University of Illinois
Committee on Workers' Compensation

Original To Workers' Compensation/Claims Management
100 Trade Centre, Suite 103, Champaign, IL MC-686

DEPARTMENT REPORT ON DISABILITY BENEFITS
Report No. _____ Final _____
NOTICE: Failure to Submit This Report on Time May Increase Liability.

Employee_____ Date_____
Department_____

Regular Scheduled Work Days S M T W T F S Hours Worked Per Day_____
(Circle Work Days)
Injured on_____ Returned to work on_____

First day of absence (Excluding Date of Injury)_____
Number of work days missed (Excluding First Day of Absence)_____

Number of workdays missed **paid** with employee benefits_____ Amount **paid** with benefits_____
Number of workdays missed **unpaid** with employee benefits_____ Amount **unpaid**_____

Hourly rate of pay at time of injury_____ Average weekly earnings at time of injury_____

The above information covers the pay period beginning_____ and ending_____

Attach a copy of the daily time report for the above pay period.

_____ _____
Date Department Head or Assignee
(I attest that the information on this report is true and correct)

If the injured employee is unable to return to work on the day of the accident, this report shall be completed and promptly forwarded at the close of each pay period until the injured employee returns to work or resigns. The information given in this report is necessary for computing Workers' Compensation benefits. Under the provisions of the Illinois Workers' Compensation Act, compensation for time lost begins if more than 3 working days are lost unless 14 or more calendar days are lost, then compensation commences on the day following the accident. FAILURE TO PAY COMPENSATION, AS OUTLINED, SHALL BE CONSIDERED UNREASONABLE DELAY AND THE COMMISSION MAY AWARD ADDITIONAL COMPENSATION. If the amount stated in number of work days unpaid is less than the Workers' Compensation payment for time lost, there will be a payment to the injured employee, a deduction for a subsequent pay period, and a credit to earned university benefits. All payments of Workers' Compensation must be approved by the Committee. Accurate reports, promptly submitted, assist the injured employee and the University. Questions concerning this report should be directed to the Claims Management Office.

To be filled out by Claims Management

Department paid benefits_____ Amount $_____

Workers' Compensation pays_____ Amount $_____
(calendar days in weeks) X (weekly rate)

No Deductions to be made. Pay $_____ Deduct $ _____ Credit Earned Benefits hours_____

Month Year Calendar Days

Total calendar days lost_____ - 3 =_____ ÷ 7 =_____ X_____ = $_____
(if not 14) (weeks) (weekly rate) W/C Payment

Form 78973 (Revised 011/2005)