THE LABOR COMMISSION OF UTAH

_____Applicant,	*	
	*	PETITION FOR REIMBURSEMENT
Social Security Number: _____	*	FROM THE
vs.	*	EMPLOYERS' REINSURANCE FUND
_____Defendants.	*	

* *

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