

# Annual Claim for Reimbursement from the Second Injury Fund



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.	443 Lafayette Road N.	
St. Paul, MN 55155-4301	St. Paul, MN 55155-4301	

**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)

**MEDICAL AND REHABILITATION EXPENSE DETAIL**

Attach detailed description/itemization of rehabilitation and/or medical expenses. Include the dates of service, dates paid, amounts paid and names of providers. (Computerized printouts are sufficient if they include all required information.)

These medical expenses  do **NOT** exceed  **DO** exceed permissible limits set for medical services in Minnesota Rules Chapter 5221. If the medical fee schedule has not been applied to any bills for medical services, **ATTACH A COPY OF THE BILL SHOWING THE CPT CODE.**

**DATES for which you are requesting reimbursement**  through

1. a. Medical and rehabilitation expenses claimed this period \_\_\_\_\_

b. Less deductible to this date of injury \_\_\_\_\_ - \_\_\_\_\_

**SUBTOTAL** \_\_\_\_\_

c. Percent apportioned (**Attach proof of apportionment if claiming for the first time**) \_\_\_\_\_ %

**SUBTOTAL** \_\_\_\_\_

d. Lump sum amount to be reimbursed \_\_\_\_\_

e. **TOTAL Medical and Rehabilitation** expenses claimed  \$ \_\_\_\_\_

**INDEMNITY EXPENSE DETAIL**

**Complete an Interim Status Report** for the period covered by this claim. **Transfer** the information from the **Interim Status Report.**

**DATES for which you are requesting reimbursement**  through

2. a. Temporary Partial Benefits paid \_\_\_\_\_

Retraining Benefits paid \_\_\_\_\_

Temporary Total Benefits paid \_\_\_\_\_

Permanent Total Benefits paid \_\_\_\_\_

**SUBTOTAL** \_\_\_\_\_

b. Less deductible to this date of injury \_\_\_\_\_ - \_\_\_\_\_

**SUBTOTAL** \_\_\_\_\_

c. Percent apportioned (**Attach proof of apportionment if claiming for the first time**) \_\_\_\_\_ %

**SUBTOTAL** \_\_\_\_\_

d. Permanent Partial, Impairment Compensation, Economic Recovery claimed  
(**circle type of permanency paid**) \_\_\_\_\_

e. Lump sum to be reimbursed \_\_\_\_\_

f. **TOTAL indemnity** reimbursement claimed  \$ \_\_\_\_\_

3. **TOTAL reimbursement claimed (1e + 2f)**  \$ \_\_\_\_\_

**SPECIAL COMPENSATION FUND USE ONLY**

Indemnity Amount Approved	\$ _____	Adjustment Code	_____
Medical Amount Approved	\$ _____	Approved by	_____
Amount Adjusted	\$ _____	Date Approved	_____
Total Approved	\$ _____	Date Paid	_____
Paid by	_____	Batch Number	_____
Vendor Number	_____		