Reset

N F 0 1

DO NOT USE THIS SPACE

Notice of File Closing

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

WID or SSN	DATE OF INJURY
EMPLOYEE	
EMPLOYER	
INSURER CLAIM NUMBER	

THIS IS TO NOTIFY YOUR OFFICE THAT ALL PAYMENTS AND OTHER ACTIVITIES HAVE BEEN COMPLETED ON THIS FILE. AS A RESULT, WE ARE NOW CLOSING IT ON OUR SYSTEM.

CLAIM REPRESENTATIVE NAME	DATE
ADDRESS	INSURER/SELF-INSURER/TPA
CITY STATE ZIP CODE	PHONE NUMBER (include area code)

Send completed form to:

Minnesota Department of Labor and Industry
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.