Annual Claim for Reimbursement from the Second Injury Fund

PRINT IN INK or TYPE YOUR RESPONSES
ALL DATES MUST BE ENTERED in MM/DD/YYYY

FOR SCF USE ONLY

WID or SSN	DATE OF INJURY	
EMPLOYEE NAME		INSURER/SELF-INSURER (Reimbursement Payable To)
EMPLOYER NAME		ADDRESS
INSURER CLAIM NUMBER		CITY STATE ZIP CODE

Claim status

- ☐ A. **First claim for this case**
- ☐ AA. **First and last claim** as a result of full, final and complete settlement
- ☐ B. **Continuing** - Attach **EVIDENCE** of contact with employee during the time period claimed which **SUPPORTS ELIGIBILITY** for benefits claimed (i.e., status check confirming employee remains disabled, medical and/or rehabilitation reports from the time period claimed, etc.).
- ☐ C. **Final Claim** for this case. Reason:
  - ☐ 1) Returned to work on: ________________________
  - ☐ 2) Death of employee on: ________________________ **ATTACH DEATH CERTIFICATE**
  - ☐ 3) Closed by settlement
  - ☐ 4) Other: Explain:

Mail or fax completed copy to:

In Person:	Mailing Address:	Fax:
Department of Labor & Industry	Department of Labor & Industry	(651) 215-9099
Special Compensation Fund	Special Compensation Fund	
443 Lafayette Road N.	PO Box 64229	
St. Paul, MN 55155-4301	St. Paul, MN 55164-0029	

YOU MUST COMPLETE THE BACK SIDE OF THIS FORM.

Name of Preparer	E-mail address	Date
Company Name (if different from above)		Phone No. (include area code & ext.)
Address		Fax No. (include area code)

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

(over)

MEDICAL AND REHABILITATION EXPENSE DETAIL

Attach detailed description/itemization of rehabilitation and/or medical expenses. Include the dates of service, dates paid, amounts paid and names of providers. (Computerized printouts are sufficient if they include all required information.)

These medical expenses ☐ do **NOT** exceed ☐ **DO** exceed permissible limits set for medical services in Minnesota Rules Chapter 5221. If the medical fee schedule has not been applied to any bills for medical services, **ATTACH A COPY OF THE BILL SHOWING THE CPT CODE.**

DATES for which you are requesting reimbursement ________ **through** ________

1. a. Medical and rehabilitation expenses claimed this period ________

   b. Less deductible to this date of injury - ________

   SUBTOTAL ________

   c. Percent apportioned **(Attach proof of apportionment if claiming for the first time)** ________ %

   SUBTOTAL ________

   d. Lump sum amount to be reimbursed

   e. **TOTAL Medical and Rehabilitation** expenses claimed $ ________

INDEMNITY EXPENSE DETAIL

Complete an Interim Status Report for the period covered by this claim. **Transfer** the information from the **Interim Status Report.**

DATES for which you are requesting reimbursement ________ **through** ________

2. a. Temporary Partial Benefits paid ________

   Retraining Benefits paid ________

   Temporary Total Benefits paid ________

   Permanent Total Benefits paid ________

   SUBTOTAL ________

   b. Less deductible to this date of injury - ________

   SUBTOTAL ________

   c. Percent apportioned **(Attach proof of apportionment if claiming for the first time)** ________ %

   SUBTOTAL ________

   d. Permanent Partial, Impairment Compensation, Economic Recovery claimed **(circle type of permanency paid)** ________

   e. Lump sum to be reimbursed

   f. **TOTAL indemnity** reimbursement claimed $ ________

3. **TOTAL reimbursement claimed (1e + 2f)** $ ________

SPECIAL COMPENSATION FUND USE ONLY

Indemnity Amount Approved	$ ________		
Medical Amount Approved	$ ________	Adjustment Code	________
Amount Adjusted	$ ________	Approved by	________
Total Approved	$ ________	Date Approved	________
Paid by	________	Date Paid	________
Vendor Number	________	Batch Number	________