

## Employee's Objection To Discontinuance

of Temporary Total, Temporary Partial  
 or Permanent Total Disability Benefits  
 PRINT IN INK or TYPE  
 ENTER DATES in MM/DD/YYYY FORMAT



DO NOT USE THIS SPACE



WID or SSN	DATE(S) OF CLAIMED INJURY
EMPLOYER	AND
INSURER	AND
EMPLOYEE	VS.

*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.*

**TO THE WORKERS' COMPENSATION DIVISION, DEPARTMENT OF LABOR AND INDUSTRY**

1. The Objection to Discontinuance is filed in response to:

An administrative decision issued under Minn. Stat. § 176.239 by \_\_\_\_\_ served  
 and filed on \_\_\_\_\_ Name of Judge

or  A Notice of Intention to Discontinue Benefits dated \_\_\_\_\_ (Check only if no administrative decision has been  
 issued on this discontinuance.)

or  Other \_\_\_\_\_

2. The employee alleges that he/she is entitled to the following additional benefits:

- a. Temporary Total from \_\_\_\_\_ to \_\_\_\_\_
- b. Temporary Partial from \_\_\_\_\_ to \_\_\_\_\_
- c. Permanent Total from \_\_\_\_\_ to \_\_\_\_\_

3. Trial Data:

- a. Requested place of: Pretrial \_\_\_\_\_ Trial \_\_\_\_\_
- b. Estimated hours to present evidence: \_\_\_\_\_
- c. If an interpreter is requested for a hearing or conference, specify the language/dialect: \_\_\_\_\_
- d. If a reasonable accommodation of disability is requested for a hearing or conference, describe: \_\_\_\_\_

WHEREFORE, the Employee objects to the discontinuance of compensation benefits and requests that this matter be set for hearing in accordance with Minn. Stat. § 176.238.

EMPLOYEE SIGNATURE			ATTORNEY FOR EMPLOYEE SIGNATURE		
ADDRESS			ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
TELEPHONE			ATTORNEY REGISTRATION #	TELEPHONE	

