

## GENERAL INFORMATION - FORM 701

The Form WC-701 (hereafter referred to as Form 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 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 was 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 Form 701's 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 701. If the redemption involves a claim which is in payment status, the system will automatically close out the weekly payments **assuming** that the weekly rate, date of injury and carrier listed on the redemption order match the information on the latest Form 701. If not, a Form 701 must be filed closing out the weekly payments. A Form 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 701. If the advance payment order results in a reduction or termination of the weekly rate, a Form 701 must be filed showing the rate change or termination.

In February of each year, the Agency runs a program which closes all open paying claims as of December 31<sup>st</sup> and reopens them on January 1<sup>st</sup>. Once that is done, an Open Claim Validation Report is sent to each carrier or service company/TPA listing all claims that closed and reopened as well as those that could not be closed because of an error. This report should be used to verify that all claims on the report are still in open payment status and that the rate is correct. If not, the appropriate Form 701's 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 701 must be filed.

Form 701's 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 701

### PART A

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

- #1. **Social Security Number:** 9 digit numeric.
- #2. **Date of Injury:** Must be complete date (MM/DD/YY).
- #3. **Employee Name:** Employee's last name, first name and middle initial.
- #4. **Date of Birth:** Must be complete date (MM/DD/YY).
- #5. **Date of Death:** If employee is deceased, enter complete date (MM/DD/YY).
- #6-9. **Employee Address:** Complete mailing address of employee.
- #10. **Employer Name:** Enter complete business name of employer (DBA, 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/TPA 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. **Service Company/TPA Name:** Enter name of service company/TPA handling claim, if applicable.
- #20. **Service Company/TPA Number:** The 3 digit service company/TPA ID number assigned by the Agency must be reported if a service company/TPA name is present in #19.
- #21. **Zip Code of Issuing Office:** Zip code of carrier, self-insured employer or service company/TPA filing the form. The zip code will be used in conjunction with the carrier or service company/TPA ID 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:** The date carrier received notice of injury. This information is required on all voluntary payment cases 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 cases 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 701.

- #25. **Nature of Injury:** Provide a brief description of the injury or disease. If desired, the codes from the attached list 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 attached list 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 in 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 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 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. Used whenever benefits are commencing and continuing. Complete the Basis of Payment, Benefit Type, Special Payment (if applicable), Weekly Rate, and From Date.
  - B. Used whenever there is a change in the current rate and benefits are continuing. 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 701.
  - C. Used whenever benefits that were previously reported are now being terminated. Complete the entire first line showing the total payments made for the current calendar year only.
  - D. Used whenever benefits that have never been previously reported are both commencing and terminating. Complete the entire first line showing the total payments that were made.
  - E. 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. 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. Used whenever a claim that had previously been in payment status is now reopening and benefits are continuing. Complete the Basis of Payment, Benefit Type, Special Payment (if applicable), Weekly Rate, and From Date.
- G. Used whenever benefits are both commencing and terminating on a claim that had previously been in payment status. Complete the entire first line showing the total payments that were made.
- H. Used to report the amount of partial benefits that were paid on all claims which are in partial benefit status as of 12/31. 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. 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 12/31 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. Used whenever information was improperly reported on a previous Form 701.

**#36. Weekly Compensation Base Rate:** The base rate which is owed prior to taking into account any adjustment(s) specified in item 37.

**#37. Weekly Adjustments to Base Rate:** This item should always be completed when the base rate in item 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 equal to A-G (coordination of benefits), the appropriate section in Part E should also be completed on the back of the form. If the code is equal to "J" or "K", the order number must also be entered in the space provided below Part D.

**#38. 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 701 on a claim:

##### **BASIS OF PAYMENT**

Indicate the appropriate code from the back of the Form 701. 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 back of the Form 701. 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.

