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

WC CLAIM NO:	9999-999999	IF YOU CALL OR WRITE US
INJURY DATE:	05/01/85	PLEASE USE WC CLAIM NO.
EMPLOYEE:	SAMPLE SIMPLES, SAMPLE	
EMPLOYER:	SAMPLE EMPLOYER INC	
INSURER NO:		

According to our records, you submitted an incomplete Wage Information Supplement, WKC-13A or WKC-13A1. We need to verify 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.

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 during the time of injury?

   _____

2. What were the total earnings during those weeks? Include bonus or premium pay, but exclude tips.

   $_____

Part-time work:

1. How many hours per week was the employee usually scheduled to work? _____
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? _____
4. How many hours per week did full-time employees work? _____

Thank you for your help in assuring correct compensation payments.

Failure to submit this required report within 30 days may result in a $100 surcharge pursuant to sec. 102.35(1), Wis. Stats.

Wage Analyst
(608) 266-3264

WC45H (R. 11/2022)