

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.

#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 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.
- #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 Licensing and Regulatory Affairs
 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 N/A
13. Employer Street Address		14. City	15. State	16. ZIP Code
17. Carrier or Self-Insured Name			18. NAIC or Self-Insured Number	
19. Self-Insurer's Service Company Name			20. Service Company 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 LINE 40.

PART E – 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, 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.

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

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	
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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
IF NO – COORDINATE AMOUNT IN LINE C	
IF YES – WERE SOCIAL SECURITY OLD AGE RETIREMENT BENEFITS BEING PAID ON THE DATE OF INJURY?	<input type="checkbox"/> YES <input type="checkbox"/> 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 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) Completion: Mandatory Penalty: Workers' Disability Compensation Act, 418.631; 418.801
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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 | G. Reopening and Closing Claim |
| C. Terminating Benefits | 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 (-) | J. Advance Payment (-) |
| B. Social Security Coordination (-) | K. 30% Appeal Adjustment (-) |
| 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 (-) |
| 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 |
| D. 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
						Deps ____ Base Amt \$ _____ Adjustment Code ____ \$ _____ Adjustment Code ____ \$ _____
						Deps ____ Base Amt \$ _____ Adjustment Code ____ \$ _____ Adjustment Code ____ \$ _____
						Deps ____ Base Amt \$ _____ Adjustment Code ____ \$ _____ Adjustment Code ____ \$ _____
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						Deps ____ Base Amt \$ _____ Adjustment Code ____ \$ _____ 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
- W = Rate with Post Injury Wage Earning Capacity (PIWEC)

Special Payment

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

Weekly Adjustments to Base Rate

- | | |
|--|--|
| <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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 Q = Other R = Post Injury Wage Earning Capacity (PIWEC) |
|--|--|

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 WC-701 Examples

EXAMPLE #	FILING REASON	DESCRIPTION
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
5a	D	Commencing and terminating benefits
5b	D	Commencing and terminating benefits – reduced to zero more than 14 days
6	F	Reopening claim
7a	G	Reopening and closing claim
7b	G	Reopening and closing claim – reduced to zero more than 14 days
8	H	Yearly report of partial payments
9	B	Commencing benefits as the result of an open award
10	E	Reporting a compromised payment
11	D	Change in weekly rate due to reporting of P&T differential benefits
12	A	Rate with post injury wage earning capacity (PIWEC)
13	A	Old-age social security benefits being paid on DOI occurring after 12/19/11
14	A	Old-age social security benefits not being paid on DOI occurring after 12/19/11
15	A	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

PART A

1. Social Security Number 111-22-3333	2. Date of Injury 02/01/2007	3. Employee Name (Last, First, MI) Doe, John R.	4. Date of Birth 09/04/1950	5. Date of Death
6. Employee Street Address 123 North Elm Street		7. City Lansing	8. State MI	9. ZIP Code 48910
10. Employer Name Smith's Auto Repair			11. Federal ID Number 38-1111111	12. Injury Location Code N/A
13. Employer Street Address 34310 South Baker Street		14. City Lansing	15. State MI	16. ZIP Code 48915
17. Carrier or Self-Insured Name United States Insurance Company			18. NAIC or Self-Insured Number 999999999	
19. Self-Insurer's Service Company Name			20. Service Company ID Number	
21. ZIP Code of Issuing Office 48912	22. Carrier or Self-Insured Claim Number D12345-1	23. Date Carrier Received Notice of Injury 02/03/2007	24. Date First Payment Made 02/07/2007	

PART B

25. Nature of Injury Sprain (310)		26. Part of Body Ankle (520)	
27. Average Weekly Wage \$ 450.00	28. Discontinued Fringes \$ 0.00	29. Second Employer A.W.W. \$	30. Second Employer Discontinued Fringes \$
31. Tax Filing Status on Date of Injury C	32. Last Day Worked 02/01/2007	33. Number of Days in Work Week 7	34. Number of Dependents 3

PART C

35. Reason for Filing A	36. Weekly Compensation Base Rate \$ 310.14
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
A	A		\$ 310.14	02/02/2007				

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) Jane Smith	41. Telephone Number 517-999-9999	42. Date 02/12/2007

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

PART A

1. Social Security Number 111-22-3333		2. Date of Injury 02/01/2007		3. Employee Name (Last, First, MI) Doe, John R.		4. Date of Birth 09/04/1950		5. Date of Death	
6. Employee Street Address 123 North Elm Street				7. City Lansing		8. State MI		9. ZIP Code 48910	
10. Employer Name Smith's Auto Repair						11. Federal ID Number 38-1111111		12. Injury Location Code N/A	
13. Employer Street Address 34310 South Baker Street				14. City Lansing		15. State MI		16. ZIP Code 48915	
17. Carrier or Self-Insured Name United States Insurance Company						18. NAIC or Self-Insured Number 999999999			
19. Self-Insurer's Service Company Name						20. Service Company ID Number			
21. ZIP Code of Issuing Office 48912		22. Carrier or Self-Insured Claim Number D12345-1		23. Date Carrier Received Notice of Injury 02/03/2007		24. Date First Payment Made 02/07/2007			

PART B

25. Nature of Injury Sprain (310)		26. Part of Body Ankle (520)	
27. Average Weekly Wage \$ 450.00		28. Discontinued Fringes \$ 0.00	
29. Second Employer A.W.W. \$		30. Second Employer Discontinued Fringes \$	
31. Tax Filing Status on Date of Injury C		32. Last Day Worked 02/01/2007	
33. Number of Days in Work Week 7		34. Number of Dependents 3	

PART C

35. Reason for Filing A		36. Weekly Compensation Base Rate \$ 310.14	
37. Weekly Adjustments to Base Rate			
A \$ 387.68		\$	
\$		\$	
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
A	A		\$0.00	02/02/2007				

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)	
		Jane Smith	
41. Telephone Number		42. Date	
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.

EXAMPLE #2 – continued**PART E – COORDINATION OF BENEFITS**

	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 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.

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

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	
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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
IF NO – COORDINATE AMOUNT IN LINE C	
IF YES – WERE SOCIAL SECURITY OLD AGE RETIREMENT BENEFITS BEING PAID ON THE DATE OF INJURY?	<input type="checkbox"/> YES <input type="checkbox"/> 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 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)
Completion: Mandatory
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

PART A

1. Social Security Number 111-22-3333	2. Date of Injury 02/01/2007	3. Employee Name (Last, First, MI) Doe, John R.	4. Date of Birth 09/04/1950	5. Date of Death
6. Employee Street Address 123 North Elm Street		7. City Lansing	8. State MI	9. ZIP Code 48910
10. Employer Name Smith's Auto Repair			11. Federal ID Number 38-1111111	12. Injury Location Code N/A
13. Employer Street Address 34310 South Baker Street		14. City Lansing	15. State MI	16. ZIP Code 48915
17. Carrier or Self-Insured Name United States Insurance Company			18. NAIC or Self-Insured Number 999999999	
19. Self-Insurer's Service Company Name			20. Service Company ID Number	
21. ZIP Code of Issuing Office 48912	22. Carrier or Self-Insured Claim Number D12345-1	23. Date Carrier Received Notice of Injury 02/03/2007	24. Date First Payment Made 02/07/2007	

PART B

25. Nature of Injury Sprain (310)		26. Part of Body Ankle (520)	
27. Average Weekly Wage \$ 450.00	28. Discontinued Fringes \$ 0.00	29. Second Employer A.W.W. \$	30. Second Employer Discontinued Fringes \$
31. Tax Filing Status on Date of Injury C	32. Last Day Worked 02/01/2007	33. Number of Days in Work Week 7	34. Number of Dependents 3

PART C

35. Reason for Filing A	36. Weekly Compensation Base Rate \$ 310.14
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
A	A		\$ 310.14	02/02/2007				

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) Jane Smith	41. Telephone Number 517-999-9999	42. Date 02/12/2007

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

1. Social Security Number 111-22-3333	2. Date of Injury 02/01/2007	3. Employee Name (Last, First, MI) Doe, John R.	4. Date of Birth 09/04/1950	5. Date of Death
6. Employee Street Address 123 North Elm Street		7. City Lansing	8. State MI	9. ZIP Code 48910
10. Employer Name Smith's Auto Repair			11. Federal ID Number 38-1111111	12. Injury Location Code N/A
13. Employer Street Address 34310 South Baker Street		14. City Lansing	15. State MI	16. ZIP Code 48915
17. Carrier or Self-Insured Name United States Insurance Company			18. NAIC or Self-Insured Number 999999999	
19. Self-Insurer's Service Company Name			20. Service Company ID Number	
21. ZIP Code of Issuing Office 48912	22. Carrier or Self-Insured Claim Number D12345-1	23. Date Carrier Received Notice of Injury 02/03/2007	24. Date First Payment Made 02/07/2007	

PART B

25. Nature of Injury Sprain (310)		26. Part of Body Ankle (520)	
27. Average Weekly Wage \$ 450.00	28. Discontinued Fringes \$ 0.00	29. Second Employer A.W.W. \$	30. Second Employer Discontinued Fringes \$
31. Tax Filing Status on Date of Injury C	32. Last Day Worked 02/01/2007	33. Number of Days in Work Week 7	34. Number of Dependents 2

PART C

35. Reason for Filing B	36. Weekly Compensation Base Rate \$ 303.95
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
A	A		\$ 310.14	02/02/2007	03/12/2007	\$ 1,727.92	2007	
A	A		\$ 303.95	03/13/2007				

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 Jane Smith	40. Person Handling Claim (Please print) Jane Smith	41. Telephone Number 517-999-9999	42. Date 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

PART A

1. Social Security Number 111-22-3333	2. Date of Injury 02/01/2007	3. Employee Name (Last, First, MI) Doe, John R.	4. Date of Birth 09/04/1950	5. Date of Death
6. Employee Street Address 123 North Elm Street		7. City Lansing	8. State MI	9. ZIP Code 48910
10. Employer Name Smith's Auto Repair			11. Federal ID Number 38-1111111	12. Injury Location Code N/A
13. Employer Street Address 34310 South Baker Street		14. City Lansing	15. State MI	16. ZIP Code 48915
17. Carrier or Self-Insured Name United States Insurance Company			18. NAIC or Self-Insured Number 999999999	
19. Self-Insurer's Service Company Name			20. Service Company ID Number	
21. ZIP Code of Issuing Office 48912	22. Carrier or Self-Insured Claim Number D12345-1	23. Date Carrier Received Notice of Injury 02/03/2007	24. Date First Payment Made 02/07/2007	

PART B

25. Nature of Injury Sprain (310)		26. Part of Body Ankle (520)	
27. Average Weekly Wage \$ 450.00	28. Discontinued Fringes \$ 0.00	29. Second Employer A.W.W. \$	30. Second Employer Discontinued Fringes \$
31. Tax Filing Status on Date of Injury C	32. Last Day Worked 02/01/2007	33. Number of Days in Work Week 7	34. Number of Dependents 3

PART C

35. Reason for Filing A	36. Weekly Compensation Base Rate \$ 310.14
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
A	A		\$ 310.14	02/02/2007				

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) Jane Smith	41. Telephone Number 517-999-9999	42. Date 02/12/2007

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

1. Social Security Number 111-22-3333	2. Date of Injury 02/01/2007	3. Employee Name (Last, First, MI) Doe, John R.	4. Date of Birth 09/04/1950	5. Date of Death
6. Employee Street Address 123 North Elm Street		7. City Lansing	8. State MI	9. ZIP Code 48910
10. Employer Name Smith's Auto Repair			11. Federal ID Number 38-1111111	12. Injury Location Code N/A
13. Employer Street Address 34310 South Baker Street		14. City Lansing	15. State MI	16. ZIP Code 48915
17. Carrier or Self-Insured Name United States Insurance Company			18. NAIC or Self-Insured Number 999999999	
19. Self-Insurer's Service Company Name			20. Service Company ID Number	
21. ZIP Code of Issuing Office 48912	22. Carrier or Self-Insured Claim Number D12345-1	23. Date Carrier Received Notice of Injury 02/03/2007		24. Date First Payment Made 02/07/2007