##### **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. When the termination reason is "B" (recovered from disability), a medical report must be attached. 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 agreement (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.
- #41. 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 Labor & Economic Growth  
 Workers' Compensation Agency  
 P.O. Box 30016, Lansing, MI 48909

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

**PART A**

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth	5. Date of Death
6. Employee Street Address		7. City	8. State	9. ZIP Code
10. Employer Name			11. Federal ID Number	12. Injury Location Code
13. Employer Street Address		14. City	15. State	16. ZIP Code
17. Carrier or Self-Insured Name			18. NAIC or Self-Insured Number	
19. Service Company/TPA Name (if applicable)			20. Service Company/TPA ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made

**PART B**

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

**PART C**

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

**PART D**

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

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

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

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

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

# FILING CODES FOR FORM WC -701

**31. TAX FILING STATUS**

- A = SINGLE
- B = SINGLE/HEAD OF HOUSEHOLD
- C = MARRIED/FILING JOINT
- D = MARRIED/FILING SEPARATE

**37. WEEKLY ADJUSTMENTS TO BASE RATE**

- A = WAGE CONTINUATION OFFSET (-)
- B = SOCIAL SECURITY COORDINATION (-)
- C = PENSION OFFSET (-)
- D = UNEMPLOYMENT OFFSET (-)
- E = DISABILITY INSURANCE OFFSET (-)
- F = SELF INSURANCE OFFSET (-)
- G = OTHER BENEFIT COORDINATION (-)
- H = AGE 65 REDUCTION (-)
- I = COMPENSATION SUPPLEMENT (+)
- J = ADVANCE PAYMENT (-)
- K = 30% APPEAL ADJUSTMENT (-)
- L = SIF DIFFERENTIAL BENEFITS (+)
- M = DOUBLE COMPENSATION (+)
- N = THIRD PARTY OFFSET (-)
- O = 2 YEARS CONTINUOUS DISABILITY (+)
- P = RECOUPMENT OF OVERPAYMENT (-)
- O = OTHER

**38. REIMBURSEMENT BY A FUND\***

- A = SILICOSIS, DUST DISEASE & LOGGING INDUSTRY COMPENSATION FUND
- B = SELF-INSURERS' SECURITY FUND
- C = VOCATIONALLY HANDICAPPED PROVISIONS/SIF
- D = OTHER

\*DO NOT REPORT REIMBURSEMENTS RECEIVED AS A RESULT OF THE 70% OR DUAL EMPLOYMENT PROVISIONS. THIS INFORMATION WILL BE PROVIDED TO US BY THE SECOND INJURY FUND.

**35. REASON FOR FILING**

- A = COMMENCING BENEFITS
- B = CHANGE IN WEEKLY RATE
- C = TERMINATING BENEFITS
- D = COMMENCING AND TERMINATING BENEFITS
- E = REIMBURSEMENT BY A FUND
- F = REOPENING CLAIM
- G = REOPENING AND CLOSING CLAIM
- H = YEARLY REPORT OF PARTIAL PAYMENTS
- I = ERROR ON PREVIOUS FILING (ATTACH COPY)

**PART D – BASIS OF PAYMENT**

- A = VOLUNTARY PAYMENT
- B = OPEN AWARD
- C = CLOSED AWARD
- D = STIPULATED AWARD
- E = COMPROMISE
- F = FORM 115 VOLUNTARY PAY

**PART D – BENEFIT TYPE**

- A = GENERAL DISABILITY
- B = PARTIAL WAGE LOSS
- C = SPECIFIC LOSS
- D = PERMANENT TOTAL
- E = DEATH
- F = OTHER

**PART D – SPECIAL PAYMENT**

- A = ACCRUED BENEFITS
- B = INTEREST
- C = 30% APPEAL ADJUSTMENT
- D = OTHER

**PART D – TERMINATION REASON**

- A = RETURNED TO WORK WITH NO WAGE LOSS
- B = RECOVERED FROM DISABILITY (ATTACH MEDICAL)
- C = AWARD REVERSED
- D = END OF SPECIFIC LOSS
- E = CLAIMANT DECEASED (ATTACH DEATH CERTIFICATE)
- F = CLOSING OUT WEEKLY DUE TO REDEMPTION
- G = CLOSING OUT WEEKLY DUE TO ADVANCE PAYMENT
- H = OTHER

## PART E – COORDINATION OF BENEFITS

**SECTION 1-5**

	1. PENSION	2. WAGE CONTINUATION	3. DISABILITY INSURANCE	4. SELF INSURANCE	5. 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*					
E. STATE INCOME TAX*					
F. % EMPLOYER CONTRIBUTION					
G. INCOME TO BE COORDINATED**					

\* Does not apply in all cases. If applicable, include the value of FICA and state income tax using the figures provided in the back of the agency's rate tables corresponding to the year of injury.

\*\* Line G = (Line C + D + E) x Line F. (This figure should appear in Section 37 with the appropriate adjustment code.)

