Reset

Annual Claim for Reimbursement of Supplementary Benefits

AC03

PRINT IN INK OR TYPE YOUR RESPONSES
ALL DATES MUST BE ENTERED IN MM/DD/YYYY

FOR SCF 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:

Mail or fax completed copy to:

In Person:	**Mailing Address:**	**Fax:**
Department of Labor & Industry	Department of Labor & Industry	(651) 215-9099
Special Compensation Fund	Special Compensation Fund	
443 Lafayette Road N.	PO Box 64229	
St. Paul, MN 55155-4301	St. Paul, MN 55164-0029	

YOU MUST COMPLETE THE BACK SIDE OF THIS FORM.		
Name of Preparer	E-mail address	Date
Company Name (if different from above)		Phone No. (include area code & ext.)
Address		Fax No. (include area code)

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.

(over)

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 ☐ Disability ☐					TOTAL	

***ATTACH EVIDENCE OF GOVERNMENT DISABILITY BENEFIT CHANGES IF OTHER THAN STANDARD COST OF LIVING ADJUSTMENTS.**

SPECIAL COMPENSATION FUND USE ONLY

Total Amount Claimed _____

Amount Adjusted _____ Adjustment Code _____

Amount Approved _____

Approved by _____ Date Approved _____ Vendor Number _____

Paid by _____ Date Paid _____ Batch Number _____