**Department of Workforce Development**
**Worker's Compensation Division**
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.wisconsin.gov/wc

# Annual Report of Permanent Total Disability Payments Made

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

This information is required per s. DWD 80.02 (2) (k), Wisconsin Administrative Code and is due by June 30th of the current year.

| Claimant Name | | |
|---|---|---|
| WC Claim Number | Employee Social Security Number | Injury Date (mm/dd/yyyy) |
| Insurance Company Name | | |

| Type of Payment | Begin Date (mm/dd/yyyy) | End Date (mm/dd/yyyy) | Rate | Total Amount Paid |
|---|---|---|---|---|
| ☐ PTD<br>☐ Annuity | | | | $ |
| Supplemental Benefits (if applicable) | | | | $ |
| Attorney Fees | | | | $ |
| | | | | **Total:** $ |

| Report Prepared By | Work Telephone Number<br>( ) - | Date Signed (mm/dd/yyyy) |
|---|---|---|