Worker's Compensation
201 East Washington Avenue
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Madison, WI 53707-7901
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State of Wisconsin
Department of Workforce Development

Worker's Compensation Insurance Letter

INS #	473
Date	March 31, 2008
Program	Claims Management
Type	Informational
Replaces	Insurance Letter 467

To: Insurance Carriers, Self Insured Employers and Claims Handling Offices
From: Frances Huntley-Cooper, Division Administrator
Subject: Supplemental Benefits Payments under s. 102.44(1), Wis. Stats.

Purpose: Inform insurers of Supplemental Benefit rate increases under s. 102.44(1) effective April 1, 2008.

Background: S. 102.44(1)(a), Wis Stats. was amended to raise the maximum weekly benefit payable for injuries occurring prior to January 1, 1993 from $338 to $450 for supplemental benefit payments. Persons receiving less than the maximum rate for dates of injury prior to January 1, 1993 receive the same percent of $450 that their compensation rate bears to the maximum rate in effect at the time of their injury. Reimbursement for these supplemental payments will be made by the Department of Workforce Development, from the Work Injury Supplemental Benefit Fund.

Action Requested: Please submit Form WKC-140, entitled, "Supplemental Payments Reimbursement Request" for reimbursement of 2007 supplemental benefits payments under s. 102.44(1), Wis. Stats. Each insurance company or self-insured employer that made supple-mental payments should use a separate form for each claim upon which reimbursement is being requested. A copy of the form is enclosed and may be copied if additional pages are needed.
If you did not make this adjustment in prior years, please do so immediately. Please notify all personnel who handle Wisconsin claims of this process.

Inquiries: If you have any questions, please contact Abby Butler at (608) 266-6771 or e-mail her at abby.butler@dwd.state.wi.us.

Enclosure : WKC-140 'Supplemental Payments Reimbursement Request' on reverse side. An electronic version of this form is also available on our website at:

http://www.dwd.state.wi.us/dwd/forms/wkc/wkc_140_e.htm.

Reference: Insurance Letter 467

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Supplemental Payments Reimbursement Request

The provision of your social security number is voluntary. Failure to provide it may result in an information processing delay.
Personal information you provide may be used for secondary purposes [(Privacy Law, s. 15.04(1)(m)].

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	Insurance Company Name

Weekly Supplemental Rate	Begin Date	End Date	Number of Weeks and Days	Amount of Reimbursement Requested

Total:
$

I certify the above amount requested for reimbursement is true and correct and was 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.