

Notice of Intention to Discontinue Workers' Compensation Benefits



DO NOT USE THIS SPACE

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

WID or SSN	DATE OF INJURY	
EMPLOYEE (last, first, mi)	EMPLOYER	
EMPLOYEE ADDRESS		
CITY	STATE	ZIP CODE
INSURER CLAIM NUMBER		

Your benefits for (check one) TEMPORARY TOTAL TEMPORARY PARTIAL PERMANENT TOTAL
disability are being discontinued for one of the following reasons:

- You have returned to work on _____ (date) at full wage.
- You have returned to work on _____ (date) at reduced hours or wages.
Temporary partial will will not be paid. Temporary partial is usually based on the difference
between your wage of \$ _____ at the time of the injury and your current weekly wage.
- Reasons other than return to work. Payment will be made through _____ (date)
Give reasons and facts below. (Appropriate medical reports must be attached).

Reasonable medical expenses and any permanent partial disability due will still be paid, unless your claim has been denied.

INSTRUCTIONS TO EMPLOYEE – THIS REQUIRES YOUR IMMEDIATE ATTENTION

You are responsible for reviewing this form to make sure that you have been properly paid the benefits due you.
**YOU DO NOT NEED TO TAKE ANY ACTION IF YOU BELIEVE THAT YOU HAVE RECEIVED ALL BENEFITS DUE OR THAT THE
REDUCTION OF BENEFITS IS PROPER.**

**If Box 1 or 2 is checked above and you believe that your benefits should be reinstated due to an occurrence during the initial 14
calendar days after your return to work, you may request a conference. Your request must be received by the Workers'
Compensation Division within 30 calendar days after the date that you returned to work.**

**If Box 3 is checked above and you think the reason for stopping your benefits is incorrect, or you disagree with the proposed
discontinuance, you may request a conference. Your request must be received within 12 calendar days after this notice is received
by the Workers' Compensation Division.**

**TO REQUEST A CONFERENCE, YOU MUST MAIL OR DELIVER THE ATTACHED FORM TO THE WORKERS' COMPENSATION
DIVISION SO THAT IT IS RECEIVED WITHIN THE ABOVE TIME LIMITS. TELEPHONE REQUESTS WILL ALSO BE ACCEPTED AT (651)
361-7901 OR 1-800-342-5354.**

The conference will be scheduled within 10 calendar days of the date your request is received by the Division. You, your employer, and the
insurer will be invited to attend. You are not required to bring an attorney, but may bring one if you wish. You should bring to the conference
any current reports and return-to-work restrictions, if available.

You may instead file an Objection to Discontinuance with the Division. This is a formal procedure before a compensation judge which takes
longer than the administrative conference process and usually requires an attorney. If you do this, your benefits will stop on the date stated in
this notice and will not be paid during the time you wait for the hearing.

If the insurer is denying primary liability for your claim and you disagree with the denial, cannot return to your former employment and would like vocational rehabilitation assistance, contact the Department of Labor and Industry, Vocational Rehabilitation Unit at (651) 284-5038.

If you have questions about your benefits, you should first contact the claim representative whose telephone number is at the bottom of the page. Be sure to provide that person with any additional information you have to support your claim. If you still have questions, contact the Workers' Compensation Division's Benefit Management and Resolution Unit at the office nearest you.

Minnesota Department of Labor and Industry

525 Lake Avenue South, Suite 330
 Duluth, MN 55802-2368
 Telephone: (218) 733-7810
 1-800-342-5354

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

Mailing Address
 Workers' Compensation Division
 PO Box 64221
 St. Paul, MN 55164-0221

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI) Voice or TDD (651) 297-4198.

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 SECTION 609.52, SUBDIVISION 3.

THE FOLLOWING BENEFITS HAVE BEEN PAID	FROM	THROUGH	WEEKS	RATE	*TOTAL
<input type="checkbox"/> Temporary Total Disability or					
<input type="checkbox"/> Permanent Total Disability					
<div style="border: 1px solid black; height: 40px; width: 100%;"></div>					
<input type="checkbox"/> Benefit Addendum Attached					
Temporary Partial Disability					
Retraining Benefits					
Permanent Partial Disability _____%					
<input type="checkbox"/> Injuries on or after 10/01/95					
<input type="checkbox"/> Impairment Compensation (injuries 01/01/1984 - 09/30/1995)					
<input type="checkbox"/> Economic Recovery Compensation (injuries 01/01/1984 - 09/30/1995)					
<input type="checkbox"/> _____ [part of body] (injuries before 01/01/1984)					
Attorney Fees/Expenses		Benefit Totals			
M.S. 176.081, subd. 1 & 3 Paid				*Lump sum Payment Under Award or Order	
M.S. 176.081, subd. 1 & 3 Still Withheld				Attorney Fees Reimbursed to Employee (M.S. 176.081, subd. 7)	
Heaton Fees Paid				Interest Paid	
Roraff Fees Paid				*TOTAL COMPENSATION PAID	
M.S. 176.191 Paid				*Total Supplementary Benefits	
Other Fees Paid				Total Medical Expenses Paid to Date	
Costs & 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.