WID or SSN
DATE(S) OF CLAIMED INJURY

Minnesota Department of Labor and Industry
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5032 or 1-800-342-5354

Reset

RT01

DO NOT USE THIS SPACE

EMPLOYEE VS.
EMPLOYER(S) AND
INSURER(S) AND
NAME OF ATTORNEY REQUESTING FEES

Employee or Insurer's Objection to Requested Attorney Fees and/or Costs

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

Private or confidential data you supply on this form, and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.

1. I object to the attorney's request for (objection may be made to any requested fee or cost):

☐ Attorney fees in the amount of $ _____ ☐ Costs in the amount of $ _____

2. The reasons for my objection are:

_____

_____

_____

NOTE: If a compensation judge is required to evaluate the reasonableness of the requested fees, the following factors will be considered. These factors may be used as a guideline to assist you in agreeing or objecting to the requested fees.

- The dollar amount involved;
- The time and expense necessary for case preparation;
- The responsibility taken by the attorney;
- The attorney's level of experience in and knowledge of workers' compensation;
- How complicated the issues were;
- How difficult the case was to prove and what the results were.

3. Do you request a hearing? ☐ No ☐ Yes, on attorney fees ☐ Yes, on costs

If a hearing is held, specify the language/dialect of any needed interpreter: _____

If a reasonable accommodation of disability is requested for a hearing, describe: _____

_____

4. On _____ (date) I mailed a copy of this form to the above-named attorney at the following address:

_____

This form is being filed by ☐ employee ☐ insurer:

SIGNATURE	DATE

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354/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.