

REIMBURSEMENT REQUEST OF GROUP INSURANCE CARRIER/DISABILITY BENEFITS PROVIDER

Instructions: Any group insurance carrier or disability benefits provider must file this form in order to indicate a request for reimbursement for disability benefits paid during the pendency of a claim. A copy shall be sent to all parties at interest. If a hearing is pending when the Board receives this, then the Board will mail a copy of the hearing notice to the party filing this form. If a hearing is not pending, then the Board will issue an order allowing all parties 15 days to file an objection, which must be filed on Form WC-102gb.

Employee:
Injury Date(s):
Claim Number:

The reason that reimbursement for disability benefits should be ordered is as follows:

_____, of the mailing address of _____
and the telephone number (____)_____, requests reimbursement for the following list of payments, and supporting documentation is attached: [Use additional pages if necessary]

I certify that I have today sent a copy of this to all
counsel and unrepresented parties listed here:

Signature

Date

Type here your name: