Reset

Department of Labor and Industry
Special Compensation Fund
PO Box 64229
St. Paul, MN 55164-0229
(651) 284-5045 or 1-800-342-5354

Notice of Intention to Claim Reimbursement From the Second Injury Fund

RS05

DO NOT USE THIS SPACE

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

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

ATTACH COPY OF ACCEPTED REGISTRATION OR DOCUMENTATION OF AUTOMATIC REGISTRATION

1. Nature of registered condition	2. Dates of previous work-related injuries, if any

3. Nature of subsequent injury causing disability for which reimbursement is being claimed

4. The insurer is claiming that this disability is (check one):
   a. ☐ more serious because of the registered condition (substantially greater) M.S. § 176.131, subd. 1.
   b. ☐ caused by the registered condition (except for) M.S. § 176.131, subd. 2.

ATTACH MEDICAL REPORTS TO SUPPORT THE ITEM CHECKED ABOVE
COMPLETE THE REHABILITATION AND WORK STATUS REPORT ON THE BACK OF THIS FORM

Name of Preparer	Date
TPA Name	Phone No. (include area code & ext.)
Address	

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.

SPECIAL COMPENSATION FUND OFFICE USE ONLY

Claim **APPROVED** on _____ by _____

Deductibles
☐ 26 weeks and $1,000 ☐ 52 weeks and $2,000; apportionment under M.S. § 176.131, subd.1(a)
☐ 52 weeks and $2,000 ☐ No deductibles

Other: _____

Claim **REJECTED** on _____ by _____

Deductibles
☐ No registration found ☐ Documentation of automatic registration not attached
☐ Notice was filed late ☐ Medical reports to support claim not attached

Other: _____

(over)

VOCATIONAL REHABILITATION AND WORK STATUS REPORT

1. Has the employee returned to work? ☐ Yes ☐ No

   Do temporary partial benefits continue to be paid? ☐ Yes ☐ No

2. Has this case been referred for vocational rehabilitation?

   ☐ Yes (Complete #3)

   ☐ No Reason:

   ☐ Disability Status Report filed requesting rehabilitation waiver

3. Current status (check **ALL** that apply):

   ☐ a. Plan in progress, R-2 submitted

   ☐ b. On-The-Job Training Plan approved and in progress

   ☐ c. Retraining approved and in progress

   ☐ d. Rehabilitation closed, R-8 submitted (check one below):

      ☐ 1. Employee returned to work

      ☐ 2. Employee retired

      ☐ 3. Employee died

      ☐ 4. Rehabilitation discontinued by settlement, mediation, arbitration or order

      ☐ 5. Other Explain:

Mail completed copy to:	
In Person	**Mailing Address**
Department of Labor and Industry	Department of Labor and Industry
Special Compensation Fund	Special Compensation Fund
443 Lafayette Road N.	PO Box 64229
St. Paul, MN 55155-4301	St. Paul, MN 55164-0229