Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.state.wi.us/wc/
e-mail: DWDDWC@dwd.state.wi.us

ADVANCEMENT OR LUMP SUM REQUEST

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)].

WC Claim Number **(office use only)**	Employee Name	Today's Date
Social Security Number	Employee Address (Number, Street, City, State and Zip Code)	

Injury Date	Employee Telephone Number ( )	Date of Birth	Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced

Are you currently employed? ☐ Yes ☐ No If "Yes" Start Date: ________________________

Employer Name	Employer Phone Number ( )
Employer Address (Number, Street, City, State, Zip Code)	

Your gross salary or wages $___________________ per _____________ Hours Per Week: __________________

Present income of injured (all sources) ____________________________

Social Security Benefits ________________________

If spouse employed, enter gross wages: $___________________ per _____________

Number of dependents under 18 years of age: ___________

Child Support Obligation: ________________

Savings: _______________

Property owned by injured (personal and real estate)	Estimated Value	Amount of money owed on property

To expedite our resonse please give the amount and reason why advancement is requested. Be specific. Provide current copies of bills that are in arrears.

Certified as correct by: (signature of injured employee)

____ Signature

____________________________________ Date Signed

Return completed form to: Worker's Compensation Division, P.O. Box 7901, Madison, WI 53707-7901

WKC-136 (R. 07/2001)

Dear Employee:

You have requested an advancement of your permanent disability benefit or from a restricted account. Although payments are to be paid monthly, in emergency situations advances may be approved. The Worker's Compensation Act allows advancements of these benefits only when it can be determined that this payment would be in the best interest of the injured worker and his or her dependents. To assist us in making this determination, you must provide us with all of the information requested on the financial statement on the back of this letter.

In most cases, you can expect to receive a decision regarding your advance request within 10 days after we receive your completed financial statement.

It is important for you to know that in all cases where monthly unaccrued permanent disability benefits are being advanced by an insurance carrier or self-insured employer, there will be a 7% interest credit allowed. This interest, compounded annually on the unaccrued benefits, **will reduce the total compensation payable to you**. Advancement checks will be made out in joint draft to you and the party to whom you are indebted.

Advance requests and disputes over any decisions regarding these requests **must be submitted in writing.**

Not all advance requests will be approved. No advancements will be granted on such items as credit card bills or personal loans.

Please send your completed financial statement to:

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