

TEST INSURER 2
C/O TEST INSURER 2
RM C100
201 E WASHINGTON AVE
MADISON WI 53703

WC CLAIM NO: 9999-999999
INJURY DATE: 05/01/85
EMPLOYEE: SAMPLE SIMPLES, SAMPLE
EMPLOYER: SAMPLE EMPLOYER INC
INSURER NO:

IF YOU CALL OR WRITE US
PLEASE USE WC CLAIM NO.

This is a request for overdue information.

The Wage Information Supplement, WKC-13A, you submitted was incomplete. We need to determine the correct average weekly wage for computing the TTD rate. Please answer the following questions and return this form to the Worker's Compensation Division within 30 days.

Part-time work:

1. How many hours per week was the employee scheduled when injured? _____
2. How many other employees worked the same schedule of hours per week? _____
3. How many full-time employees did the same type of work? _____

Please refer to the Insurers' Pending Reports on our web site for the missing required wage report at <https://dwd.wisconsin.gov/wc/insurance/pending-rpts.htm>.

If you have any questions about submitting the above requested information, please contact us by calling (608) 266-1340 and then ask for a wage analyst.

As a self-insured employer it is your responsibility to submit all required reports and respond to information requested by the Department in a timely manner.

Department of Workforce Development
Worker's Compensation Division

WKC-17674-E (R.11/2014) BIP45D