation Act, R408.31(6a-d)
other reasonable accommodations are available upon request to individuals	Completion:	Mandatory
with disabilities.	Penalty:	Workers' Disability Compensation Act, 418.631; 418.801

EXAMPLE #8 - Filing Reason "H" Yearly report of partial payments

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING #	1

				P.O. Box 3001	6, Lansing,	WII 48909					
PART A											
1. Social Se 111-22-	curity Number 3333		te of Injury 04/2007	3. Employee Name (Last, First, MI) Doe, John R.				Pate of Birth /04/1950		5. Date of	of Death
	Street Address Th Elm Stre	et			7. City Lansing		8. State MI			9. ZIP C 48910	
	Auto Repai				1		11. Federal ID Number 12. 38-1111111		12. Injur	y Location Code N/A	
	er Street Address South Bake				14. City Lansing		15. Stat	te		16. ZIP (4891	
	or Self-Insured Na States Insur		pany		1		-	C or Self 199999		Number	
19. Self-Insu	urer's Service Cor	mpany Name					20. Ser	vice Com	pany ID	Number	
21. ZIP Cod 48912	e of Issuing Office		arrier or Self-Insure 2345-1	d Claim Number	23. Date Carrie 11/08/200	er Received Notice of I	l njury			First Payment /2007	Made
PART B	of Injury				26. Part of B	ody					
	Loss (230))			Ears (12						
•	Weekly Wage		28. Discontinu	· ·		Employer A.W.W.			ond Emp	loyer Discontin	ued Fringes
_	0.00 ng Status on Date	of Injury	\$ 0.00 32. Last Day V	Vorked		of Days in Work Week					
С			11/04/200	07	7			3			
PART C 35. Reason	for Filina				36. Weekly 0	Compensation Base Ra	ate				
Α	Ŭ				\$ 310						
	Adjustments to Ba		\$		<u> </u>				\$		
	\$		\$_		\$	\$\$\$\$\$					
38. Weekly	Amount Being Re	imbursed by a F	und (Not reported of	on Line 37)							
	.\$		\$_		\$	j	\$				
PART D											
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH	,	TOT <i>A</i> AMOUNT		YEAR PAID	TERMINATION REASON
А	В			11/05/2007	,						
IF BASIS	OF PAYMEN	T IS OTHER	THAN "A" (VC	LUNTARY PAYMEN	NT) OR LINE :	37 IS EQUAL TO	"J" OR	"K," EN	ITER C	ORDER #_	
IF BENEF	IT TYPE IS "(C" (SPECIFIC	C LOSS), ENT	ER NUMBER OF WE	EEKS	AND E	FFECTI	IVE DA	TE OF	LOSS	
IF ANY FI	LING CODES	ON THIS F	ORM REPRES	SENT "OTHER," PLE	ASE BE SPE	CIFIC					
	Makir	ng a false o		statement for the por civil prosecution				enefits	can r	esult in	
		THIS IS TO	CERTIFY THAT	A COPY OF THIS FO	DRM HAS BEE	N MAILED OR GI	VEN TO	THE E	MPLO	/EE	
00 4 11				40. D	(DI	1				1	5-1-

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

41. Telephone Number

517-999-9999

42. Date 11/14/2007

40. Person Handling Claim (Please print)

Jane Smith

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING #	2

	urity Number									
111-22-3 6. Employee S	urity Number									
	333		e of Injury 14/2007	3. Employee Name (Last Doe, John R.	First, MI)		e of Birth 04/1950	5. Date of	of Death	
1/3 North	Street Address h Elm Stre	et			7. City Lansing	8. Sta	te	9. ZIP C		
10. Employer I	Name				Landing	11. Fe	ederal ID Number		y Location Code	
	Auto Repa				14. City	15. St	1111111 ate	16. ZIP (N/A	
	outh Bake				Lansing	MI	uio	4891		
	Self-Insured Na tates Insur	me ance Com	pany				AIC or Self-Insured	Number		
	er's Service Cor		· · ·			20. Se	ervice Company ID	Number		
21. ZIP Code (48912	of Issuing Office		arrier or Self-Insure	d Claim Number	23. Date Carrier Received No. 11/08/2007	tice of Injury		e First Payment 1/2007	Made	
ART B		l					<u> </u>			
25. Nature of I	Injury LOSS (230)	ı			26. Part of Body Ears (124)					
27. Average W	Veekly Wage		28. Discontinu	ed Fringes	29. Second Employer A.W.	W.	30. Second Em	mployer Discontinued Fringes		
\$ 450.			\$ 0.00		\$		\$			
31. Tax Filing C	Status on Date	of Injury	32. Last Day V		33. Number of Days in Wor	k Week	34. Number of D	Dependents		
PART C 35. Reason for	r Filing		•		36. Weekly Compensation	Pose Pote				
H	i i iiiig				\$ 310.14	Dase Nate				
-	djustments to Ba									
					\$		\$			
					\$					
-	_	-	und (Not reported o	on Line 37)	\$		\$			
ART D										
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUG	iH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATIO REASON	
Α	В			11/05/2007	12/30/20	007	\$ 188.03	2007		
Α	В			12/31/2007						
BASIS O	F PAYMEN	T IS OTHER	THAN "A" (VC	LUNTARY PAYMEN	T) OR LINE 37 IS EQUA	AL TO "J" OF	R "K," ENTER	ORDER #		
					EKS					
					ASE BE SPECIFIC					
					urpose of obtaining o					

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				
	Jane Smith	517-999-9999	01/02/2008				

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

Print Date: 08/01/2012 Print Time: 10:19:02

Workers' Compensation Agency Verification of Monetary Information Partial Benefit Rates

