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APPLICATION FOR REIMBURSEMENT FROM THE COMPENSATION SUPPLEMENT FUND

Michigan Department of Labor and Economic Opportunity
Workers' Disability Compensation Agency
PO Box 30016, Lansing, MI 48909

☐ Initial (For Quarter)
☐ Corrected

Employer Name (Type or print) _____ Carrier File No. _____

Employee Name (Last, First, MI)					
Employee Street Address		City		State	Zip Code
Social Security Number	Date of Injury (MM-DD-YYYY)	Average Weekly Wage on Date of Injury		Date of Birth (MM-DD-YYYY)	
Name of Insurance Company or Self-Insured				Carrier I.D. Number	
Carrier Address (Street)		City		State	Zip Code
Federal Employer I.D. Number	Reimbursement Requested For: Quarter _____ Calendar Year _____			Weekly Comp. Rate on Jan. 1, 1982	

Compensation Paid		Weeks	Days	Supplement Percentage	Weekly Second Injury Fund Differential Benefits Paid	Weekly Compensation Supplement	Total Supplement Paid
Date from (MM-DD-YYYY)	Date to (MM-DD-YYYY)						
						Total Reimbursement Requested	$ _____

☐ Date of death _____
☐ Date of redemption _____
☐ Return to work _____
☐ Other _____

Comments:

Signature of Authorized Representative (In Ink)	Name of Person to Whom Correspondence Should Be Sent (Please Print)	
Date of This Report	Address	Telephone Number

NOTICE: The initial form WC-114 must be filed within three (3) months after the end of the calendar quarter in which benefits are first paid. No subsequent reimbursements will be allowed for a period which is more than one (1) year prior to the filing date of the form WC-114.

Authority: Workers' Disability Compensation Act, 418.352; R408.32(2)(3) Completion: Mandatory Penalty: Workers' Disability Compensation Act, 418.631; 418.801	LEO is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.