

CARRIER'S REQUEST FOR REIMBURSEMENT OF COMPENSATION PAYMENTS UNDER SEC. 15-8

WCB CASE NO.	CARRIER CASE NO.	CARRIER ID NO. W	SOC. SEC. NO.
CARRIER'S NAME		CARRIER'S ADDRESS	
CLAIMANT'S NAME			

The Carrier requests reimbursement for benefits paid, as follows:

- A. _____ weeks from _____ to _____ at \$ _____ \$ _____
 _____ weeks from _____ to _____ at \$ _____ \$ _____
 _____ weeks from _____ to _____ at \$ _____ \$ _____
- B. Lump sum payment representing _____ weeks at \$ _____ per week. \$ _____
- C. Funeral Expenses _____ \$ _____
- D. Other (Specify) _____ \$ _____

TOTAL CLAIM FOR REIMBURSEMENT \$ _____

1. Does this claim represent an initial request for reimbursement of compensation payments ? Yes No
2. Date Claimant's status was last checked _____

The summary below is to be used for all initial claims. If desired, Form C-8/8.6 may be substituted and attached to the original copy. The summary (or Form C-8/8.6) must include all payments from date of accident through the period for which reimbursement is requested.

SUMMARY OF COMPENSATION PAYMENTS				
Period(s) of Payments		Less Days Worked	Number of Weeks	Weekly Rate
From	To			

3. Is there a third party action on this claim? Yes No If yes, is this action pending dismissed settled

STATEMENT

I hereby certify that this request for reimbursement made to the Chair of the Workers' Compensation Board is true and correct; that no part thereof has been previously paid and the amount stated therein is due and owing.

Signature: _____ Date: _____

Title: _____ Telephone No.: _____

INSTRUCTIONS:

1. Where possible, claim should be submitted for 26 week periods.
2. Forward original and two copies to the local office of the Special Funds Conservation Committee.
3. Retain one copy.

DO NOT USE SPACE BELOW

TO: CHAIR, WORKERS' COMPENSATION BOARD
The Special Funds Conservation Committee approves reimbursement for the above claim totaling \$ _____.
Agreed Date for Compensation Reimbursement _____
By _____
Date _____