Department of Workforce Development
Worker's Compensation Division

Dear Employee:

You have requested an advancement of your permanent disability benefit or from a restricted account. Although payments are to be paid monthly, in emergency situations advances may be approved. The Worker's Compensation Act allows advancements of these benefits only when it can be determined that this payment would be in the best interest of the injured worker and his or her dependents. To assist us in making this determination, **you must provide us with all of the information requested on the financial statement on the back of this letter.**

In most cases, you can expect to receive a decision regarding your advance request within 10 days after we receive your completed financial statement.

It is important for you to know that in all cases where monthly unaccrued permanent disability benefits are being advanced by an insurance carrier or self-insured employer, there will be a 5% interest credit allowed. This interest, compounded annually on the unaccrued benefits, **will reduce the total compensation payable to you**. Advancement checks will be made out in joint draft to you and the party to whom you are indebted.

Advance requests and disputes over any decisions regarding these requests **must be submitted in writing.**

Not all advance requests will be approved. No advancements will be granted on such items as credit card bills or personal loans.

Under the Worker's Compensation Act, you are limited to three advance payments in a calendar year.

Please send your completed financial statement to:

Department of Workforce Development
Worker's Compensation Division
P.O. Box 7901
Madison, WI 53707

ADVANCEMENT OR LUMP SUM REQUEST

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave.
P.O. Box 7901
Madison, WI 53707
Telephone: (608) 266-1340
Fax: (608) 260-3053
https://dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.

The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats. The purpose of this form is to assist with the procurement of information related to or required by Chapter 102. Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102. DWD may use the personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

WC Claim Number	Employee Name	Social Security Number*
Date of Injury	Requester Name (if other than employee)	Requesting as Beneficiary due to work related fatality? ☐ Yes ☐ No

Address (Number, Street, City, State and Zip Code)	Date of Birth	Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced

Are you currently employed? ☐ Yes ☐ No If "Yes," Start Date: _____

Employer Name	Employer Phone Number

Employer Address (Number, Street, City, State, Zip Code)

Your gross salary or wages $_____ per _____ Hours Per Week: _____

Present income of injured (all sources) _____

Social Security Benefits _____

If spouse employed, enter gross wages: $_____ per _____

Number of dependents under 18 years of age: _____

Child Support Obligation: _____

Savings: _____

Property owned (personal and real estate)	Estimated Value	Amount of money owed on property

To expedite our response, please give the amount and reason why advancement is requested. Be specific. Provide current copies of bills that are in arrears.

Certified as correct by: (signature of injured employee)

Signature _____ Date Signed _____

Telephone Number:

Under the Worker's Compensation Act, you are limited to three advance payments in a calendar year.

Return completed form to: Worker's Compensation Division, P.O. Box 7901, Madison, WI 53707