PART B

25. Nature of Injury Sprain (310)		26. Part of Body Ankle (520)	
27. Average Weekly Wage \$ 450.00	28. Discontinued Fringes \$ 0.00	29. Second Employer A.W.W. \$	30. Second Employer Discontinued Fringes \$
31. Tax Filing Status on Date of Injury C	32. Last Day Worked 04/04/2007	33. Number of Days in Work Week 7	34. Number of Dependents 3

PART C

35. Reason for Filing C	36. Weekly Compensation Base Rate \$ 310.14
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
A	A		\$ 310.14	02/02/2007	04/06/2007	\$ 2,835.57	2007	A

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) Jane Smith	41. Telephone Number 517-999-9999	42. Date 04/12/2007

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

PART A

1. Social Security Number 111-22-3333	2. Date of Injury 02/01/2007	3. Employee Name (Last, First, MI) Doe, John R.	4. Date of Birth 09/04/1950	5. Date of Death
6. Employee Street Address 123 North Elm Street		7. City Lansing	8. State MI	9. ZIP Code 48910
10. Employer Name Smith's Auto Repair			11. Federal ID Number 38-1111111	12. Injury Location Code N/A
13. Employer Street Address 34310 South Baker Street		14. City Lansing	15. State MI	16. ZIP Code 48915
17. Carrier or Self-Insured Name United States Insurance Company			18. NAIC or Self-Insured Number 999999999	
19. Self-Insurer's Service Company Name			20. Service Company ID Number	
21. ZIP Code of Issuing Office 48912	22. Carrier or Self-Insured Claim Number D12345-1	23. Date Carrier Received Notice of Injury 02/03/2007	24. Date First Payment Made 02/07/2007	

PART B

25. Nature of Injury Burn (120)		26. Part of Body Arm (310)	
27. Average Weekly Wage \$ 450.00	28. Discontinued Fringes \$ 0.00	29. Second Employer A.W.W. \$	30. Second Employer Discontinued Fringes \$
31. Tax Filing Status on Date of Injury C	32. Last Day Worked 02/01/2007	33. Number of Days in Work Week 7	34. Number of Dependents 3

PART C

35. Reason for Filing D	36. Weekly Compensation Base Rate \$ 310.14
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
A	A		\$ 310.14	02/02/2007	03/12/2007	\$ 1,727.92	2007	A

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) Jane Smith	41. Telephone Number 517-999-9999	42. Date 03/13/2007

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

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

1. Social Security Number 111-22-3333		2. Date of Injury 01/09/2017		3. Employee Name (Last, First, MI) Doe, John R.		4. Date of Birth 09/04/1950		5. Date of Death	
6. Employee Street Address 123 North Elm Street				7. City Lansing		8. State MI		9. ZIP Code 48910	
10. Employer Name Smith's Auto Repair						11. Federal ID Number 38-1111111		12. Injury Location Code N/A	
13. Employer Street Address 34310 South Baker Street				14. City Lansing		15. State MI		16. ZIP Code 48915	
17. Carrier or Self-Insured Name United States Insurance Company						18. NAIC or Self-Insured Number 999999999			
19. Self-Insurer's Service Company Name						20. Service Company ID Number			
21. ZIP Code of Issuing Office 48912		22. Carrier or Self-Insured Claim Number D12345-1		23. Date Carrier Received Notice of Injury 01/11/2017			24. Date First Payment Made 01/17/2017		

PART B

25. Nature of Injury Sprain (310)		26. Part of Body Ankle (520)	
27. Average Weekly Wage \$ 450.00		28. Discontinued Fringes \$ 0.00	
29. Second Employer A.W.W. \$		30. Second Employer Discontinued Fringes \$	
31. Tax Filing Status on Date of Injury C		32. Last Day Worked 01/09/2017	
33. Number of Days in Work Week 7		34. Number of Dependents 3	

PART C

35. Reason for Filing D		36. Weekly Compensation Base Rate \$ 310.14	
37. Weekly Adjustments to Base Rate			
A \$ 387.68		_____ \$ _____	
_____ \$ _____		_____ \$ _____	
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
A	A		\$0.00	01/10/2017	01/24/2017	\$0.00	2017	H

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 Coordination reduced to 0 more than 14 days

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)	
		Jane Smith	
41. Telephone Number		42. Date	
517-999-9999		02/12/2017	

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

EXAMPLE #5b – continued**PART E – COORDINATION OF BENEFITS**

	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 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.

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

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	
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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
IF NO – COORDINATE AMOUNT IN LINE C	
IF YES – WERE SOCIAL SECURITY OLD AGE RETIREMENT BENEFITS BEING PAID ON THE DATE OF INJURY?	<input type="checkbox"/> YES <input type="checkbox"/> 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 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)
Completion: 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

PART A

1. Social Security Number 111-22-3333	2. Date of Injury 02/01/2007	3. Employee Name (Last, First, MI) Doe, John R.	4. Date of Birth 09/04/1950	5. Date of Death
6. Employee Street Address 123 North Elm Street		7. City Lansing	8. State MI	9. ZIP Code 48910
10. Employer Name Smith's Auto Repair			11. Federal ID Number 38-1111111	12. Injury Location Code N/A
13. Employer Street Address 34310 South Baker Street		14. City Lansing	15. State MI	16. ZIP Code 48915
17. Carrier or Self-Insured Name United States Insurance Company			18. NAIC or Self-Insured Number 999999999	
19. Self-Insurer's Service Company Name			20. Service Company ID Number	
21. ZIP Code of Issuing Office 48912	22. Carrier or Self-Insured Claim Number D12345-1	23. Date Carrier Received Notice of Injury 02/03/2007	24. Date First Payment Made 02/07/2007	

