

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.

The Wage Information Supplement, form WKC-13A or WKC-13A1, you submitted was incomplete. Please provide the information requested below and return this form to the Worker's Compensation Division immediately.

Gross Earnings:

1. During the 52-week period prior to the date of injury, how many weeks did the employee work at the same type of employment that he or she was performing at the time of injury?

2. What were the employee's total earnings during those weeks? Include any bonus or premium, but exclude tips.

\$ _____

Failure to report this required information within 30 days may result in a \$100 surcharge under s. 102.35(1), Wis. Stats.

Wage Analyst
608-266-3264

WC45B (R. 11/2022)