

**Department of Workforce Development  
Division of Worker's Compensation**

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**State of Wisconsin  
Department of Workforce Development**

**Jim Doyle, Governor**

**Roberta Gassman, Secretary**

**Frances Huntley-Cooper, Division Administrator**

September 30, 2010

INSURER  
ADDRESS 1  
ADDRESS 2  
CITY ST ZIP

WC CLAIM NO: 000-000000  
INJURY DATE: 00/00/00  
EMPLOYEE: SIMPLE SAMPLE  
EMPLOYER: SIMPLE SAMPLE  
INSURER NO:

IF YOU CALL OR WRITE US  
PLEASE USE WC CLAIM NO.

We are making an annual follow-up for this permanent total injury. Please answer the two questions below, fill in all of the appropriate payment information and return this form to the department.

1. Has there been any change in this employee's condition? Yes No
2. What is the employee's current address?

Payment Information					
Type of Payment	From January 1 of previous year	To December 31 of previous year	Rate	Amount of Compensation Paid	Accumulated Total Amount Paid
<input type="checkbox"/> Perm Total <input type="checkbox"/> Annuity	January 1	December 31			
Supplemental Benefits	January 1	December 31			
Attorney Fees	January 1	December 31			

If applicable, indicate balance remaining on Third Party Cushion as of 12/31: \_\_\_\_\_

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

WKC-13052-E (R. 09/2010) AU03