

## APPLICATION FOR REIMBURSEMENT

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
 FUNDS ADMINISTRATION  
 7150 Harris Drive, 1<sup>st</sup> Floor, A-Wing Lansing, MI 48913

### FUNDS ADMINISTRATION

1. Total & Permanent Disability Provision - Section 521 (1) (2)
2. 70% Reimbursement Provision - Section 862
3. Two Years of Continuous Disability Provision - Section 356 (1)
4. Vocationally Handicapped Provision - Section 925
5. Dual Employment Provision - Section 372
6. Silicosis, Dust Disease and Logging Industry Compensation Fund - Section 531

REQUEST NUMBER

CARRIER FILE NUMBER

### COMPLETE THIS SECTION FOR ALL FUNDS

**Applications for reimbursement should be submitted every six months unless otherwise indicated.**

EMPLOYEE NAME (Last, First, Middle)		SOCIAL SECURITY NUMBER	INJURY DATE		BIRTH DATE
EMPLOYEE ADDRESS (Street Number and Name)		CITY	STATE	ZIP CODE	PHONE NUMBER ( )
NAME OF EMPLOYER		EMPLOYER ADDRESS			
CARRIER (Insurance Company or Self-Insured Employer)*		SERVICE COMPANY OR TPA (If Applicable)			
CARRIER FEDERAL I.D. NUMBER	CONTACT PERSON		EMAIL ADDRESS		PHONE NUMBER ( )
PAYMENT ADDRESS <b>(*To receive payment carrier must be registered with the State of Michigan, Budget Office. Register at <a href="http://www.michigan.gov/cpexpress">www.michigan.gov/cpexpress</a> or 1-888-734-9749)</b>					

AVERAGE WEEKLY WAGE \$	DISCONTINUED FRINGES \$	TAX FILING STATUS (AT DOI)	CARRIER/EMPLOYER PRESENT WEEKLY COMPENSATION RATE \$	Benefits Calculated on ____ Day Week	IS THERE A THIRD PARTY CLAIM <input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, provide pertinent information on claim)
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#### DEPENDENTS

SPOUSE \_\_\_\_\_

CHILDREN (Name and Date of Birth) \_\_\_\_\_ (Name and Birth Date) \_\_\_\_\_ (Name and Date of Birth) \_\_\_\_\_ (Name and Date of Birth) \_\_\_\_\_

HAS BASIC BENEFIT CHANGED or TERMINATED DURING PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO  EFFECTIVE DATE: _____	<b>REASON FOR CHANGE</b> <input type="checkbox"/> Age Reduction <input type="checkbox"/> Benefit Coordination <input type="checkbox"/> Employments <input type="checkbox"/> Unemployment Compensation <input type="checkbox"/> Dependency Change (Attach Verification) <input type="checkbox"/> Other _____ <input type="checkbox"/> Death Date of Death _____ (Attach Death Certificate)
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HAS EMPLOYEE BEEN GAINFULLY EMPLOYED DURING PERIOD COVERED BY THIS REIMBURSEMENT?

YES - Attach records confirming employment with evidence of weeks and hours worked, and earnings statement.  
 (Provide evidence on value of fringe benefits if applicable)

NO - Attach information received verifying continuing disability and current activities

**(1) COMPLETE this section when requesting reimbursement from the Second Injury Fund - TOTAL AND PERMANENT DISABILITY PROVISION:**

Weekly differential benefits paid on Fund's behalf:

\_\_\_\_\_ thru \_\_\_\_\_, \_\_\_\_\_ weeks at \$ \_\_\_\_\_ = \$ \_\_\_\_\_

\_\_\_\_\_ thru \_\_\_\_\_, \_\_\_\_\_ weeks at \$ \_\_\_\_\_ = \$ \_\_\_\_\_

TOTAL AMOUNT REQUESTED IN THIS REIMBURSEMENT \$ \_\_\_\_\_

**(2) COMPLETE this section when requesting reimbursement from the Second Injury Fund - 70% REIMBURSEMENT PROVISION:**  
 (submit after all appeals are final)

(a) Attach decision by Board of Magistrates ordering payment and all subsequent orders and decisions including order reversing/modifying decision.  
 (b) Confirmation that ALL appeals are final  YES  NO  
 (c) Attach copy of all 701's.  
 (d) Provide written verification of dependents during appeal period.

**NOTE:** Request reimbursement for medical expenses paid under section 862(2) by completing WCA Form 271.

70% Benefits Paid on Appeal:

\_\_\_\_\_ thru \_\_\_\_\_, \_\_\_\_\_ weeks at \$ \_\_\_\_\_ = \$ \_\_\_\_\_

\_\_\_\_\_ thru \_\_\_\_\_, \_\_\_\_\_ weeks at \$ \_\_\_\_\_ = \$ \_\_\_\_\_

Total 70% Benefits Paid: \$ \_\_\_\_\_

Minus: Dollar Value of final award, including interest (if applicable): - \$ \_\_\_\_\_

TOTAL AMOUNT REQUESTED IN THIS REIMBURSEMENT \$ \_\_\_\_\_

**(3) COMPLETE this section when requesting reimbursement from the Second Injury Fund - TWO YEARS OF CONTINUOUS DISABILITY PROVISION**  
 Reimbursement due on a quarterly basis.