PART B

25. Nature of Injury Sprain (310)		26. Part of Body Ankle (520)	
27. Average Weekly Wage \$ 450.00	28. Discontinued Fringes \$ 0.00	29. Second Employer A.W.W. \$	30. Second Employer Discontinued Fringes \$
31. Tax Filing Status on Date of Injury C	32. Last Day Worked 02/01/2007	33. Number of Days in Work Week 7	34. Number of Dependents 3

PART C

35. Reason for Filing D	36. Weekly Compensation Base Rate \$ 310.14
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
A	A		\$ 310.14	02/02/2007	03/12/2007	\$ 1,727.92	2007	A

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) Jane Smith	41. Telephone Number 517-999-9999	42. Date 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

PART A

1. Social Security Number 111-22-3333	2. Date of Injury 02/01/2007	3. Employee Name (Last, First, MI) Doe, John R.	4. Date of Birth 09/04/1950	5. Date of Death
6. Employee Street Address 123 North Elm Street		7. City Lansing	8. State MI	9. ZIP Code 48910
10. Employer Name Smith's Auto Repair			11. Federal ID Number 38-1111111	12. Injury Location Code N/A
13. Employer Street Address 34310 South Baker Street		14. City Lansing	15. State MI	16. ZIP Code 48915
17. Carrier or Self-Insured Name United States Insurance Company			18. NAIC or Self-Insured Number 999999999	
19. Self-Insurer's Service Company Name			20. Service Company ID Number	
21. ZIP Code of Issuing Office 48912	22. Carrier or Self-Insured Claim Number D12345-1	23. Date Carrier Received Notice of Injury 02/03/2007	24. Date First Payment Made 02/07/2007	

PART B

25. Nature of Injury Sprain (310)		26. Part of Body Ankle (520)	
27. Average Weekly Wage \$ 450.00	28. Discontinued Fringes \$ 0.00	29. Second Employer A.W.W. \$	30. Second Employer Discontinued Fringes \$
31. Tax Filing Status on Date of Injury C	32. Last Day Worked 04/04/2007	33. Number of Days in Work Week 7	34. Number of Dependents 3

PART C

35. Reason for Filing F	36. Weekly Compensation Base Rate \$ 310.14
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
A	A		\$ 310.14	04/05/2007				

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) Jane Smith	41. Telephone Number 517-999-9999	42. Date 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

PART A

1. Social Security Number 111-22-3333	2. Date of Injury 02/01/2007	3. Employee Name (Last, First, MI) Doe, John R.	4. Date of Birth 09/04/1950	5. Date of Death
6. Employee Street Address 123 North Elm Street		7. City Lansing	8. State MI	9. ZIP Code 48910
10. Employer Name Smith's Auto Repair			11. Federal ID Number 38-1111111	12. Injury Location Code N/A
13. Employer Street Address 34310 South Baker Street		14. City Lansing	15. State MI	16. ZIP Code 48915
17. Carrier or Self-Insured Name United States Insurance Company			18. NAIC or Self-Insured Number 999999999	
19. Self-Insurer's Service Company Name			20. Service Company ID Number	
21. ZIP Code of Issuing Office 48912	22. Carrier or Self-Insured Claim Number D12345-1	23. Date Carrier Received Notice of Injury 02/03/2007	24. Date First Payment Made 02/07/2007	

PART B

25. Nature of Injury Sprain (310)		26. Part of Body Ankle (520)	
27. Average Weekly Wage \$ 450.00	28. Discontinued Fringes \$ 0.00	29. Second Employer A.W.W. \$	30. Second Employer Discontinued Fringes \$
31. Tax Filing Status on Date of Injury C	32. Last Day Worked 02/01/2007	33. Number of Days in Work Week 7	34. Number of Dependents 3

PART C

35. Reason for Filing D	36. Weekly Compensation Base Rate \$ 310.14
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
A	A		\$ 310.14	02/02/2007	03/12/2007	\$ 1,727.92	2007	A

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) Jane Smith	41. Telephone Number 517-999-9999	42. Date 03/13/2007

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

1. Social Security Number 111-22-3333	2. Date of Injury 02/01/2007	3. Employee Name (Last, First, MI) Doe, John R.	4. Date of Birth 09/04/1950	5. Date of Death
6. Employee Street Address 123 North Elm Street		7. City Lansing	8. State MI	9. ZIP Code 48910
10. Employer Name Smith's Auto Repair			11. Federal ID Number 38-1111111	12. Injury Location Code N/A
13. Employer Street Address 34310 South Baker Street		14. City Lansing	15. State MI	16. ZIP Code 48915
17. Carrier or Self-Insured Name United States Insurance Company			18. NAIC or Self-Insured Number 999999999	
19. Self-Insurer's Service Company Name			20. Service Company ID Number	
21. ZIP Code of Issuing Office 48912	22. Carrier or Self-Insured Claim Number D12345-1	23. Date Carrier Received Notice of Injury 02/03/2007	24. Date First Payment Made 02/07/2007	

PART B

25. Nature of Injury Sprain (310)		26. Part of Body Ankle (520)	
27. Average Weekly Wage \$ 450.00	28. Discontinued Fringes \$ 0.00	29. Second Employer A.W.W. \$	30. Second Employer Discontinued Fringes \$
31. Tax Filing Status on Date of Injury C	32. Last Day Worked 04/04/2007	33. Number of Days in Work Week 7	34. Number of Dependents 3

PART C

35. Reason for Filing G	36. Weekly Compensation Base Rate \$ 310.14
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
A	A		\$ 310.14	04/05/2007	04/20/2007	\$ 708.89	2007	A

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) Jane Smith	41. Telephone Number 517-999-9999	42. Date 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