Page: 1 Version: 13.0

For Year: 2007

File

Name: John R. Doe

Name: John R. Doe Update: 08/01/2012 10:18:44

Prior to Injury

	Upda	ite: 08/01/2012	10:18:44
	· •		
Year of Injury:	2007		
Gross Weekly Wage:	\$450.00		
Discontinued Fringes:	\$0.00		
Nbr of Dependents:	3		
Tax Class:	3		
		_	
80 Percent Rate	\$310.14 (Inclu	dina frinaes)	
ou reiteilt Kate	ψ510.14 (ΠΙΟΙΔ	unig miliges)	

After Injury

Begin Date	End Date	Year Paid	80% Rate Before Injury	Wages Received	80% Rate After Injury	Partial Rate
11/05/2007	11/11/2007	2007	\$310.14	400.00	279.81	30.33
11/12/2007	11/18/2007	2007	\$310.14	386.00	271.25	38.89
11/19/2007	11/25/2007	2007	\$310.14	450.00	310.14	0.00
11/26/2007	12/02/2007	2007	\$310.14	410.00	285.92	24.22
12/03/2007	12/09/2007	2007	\$310.14	320.00	230.59	79.55
12/10/2007	12/16/2007	2007	\$310.14	425.00	295.10	15.04
12/17/2007	12/23/2007	2007	\$310.14	450.00	310.14	0.00
12/24/2007	12/30/2007	2007	\$310.14	450.00	310.14	0.00
Gra	\$188.03					

Number of Weeks: 8

EXAMPLE #9 - Basis of Payment "B" Open Award

Benefits ordered @ \$397.02 per week beginning on 3/12/06; accrued benefits paid on 5/8/07

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING #	1

111-22-			e of Injury 1/2006	3. Employee Name (Las Doe, John R.	t, First, MI)			of Birth 4/1950	5. Date	of Death		
	Street Address th Elm Stre	et			7. City Lansing		8. State	9	9. ZIP 489			
10. Employe Smith's	^{r Name} Auto Repai	r			1			leral ID Numbe 1111111	12. Inj	ury Location Code		
	r Street Address South Baker	Street		14. City Lansing		15. Star	te	16. ZIF 489				
	r Self-Insured Na States Insur		pany					C or Self-Insur 199999	ed Number			
19. Self-Insu	rer's Service Con	npany Name					20. Ser	vice Company	D Number			
21. ZIP Code 48912	e of Issuing Office		rrier or Self-Insure 345-1	ed Claim Number	23. Date Carrie 03/13/200	r Received Notice of I	njury		ate First Payme 08/2007	nt Made		
PART B 25. Nature o	f Injury				26. Part of Bo							
Heart At	tack (991)				Heart (80	01)						
27. Average \$ 610	Weekly Wage		28. Discontinu \$ 0.00	•		mployer A.W.W.		30. Second Employer Discontinued Fringes				
	g Status on Date	of Injury	32. Last Day \ 03/11/20	Vorked	33. Number o	33. Number of Days in Work Week 34. Number of D			Dependents	pendents		
ART C			"				I.					
35. Reason f	for Filing				36. Weekly Compensation Base Rate \$ 397.02							
37. Weekly A	Adjustments to Ba		r.		Φ.							
						\$ \$			_			
38. Weekly A	-	-	und (Not reported o	on Line 37)	\$	\$			\$			
PART D												
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH	,	TOTAL AMOUNT PAID	YEAR PAIL	TERMINATI REASON		
В	A		\$ 397.02	05/09/2007	7							
BENEFI	T TYPE IS "C	" (SPECIFIC	C LOSS), ENT	DLUNTARY PAYMEN ER NUMBER OF WI	EEKS	AND E	FFECTI	IVE DATE C	F LOSS			
IF BENEFI	T TYPE IS "C LING CODES	ON THIS FO	C LOSS), ENT DRM REPRES		EEKS ASE BE SPEC	AND E	FFECTI	IVE DATE (F LOSS			

THIS IS TO CERTIFY THA	T A COPY OF THIS FORM HAS BEEN MAILED O	R GIVEN TO THE EMPLOYEE	
39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	05/10/2007

Print Date: 08/01/2012 Print Time: 11:36:49

Workers' Compensation Agency Verification of Monetary Information Accrued Payment & Interest

V	ersion:	13.	U

Begin Date	End Date	Paid Date	Comp Rate	Days Worked	Total Weeks	Rem Days	Total Comp	Total Interest	Total Comp & Interest
03/12/2006	05/08/2007	05/08/2007	\$397.02	7	60	3	\$23,991.35	\$1,347.69	\$25,339.04
			Grand '	Totals	60	3	\$23,991.35	\$1,347.69	\$25,339.04

REPORT OF ACCRUED BENEFITS

SS# _	111-22-3333	DOI <u>03/11/2006</u>	Employee	Name	Doe, John R.
0 1 "	0.40007000		_ , ,		2027
Order #	042007008	Basis Payment Code		Year Paid	2007

Benefit Type	Special Payment	Adjusted Rate	From	Through	Total	Variable Rate Factors
А	А	\$397.02	03/12/2006	05/08/2007	\$23,991.35	Deps 2 Base Amt \$ 397.02 Adjustment Code \$ Adjustment Code \$
	В			05/08/2007	\$1,347.69	DepsBase Amt \$ Adjustment Code\$ Adjustment Code\$
						DepsBase Amt \$ Adjustment Code \$ Adjustment Code \$
						DepsBase Amt \$ Adjustment Code\$ Adjustment Code\$
						DepsBase Amt \$ Adjustment Code\$ Adjustment Code\$
						DepsBase Amt \$ Adjustment Code \$ Adjustment Code \$
						DepsBase Amt \$ Adjustment Code \$ Adjustment Code \$
						DepsBase Amt \$ Adjustment Code\$ Adjustment Code\$

Basis of Payment Benefit Type

A =Voluntary PaymentA =General DisabilityB =Open AwardB =Partial Wage LossC =Closed AwardC =Specific LossD =Stipulated AwardD =Permanent TotalE =CompromiseE =Death