**SECTION 6 – SOCIAL SECURITY**

A. MONTHLY OLD-AGE BENEFIT	\$ _____
B. WEEKLY OLD-AGE BENEFIT (ABOVE AMOUNT ÷ 4.33)	\$ _____
C. TOTAL AMOUNT OF SOCIAL SECURITY BENEFITS TO BE COORDINATED (50% OF LINE B)	\$ _____ (ENTER WITH CODE "B" IN SECTION 37)

**SECTION 7 – UNEMPLOYMENT COMPENSATION**

A. NUMBER OF WEEKS AWARDED _____	
B. BEGINNING DATE OF UNEMPLOYMENT COMPENSATION _____ / _____ / _____	SCHEDULED EXPIRATION DATE _____ / _____ / _____
C. TOTAL WEEKLY UNEMPLOYMENT COMPENSATION BENEFITS \$ _____	(ENTER WITH CODE "D" IN SECTION 37)

The Department of Labor & Economic Growth will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

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

# 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
						Deps ____ Base Amt \$ _____ Adjustment Code ____ \$ _____ _____ \$ _____
						Deps ____ Base Amt \$ _____ Adjustment Code ____ \$ _____ _____ \$ _____
						Deps ____ Base Amt \$ _____ Adjustment Code ____ \$ _____ _____ \$ _____
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						Deps ____ Base Amt \$ _____ Adjustment Code ____ \$ _____ _____ \$ _____

**Basis of Payment**

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

**Benefit Type**

- A = General Disability
- B = Partial Wage Loss
- C = Specific Loss
- D = Permanent Total
- E = Death
- F = Other

**Special Payment**

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

**Weekly Adjustments to Base Rate**

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>A = Wage Continuation Offset</li> <li>B = Social Security Coordination</li> <li>C = Pension Offset</li> <li>D = Unemployment Offset</li> <li>E = Disability Insurance Offset</li> <li>F = Self-Insurance Offset</li> <li>G = Other Benefit Coordination</li> <li>H = Age 65 Reduction</li> <li>I = Compensation Supplement</li> </ul> | <ul style="list-style-type: none"> <li>J = Advance Payment</li> <li>K = 30% Appeal Adjustment</li> <li>L = SIF Differential Benefits</li> <li>M = Double Compensation</li> <li>N = Third-Party Offset</li> <li>O = 2-Years Continuous Disability</li> <li>P = Recoupment of Overpayment</li> <li>Q = Other</li> </ul> |
|--|---|

## NATURE OF INJURY CODES

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

## NATURE OF INJURY CODES

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

## PART OF BODY CODES

Code	Description	Code	Description
410	Abdomen (include internal organs); Hernia, inguinal	350	Fingertip(s)
520	Ankle	530	Foot (not ankle or toe); Metatarsal
310	Arm(s), above wrist, unspecified	315	Forearm; Radius; Ulna
318	Arm, multiple	397	Hand & Finger(s)
319	Arm, not elsewhere classified	330	Hand (not wrist or fingers); Metacarpal
801	Arteries; Blood; Circulatory system; Heart; Veins	198	Head, multiple
420	Back (include back muscles); Coccyx; Lumbar; Sacrum; Spinal cord; Spine	100	Head, unspecified
311	Biceps; Humerus; Triceps; Upper arm	513	Knee; Patella
820	Bladder; Excretory system; Intestines; Kidneys	510	Leg(s) (above ankle), unspecified
800	Body system, unspecified	518	Leg, multiple
830	Bones; Joints; Muscles; Musculo-skeletal system; Tendons	519	Leg, not elsewhere classified
110	Brain; Concussion	144	Lips; Mouth (includes sense of taste, excludes teeth); Throat; Tongue
430	Breastbone; Chest (internal organs); Pectorals; Ribs; Sternum; Thorax	598	Lower extremities, multiple
440	Buttocks; Hips; Pelvic organs; Pelvis	500	Lower extremities, unspecified
200	Cervical; Neck	850	Lungs; Respiratory system
141	Cheek; Chin; Jaw; Mandible	700	Multiple parts (use when more than one major body part has been affected)
450	Clavicle; Deltoid; Scapula; Shoulder(s)	146	Nasal passages; Nose (includes sense of smell); Sinus
810	Digestive system	999	Nonclassifiable (insufficient information to identify affected part)
121	Ear(s), external	880	Other body systems
124	Ear(s), internal	150	Scalp
120	Ear(s), unspecified	160	Skull
313	Elbow; Olecranon	147	Teeth
840	Epilepsy; Nervous system	540	Toe(s)
130	Eye(s); Eyelid; Optic nerves; Vision	550	Toetip(s)
148	Face, multiple parts	498	Trunk, multiple
149	Face, not elsewhere classified; Forehead	400	Trunk, unspecified
140	Face, unspecified	398	Upper extremities, multiple
511	Femur; Thigh	300	Upper extremities, unspecified
515	Fibula; Lower leg; Tibia	320	Wrist
340	Finger(s)		