PART A

1. Social Security Number 111-22-3333		2. Date of Injury 01/09/2017		3. Employee Name (Last, First, MI) Doe, John R.		4. Date of Birth 09/04/1950		5. Date of Death	
6. Employee Street Address 123 North Elm Street				7. City Lansing		8. State MI		9. ZIP Code 48910	
10. Employer Name Smith's Auto Repair						11. Federal ID Number 38-1111111		12. Injury Location Code N/A	
13. Employer Street Address 34310 South Baker Street				14. City Lansing		15. State MI		16. ZIP Code 48915	
17. Carrier or Self-Insured Name United States Insurance Company						18. NAIC or Self-Insured Number 999999999			
19. Self-Insurer's Service Company Name						20. Service Company ID Number			
21. ZIP Code of Issuing Office 48912		22. Carrier or Self-Insured Claim Number D12345-1		23. Date Carrier Received Notice of Injury 01/11/2017			24. Date First Payment Made 01/17/2017		

PART B

25. Nature of Injury Sprain (310)		26. Part of Body Ankle (520)	
27. Average Weekly Wage \$ 450.00		28. Discontinued Fringes \$ 0.00	
29. Second Employer A.W.W. \$		30. Second Employer Discontinued Fringes \$	
31. Tax Filing Status on Date of Injury C		32. Last Day Worked 02/01/2017	
33. Number of Days in Work Week 7		34. Number of Dependents 3	

PART C

35. Reason for Filing G		36. Weekly Compensation Base Rate \$ 310.14	
37. Weekly Adjustments to Base Rate			
A \$ 387.68		\$	
\$		\$	
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
A	A		\$0.00	02/02/2007	02/16/2017	0.00	2017	H

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 Coordination reduced to 0 more than 14 days

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)	
		Jane Smith	
41. Telephone Number		42. Date	
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.

EXAMPLE #7b – continued**PART E – COORDINATION OF BENEFITS**

	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 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.

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

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	
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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
IF NO – COORDINATE AMOUNT IN LINE C	
IF YES – WERE SOCIAL SECURITY OLD AGE RETIREMENT BENEFITS BEING PAID ON THE DATE OF INJURY?	<input type="checkbox"/> YES <input type="checkbox"/> 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 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)
Completion: Mandatory
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

PART A

1. Social Security Number 111-22-3333	2. Date of Injury 11/04/2007	3. Employee Name (Last, First, MI) Doe, John R.	4. Date of Birth 09/04/1950	5. Date of Death
6. Employee Street Address 123 North Elm Street		7. City Lansing	8. State MI	9. ZIP Code 48910
10. Employer Name Smith's Auto Repair			11. Federal ID Number 38-1111111	12. Injury Location Code N/A
13. Employer Street Address 34310 South Baker Street		14. City Lansing	15. State MI	16. ZIP Code 48915
17. Carrier or Self-Insured Name United States Insurance Company			18. NAIC or Self-Insured Number 999999999	
19. Self-Insurer's Service Company Name			20. Service Company ID Number	
21. ZIP Code of Issuing Office 48912	22. Carrier or Self-Insured Claim Number D12345-1	23. Date Carrier Received Notice of Injury 11/08/2007	24. Date First Payment Made 11/11/2007	

PART B

25. Nature of Injury Hearing Loss (230)		26. Part of Body Ears (124)	
27. Average Weekly Wage \$ 450.00	28. Discontinued Fringes \$ 0.00	29. Second Employer A.W.W. \$	30. Second Employer Discontinued Fringes \$
31. Tax Filing Status on Date of Injury C	32. Last Day Worked 11/04/2007	33. Number of Days in Work Week 7	34. Number of Dependents 3

PART C

35. Reason for Filing A	36. Weekly Compensation Base Rate \$ 310.14
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
A	B			11/05/2007				

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) Jane Smith	41. Telephone Number 517-999-9999	42. Date 11/14/2007

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

1. Social Security Number 111-22-3333	2. Date of Injury 11/04/2007	3. Employee Name (Last, First, MI) Doe, John R.	4. Date of Birth 09/04/1950	5. Date of Death
6. Employee Street Address 123 North Elm Street		7. City Lansing	8. State MI	9. ZIP Code 48910
10. Employer Name Smith's Auto Repair			11. Federal ID Number 38-1111111	12. Injury Location Code N/A
13. Employer Street Address 34310 South Baker Street		14. City Lansing	15. State MI	16. ZIP Code 48915
17. Carrier or Self-Insured Name United States Insurance Company			18. NAIC or Self-Insured Number 999999999	
19. Self-Insurer's Service Company Name			20. Service Company ID Number	
21. ZIP Code of Issuing Office 48912	22. Carrier or Self-Insured Claim Number D12345-1	23. Date Carrier Received Notice of Injury 11/08/2007	24. Date First Payment Made 11/11/2007	

PART B

25. Nature of Injury Hearing Loss (230)		26. Part of Body Ears (124)	
27. Average Weekly Wage \$ 450.00	28. Discontinued Fringes \$ 0.00	29. Second Employer A.W.W. \$	30. Second Employer Discontinued Fringes \$
31. Tax Filing Status on Date of Injury C	32. Last Day Worked 11/04/2007	33. Number of Days in Work Week 7	34. Number of Dependents 3

PART C

35. Reason for Filing H	36. Weekly Compensation Base Rate \$ 310.14
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
A	B			11/05/2007	12/30/2007	\$ 188.03	2007	
A	B			12/31/2007				

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) Jane Smith	41. Telephone Number 517-999-9999	42. Date 01/02/2008

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

Workers' Compensation Agency
Verification of Monetary Information
Partial Benefit Rates

For Year: 2007

File

Name: John R. Doe

Last

Update: 08/01/2012 10:18:44

**Prior to
Injury**

Year of Injury:	2007
Gross Weekly Wage:	\$450.00
Discontinued Fringes:	\$0.00
Nbr of Dependents:	3
Tax Class:	3
<hr/>	
80 Percent Rate	\$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
Grand Totals:						\$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

