Annual Claim for Reimbursement of Supplementary Benefits

PRINT IN INK OR TYPE YOUR RESPONSES
ALL DATES MUST BE ENTERED IN MM/DD/YYYY

FOR SCF USE ONLY

WID or SSN	DATE OF INJURY	
EMPLOYEE NAME		INSURER/SELF-INSURER (Reimbursement Payable To)
EMPLOYER NAME		ADDRESS
INSURER CLAIM NUMBER		CITY STATE ZIP CODE

Claim status

☐ A. **First claim for this case**

☐ AA. **First and last claim** as a result of full, final and complete settlement

☐ B. **Continuing** - Attach **EVIDENCE** of contact with employee during the time period claimed which **SUPPORTS ELIGIBILITY** for benefits claimed (i.e., status check confirming employee remains disabled, medical and/or rehabilitation reports from the time period claimed, etc.).

☐ C. **Final Claim** for this case. Reason:

☐ 1) Returned to work on: ______________________

☐ 2) Death of employee on: ______________________ **ATTACH DEATH CERTIFICATE**

☐ 3) Closed by settlement

☐ 4) Other: Explain:

Mail or fax completed copy to:

In Person:	**Mailing Address:**	**Fax:**
Department of Labor & Industry	Department of Labor & Industry	(651) 215-9099
Special Compensation Fund	Special Compensation Fund	
443 Lafayette Road N.	PO Box 64229	
St. Paul, MN 55155-4301	St. Paul, MN 55164-0029	

YOU MUST COMPLETE THE BACK SIDE OF THIS FORM.

Name of Preparer	E-mail address	Date
Company Name (if different from above)		Phone no. (include area code & ext.)
Address		Fax no. (include area code)

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

(over)

Specify TTD or PTD	From	Through	(1) Number of Weeks	(2) Weekly Comp Rate	(3) Government Benefits* Weekly Soc Security	(3) Government Benefits* Weekly other	(4) SUBTOTAL Col 2 - 3	(5) Max. (ROUNDED) supp. benefit minus Col 4	(6) 5% Offset	(7) Net supp benefits Col 5 – 6	TOTAL Col 1 X 7
Date of Birth ______________________________					Retirement ☐ Disability ☐					TOTAL	

***ATTACH EVIDENCE OF GOVERNMENT DISABILITY BENEFIT CHANGES IF OTHER THAN STANDARD COST OF LIVING ADJUSTMENTS.**

CLAIMS SERVICES AND INVESTIGATIONS USE ONLY

Total Amount Claimed ______________________

Amount Adjusted ______________________ Adjustment Code ______________________

Amount Approved ______________________

Approved by ______________________ Date Approved ______________________ Vendor Number ______________________

Paid by ______________________ Date Paid ______________________ Batch Number ______________________