E = Compromise E = Death F = Form 115 Voluntary Pay F = Other

W= Reduced Wage Earning Capacity

Special Payment

B = Interest

D = Other

A = Accrued Benefits

C = 30% Appeal Adjustment

Weekly Adjustments to Base Rate

Wage Continuation Offset Advance Payment J = Social Security Coordination 30% Appeal Adjustment K = C = Pension Offset SIF Differential Benefits L= D = Unemployment Offset M= **Double Compensation** E = Disability Insurance Offset N = Third-Party Offset F = Self-Insurance Offset O = 2-Years Continuous Disability G = Other Benefit Coordination P = Recoupment of Overpayment Q

H = Age 65 Reduction Q = Other

I = Compensation Supplement R = Residual Wage Earning Capacity Reduction

EXAMPLE #10 – Basis of Payment "E" Compromise (rate and termination reason not required)

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING #	1

	curity Number		te of Injury	3. Employee Name (Last	, First, MI)		te of Birth	5. Date of	of Death
111-22-3		02/0	05/2007	Doe, John R.		09/0			
123 Nor	Street Address th Elm Stre	et			7. City Lansing	8. Sta	ate	9. ZIP Ci 4891(
	Auto Repa						ederal ID Number 1111111	12. Injur	y Location Code N/A
34310 S	r Street Address outh Bake	r Street			14. City Lansing	15. S MI		16. ZIP (48915	
United S	r Self-Insured Na States Insur	rance Com	pany				AIC or Self-Insured 1999999	Number	
19. Self-Insu	rer's Service Cor	mpany Name				20. S	ervice Company ID	Number	
21. ZIP Code 48912	e of Issuing Office		arrier or Self-Insure 2345-1	d Claim Number	23. Date Carrier Received 02/10/2007	Notice of Injury		e First Payment 2/2007	Made
PART B									
	ation (260)				26. Part of Body Hip (440)				
J	Weekly Wage		28. Discontinu	· ·	29. Second Employer A.	W.W.	· .	ployer Discontinued Fringes	
\$ 31. Tax Filinç	g Status on Date	of Injury	\$ 0.00 32. Last Day V		33. Number of Days in W	Vork Week	\$ 34. Number of D	Pependents	
PART C									
35. Reason f	or Filing				36. Weekly Compensation	on Base Rate			
D					\$				
•	Adjustments to Ba		¢		¢		¢		
	φ \$		Ψ\$		\$		\$\$ \$		
			Fund (Not reported of				Ψ.		
	•	•		*	\$				
PART D									
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THRO	UGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
E	Α						\$ 1,500.00	2007	
IF BASIS C	OF PAYMEN	T IS OTHER	THAN "A" (VC	LUNTARY PAYMEN	T) OR LINE 37 IS EQ	UAL TO "J" OI	R "K," ENTER	ORDER #	042807010
IF BENEFI	T TYPE IS "(C" (SPECIFIC	C LOSS), ENT	ER NUMBER OF WE	EKS	_AND EFFEC	TIVE DATE OF	LOSS	
IF ANY FIL	ING CODES	ON THIS F	ORM REPRES	SENT "OTHER," PLEA	ASE BE SPECIFIC				
	Makir	ng a false o			urpose of obtaining n, or both, and denia			result in	
		THERETO		-	RM HAS BEEN MAILE			VEE	

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

41. Telephone Number

517-999-9999

42. Date 05/12/2007

40. Person Handling Claim (Please print)

Jane Smith

EXAMPLE #11 – Basis of Payment "D" Permanent Total

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING #	2

				P.O. Box 3001	6, Lansi	ng, MI 48909					
1. Social Sec 111-22-3	curity Number		e of Injury 5/2007	3. Employee Name (Last Doe, John R.		4. Date of Birth 09/04/1950		5. Date of	of Death		
	Street Address th Elm Stre	et		<u> </u>	7. City Lansin	ıg	8. Stat	е		9. ZIP Co	
10. Employe	r Name Auto Repa	r						deral ID Nu 111111		12. Injur	y Location Code
	r Street Address South Baker	14. City Lansin	g	15. Sta	ate		16. ZIP 0 48915	Code			
	r Self-Insured Na States Insur		pany		- L			IC or Self-I 999999		Number	
19. Self-Insu	rer's Service Cor	npany Name					20. Se	rvice Comp	any ID I	Number	
21. ZIP Code 48912	e of Issuing Office		arrier or Self-Insure 345-1	d Claim Number	23. Date 0	Carrier Received Notice of 2007	l Injury			First Payment /2007	Made
PART B 25. Nature of	E lations				L oc Dart	of Dade					
	al Loss of U	se				of Body (510)					
27. Average	Weekly Wage		28. Discontinu	ed Fringes	29. Sec	ond Employer A.W.W.		30. Secon	nd Empl	loyer Discontin	ued Fringes
\$ 226			\$ 0.00		\$	\$		\$			
31. Tax Filin	g Status on Date	of Injury	32. Last Day V 10/15/200		33. Num				34. Number of Dependents 2		
PART C											
35. Reason f	or Filing				36. Wee	ekly Compensation Base R	ate				
В					\$ 161.38						
,	Adjustments to Ba		_			_					
_ <u>L</u>											
					\$\$\$						
	_		und (Not reported o			•			•		
	\$		\$			\$			\$_		
PART D											
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH		TOTAL AMOUNT I		YEAR PAID	TERMINATION REASON
В	Α		\$ 161.38	10/16/2007	,	12/31/2007		\$ 1,775	5.18	2007	
В	D		\$ 205.01	01/01/2008	1						
IF BASIS C	OF PAYMEN	T IS OTHER	THAN "A" (VC	LUNTARY PAYMEN	NT) OR LII	NE 37 IS EQUAL TO	"J" OR	"K," EN	TER C	ORDER #	
IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKSAND EFFECTIVE DATE OF LOSS											
IF ANY FIL	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 FO	ORM HAS	BEEN MAILED OR G	IVEN TO	THE EN	//PLOY	/EE	