PART A

1. Social Security Number 111-22-3333	2. Date of Injury 03/11/2006	3. Employee Name (Last, First, MI) Doe, John R.	4. Date of Birth 09/04/1950	5. Date of Death
6. Employee Street Address 123 North Elm Street		7. City Lansing	8. State MI	9. ZIP Code 48910
10. Employer Name Smith's Auto Repair			11. Federal ID Number 38-1111111	12. Injury Location Code N/A
13. Employer Street Address 34310 South Baker Street		14. City Lansing	15. State MI	16. ZIP Code 48915
17. Carrier or Self-Insured Name United States Insurance Company			18. NAIC or Self-Insured Number 999999999	
19. Self-Insurer's Service Company Name			20. Service Company ID Number	
21. ZIP Code of Issuing Office 48912	22. Carrier or Self-Insured Claim Number D12345-1	23. Date Carrier Received Notice of Injury 03/13/2006	24. Date First Payment Made 05/08/2007	

PART B

25. Nature of Injury Heart Attack (991)		26. Part of Body Heart (801)	
27. Average Weekly Wage \$ 610.00	28. Discontinued Fringes \$ 0.00	29. Second Employer A.W.W. \$	30. Second Employer Discontinued Fringes \$
31. Tax Filing Status on Date of Injury C	32. Last Day Worked 03/11/2006	33. Number of Days in Work Week 7	34. Number of Dependents 2

PART C

35. Reason for Filing A	36. Weekly Compensation Base Rate \$ 397.02
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
B	A		\$ 397.02	05/09/2007				

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER # 042007008

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) Jane Smith	41. Telephone Number 517-999-9999	42. Date 05/10/2007

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

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

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 03/11/2006 Employee Name Doe, John R.

Order # 042007008 Basis Payment Code B Year Paid 2007

Benefit Type	Special Payment	Adjusted Rate	From	Through	Total	Variable Rate Factors
A	A	\$397.02	03/12/2006	05/08/2007	\$23,991.35	Deps <u>2</u> Base Amt \$ <u>397.02</u> Adjustment Code _____ \$ Adjustment Code ____ \$ _____
	B			05/08/2007	\$1,347.69	Deps _____ Base Amt \$ Adjustment Code _____ \$ Adjustment Code ____ \$ _____
						Deps ____ Base Amt \$ _____ Adjustment Code ____ \$ _____ Adjustment Code ____ \$ _____
						Deps _____ Base Amt \$ Adjustment Code _____ \$ Adjustment Code ____ \$ _____
						Deps _____ Base Amt \$ Adjustment Code _____ \$ Adjustment Code ____ \$ _____
						Deps _____ Base Amt \$ Adjustment Code _____ \$ Adjustment Code ____ \$ _____
						Deps _____ Base Amt \$ Adjustment Code _____ \$ Adjustment Code ____ \$ _____
						Deps _____ Base Amt \$ Adjustment Code _____ \$ 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
- W = Reduced Wage Earning Capacity

Special Payment

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

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
- Q = Other
- 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

PART A

1. Social Security Number 111-22-3333	2. Date of Injury 02/05/2007	3. Employee Name (Last, First, MI) Doe, John R.	4. Date of Birth 09/04/1950	5. Date of Death
6. Employee Street Address 123 North Elm Street		7. City Lansing	8. State MI	9. ZIP Code 48910
10. Employer Name Smith's Auto Repair			11. Federal ID Number 38-1111111	12. Injury Location Code N/A
13. Employer Street Address 34310 South Baker Street		14. City Lansing	15. State MI	16. ZIP Code 48915
17. Carrier or Self-Insured Name United States Insurance Company			18. NAIC or Self-Insured Number 999999999	
19. Self-Insurer's Service Company Name			20. Service Company ID Number	
21. ZIP Code of Issuing Office 48912	22. Carrier or Self-Insured Claim Number D12345-1	23. Date Carrier Received Notice of Injury 02/10/2007	24. Date First Payment Made 05/02/2007	

PART B

25. Nature of Injury Inflammation (260)		26. Part of Body Hip (440)	
27. Average Weekly Wage \$	28. Discontinued Fringes \$ 0.00	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 7	34. Number of Dependents

PART C

35. Reason for Filing D	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
E	A					\$ 1,500.00	2007	

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER # 042807010

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) Jane Smith	41. Telephone Number 517-999-9999	42. Date 05/12/2007

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

**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

PART A

1. Social Security Number 111-22-3333	2. Date of Injury 10/15/2007	3. Employee Name (Last, First, MI) Doe, John R.	4. Date of Birth 09/04/1950	5. Date of Death
6. Employee Street Address 123 North Elm Street		7. City Lansing	8. State MI	9. ZIP Code 48910
10. Employer Name Smith's Auto Repair			11. Federal ID Number 38-1111111	12. Injury Location Code N/A
13. Employer Street Address 34310 South Baker Street		14. City Lansing	15. State MI	16. ZIP Code 48915
17. Carrier or Self-Insured Name United States Insurance Company			18. NAIC or Self-Insured Number 999999999	
19. Self-Insurer's Service Company Name			20. Service Company ID Number	
21. ZIP Code of Issuing Office 48912	22. Carrier or Self-Insured Claim Number D12345-1	23. Date Carrier Received Notice of Injury 10/18/2007	24. Date First Payment Made 10/21/2007	

PART B

25. Nature of Injury Industrial Loss of Use		26. Part of Body Legs (510)	
27. Average Weekly Wage \$ 226.00	28. Discontinued Fringes \$ 0.00	29. Second Employer A.W.W. \$	30. Second Employer Discontinued Fringes \$
31. Tax Filing Status on Date of Injury D	32. Last Day Worked 10/15/2007	33. Number of Days in Work Week 7	34. Number of Dependents 2