## List of Form 701 Examples

<b>Example #</b>	<b>Filing Reason</b>	<b>Description</b>
1	A	Commencing Benefits (No adjustments to base rate)
2	A	Commencing Benefits (With adjustments to base rate)
3	B	Change in Weekly Rate due to decrease in dependents
4	C	Terminating Benefits
5	D	Commencing & Terminating Benefits
6	F	Reopening Claim
7	G	Reopening & Closing Claim
8	H	Yearly Report of Partial Payments
9	A	Commencing Benefits as the result of an Open Award
10	D	Reporting of a Compromised Payment
11	B	Change in Weekly Rate due to reporting of P & T differential benefits

**EXAMPLE #1**

**FILING REASON “A” – COMMENCING BENEFITS**

**(NO ADJUSTMENTS TO BASE RATE)**

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

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

**PART A**

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth	5. Date of Death
6. Employee Street Address		7. City	8. State	9. ZIP Code
10. Employer Name			11. Federal ID Number	12. Injury Location Code
13. Employer Street Address		14. City	15. State	16. ZIP Code
17. Carrier or Self-Insured Name			18. NAIC or Self-Insured Number	
19. Service Company/TPA Name (if applicable)			20. Service Company/TPA ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made

**PART B**

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

**PART C**

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

**PART D**

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

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

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

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

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

**EXAMPLE #2**

**FILING REASON “A” – COMMENCING BENEFITS**

**(WITH ADJUSTMENTS TO BASE RATE)**

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

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

**PART A**

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

**PART B**

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

**PART C**

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

**PART D**

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

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

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

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# FILING CODES FOR FORM WC -701

<b>31. TAX FILING STATUS</b> A = SINGLE B = SINGLE/HEAD OF HOUSEHOLD C = MARRIED/FILING JOINT D = MARRIED/FILING SEPARATE	<b>37. WEEKLY ADJUSTMENTS TO BASE RATE</b> A = WAGE CONTINUATION OFFSET (-) B = SOCIAL SECURITY COORDINATION (-) C = PENSION OFFSET (-) D = UNEMPLOYMENT OFFSET (-) E = DISABILITY INSURANCE OFFSET (-) F = SELF INSURANCE OFFSET (-) G = OTHER BENEFIT COORDINATION (-) H = AGE 65 REDUCTION (-) I = COMPENSATION SUPPLEMENT (+) J = ADVANCE PAYMENT (-) K = 30% APPEAL ADJUSTMENT (-) L = SIF DIFFERENTIAL BENEFITS (+) M = DOUBLE COMPENSATION (+) N = THIRD PARTY OFFSET (-) O = 2 YEARS CONTINUOUS DISABILITY (+) P = RECOUPMENT OF OVERPAYMENT (-) O = OTHER	<b>38. REIMBURSEMENT BY A FUND*</b> A = SILICOSIS, DUST DISEASE & LOGGING INDUSTRY COMPENSATION FUND B = SELF-INSURERS' SECURITY FUND C = VOCATIONALLY HANDICAPPED PROVISIONS/SIF D = OTHER  *DO NOT REPORT REIMBURSEMENTS RECEIVED AS A RESULT OF THE 70% OR DUAL EMPLOYMENT PROVISIONS. THIS INFORMATION WILL BE PROVIDED TO US BY THE SECOND INJURY FUND.
<b>35. REASON FOR FILING</b> A = COMMENCING BENEFITS B = CHANGE IN WEEKLY RATE C = TERMINATING BENEFITS D = COMMENCING AND TERMINATING BENEFITS E = REIMBURSEMENT BY A FUND F = REOPENING CLAIM G = REOPENING AND CLOSING CLAIM H = YEARLY REPORT OF PARTIAL PAYMENTS I = ERROR ON PREVIOUS FILING (ATTACH COPY)		