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

41. Telephone Number

517-999-9999

42. Date 01/05/2008

40. Person Handling Claim (Please print)

Jane Smith

EXAMPLE #12 – Filing Reason "A" Rate with post injury wage earning capacity (PIWEC)

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016. Lansing. MI 48909

FILING #	1

				P.O. Box 3001	6, Lansin	g, MI 48909					
1. Social Secu 111-22-3			e of Injury 15/2012	3. Employee Name (Last Doe, John R.					of Birth 5. Date of E		of Death
6. Employee S 123 North	Street Address n Elm Stre	7. City Lansing		8. State	е		9. ZIP Ci				
10. Employer I Smith's A	Name Auto Repai	r						deral ID N		12. Injur	y Location Code
	Street Address outh Baker	Street			14. City Lansing		15. Sta	ate		16. ZIP (Code
	Self-Insured Nar	ne ance Com	pany		1			IC or Self 99999		Number	
19. Self-Insure	er's Service Com	npany Name					20. Sei	rvice Com	npany ID	Number	
21. ZIP Code o	of Issuing Office		arrier or Self-Insure 2345-1	d Claim Number	23. Date Ca	rrier Received Notice of I 012	<u>I</u> njury			First Payment /2012	Made
PART B											
25. Nature of I Sprain (3					26. Part o						
27. Average W	eekly Wage		28. Discontinu	ed Fringes	29. Secon	29. Second Employer A.W.W. 30. Second Employer Discontin					ued Fringes
\$ 850.			\$ 0.00			\$		\$			
31. Tax Filing	Status on Date	of Injury	32. Last Day V 04/15/201		33. Number of Days in Work Week 34. Number of De 3			pendents			
PART C											
35. Reason fo	r Filing				36. Week	ly Compensation Base Ra	ate				
Α					\$ 5	48.46					
,	ljustments to Ba										
						\$		-	\$		
-	_		und (Not reported o								
	<u> </u>	_	\$_			_\$	_		\$_		
PART D											
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH		TOT/ AMOUN		YEAR PAID	TERMINATION REASON
А	W		\$ 388.46	04/16/2012							
IF BASIS OI	F PAYMENT	IS OTHER	THAN "A" (VC	LUNTARY PAYMEN	IT) OR LIN	E 37 IS EQUAL TO	"J" OR	"K," EN	NTER C	ORDER #	
IF BENEFIT	TYPE IS "C	" (SPECIFIC	C LOSS), ENT	ER NUMBER OF WE	EEKS	AND E	FFECT	IVE DA	TE OF	LOSS	
IF ANY FILI	NG CODES	ON THIS FO	ORM REPRES	ENT "OTHER," PLE	ASE BE SF	PECIFIC					
	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 FO	ORM HAS B	EEN MAILED OR GI	VEN TO	THE E	:MPLO	/EE	

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

41. Telephone Number

517-999-9999

42. Date

02/12/2007

40. Person Handling Claim (Please print)

Jane Smith

PART F - COORDINATION OF BENEFITS

	PENSION	WAGE CONTINUATION	DISABILITY INSURANCE	SELF INSURANCE	OTHER
A. WEEKLY BENEFIT AMOUNT					
B. 80% AFTER-TAX AMOUNT OF (A)					
	x 1.25	x 1.25	x 1.25	x 1.25	x 1.25
C. 100% AFTER-TAX AMOUNT					
D. FICA TAX ¹					
E. STATE INCOME TAX ¹					
F. % EMPLOYER CONTRIBUTION					
G. INCOME TO BE COORDINATED ²					
¹ Does not apply in all cases. If applicable, incluthe year of injury.	de the value of FICA and	state income tax using the figu	res provided in the back of	of the agency's rate tables co	orresponding to
2 Line G = (Line C + D + E) x Line F. (This figur	e should appear in Part C	, Line 37, with the appropriate a	adjustment code)		

ی	SOCIAL SECONT 1 This section applies to did age retirement benefits only. (Enter net benefit with code 18 in Part C, Line 37)							
A.	MONTHLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT							
B.	WEEKLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT (Line A divided by 4.33)							
C.	50% OF LINE B							
D.	50% OF BASE RATE (Found in Box 36)							
E.	IS DATE OF INJURY ON OR AFTER 12/19/11?	□YES	□NO					
	IF NO – COORDINATE AMOUNT IN LINE C							
	IF YES – WERE SOCIAL SECURITY OLD AGE RETIREMENT BENEFITS BEING PAID ON THE DATE OF INJURY?	□YES	□NO					
	IF NO – COORDINATE AMOUNT IN LINE C							
	IF YES – COORDINATE THE LOWEST AMOUNT FOUND IN LINE C OR D							

UNEMPLOYMENT COMPENSATION A. NUMBER OF WEEKS AWARDED B. BEGINNING DATE OF UNEMPLOYMENT COMPENSATION C. SCHEDULED EXPIRATION DATE D. TOTAL WEEKLY UNEMPLOYMENT COMPENSATION BENEFITS (Enter with code "D" in Part C, Line 37)

PART F – RATE ADJUSTMENT³ FOR POST INJURY WAGE EARNING CAPACITY (PIWEC) (MCL 418.301(8) & 401(6))

\$ 850.00
\$ 548.46
\$ 685.58
\$ 200.00
\$ 485.58
\$ 388.46
\$ 160.00

° For injury dates on or after 12/19/11, the weekly benefit rate payable is 80% of the difference between the injured employee's after-tax average weekly wage before the personal injury and the employee's wage earning capacity after the personal injury but not more than the maximum weekly rate determined under section 355.

LARA is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.

