Department of Workforce Development
Worker's Compensation Division
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Supplemental Payments Reimbursement Request

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

To: Department of Workforce Development, Worker's Compensation Division

Request is made for reimbursement of supplemental benefits paid during the preceding calendar year under the provisions of s.102.44(1), Wisconsin Statutes, in the following case and in the amount indicated.

WC Claim Number	Employee Name
Employee Social Security Number	Employer Name
Injury Date (MM/dd/yyyy)	Insurance Company Name
☐ Original Reimbursement Request	☐ Adjusted Reimbursement Request

Weekly Supplemental Rate	Begin Date (MM/dd/yyyy)	End Date (MM/dd/yyyy)	Number of Weeks and Days	Calendar Year in Which the Payments Were Made	Amount of Reimbursement Requested
			Weeks: Days:	Year:	
			Weeks: Days:	Year:	
			Weeks: Days:	Year:	
			Weeks: Days:	Year:	
					Total: $

I certify the above amount requested for reimbursement is true and correct. I also certify that the reimbursement requested is for supplemental benefit payments paid during the preceding calendar year.

Name of Carrier or Exempt Employer to Whom Check Should be Mailed	Mailing Address (Number, Street, City, State, Zip Code)	
Signed by	Title	Date Signed (MM/dd/yyyy)
FEIN Number	Telephone Number ( ) - Ext.	