TEST INSURER 2
C/O TEST INSURER 2
123 JENNIFER ST
MADISON WI 53703

WC CLAIM NO:	9999-999999	IF YOU CALL OR WRITE US
INJURY DATE:	01/01/98	PLEASE USE WC CLAIM NO.
EMPLOYEE:	SIMPLES-SAMPLER, TESTER SAMPLE	
EMPLOYER:	SAMPLE EMPLOYER	
INSURER NO:		

On the reverse of this letter you will find our form for the annual reporting of Permanent Total Disability benefits.

The addition to the Wisconsin Administrative Code of section DWD 80.02(2)(k), effective November 1, 2015, requires that all worker's compensation carriers and self-insured employers report annual permanent total disability payments, for the previous calendar year, to us by June 30th of each year. In order to bring our internal work processes in line with these new requirements, this annual reminder will be mailed on all claims for which we have not received updated permanent total disability payment information by June 30th.

This may represent a change in the schedule on which you were previously reporting permanent total disability benefits to us. Please adjust your reporting practices to align with the new requirements of the Administrative Code.

(PLEASE SEE OTHER SIDE)

We are making an annual follow-up for this permanent total injury. Please answer the two questions below, fill in all of the appropriate payment information and return this form to the department.

1. Has there been any change in this employee's condition? Yes No
2. What is the employee's current address?

Payment Information					
Type of Payment	From January 1 of previous year	To December 31 of previous year	Rate	Amount of Compensation Paid	Accumulated Total Amount Paid
☐ Perm Total ☐ Annuity	January 1	December 31			
Supplemental Benefits	January 1	December 31			
Attorney Fees	January 1	December 31			

If applicable, indicate balance remaining on Third Party Cushion as of 12/31: _____

Completed by: _____ Date: _____