Authority: Workers' Disability Compensation Act, R408.31(6a-d)
Mandatory
Workers' Disability Compensation Act, 418.631; 418.801

EXAMPLE #13 – Filing Reason "A" Old-age social security benefits being paid on DOI occurring after 12/19/11

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING	#	1

				P.O. Box 3001	6, Lar	nsing, MI 48909					
PART A											
1. Social Security Number 2. Date of Injury 3. Employee Name (Last, 111-22-3333 12/20/2011 Doe, John R.					First, M	()	4. Date of Birth 03/04/1949		9	5. Date of	of Death
' '	Street Address th Elm Stre	et			7. City Lans		8. Sta	te		9. ZIP Co 4891(
10. Employe Smith's	r Name Auto Repa	ir						ederal ID N 111111		12. Injur	y Location Code N/A
	r Street Address South Bake				14. Cit Lans	,	15. St MI	ate		16. ZIP 0	Code
	r Self-Insured Na States Insul	ame rance Comp	oany					AIC or Self 99999		Number	
19. Self-Insu	ırer's Service Co	mpany Name					20. Se	ervice Com	npany ID	Number	
21. ZIP Code 48912	e of Issuing Offic		rrier or Self-Insure 345-1	ed Claim Number		te Carrier Received Notice (0/2011	of Injury		24. Date 12/27	First Payment 7/2011	Made
PART B		1						•			
25. Nature of Sprain (3	310)				An	Part of Body kle (520)					
_	Weekly Wage		28. Discontinu	· ·					ployer Discontinued Fringes		
\$ 650	g Status on Date	of Injury	\$ 0.00 32. Last Day \			\$ 33. Number of Days in Work Week 34. Number of Dependents					
С			12/20/20		7 1						
PART C 35. Reason f	for Filing				26.1	Veekly Compensation Base	Data				
	ioi Filling					Veekly Compensation Base \$ 416.89	Kale				
A 37. Weekly A	Adjustments to B	ase Rate				410.09					
-	-		\$_			\$			\$		
	\$		\$_		_	\$			\$		
38. Weekly A	Amount Being Re	eimbursed by a Fu	und (Not reported								
	\$		\$_		_	\$			\$_		
PART D											
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH		TOTA AMOUNT		YEAR PAID	TERMINATION REASON
Α	А		\$ 208.44	12/21/2011							
IF BASIS (OF PAYMEN	T IS OTHER	THAN "A" (VC	DLUNTARY PAYMEN	T) OR	LINE 37 IS EQUAL T	O "J" OF	R "K," EN	NTER C	ORDER #	
IF BENEFI	T TYPE IS "	C" (SPECIFIC	LOSS), ENT	ER NUMBER OF WE	EKS_	AND	EFFEC1	ΓIVE DA	TE OF	LOSS	
IF ANY FIL	LING CODES	ON THIS FO	ORM REPRES	SENT "OTHER," PLEA	ASE BI	E SPECIFIC					
	Makir	ng a false or		statement for the poor civil prosecution					can r	esult in	

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

41. Telephone Number

517-999-9999

42. Date

12/27/2011

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

40. Person Handling Claim (Please print)

Jane Smith

PART E - COORDINATION OF BENEFITS

PENSION	WAGE CONTINUATION	DISABILITY INSURANCE	SELF INSURANCE	OTHER
x 1.25	x 1.25	x 1.25	x 1.25	x 1.25
			PENSION WAGE CONTINUATION INSURANCE	PENSION WAGE CONTINUATION INSURANCE SELF INSURANCE

the year of injury.

SOCIAL SECURITY This section applies to old age retirement benefits only. (Enter net benefit with code "B" in Part C, Line 37)

A. MONTHLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT	\$ 2,100.00
B. WEEKLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT (Line A divided by 4.33)	\$ 484.99
C. 50% OF LINE B	\$242.50
D. 50% OF BASE RATE (Found in Box 36)	\$ 208.45
E. IS DATE OF INJURY ON OR AFTER 12/19/11?	⊠YES □NO
IF NO – COORDINATE AMOUNT IN LINE C	
IF YES - WERE SOCIAL SECURITY OLD AGE RETIREMENT BENEFITS BEING PAID ON THE DATE OF INJURY?	⊠YES □NO
IF NO – COORDINATE AMOUNT IN LINE C	
IF YES – COORDINATE THE LOWEST AMOUNT FOUND IN LINE C OR D	\$208.45

UNEMPLOYMENT COMPENSATION

A.	NUMBER OF WEEKS AWARDED	
В.	BEGINNING DATE OF UNEMPLOYMENT COMPENSATION	
C.	SCHEDULED EXPIRATION DATE	
D.	TOTAL WEEKLY UNEMPLOYMENT COMPENSATION BENEFITS (Enter with code "D" in Part C, Line 37)	

PART F - RATE ADJUSTMENT³ FOR POST INJURY WAGE EARNING CAPACITY (PIWEC)

(MCL 418.301(8) & 401(6))

A.	AVERAGE WEEKLY WAGE (On front, Line 27)	
B.	80% AFTER-TAX AMOUNT OF LINE A (See calc program or rate charts)	
C.	100% AFTER-TAX AMOUNT (Line B multiplied by 1.25)	
D.	GROSS WEEKLY POST INJURY WAGE EARNING CAPACITY (PIWEC) AMOUNT	
E.	DIFFERENCE BETWEEN 100% AFTER-TAX AMOUNT AND PIWEC (Line C minus Line D) If the calculation in line E is less than or equal to \$0, report base rate as adjustment amount in G.	
F.	80% of Line E (Line E multiplied by .8) ³	
G.	AMOUNT OF ADJUSTMENT FOR PIWEC (Base rate from front, Line 36, minus Line F) This figure should appear on front, Part C, Line 37, with appropriate adjustment code R. If the adjustment calculation shows an amount that is less than or equal to \$0, no adjustment can be applied.	
3 _		

³ For injury dates on or after 12/19/11, the weekly benefit rate payable is 80% of the difference between the injured employee's after-tax average weekly wage before the personal injury and the employee's wage earning capacity after the personal injury but not more than the maximum weekly rate determined under section 355.

