State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 7-13-2009

44

WCC File #

Date filed in District

(for WCC use only)

Order to Second Injury Fund in Cases of Concurrent Employment

The Insurer / Payor shall furnish the Treasurer such documents as is necessary to verify payments for which it is seeking reimbursement.

ORDER

Pursuant to C.G.S. Section 31-310, the Treasurer of the State of Connecticut is ordered to reimburse the subject Insurer / Payor for the prorated share it has expended under Voluntary Agreement approved on

_____
(date)

for the captioned injury.

The Insurer / Payor attests that it has paid the complete adjusted total weekly benefit as agreed to on the subject Voluntary Agreement and now seeks reimbursement for the prorated share in the amount of

$ _____

for the weekly periods enumerated below, check to be made payable to:

_____

Temporary Total Benefits = $ _____

from _____ to _____

Temporary Partial Benefits = $ _____

from _____ to _____

Permanent Partial Benefits = $ _____

from _____ to _____

The Form 44 will NOT be processed without both signatures:

_____
Signature of INSURER / PAYOR Representative Date *(MM/DD/YY)*

_____
Date *(MM/DD/YY)*
Sent to SIF

_____
Signature of SECOND INJURY FUND Representative Date *(MM/DD/YY)*

CLAIMANT

Name _____

D.O.B. *(required)* _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

INJURY

Date of Injury _____

EMPLOYER

Name _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

INSURER / PAYOR

Name _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

Contact Person _____

WORKERS' COMPENSATION COMMISSION APPROVAL

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