

Mail or fax to:  
Department of Labor and Industry  
Workers' Compensation Division  
P.O. Box 64221  
St. Paul, MN 55164-0221  
(651) 284-5032 or 1-800-342-5354  
Fax: (651) 284-5731

## Notice of Benefit Payment

Print in ink or type  
Enter dates in MM/DD/YYYY format



Do not use this space

|                            |                      |                            |
|----------------------------|----------------------|----------------------------|
| WID number or SSN          | Date of injury (DOI) | Average weekly wage at DOI |
| Employee (last, first, MI) | Employer             |                            |
| Employee address           |                      |                            |
| City                       | State                | ZIP code                   |
| Insurer claim number       |                      |                            |

**The following permanent partial disability benefit will be paid to you:**

\_\_\_\_\_ % of whole body according to Minnesota Workers' Compensation Permanent Partial Disability Schedule rule number(s):  
\_\_\_\_\_.

The rating is based on the attached medical report of Dr. \_\_\_\_\_  
dated \_\_\_\_\_, received by the insurer on \_\_\_\_\_ (date).

This payment is based on the preliminary rating. If your final disability rating is higher, additional payments may be made.

**For injuries on or after 10/01/1995:**

The initial payment of weekly benefits was or will be made on \_\_\_\_\_ (date). Benefits will be paid at a weekly rate of \$ \_\_\_\_\_ through \_\_\_\_\_ (date) for a total of \$ \_\_\_\_\_.

A lump-sum payment of \$ \_\_\_\_\_, instead of weekly payments, was or will be made on \_\_\_\_\_ (date) as requested by the employee on \_\_\_\_\_ (date).

**For injuries from 01/01/1984 through 09/30/1995** payment of:

\$ \_\_\_\_\_ for **impairment compensation** was or will be paid in a lump sum on \_\_\_\_\_ (date).

**Periodic impairment compensation** or  **Periodic economic recovery compensation** will be paid at a weekly rate of \$ \_\_\_\_\_ through \_\_\_\_\_ (date) for a total of \$ \_\_\_\_\_.

**Your final payment of \$ \_\_\_\_\_ for \_\_\_\_\_ benefits was or will be paid on \_\_\_\_\_ (date) according to:**

- A.** An award on agreement of the parties served and filed on \_\_\_\_\_ (date).

**B.** A prior Notice of Benefit Payment form for periodic payment of permanent partial disability dated \_\_\_\_\_.

**C.** An administrative decision under Minnesota Statutes § 176.239 served and filed on \_\_\_\_\_ (date).

**D.** A judge's decision and order served and filed on \_\_\_\_\_ (date).

**Amending payment information only at the request of the Workers' Compensation Division in follow-up to a Notice of Intention to Discontinue Benefits form served on the employee on \_\_\_\_\_ (date).**

## Instructions to employee

**Review this form to make sure your benefits have been properly paid. You do not need to take any action if the benefits listed are correct.**

If you have questions about your benefits, contact the claim representative whose telephone number is at the bottom of the page. If you still have questions after talking to the claim representative, contact either Workers' Compensation Division office:

525 Lake Ave. S., Suite 330  
Duluth, MN 55802-2368  
(218) 733-7810 or 1-800-342-5354

443 Lafayette Road N.  
St. Paul, MN 55155-4301  
(651) 284-5030 or 1-800-342-5354

This document can be given to you in Braille, large print or audio. To request, call (651) 284-5032 or 1-800-342-5354.

**Any person who, with intent to defraud, receives workers' compensation benefits to which the person is not entitled by knowingly misrepresenting, misstating, or failing to disclose any material fact is guilty of theft and shall be sentenced pursuant to Minnesota Statutes § 609.52, subdivision 3.**

| The following benefits have been paid  | From                             | Through  | Weeks                   | Rate      | *Total                  |
|--|----------------------------------|--|-------------------------|-----------|-------------------------|
| <input type="checkbox"/> Temporary total disability or<br><input type="checkbox"/> Permanent total disability<br><div style="border: 1px solid black; height: 40px; width: 300px; margin: 5px 0;"></div> <input type="checkbox"/> Benefit addendum attached  |                                  |  |                         |           |                         |
|  |                                  |  |                         |           |                         |
|  |                                  |  |                         |           |                         |
|  |                                  |  |                         |           |                         |
|  |                                  |  |                         |           |                         |
| Temporary partial disability   |                                  |  |                         |           |                         |
| Retraining benefits  |                                  |  |                         |           |                         |
| Permanent partial disability _____%<br><input type="checkbox"/> Injuries on or after 10/01/1995<br><input type="checkbox"/> Impairment compensation (injuries 01/01/1984 through 09/30/1995)<br><input type="checkbox"/> Economic recovery compensation (injuries 01/01/1984 through 09/30/1995)<br><input type="checkbox"/> _____ [part of body] (injuries before 01/01/1984) |                                  |  |                         |           |                         |
| Attorney fees and attorney expenses  |                                  | Benefit totals   |                         |           |                         |
| M.S. § 176.081, subd. 1 contingency fees paid  |                                  | *Lump-sum payment under award or order                         |                         |           |                         |
| M.S. § 176.081, subd. 1 contingency fees still withheld  |                                  | Attorney fees reimbursed to employee (M.S. § 176.081, subd. 7) |                         |           |                         |
| Heaton fees paid   |                                  | Interest paid  |                         |           |                         |
| Roraff fees paid   |                                  | <b>*Total compensation paid</b>                                |                         |           |                         |
| M.S. § 176.191 fees paid   |                                  | *Total supplementary benefits                                  |                         |           |                         |
| Other fees paid  |                                  | <b>Total medical expenses paid to date</b>                     |                         |           |                         |
| Costs and disbursements paid   |                                  |  |                         |           |                         |
| Insurer/self-insurer/TPA   | Claim representative name        |  |                         |           |                         |
| Address  | Phone number (include area code) |  |                         | Extension |                         |
| City   | State                            | ZIP code   | Date served on employee |           | Date served on attorney |

\*Include attorney fees in these totals.