LARA is an equal opportunity employer/program. Auxiliary aids, services and Authority: Workers' Disability Compensation Act, R408.31(6a-d) other reasonable accommodations are available upon request to individuals Completion: Mandatory with disabilities. Penalty: Workers' Disability Compensation Act, 418.631; 418.801

² Line G = (Line C + D + E) x Line F. (This figure should appear in Part C, Line 37, with the appropriate adjustment code)

EXAMPLE #14 – Filing Reason "A" Old-age social security benefits not being paid on DOI occurring after 12/19/11

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING #	1

				P.O. Box 3001	6, Lar	sing, MI 48909					
PART A 1. Social Se	curity Number	2. Dat	e of Injury	3. Employee Name (Last,	First, MI)	4. Dat	e of Birth	5. Date	of Death	
111-22-	3333	12/2			03/0)4/1949					
	Street Address th Elm Stre	et			7. City Lans		8. Sta	te	9. ZIP 4891		
10. Employe Smith's	r Name Auto Repa	ir						ederal ID Numb I 111111	er 12. Inji	ury Location Code	
	r Street Address South Bake				14. Cit		15. St	ate	16. ZIF 4891	Code	
	or Self-Insured Na States Insul	ame rance Com	pany					AIC or Self-Insu	red Number		
	ırer's Service Co		. ,				20. Se	ervice Company	ID Number		
21. ZIP Code 48912	e of Issuing Offic		arrier or Self-Insure 2345-1	d Claim Number		te Carrier Received Notice on 0/2011	f Injury		Date First Payme 1/27/2011	nt Made	
PART B											
25. Nature o Sprain (Part of Body Kle (520)					
_	Weekly Wage		28. Discontinu	ied Fringes	29. 5	29. Second Employer A.W.W. 30. Second Employer Disc				nued Fringes	
\$ 650			\$ 0.00			\$		\$			
C 31. Tax Filin	g Status on Date	of Injury	32. Last Day V 12/20/20		33. Number of Days in Work Week 7 34. Number of Dependents 1						
PART C											
35. Reason	for Filing				36. Weekly Compensation Base Rate						
Α						3 416.89					
-	Adjustments to B		\$			\$\$			\$		
						\$					
38. Weekly	Amount Being Re	eimbursed by a F	und (Not reported o	on Line 37)							
	\$		\$_		_	\$			\$		
PART D											
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH		TOTAL AMOUNT PAI	D YEAR PAID	TERMINATION REASON	
Α	А		\$ 174.39	12/21/2011							
IF BASIS (OF PAYMEN	T IS OTHER	THAN "A" (VC	LUNTARY PAYMEN	T) OR	LINE 37 IS EQUAL T	O "J" OF	R "K," ENTE	R ORDER #_		
IF BENEFI	T TYPE IS "(C" (SPECIFIC	C LOSS), ENT	ER NUMBER OF WE	EKS_	AND	EFFECT	IVE DATE	OF LOSS		
IF ANY FIL	LING CODES	ON THIS FO	ORM REPRES	SENT "OTHER," PLE	ASE BE	SPECIFIC					
	Makir	ng a false oi		statement for the propertion					n result in		