PART C

35. Reason for Filing B	36. Weekly Compensation Base Rate \$ 161.38								
37. Weekly Adjustments to Base Rate									
<table border="0"> <tr> <td><u> L </u> \$ <u>43.63</u></td> <td><u> </u> \$ <u> </u></td> <td><u> </u> \$ <u> </u></td> <td><u> </u> \$ <u> </u></td> </tr> <tr> <td><u> </u> \$ <u> </u></td> <td><u> </u> \$ <u> </u></td> <td><u> </u> \$ <u> </u></td> <td><u> </u> \$ <u> </u></td> </tr> </table>		<u> L </u> \$ <u>43.63</u>	<u> </u> \$ <u> </u>	<u> </u> \$ <u> </u>	<u> </u> \$ <u> </u>	<u> </u> \$ <u> </u>	<u> </u> \$ <u> </u>	<u> </u> \$ <u> </u>	<u> </u> \$ <u> </u>
<u> L </u> \$ <u>43.63</u>	<u> </u> \$ <u> </u>	<u> </u> \$ <u> </u>	<u> </u> \$ <u> </u>						
<u> </u> \$ <u> </u>	<u> </u> \$ <u> </u>	<u> </u> \$ <u> </u>	<u> </u> \$ <u> </u>						
38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)									
<table border="0"> <tr> <td><u> </u> \$ <u> </u></td> <td><u> </u> \$ <u> </u></td> <td><u> </u> \$ <u> </u></td> <td><u> </u> \$ <u> </u></td> </tr> </table>		<u> </u> \$ <u> </u>	<u> </u> \$ <u> </u>	<u> </u> \$ <u> </u>	<u> </u> \$ <u> </u>				
<u> </u> \$ <u> </u>	<u> </u> \$ <u> </u>	<u> </u> \$ <u> </u>	<u> </u> \$ <u> </u>						

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
B	A		\$ 161.38	10/16/2007	12/31/2007	\$ 1,775.18	2007	
B	D		\$ 205.01	01/01/2008				

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) Jane Smith	41. Telephone Number 517-999-9999	42. Date 01/05/2008

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

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

PART A

1. Social Security Number 111-22-3333	2. Date of Injury 04/15/2012	3. Employee Name (Last, First, MI) Doe, John R.	4. Date of Birth 09/04/1950	5. Date of Death
6. Employee Street Address 123 North Elm Street		7. City Lansing	8. State MI	9. ZIP Code 48910
10. Employer Name Smith's Auto Repair			11. Federal ID Number 38-1111111	12. Injury Location Code N/A
13. Employer Street Address 34310 South Baker Street		14. City Lansing	15. State MI	16. ZIP Code 48915
17. Carrier or Self-Insured Name United States Insurance Company			18. NAIC or Self-Insured Number 999999999	
19. Self-Insurer's Service Company Name			20. Service Company ID Number	
21. ZIP Code of Issuing Office 48912	22. Carrier or Self-Insured Claim Number D12345-1	23. Date Carrier Received Notice of Injury 04/15/2012	24. Date First Payment Made 04/22/2012	

PART B

25. Nature of Injury Sprain (310)		26. Part of Body Ankle (520)	
27. Average Weekly Wage \$ 850.00	28. Discontinued Fringes \$ 0.00	29. Second Employer A.W.W. \$	30. Second Employer Discontinued Fringes \$
31. Tax Filing Status on Date of Injury C	32. Last Day Worked 04/15/2012	33. Number of Days in Work Week 7	34. Number of Dependents 3

PART C

35. Reason for Filing A	36. Weekly Compensation Base Rate \$ 548.46
37. Weekly Adjustments to Base Rate	
R \$ 160.00	\$
\$	\$
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
A	W		\$ 388.46	04/16/2012				

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) Jane Smith	41. Telephone Number 517-999-9999	42. Date 02/12/2007

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

EXAMPLE #12 – continued

PART E – 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, 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.

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

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	
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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
IF NO – COORDINATE AMOUNT IN LINE C	
IF YES – WERE SOCIAL SECURITY OLD AGE RETIREMENT BENEFITS BEING PAID ON THE DATE OF INJURY?	<input type="checkbox"/> YES <input type="checkbox"/> 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)	\$ 850.00
B. 80% AFTER-TAX AMOUNT OF LINE A (See calc program or rate charts)	\$ 548.46
C. 100% AFTER-TAX AMOUNT (Line B multiplied by 1.25)	\$ 685.58
D. GROSS WEEKLY POST INJURY WAGE EARNING CAPACITY (PIWEC) AMOUNT	\$ 200.00
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.	\$ 485.58
F. 80% of Line E (Line E multiplied by .8) ³	\$ 388.46
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.	\$ 160.00

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 other reasonable accommodations are available upon request to individuals with disabilities.

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

PART A

1. Social Security Number 111-22-3333	2. Date of Injury 12/20/2011	3. Employee Name (Last, First, MI) Doe, John R.	4. Date of Birth 03/04/1949	5. Date of Death
6. Employee Street Address 123 North Elm Street		7. City Lansing	8. State MI	9. ZIP Code 48910
10. Employer Name Smith's Auto Repair			11. Federal ID Number 38-1111111	12. Injury Location Code N/A
13. Employer Street Address 34310 South Baker Street		14. City Lansing	15. State MI	16. ZIP Code 48915
17. Carrier or Self-Insured Name United States Insurance Company			18. NAIC or Self-Insured Number 999999999	
19. Self-Insurer's Service Company Name			20. Service Company ID Number	
21. ZIP Code of Issuing Office 48912	22. Carrier or Self-Insured Claim Number D12345-1	23. Date Carrier Received Notice of Injury 12/20/2011	24. Date First Payment Made 12/27/2011	

PART B

25. Nature of Injury Sprain (310)		26. Part of Body Ankle (520)	
27. Average Weekly Wage \$ 650.00	28. Discontinued Fringes \$ 0.00	29. Second Employer A.W.W. \$	30. Second Employer Discontinued Fringes \$
31. Tax Filing Status on Date of Injury C	32. Last Day Worked 12/20/2011	33. Number of Days in Work Week 7	34. Number of Dependents 1

PART C

35. Reason for Filing A	36. Weekly Compensation Base Rate \$ 416.89								
37. Weekly Adjustments to Base Rate									
<table border="0"> <tr> <td><u>B</u> \$ <u>208.45</u></td> <td>\$ _____</td> <td>\$ _____</td> <td>\$ _____</td> </tr> <tr> <td>\$ _____</td> <td>\$ _____</td> <td>\$ _____</td> <td>\$ _____</td> </tr> </table>		<u>B</u> \$ <u>208.45</u>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<u>B</u> \$ <u>208.45</u>	\$ _____	\$ _____	\$ _____						
\$ _____	\$ _____	\$ _____	\$ _____						
38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)									
<table border="0"> <tr> <td>\$ _____</td> <td>\$ _____</td> <td>\$ _____</td> <td>\$ _____</td> </tr> </table>		\$ _____	\$ _____	\$ _____	\$ _____				
\$ _____	\$ _____	\$ _____	\$ _____						

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
A	A		\$ 208.44	12/21/2011				

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) Jane Smith	41. Telephone Number 517-999-9999	42. Date 12/27/2011

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

EXAMPLE #13 – continued

PART E – 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, 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.

