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

Supplemental Payments Reimbursement Request

*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.

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	Telephone Number Ext.	