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APPLICATION FOR ADVANCE PAYMENT

Michigan Department of Labor & Economic Growth
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

INSTRUCTIONS TO APPLICANT: Only applicants who are currently receiving workers' compensation benefits may file this form. It should be completed and mailed to the above address. No action will be taken on this application unless you answer all questions in Section 1 (numbers 1 through 14) and sign your name under "Applicant Signature."

SECTION 1: TO BE COMPLETED BY APPLICANT

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, Middle Initial)
4. Employer Name		5. Insurance Company Name (if applicable)
6. Applicant Name (if other than employee)		7. Relationship to Employee
8. Applicant Street Address		9. City, State, ZIP Code

10. Amount of Advance Requested	11. If amount is part of the remaining weekly benefits due, take repayment from the	12. If amount is from next payments due, repay by reducing weekly rate by
$	☐ Next ☐ Last Payments Due	$

13. The employer or its insurance carrier has the right to 10% interest per year on the advance you are requesting. If they request that this discount be taken, do you still want the advance payment to be approved?

☐ Yes ☐ No

14. Clearly state your reason(s) for requesting the advance payment.

Applicant Signature	Date
Attorney Name (if applicable)	Attorney ID # P-

SECTION 2: TO BE COMPLETED BY CARRIER

Does the carrier agree with the terms of the advance payment request? ☐ Yes ☐ No		Is the discount requested? ☐ Yes ☐ No
Carrier Signature	Carrier Name	Date

Authority: Workers' Disability Compensation Act, 418.835; 418.837 Completion: Voluntary Penalty: None	The Department of Labor & Economic Growth will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc. under the Americans with Disabilities Act, you may make your needs known to this agency.