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

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?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF NO – COORDINATE AMOUNT IN LINE C	
IF YES – WERE SOCIAL SECURITY OLD AGE RETIREMENT BENEFITS BEING PAID ON THE DATE OF INJURY?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> 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	
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 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)
Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.801

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

PART A

1. Social Security Number 111-22-3333	2. Date of Injury 12/20/2011	3. Employee Name (Last, First, MI) Doe, John R.	4. Date of Birth 03/04/1949	5. Date of Death
6. Employee Street Address 123 North Elm Street		7. City Lansing	8. State MI	9. ZIP Code 48910
10. Employer Name Smith's Auto Repair			11. Federal ID Number 38-1111111	12. Injury Location Code N/A
13. Employer Street Address 34310 South Baker Street		14. City Lansing	15. State MI	16. ZIP Code 48915
17. Carrier or Self-Insured Name United States Insurance Company			18. NAIC or Self-Insured Number 999999999	
19. Self-Insurer's Service Company Name			20. Service Company ID Number	
21. ZIP Code of Issuing Office 48912	22. Carrier or Self-Insured Claim Number D12345-1	23. Date Carrier Received Notice of Injury 12/20/2011	24. Date First Payment Made 12/27/2011	

PART B

25. Nature of Injury Sprain (310)		26. Part of Body Ankle (520)	
27. Average Weekly Wage \$ 650.00	28. Discontinued Fringes \$ 0.00	29. Second Employer A.W.W. \$	30. Second Employer Discontinued Fringes \$
31. Tax Filing Status on Date of Injury C	32. Last Day Worked 12/20/2011	33. Number of Days in Work Week 7	34. Number of Dependents 1

PART C

35. Reason for Filing A	36. Weekly Compensation Base Rate \$ 416.89										
37. Weekly Adjustments to Base Rate											
<table border="0"> <tr> <td>B</td> <td>\$ 242.50</td> <td>\$</td> <td>\$</td> <td>\$</td> </tr> <tr> <td></td> <td>\$</td> <td>\$</td> <td>\$</td> <td>\$</td> </tr> </table>		B	\$ 242.50	\$	\$	\$		\$	\$	\$	\$
B	\$ 242.50	\$	\$	\$							
	\$	\$	\$	\$							
38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)											
<table border="0"> <tr> <td>\$</td> <td>\$</td> <td>\$</td> <td>\$</td> </tr> </table>		\$	\$	\$	\$						
\$	\$	\$	\$								

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
A	A		\$ 174.39	12/21/2011				

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) Jane Smith	41. Telephone Number 517-999-9999	42. Date 12/27/2011

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

EXAMPLE #14 – continued

PART E – 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, 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.

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

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?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF NO – COORDINATE AMOUNT IN LINE C	
IF YES – WERE SOCIAL SECURITY OLD AGE RETIREMENT BENEFITS BEING PAID ON THE DATE OF INJURY?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF NO – COORDINATE AMOUNT IN LINE C	\$ 242.50
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 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)
Completion: Mandatory
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

PART A

1. Social Security Number 111-22-3333	2. Date of Injury 12/07/2011	3. Employee Name (Last, First, MI) Doe, John R.	4. Date of Birth 03/04/1949	5. Date of Death
6. Employee Street Address 123 North Elm Street		7. City Lansing	8. State MI	9. ZIP Code 48910
10. Employer Name Smith's Auto Repair			11. Federal ID Number 38-1111111	12. Injury Location Code N/A
13. Employer Street Address 34310 South Baker Street		14. City Lansing	15. State MI	16. ZIP Code 48915
17. Carrier or Self-Insured Name United States Insurance Company			18. NAIC or Self-Insured Number 999999999	
19. Self-Insurer's Service Company Name			20. Service Company ID Number	
21. ZIP Code of Issuing Office 48912	22. Carrier or Self-Insured Claim Number D12345-1	23. Date Carrier Received Notice of Injury 12/20/2011	24. Date First Payment Made 12/27/2011	

PART B

25. Nature of Injury Sprain (310)		26. Part of Body Ankle (520)	
27. Average Weekly Wage \$ 650.00	28. Discontinued Fringes \$ 0.00	29. Second Employer A.W.W. \$	30. Second Employer Discontinued Fringes \$
31. Tax Filing Status on Date of Injury C	32. Last Day Worked 12/20/2011	33. Number of Days in Work Week 7	34. Number of Dependents 1

PART C

35. Reason for Filing A	36. Weekly Compensation Base Rate \$ 416.89										
37. Weekly Adjustments to Base Rate											
<table border="0"> <tr> <td>B</td> <td>\$ 242.50</td> <td>\$</td> <td>\$</td> <td>\$</td> </tr> <tr> <td></td> <td></td> <td>\$</td> <td>\$</td> <td>\$</td> </tr> </table>		B	\$ 242.50	\$	\$	\$			\$	\$	\$
B	\$ 242.50	\$	\$	\$							
		\$	\$	\$							
38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)											
<table border="0"> <tr> <td>\$</td> <td>\$</td> <td>\$</td> <td>\$</td> </tr> </table>		\$	\$	\$	\$						
\$	\$	\$	\$								

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
A	A		\$ 174.39	12/21/2011				

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) Jane Smith	41. Telephone Number 517-999-9999	42. Date 12/27/2011

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

EXAMPLE #15 – continued

PART E – 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, 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.

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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?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> 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 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.

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