Weekly benefit rate paid on Second Injury Fund's behalf:  
 \_\_\_\_\_ thru \_\_\_\_\_, \_\_\_\_\_ weeks at \$ \_\_\_\_\_ = \$ \_\_\_\_\_  
 \_\_\_\_\_ thru \_\_\_\_\_, \_\_\_\_\_ weeks at \$ \_\_\_\_\_ = \$ \_\_\_\_\_  
 TOTAL AMOUNT REQUESTED IN THIS REIMBURSEMENT \$ \_\_\_\_\_  
 REIMBURSEMENT FOR REDEMPTION PAYMENT \$ \_\_\_\_\_

**(4) COMPLETE this section when requesting reimbursement from the Second Injury Fund - VOCATIONALLY HANDICAPPED PROVISION**  
 Vocational rehabilitation benefits under section 319 are reimbursable from the date of injury

\_\_\_\_\_ thru \_\_\_\_\_, \_\_\_\_\_ weeks at \$ \_\_\_\_\_ = \$ \_\_\_\_\_  
 \_\_\_\_\_ thru \_\_\_\_\_, \_\_\_\_\_ weeks at \$ \_\_\_\_\_ = \$ \_\_\_\_\_  
 Total weekly benefits paid on Fund's behalf: \$ \_\_\_\_\_  
 Medical expenses paid during period (attach copies of bills and reports): \$ \_\_\_\_\_  
 Vocational rehabilitation costs paid during period (attach copies of bills and reports): \$ \_\_\_\_\_  
 TOTAL AMOUNT REQUESTED IN THIS REIMBURSEMENT \$ \_\_\_\_\_

**5) COMPLETE this section when requesting reimbursement from the Second Injury Fund - DUAL EMPLOYMENT PROVISION**  
 Reimbursement due on a quarterly basis

- NOTE: (1) Include forms 100 & 701. Attach WAGE RECORDS (**by pay period ending dates**) for all employers.  
 (2) Attach DOCUMENTATION OF DISABILITY, i.e., medical records.  
 (3) Complete only Section II below on continuous reimbursement cases, otherwise, complete both.

INSTRUCTION FOR COMPLETION OF SECTION I:

- (1) 3 or more employers? Use separate sheet to provide information (employer, address, wages) required  
 (2) Carry out apportionment percentages to one hundredths of a percentage (**xx.xx% or .xxxx**)  
 (3) Average weekly wage with each employer is based upon number of weeks worked at that employer

**I. Name of Employer: Place of Injury**

	WAGES	# OF WEEKS USED	AVERAGE
_____	\$ _____ + _____		= \$ _____ (A)
Name of Other Employer _____	\$ _____ + _____		= \$ _____
Address: _____	Total average weekly wages		
_____	From separate sheet (if applicable): \$ _____		
Phone: _____	Total: \$ _____ (B)		
Has there been a return to work with any employer	Employer _____	Date: _____	
YES NO If yes, complete section across → → →	Employer _____	Date: _____	
	Employer _____	Date: _____	

**II. Carrier Apportionment % of liability:**

Dual Employment Provision's % of liability: \$ \_\_\_\_\_ (A) ÷ \$ \_\_\_\_\_ (B) = \_\_\_\_\_ % (C)  
 100% - \_\_\_\_\_ (C) = \_\_\_\_\_ % (D)  
 If (D) is less than 20% the DUAL EMPLOYMENT PROVISION has no liability pursuant to Section 372.  
 Workers' Compensation Benefits paid during period:

\_\_\_\_\_ thru \_\_\_\_\_, \_\_\_\_\_ weeks at \$ \_\_\_\_\_ = \$ \_\_\_\_\_  
 \_\_\_\_\_ thru \_\_\_\_\_, \_\_\_\_\_ weeks at \$ \_\_\_\_\_ = \$ \_\_\_\_\_  
 Total weekly benefits paid during this reimbursement period: \$ \_\_\_\_\_ (E)  
 TOTAL AMOUNT REQUESTED IN THIS REIMBURSEMENT \_\_\_\_\_ (E) x \_\_\_\_\_ % (D) = \$ \_\_\_\_\_  
 REIMBURSEMENT FOR REDEMPTION PAYMENT \$ \_\_\_\_\_

**(6) COMPLETE this section when requesting reimbursement from the SILICOSIS & DUST DISEASE FUND or LOGGING INDUSTRY COMPENSATION FUND**

Weekly benefits paid during this period:  
 \_\_\_\_\_ thru \_\_\_\_\_, \_\_\_\_\_ weeks at \$ \_\_\_\_\_ = \$ \_\_\_\_\_  
 \_\_\_\_\_ thru \_\_\_\_\_, \_\_\_\_\_ weeks at \$ \_\_\_\_\_ = \$ \_\_\_\_\_  
 \_\_\_\_\_ thru \_\_\_\_\_, \_\_\_\_\_ weeks at \$ \_\_\_\_\_ = \$ \_\_\_\_\_  
 Total benefits paid during period \$ \_\_\_\_\_  
 Minus threshold on first reimbursement only - \_\_\_\_\_  
 Apportionment percentage due (SDDF only): x \_\_\_\_\_ %  
 TOTAL AMOUNT REQUESTED IN THIS REIMBURSEMENT: \$ \_\_\_\_\_

SIGNATURE OF AUTHORIZED REPRESENTATIVE AND TITLE

DATE SUBMITTED