

**THE LABOR COMMISSION OF UTAH**

\_\_\_\_\_ Applicant,

Social Security Number: \_\_\_\_\_

vs.

\_\_\_\_\_ Defendants.

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PETITION FOR REIMBURSEMENT

FROM THE

EMPLOYERS' REINSURANCE FUND

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COMES NOW \_\_\_\_\_

employer/carrier in the above-entitled matter and represents to the Labor Commission that they have paid \$ \_\_\_\_\_ as temporary total disability compensation for the period of \_\_\_\_\_ to \_\_\_\_\_, and/or \$ \_\_\_\_\_ as medical expenses for a period of \_\_\_\_\_ to \_\_\_\_\_ on behalf of the Applicant for an industrial accident sustained on \_\_\_\_\_.

The attached medical report/order indicates the Applicant has a permanent partial impairment of \_\_\_\_\_% due to the industrial accident, and \_\_\_\_\_% due to preexisting conditions which, pursuant to Section 34A-2-703, Utah Code Annotated, is the responsibility of the Employers' Reinsurance Fund, and accordingly, the above named employer/carrier hereby requests reimbursement for \_\_\_\_\_% / \$ \_\_\_\_\_ of the foregoing amounts from the Employers' Reinsurance Fund.

ATTACHED IS VERIFICATION OF AMOUNTS EXPENDED ON THE ABOVE  
(Calculation verification tapes must be attached)

Please remit payment to: \_\_\_\_\_

\_\_\_\_\_ Complete Street Address or P O Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code

By \_\_\_\_\_ (Signed) \_\_\_\_\_ Phone Number

\_\_\_\_\_ Company's Tax Identification Number

SUBSCRIBED AND SWORN to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_

Approved/Amount \$ \_\_\_\_\_

Disapproved/Amount \$ \_\_\_\_\_

Reason(s) \_\_\_\_\_

\_\_\_\_\_  
NOTARY PUBLIC