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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? ☐ YES ☐ NO	
IF NO – COORDINATE AMOUNT IN LINE C	
IF YES – WERE SOCIAL SECURITY OLD AGE RETIREMENT BENEFITS BEING PAID ON THE DATE OF INJURY? ☐ YES ☐ NO	
IF NO – COORDINATE AMOUNT IN LINE C	
IF YES – COORDINATE THE LOWEST AMOUNT FOUND IN LINE C OR D	

UNEMPLOYMENT COMPENSATION

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

PART F – RATE ADJUSTMENT[3] FOR POST INJURY WAGE EARNING CAPACITY (PIWEC)

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

A. AVERAGE WEEKLY WAGE	
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.

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

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