Addendum to Annual Claim for Reimbursement of Supplementary Benefits

EMPLOYEE NAME	WID or SSN	DATE OF INJURY

Specify TTD or PTD	From	Through	(1) Number of Weeks	(2) Weekly Comp Rate	(3) Government Benefits*		(4) SUBTOTAL Col 2 - 3	(5) Max. (ROUNDED) supp. benefit minus Col 4	(6) 5% Offset	(7) Net supp benefits Col 5 – 6	TOTAL Col 1 X 7
					Weekly Soc Security	Weekly other					
Date of Birth _____					Retirement ☐ Disability ☐					TOTAL	