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

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

41. Telephone Number

517-999-9999

42. Date

12/27/2011

40. Person Handling Claim (Please print)

Jane Smith

	PENSION	WAGE CONTINUATION	DISABILITY INSURANCE	SELF INSURANCE	OTHER
A. WEEKLY BENEFIT AMOUNT					
B. 80% AFTER-TAX AMOUNT OF (A)					
	x 1.25	x 1.25	x 1.25	x 1.25	x 1.25
C. 100% AFTER-TAX AMOUNT					
D. FICA TAX ¹					
E. STATE INCOME TAX ¹					
F. % EMPLOYER CONTRIBUTION					
G. INCOME TO BE COORDINATED ²					
² Line G = (Line C + D + E) x Line F. (This figure SOCIAL SECURITY This section			· · · · · · · · · · · · · · · · · · ·	efit with code "B" in Part C,	Line 37)
A. MONTHLY SOCIAL SECURITY OLD AGE	RETIREMENT AMOUN	T		\$ 2,10	00.00
D WEEKLY 000IAL 050UDITY 01.5 : 05.5					
B. WEEKLY SOCIAL SECURITY OLD AGE R	ETIKEWENT AWOUNT	(Line A divided by 4.33)		\$ 484	4.99
	ETIREMENT AMOUNT	(Line A divided by 4.33)		\$ 48 ² \$ 24 ²	
C. 50% OF LINE B	ETIREMENT AMOUNT	(Line A divided by 4.33)		<u> </u>	2.50
C. 50% OF LINE B D. 50% OF BASE RATE (Found in Box 36)		(Line A divided by 4.33)		\$ 242	2.50
C. 50% OF LINE B D. 50% OF BASE RATE (Found in Box 36)	V/11?	(Line A divided by 4.33)		\$ 242 \$208	2.50 3.45
C. 50% OF LINE BD. 50% OF BASE RATE (Found in Box 36)E. IS DATE OF INJURY ON OR AFTER 12/19)/11? C		ATE OF INJURY?	\$ 242 \$208	2.50 3.45
C. 50% OF LINE B D. 50% OF BASE RATE (Found in Box 36) E. IS DATE OF INJURY ON OR AFTER 12/19 IF NO – COORDINATE AMOUNT IN LINE	//11? C AGE RETIREMENT BE		ATE OF INJURY?	\$ 242 \$208 ⊠YES	2.50 3.45 □NO
 D. 50% OF BASE RATE (Found in Box 36) E. IS DATE OF INJURY ON OR AFTER 12/19 IF NO – COORDINATE AMOUNT IN LINE IF YES – WERE SOCIAL SECURITY OLD 	n/11? C AGE RETIREMENT BE LINE C	NEFITS BEING PAID ON THE DA	ATE OF INJURY?	\$ 242 \$208	2.50 3.45 □NO
C. 50% OF LINE B D. 50% OF BASE RATE (Found in Box 36) E. IS DATE OF INJURY ON OR AFTER 12/19 IF NO – COORDINATE AMOUNT IN LINE IF YES – WERE SOCIAL SECURITY OLD IF NO – COORDINATE AMOUNT IN LINE IF YES – COORDINATE THE LOWES UNEMPLOYMENT COMPENSAT	0/11? C AGE RETIREMENT BE LINE C ST AMOUNT FOUND IN	NEFITS BEING PAID ON THE DA	ATE OF INJURY?	\$ 242 \$208	2.50 3.45 □NO
C. 50% OF LINE B D. 50% OF BASE RATE (Found in Box 36) E. IS DATE OF INJURY ON OR AFTER 12/19 IF NO – COORDINATE AMOUNT IN LINE IF YES – WERE SOCIAL SECURITY OLD IF NO – COORDINATE AMOUNT IN LINE IF YES – COORDINATE THE LOWES UNEMPLOYMENT COMPENSAT A. NUMBER OF WEEKS AWARDED	O/11? C AGE RETIREMENT BE LINE C ST AMOUNT FOUND IN	NEFITS BEING PAID ON THE DA	ATE OF INJURY?	\$ 242 \$208	2.50 3.45 □NO
C. 50% OF LINE B D. 50% OF BASE RATE (Found in Box 36) E. IS DATE OF INJURY ON OR AFTER 12/19 IF NO – COORDINATE AMOUNT IN LINE IF YES – WERE SOCIAL SECURITY OLD IF NO – COORDINATE AMOUNT IN LINE IF YES – COORDINATE THE LOWES UNEMPLOYMENT COMPENSAT A. NUMBER OF WEEKS AWARDED B. BEGINNING DATE OF UNEMPLOYMENT	O/11? C AGE RETIREMENT BE LINE C ST AMOUNT FOUND IN	NEFITS BEING PAID ON THE DA	ATE OF INJURY?	\$ 242 \$208	2.50 3.45 □NO
C. 50% OF LINE B D. 50% OF BASE RATE (Found in Box 36) E. IS DATE OF INJURY ON OR AFTER 12/19 IF NO – COORDINATE AMOUNT IN LINE IF YES – WERE SOCIAL SECURITY OLD IF NO – COORDINATE AMOUNT IN LINE IF YES – COORDINATE THE LOWES UNEMPLOYMENT COMPENSAT A. NUMBER OF WEEKS AWARDED	O/11? C AGE RETIREMENT BE LINE C ST AMOUNT FOUND IN FION COMPENSATION	NEFITS BEING PAID ON THE DA		\$ 242 \$208	2.50 3.45 □NO

A.	AVERAGE WEEKLY WAGE (On front, Line 27)					
В.	80% AFTER-TAX AMOUNT OF LINE A (See calc program or rate charts)					
C.	100% AFTER-TAX AMOUNT (Line B multiplied by 1.25)					
D.	GROSS WEEKLY POST INJURY WAGE EARNING CAPACITY (PIWEC) AMOUNT					
E.	DIFFERENCE BETWEEN 100% AFTER-TAX AMOUNT AND PIWEC (Line C minus Line D) If the calculation in line E is less than or equal to \$0, report base rate as adjustment amount in G.					
F.	80% of Line E (Line E multiplied by .8) ³					
G.	AMOUNT OF ADJUSTMENT FOR PIWEC (Base rate from front, Line 36, minus Line F) This figure should appear on front, Part C, Line 37, with appropriate adjustment code R. If the adjustment calculation shows an amount that is less than or equal to \$0, no adjustment can be applied.					
³ For injury dates on or after 12/19/11, the weekly benefit rate payable is 80% of the difference between the injured employee's after-tax average weekly wage before the personal injury and the employee's wage earning capacity after the personal injury but not more than the maximum weekly rate determined under section 355.						

LARA is an equal opportunity employer/program. Auxiliary aids, services and	Authority:	Workers' Disability Compensation Act, R408.31(6a-d)
other reasonable accommodations are available upon request to individuals	Completion:	Mandatory
with disabilities.	Penalty:	Workers' Disability Compensation Act, 418.631; 418.801

EXAMPLE #15 - Filing Reason "A"

Old-age social security benefits being paid or subsequently paid on DOI occurring before 12/19/11