<b>PART D – BASIS OF PAYMENT</b> A = VOLUNTARY PAYMENT B = OPEN AWARD C = CLOSED AWARD D = STIPULATED AWARD E = COMPROMISE F = FORM 115 VOLUNTARY PAY	<b>PART D – BENEFIT TYPE</b> A = GENERAL DISABILITY B = PARTIAL WAGE LOSS C = SPECIFIC LOSS D = PERMANENT TOTAL E = DEATH F = OTHER	<b>PART D – SPECIAL PAYMENT</b> A = ACCRUED BENEFITS B = INTEREST C = 30% APPEAL ADJUSTMENT D = OTHER	<b>PART D – TERMINATION REASON</b> A = RETURNED TO WORK WITH NO WAGE LOSS B = RECOVERED FROM DISABILITY (ATTACH MEDICAL) C = AWARD REVERSED D = END OF SPECIFIC LOSS E = CLAIMANT DECEASED (ATTACH DEATH CERTIFICATE) F = CLOSING OUT WEEKLY DUE TO REDEMPTION G = CLOSING OUT WEEKLY DUE TO ADVANCE PAYMENT H = OTHER
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## PART E – COORDINATION OF BENEFITS

### SECTION 1-5

	1. PENSION	2. WAGE CONTINUATION	3. DISABILITY INSURANCE	4. SELF INSURANCE	5. 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*					
E. STATE INCOME TAX*					
F. % EMPLOYER CONTRIBUTION					
G. INCOME TO BE COORDINATED**					

\* Does not apply in all cases. If applicable, include the value of FICA and state income tax using the figures provided in the back of the agency's rate tables corresponding to the year of injury.

\*\* Line G = (Line C + D + E) x Line F. (This figure should appear in Section 37 with the appropriate adjustment code.)

### SECTION 6 – SOCIAL SECURITY

A. MONTHLY OLD-AGE BENEFIT	\$ _____	
B. WEEKLY OLD-AGE BENEFIT (ABOVE AMOUNT ÷ 4.33)	\$ _____	
C. TOTAL AMOUNT OF SOCIAL SECURITY BENEFITS TO BE COORDINATED (50% OF LINE B)	\$ _____	(ENTER WITH CODE "B" IN SECTION 37)

### SECTION 7 – UNEMPLOYMENT COMPENSATION

A. NUMBER OF WEEKS AWARDED _____	
B. BEGINNING DATE OF UNEMPLOYMENT COMPENSATION _____ / _____ / _____	SCHEDULED EXPIRATION DATE _____ / _____ / _____
C. TOTAL WEEKLY UNEMPLOYMENT COMPENSATION BENEFITS \$ _____	(ENTER WITH CODE "D" IN SECTION 37)

The Department of Labor & Economic Growth will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.	Authority: Workers' Disability Compensation Act, R408.31(6a-d) Completion: Mandatory Penalty: Workers' Disability Compensation Act, 418.631; 418.801
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**EXAMPLE #3**

**FILING REASON “B” – CHANGE IN WEEKLY RATE**

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

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

**PART A**

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth	5. Date of Death
6. Employee Street Address		7. City	8. State	9. ZIP Code
10. Employer Name			11. Federal ID Number	12. Injury Location Code
13. Employer Street Address		14. City	15. State	16. ZIP Code
17. Carrier or Self-Insured Name			18. NAIC or Self-Insured Number	
19. Service Company/TPA Name (if applicable)			20. Service Company/TPA ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made

**PART B**

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

**PART C**

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

**PART D**

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

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

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

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

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

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

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

**PART A**

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth	5. Date of Death
6. Employee Street Address		7. City	8. State	9. ZIP Code
10. Employer Name			11. Federal ID Number	12. Injury Location Code
13. Employer Street Address		14. City	15. State	16. ZIP Code
17. Carrier or Self-Insured Name			18. NAIC or Self-Insured Number	
19. Service Company/TPA Name (if applicable)			20. Service Company/TPA ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made

**PART B**

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

**PART C**

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

**PART D**

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

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

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39. Authorized signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date

