LAB 500 EXHIBIT S

REQUEST FOR REIMBURSEMENT FROM THE SECOND INJURY FUND

This request for reimbursement must be filed no later than September 1st for all reimbursable benefits paid in the preceding calendar year.

Employee Name	Date of Subsequent Injury/Claim #
Employer Name	Date of Subsequent Disability
Employer's Insurance Carrier	Insurance Adjuster
VENDOR CODE (Check Payable To)	**EMAIL ADDRESS TO SEND PDF**

Net reimbursable payment for the year ending December 31, 20_____ $_____

Application is made for reimbursement as set forth herein, and on the related Schedule of Reimbursable Payments, Form No. WCSIF-2a. It is certified that all payments herein are verifiable by audit of applicable records as proper disbursements issued to the payee in accordance with RSA 281-A and not later than December 31st of the calendar year shown, or as proper adjustments on account of overpaid or underpaid reimbursements. It is certified further that overpaid reimbursements, as may be found by the State of New Hampshire, or as may be found by the applicant pursuant to hereby agreed annual self-audit of this claim for improper or unissued or uncashed or cancelled disbursements, shall be adjusted by immediate payment to the Labor Department or by the adjustment of amounts less than five hundred dollars ($500.00) in the next reimbursement request pertaining to this claim against the fund. It is certified further that, except in case of death of the above named-employee, the results of ongoing medical evaluations are held available by the applicant, and do clearly support the continued eligibility of the employee to receive the benefits of all payments herein, and that all necessary efforts at the employee rehabilitation and job placement continue faithfully to be applied.

I, the undersigned _____
Name Title

subscribe to the above statement this_____ day of _____, in the year_____ under the penalties of perjury.

Signature

FOR LABOR DEPARTMENT USE: Date:

APPROVED BY In the amount of $

PAID**:** REF NO. DATE

WCSIF-2 (5/2013)