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

FILING	#	1

				P.O. Box 3001	6, Lar	nsing, MI 48909					
PART A 1. Social Se	curity Number	2. Dat	e of Injury	3. Employee Name (Last,	First, M	I)	4. Date	e of Birth		5. Date of	f Death
111-22-	3333		7/2011				03/04/1949				
	6. Employee Street Address 123 North Elm Street			7. City Lans		8. State MI		9. ZIP Co 4891(
10. Employer Name Smith's Auto Repair							11. Federal ID Number 38-111111		12. Injur	/ Location Code N/A	
13. Employer Street Address 34310 South Baker Street				14. Cit Lans		15. Sta	15. State			Code	
	or Self-Insured Na States Insu	rance Com	pany					AIC or Self-In	sured N	Number	
19. Self-Insu	ırer's Service Co	mpany Name	-				20. Se	rvice Compa	any ID N	Number	
21. ZIP Code 48912	e of Issuing Offic		arrier or Self-Insure 2345-1	d Claim Number		te Carrier Received Notice of 0/2011	Injury			First Payment /2011	Made
PART B											
25. Nature o Sprain (Part of Body kle (520)					
27. Average	Weekly Wage		28. Discontinu	ed Fringes	29. \$	Second Employer A.W.W.		30. Secon	d Empl	ployer Discontinued Fringes	
\$ 650				\$ 0.00		\$		\$			
31. Tax Filin	g Status on Date	of Injury	32. Last Day V 12/20/20						34. Number of Dependents 1		
PART C											
35. Reason	for Filing				36. \	Weekly Compensation Base F	Rate				
Α					;	\$ 416.89					
,	Adjustments to B \$ 242.50		\$			\$\$			\$		
	\$					\$					
38. Weekly	Amount Being Re	eimbursed by a F	und (Not reported o	on Line 37)							
	\$		\$_		_	\$. <u>-</u>	\$_		
PART D											
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH		TOTAL AMOUNT P		YEAR PAID	TERMINATION REASON
А	А		\$ 174.39	12/21/2011							
IF BASIS (OF PAYMEN	T IS OTHER	THAN "A" (VC	DLUNTARY PAYMEN	T) OR	LINE 37 IS EQUAL TO) "J" OR	"K," ENT	ER O	RDER #_	
IF BENEFI	T TYPE IS "	C" (SPECIFIC	C LOSS), ENT	ER NUMBER OF WE	EKS_	AND E	EFFECT	IVE DATI	E OF	LOSS	
IF ANY FIL	LING CODES	ON THIS FO	ORM REPRES	SENT "OTHER," PLEA	ASE BI	E SPECIFIC					
	Makir	ng a false oi				e of obtaining or del oth, and denial of be			can re	esult in	

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

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

41. Telephone Number

517-999-9999

42. Date

12/27/2011

40. Person Handling Claim (Please print)

Jane Smith

	PENSION	WAGE CONTINUATION	DISABILITY INSURANCE	SELF INSURANCE	OTHER			
A. WEEKLY BENEFIT AMOUNT								
B. 80% AFTER-TAX AMOUNT OF (A)								
	x 1.25	x 1.25	x 1.25	x 1.25	x 1.25			
C. 100% AFTER-TAX AMOUNT								
D. FICA TAX ¹								
E. STATE INCOME TAX ¹								
F. % EMPLOYER CONTRIBUTION								
G. INCOME TO BE COORDINATED ²								
¹ Does not apply in all cases. If applicable, include the year of injury.	e the value of FICA and	state income tax using the figur	res provided in the back	of the agency's rate tables of	orresponding to			
2 Line G = (Line C + D + E) x Line F. (This figure	should appear in Part C	, Line 37, with the appropriate a	djustment code)					
SOCIAL SECURITY This section	applies to old ac	ge retirement benefits	ONIV. (Enter net bene	efit with code "B" in Part C, L	.ine 37)			
A. MONTHLY SOCIAL SECURITY OLD AGE			,	\$ 2,100				
B. WEEKLY SOCIAL SECURITY OLD AGE R	ETIREMENT AMOUNT ((Line A divided by 4.33)		\$484.	99			
O 500/ OF LINE D								

	Country Control of the country applied to the ago for other bottome of the control of the country applied to the ago for other bottome of the country applied to							
A.	MONTHLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT	\$ 2,100.00						
В.	WEEKLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT (Line A divided by 4.33)	\$484.99						
C.	50% OF LINE B	\$242.50						
D.	50% OF BASE RATE (Found in Box 36)	\$208.45						
E.	IS DATE OF INJURY ON OR AFTER 12/19/11?	□YES ⊠NO						
	IF NO – COORDINATE AMOUNT IN LINE C	\$ 242.50						
	IF YES – WERE SOCIAL SECURITY OLD AGE RETIREMENT BENEFITS BEING PAID ON THE DATE OF INJURY?	□YES □NO						
	IF NO – COORDINATE AMOUNT IN LINE C							
	IF YES – COORDINATE THE LOWEST AMOUNT FOUND IN LINE C OR D							

UNEMPLOYMENT COMPENSATION A. NUMBER OF WEEKS AWARDED

B. BEGINNING DATE OF UNEMPLOYMENT COMPENSATION
 C. SCHEDULED EXPIRATION DATE

D. TOTAL WEEKLY UNEMPLOYMENT COMPENSATION BENEFITS (Enter with code "D" in Part C, Line 37)

PART F - RATE ADJUSTMENT³ FOR POST INJURY WAGE EARNING CAPACITY (PIWEC)

(MCL 418.301(8) & 401(6))

A.	AVERAGE WEEKLY WAGE (On front, Line 27)	
B.	80% AFTER-TAX AMOUNT OF LINE A (See calc program or rate charts)	
C.	100% AFTER-TAX AMOUNT (Line B multiplied by 1.25)	
D.	GROSS WEEKLY POST INJURY WAGE EARNING CAPACITY (PIWEC) AMOUNT	
E.	DIFFERENCE BETWEEN 100% AFTER-TAX AMOUNT AND PIWEC (Line C minus Line D) If the calculation in line E is less than or equal to \$0, report base rate as adjustment amount in G.	
F.	80% of Line E (Line E multiplied by .8) ³	
G.	AMOUNT OF ADJUSTMENT FOR PIWEC (Base rate from front, Line 36, minus Line F) This figure should appear on front, Part C, Line 37, with appropriate adjustment code R. If the adjustment calculation shows an amount that is less than or equal to \$0, no adjustment can be applied.	
3 -		

³ For injury dates on or after 12/19/11, the weekly benefit rate payable is 80% of the difference between the injured employee's after-tax average weekly wage before the personal injury and the employee's wage earning capacity after the personal injury but not more than the maximum weekly rate determined under section 355.

LARA is an equal opportunity employer/program. Auxiliary aids, services and	Authority:	Workers' Disability Compensation Act, R408.31(6a-d)
other reasonable accommodations are available upon request to individuals	Completion:	Mandatory
with disabilities.	Penalty:	Workers' Disability Compensation Act, 418.631; 418.801