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**EXAMPLE #4**

**FILING REASON “C” – TERMINATING BENEFITS**

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

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

**PART A**

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth	5. Date of Death
6. Employee Street Address		7. City	8. State	9. ZIP Code
10. Employer Name			11. Federal ID Number	12. Injury Location Code
13. Employer Street Address		14. City	15. State	16. ZIP Code
17. Carrier or Self-Insured Name			18. NAIC or Self-Insured Number	
19. Service Company/TPA Name (if applicable)			20. Service Company/TPA ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made

**PART B**

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

**PART C**

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

**PART D**

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

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

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39. Authorized signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date

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

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

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

**PART A**

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth	5. Date of Death
6. Employee Street Address		7. City	8. State	9. ZIP Code
10. Employer Name			11. Federal ID Number	12. Injury Location Code
13. Employer Street Address		14. City	15. State	16. ZIP Code
17. Carrier or Self-Insured Name			18. NAIC or Self-Insured Number	
19. Service Company/TPA Name (if applicable)			20. Service Company/TPA ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made

**PART B**

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

**PART C**

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

**PART D**

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

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

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**EXAMPLE #5**

**FILING REASON “D” – COMMENCING &  
TERMINATING BENEFITS**

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

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

**PART A**

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth	5. Date of Death
6. Employee Street Address		7. City	8. State	9. ZIP Code
10. Employer Name			11. Federal ID Number	12. Injury Location Code
13. Employer Street Address		14. City	15. State	16. ZIP Code
17. Carrier or Self-Insured Name			18. NAIC or Self-Insured Number	
19. Service Company/TPA Name (if applicable)			20. Service Company/TPA ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made

**PART B**

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

**PART C**

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

**PART D**

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

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

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

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39. Authorized signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date

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**EXAMPLE #6**

**FILING REASON “F” – REOPENING CLAIM**

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

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

**PART A**

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

**PART B**

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

**PART C**

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

**PART D**

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

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER # \_\_\_\_\_  
 IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS \_\_\_\_\_ AND EFFECTIVE DATE OF LOSS \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
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39. Authorized signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date

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

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

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

**PART A**

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth	5. Date of Death
6. Employee Street Address		7. City	8. State	9. ZIP Code
10. Employer Name			11. Federal ID Number	12. Injury Location Code
13. Employer Street Address		14. City	15. State	16. ZIP Code
17. Carrier or Self-Insured Name			18. NAIC or Self-Insured Number	
19. Service Company/TPA Name (if applicable)			20. Service Company/TPA ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made

**PART B**

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

**PART C**

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

**PART D**

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

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER # \_\_\_\_\_  
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**EXAMPLE #7**

**FILING REASON “G” – REOPENING & CLOSING CLAIM**

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

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

**PART A**

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth	5. Date of Death
6. Employee Street Address		7. City	8. State	9. ZIP Code
10. Employer Name			11. Federal ID Number	12. Injury Location Code
13. Employer Street Address		14. City	15. State	16. ZIP Code
17. Carrier or Self-Insured Name			18. NAIC or Self-Insured Number	
19. Service Company/TPA Name (if applicable)			20. Service Company/TPA ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made

**PART B**

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

**PART C**

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

**PART D**

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

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER # \_\_\_\_\_  
 IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS \_\_\_\_\_ AND EFFECTIVE DATE OF LOSS \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
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**NOTICE OF COMPENSATION PAYMENTS**  
 Michigan Department of Labor & Economic Growth  
 Workers' Compensation Agency  
 P.O. Box 30016, Lansing, MI 48909

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

**PART A**

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth	5. Date of Death
6. Employee Street Address		7. City	8. State	9. ZIP Code
10. Employer Name			11. Federal ID Number	12. Injury Location Code
13. Employer Street Address		14. City	15. State	16. ZIP Code
17. Carrier or Self-Insured Name			18. NAIC or Self-Insured Number	
19. Service Company/TPA Name (if applicable)			20. Service Company/TPA ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made

**PART B**

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

**PART C**

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

**PART D**

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

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER # \_\_\_\_\_  
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**EXAMPLE #8**

**FILING REASON “H” – YEARLY REPORT OF  
PARTIAL PAYMENTS**

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

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

**PART A**

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth	5. Date of Death
6. Employee Street Address		7. City	8. State	9. ZIP Code
10. Employer Name			11. Federal ID Number	12. Injury Location Code
13. Employer Street Address		14. City	15. State	16. ZIP Code
17. Carrier or Self-Insured Name			18. NAIC or Self-Insured Number	
19. Service Company/TPA Name (if applicable)			20. Service Company/TPA ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made

