Tommy G. Thompson
Governor

Linda Stewart
Secretary

Gregory Krohm
Division Administrator

State of Wisconsin

Department of Workforce Development

WORKER'S COMPENSATION
201 East Washington Avenue
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.state.wi.us/wc/

December 18, 1998 INS 397

To: Worker's Compensation Insurance Carriers
Self-Insured Employers

From: Gregory Krohm, Administrator
Worker's Compensation Division

Subject: Supplemental Benefits Payments under s. 102.44(1), Wis. Stats.

Form for 1998 Payments. Please submit Form WKC-140, entitled, "Supplemental Payments Reimbursement Request" in duplicate, for reimbursement of 1998 supplemental benefits payments under s. 102.44(1), Wis. Stats. Each insurance company or self-insured employer that made supplemental payments should use a separate form. The form is printed on the reverse side of this letter and may be copied if additional pages are needed.

Statutory Changes from 1996. The worker's compensation law was amended to raise the maximum weekly benefit payable from $125 to 150. Persons receiving less than the maximum rate for dates of injury prior to January 1, 1976 receive the same percent of $150 that their compensation rate bears to the maximum rate in effect at the time of their injury. If you did not make this adjustment in 1997 or 1998, please do so immediately.

Please notify all personnel who handle Wisconsin claims of this process.

If you have any questions, please contact us at (608) 266-1340.

This information and the attached form can be found on the Division's web page:

http://www.dwd.state.wi.us/wc/

File Ref:

Supplemental Payments Reimbursement Request

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Avenue, Rm. 161
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340

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 cases and in the amounts indicated.

List alphabetically by injured employe names.

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)].

Injured Employe	Employer	Injury Date	Weekly Supplemental Rate	Time Period Covered and Number of Weeks and Days	Amount of Reimbursement Requested
					Total: $

I certify that the above amounts requested for reimbursement are true and correct and they were 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
FEIN Number	Telephone Number	

Please forward original and one copy to the return address shown at the top of this form.

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