

Mail completed copy to:

Department of Labor and Industry
Claims Services and Investigations
PO Box 64229
St. Paul, MN 55164-0229
(651) 284-5045 or
1-800-342-5354 (DIAL-DLI)
Fax: (651) 284-5733

Annual Claim for Reimbursement of Supplementary Benefits

PRINT IN INK or TYPE your responses
All dates must be entered in MM/DD/YYYY



FOR CSI 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:

YOU MUST COMPLETE THE BACK SIDE OF THIS FORM.

Name of Preparer	Date
Company Name (if different from above)	Phone No. (include area code & ext.)
Address	

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.

Specify TTD or PTD	From	Through	(1) Number of Weeks	(2) Weekly Comp Rate	(3) Government Benefits*		(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
					Weekly Soc Security	Weekly other					
Date of Birth _____					Retirement	<input type="checkbox"/>					
					Disability	<input type="checkbox"/>					
										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 _____