**PART B**

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

**PART C**

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

**PART D**

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

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER # \_\_\_\_\_  
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**NOTICE OF COMPENSATION PAYMENTS**  
 Michigan Department of Labor & Economic Growth  
 Workers' Compensation Agency  
 P.O. Box 30016, Lansing, MI 48909

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

**PART A**

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth	5. Date of Death
6. Employee Street Address		7. City	8. State	9. ZIP Code
10. Employer Name			11. Federal ID Number	12. Injury Location Code
13. Employer Street Address		14. City	15. State	16. ZIP Code
17. Carrier or Self-Insured Name			18. NAIC or Self-Insured Number	
19. Service Company/TPA Name (if applicable)			20. Service Company/TPA ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made

**PART B**

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

**PART C**

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

**PART D**

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

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER # \_\_\_\_\_  
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**Workers' Compensation Agency**  
**Verification of Monetary Information**  
**Partial Benefit Rates**  
 For Year: 2007

**File Name:** John R. Doe

**Last Update:** 09/03/2008 11:48:20

**Prior to Injury**

<b>Year of Injury:</b>	2007
<b>Gross Weekly Wage:</b>	\$450.00
<b>Discontinued Fringes:</b>	\$0.00
<b>Nbr of Dependents:</b>	3
<b>Tax Class:</b>	3
<hr/>	
<b>80 Percent Rate</b>	\$310.14 (Including fringes)

**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
<b>Grand Totals:</b>						<b>\$188.03</b>

**Number of Weeks: 8**

**EXAMPLE #9**

**BASIS OF PAYMENT “B” – OPEN AWARD**

**BENEFITS ORDERED @ \$345.98 PER WEEK  
BEGINNING ON 3/12/06**

**ACCRUED BENEFITS PAID ON 5/8/07**

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

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

**PART A**

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

**PART B**

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

**PART C**

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

**PART D**

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

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER # \_\_\_\_\_  
 IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS \_\_\_\_\_ AND EFFECTIVE DATE OF LOSS \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
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**Workers' Compensation Agency**  
**Verification of Monetary Information**  
**Accrued Payment & Interest**

<b>Begin Date</b>	<b>End Date</b>	<b>Paid Date</b>	<b>Comp Rate</b>	<b>Days Worked</b>	<b>Total Weeks</b>	<b>Rem Days</b>	<b>Total Comp</b>	<b>Total Interest</b>	<b>Total Comp &amp; Interest</b>
03/12/2006	05/08/2007	05/08/2007	\$345.98	7	60	3	\$20,907.08	\$1,174.43	\$22,081.51
<b>Grand Totals</b>					<b>60</b>	<b>3</b>	<b>\$20,907.08</b>	<b>\$1,174.43</b>	<b>\$22,081.51</b>

**EXAMPLE #10**

**BASIS OF PAYMENT “E” – COMPROMISE**

**(RATE & TERMINATION REASON NOT REQUIRED)**

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

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

**PART A**

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth	5. Date of Death
6. Employee Street Address		7. City	8. State	9. ZIP Code
10. Employer Name			11. Federal ID Number	12. Injury Location Code
13. Employer Street Address		14. City	15. State	16. ZIP Code
17. Carrier or Self-Insured Name			18. NAIC or Self-Insured Number	
19. Service Company/TPA Name (if applicable)			20. Service Company/TPA ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made

**PART B**

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

**PART C**

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

**PART D**

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

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER # \_\_\_\_\_  
 IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS \_\_\_\_\_ AND EFFECTIVE DATE OF LOSS \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
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**EXAMPLE #11**

**BENEFIT TYPE “D” – PERMANENT TOTAL**

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

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

**PART A**

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth	5. Date of Death
6. Employee Street Address		7. City	8. State	9. ZIP Code
10. Employer Name			11. Federal ID Number	12. Injury Location Code
13. Employer Street Address		14. City	15. State	16. ZIP Code
17. Carrier or Self-Insured Name			18. NAIC or Self-Insured Number	
19. Service Company/TPA Name (if applicable)			20. Service Company/TPA ID Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made

**PART B**

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

**PART C**

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

**PART D**

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

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

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

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

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