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FUNDS ADMINISTRATION USE ONLY

APPLICATION FOR REIMBURSEMENT

MICHIGAN DEPARTMENT OF LABOR AND ECONOMIC OPPORTUNITY
FUNDS ADMINISTRATION
P.O. Box 30182, Lansing, MI 48909

FUNDS ADMINISTRATION

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

REQUEST NUMBER

CARRIER FILE NUMBER

COMPLETE THIS SECTION FOR ALL FUNDS

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

EMPLOYEE NAME (Last, First, Middle)	SOCIAL SECURITY NUMBER	INJURY DATE		BIRTH DATE
EMPLOYEE ADDRESS (Street Number and Name)	CITY	STATE	ZIP CODE	PHONE NUMBER ( )
NAME OF EMPLOYER	EMPLOYER ADDRESS			
CARRIER (Insurance Company or Self-Insured Employer)*	SERVICE COMPANY OR TPA (If Applicable)			
CARRIER FEDERAL I.D. NUMBER / CONTACT PERSON	EMAIL ADDRESS			PHONE NUMBER ( )

PAYMENT ADDRESS **(*To receive payment carrier must be registered with the State of Michigan, Budget Office. Register at http://michigan.gov/cpexpress or 1-888-734-9749.**

AVERAGE WEEKLY WAGE $	DISCONTINUED FRINGES $	TAX FILING STATUS **(AT DOI)**	CARRIER/EMPLOYER PRESENT WEEKLY COMPENSATION RATE $	Benefits Calculated on_____Day Week	IS THERE A THIRD PARTY CLAIM ☐ YES ☐ NO (If YES, provide pertinent information on claim)

DEPENDENTS

SPOUSE_____

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

_____ _____ _____ _____

HAS BASIC BENEFIT CHANGED or TERMINATED DURING PERIOD?

☐ YES ☐ NO

EFFECTIVE DATE:_____

REASON FOR CHANGE

☐ Age Reduction ☐ Benefit Coordination ☐ Employments ☐ Unemployment Compensation
☐ Dependency Change (Attach Verification) ☐ Other_____
☐ Death Date of Death_____ (Attach Death Certificate)

HAS EMPLOYEE BEEN GAINFULLY EMPLOYED DURING PERIOD COVERED BY THIS REIMBURSEMENT?

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

☐ NO - Attach information received verifying continuing disability and current activities

(1) COMPLETE this section when requesting reimbursement from the Second Injury Fund **- TOTAL AND PERMANENT DISABILITY PROVISION:**
Weekly differential benefits paid on Fund's behalf:

_____ thru _____ , _____ weeks at $_____ = $ _____

_____ thru _____ , _____ weeks at $_____ = $_____

TOTAL AMOUNT REQUESTED IN THIS REIMBURSEMENT $_____

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

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

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

70% Benefits Paid on Appeal:

_____ thru _____ , _____ weeks at $_____ = $_____

_____ thru _____ , _____ weeks at $_____ = $_____

Total 70% Benefits Paid: $_____

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

TOTAL AMOUNT REQUESTED IN THIS REIMBURSEMENT $_____

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

Weekly benefit rate paid on Second Injury Fund's behalf:

_____ thru _____ , _____ weeks at $_____ = $_____

_____ thru _____ , _____ weeks at $_____ = $_____

TOTAL AMOUNT REQUESTED IN THIS REIMBURSEMENT $_____

REIMBURSEMENT FOR REDEMPTION PAYMENT $_____

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

_____ thru _____ , _____ weeks at $_____ = $_____

_____ thru _____ , _____ weeks at $_____ = $_____

Total weekly benefits paid on Fund's behalf: $_____

Medical expenses paid during period (attach copies of bills and reports): $_____

Vocational rehabilitation costs paid during period (attach copies of bills and reports): $_____

TOTAL AMOUNT REQUESTED IN THIS REIMBURSEMENT $_____

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

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

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

I. Name of Employer: Place of Injury **WAGES** **# OF** WEEKS USED **AVERAGE**

_____ $_____ ÷ _____ = $_____(A)
Name of Other Employer

_____ $_____ ÷ _____ = $_____
Address: _____ Total average weekly wages
_____ From separate sheet (if applicable): $_____
Phone: _____ Total: $_____(B)

Has there been a return to work with any employer Employer_____Date:_____
☐ YES ☐ NO If yes, complete section across → → → Employer_____ Date:_____
Employer_____Date:_____

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

_____ thru _____ , _____ weeks at $_____ = $_____

_____ thru _____ , _____ weeks at $_____ = $_____

Total weekly benefits paid during this reimbursement period: $_____ (E)

TOTAL AMOUNT REQUESTED IN THIS REIMBURSEMENT _____ (E) x _____ % (D) = $_____
REIMBURSEMENT FOR REDEMPTION PAYMENT $_____

(6) COMPLETE this section when requesting reimbursement from the **SILICOSIS & DUST DISEASE FUND and LOGGING INDUSTRY COMPENSATION FUND**
Weekly benefits paid during this period:

_____ thru _____ , _____ weeks at $_____ = $_____

_____ thru _____ , _____ weeks at $_____ = $_____

_____ thru _____ , _____ weeks at $_____ = $_____

Total benefits paid during period $_____

Minus threshold **on first reimbursement only** -_____

Apportionment percentage due (SDDF only): x _____ %

TOTAL AMOUNT REQUESTED IN THIS REIMBURSEMENT: $_____

SIGNATURE OF AUTHORIZED REPRESENTATIVE AND TITLE	DATE SUBMITTED

Authority: Workers Disability Compensation Act R408.46
Completion: Mandatory
Penalty: Reimbursement denied

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