

After 26 Weeks Wage Reimbursement Request form

Claim Number: _____

Workers Name: _____

Date Claiming From: _____ To: _____

Number of Working: Days _____ Hours: _____
(Days/hours employer is claiming for when worker has not been at work)

1. Normal Weekly Earnings _____
(As per our letter)

2. Less Earnings: _____
(Amount paid for hours worked)

3. Balance: _____
(1 - 2 =)

4. Balance x 75% or 90% _____
The worker has now received weekly payments for 26 weeks.
Pursuant to section 65 of *The Workers Rehabilitation and Compensation Act*, the worker is now entitled to compensation equal to 75% of his/her loss of earning capacity or 90%, which ever is the lesser amount.

Employer paid the worker 2 + 4 = _____

Please reimburse as indicated above.

Balance (#4)

Signature _____ Date: ____ / ____ / ____