

Section 8

Case Study

The Beginning of the Story – Liability Determination

Pat Williams is a 56 year old church secretary. On March 21, 2007 Pat had a low back injury at work and immediately notified the supervisor. Pat lost two hours on the date of injury to go to the emergency room. The doctor prescribed painkillers and authorized time off from work through March 23rd. Pat returned to work on March 26th. On March 27th, Pat felt that the pain was getting worse instead of better and sought additional medical treatment from Dr. Crunch, D.C. half way through the work day. Pat was taken off work for one week as of that date and notified the employer of this on the same day. Pat normally works Monday through Friday, eight hours per day at \$15.00 per hour, with an average weekly wage on the date of injury of \$600.

You have been assigned this claim.

1. What are the dates of the waiting period?
2. By what date is the FROI required to be filed with the department?
3. On what date is either payment or denial due?
4. As of March 27th, when Pat starts losing time again, would the waiting period be payable? If so, why? If not, when would it become payable.
5. You have determined that the injury and lost time are compensable. Fill out the NOPLD (leave the payment information, except for the date of payment, blank for now).

Notice of Insurer's Primary Liability Determination

See instructions on reverse side.

PRINT IN INK or TYPE

Enter dates in MM/DD/YYYY format.



DO NOT USE THIS SPACE

Amended

| | | |
|--------------------------|----------------|-------------------------------|
| WID or SSN | DATE OF INJURY | DATE OF DEATH (if applicable) |
| EMPLOYEE | | |
| EMPLOYER | | |
| INSURER/SELF-INSURER/TPA | | |
| INSURER CLAIM NUMBER | | |

| | | | |
|--|--|---|---------------------------------------|
| First date of lost time | Date employer notified of this lost time | Initial date of return to work | Average weekly wage at date of injury |
| If the initial return to work was followed by a new period of lost time, complete the following information: | | | |
| First date of new period of lost time: _____ | | Date employer notified of this lost time: _____ | |

1. Your claim is ACCEPTED and wage loss benefits will be paid.

| | | | |
|--|-------------------|---|-------------------|
| Benefit type: <input type="checkbox"/> Temporary Total (TTD) <input type="checkbox"/> Temporary Partial (TPD) <input type="checkbox"/> Permanent Total (PTD) <input type="checkbox"/> Dependency (DEP) | | | |
| Date of payment | Amount of payment | Time period covered with this payment Date from _____ Date through _____ | Compensation rate |
| Any ongoing payments will be made on _____ (day of week) at _____ (weekly, biweekly, etc.) intervals. | | | |

| | |
|----------------------|---|
| Check all that apply | <input type="checkbox"/> Full wage continuation by the employer under M.S. § 176.221, subd. 9. <input type="checkbox"/> TPD payment made according to the wage loss verification received by the insurer on _____ (date). <input type="checkbox"/> Fatality with dependents. Payment is being made according to dependent information, which must be ATTACHED . <input type="checkbox"/> Fatality with no dependents. Payment is being made to the estate or the Special Compensation Fund. |
|----------------------|---|

2. Your claim is ACCEPTED. However, wage loss benefits will not be paid at this time for the following reason:

| | |
|----------------|---|
| Check only one | <input type="checkbox"/> A. Injury did not cause lost time from work beyond the three calendar day waiting period. If employee's work schedule is not Monday through Friday, explain: _____ <input type="checkbox"/> B. Verification of reduced wages for TPD has not been received from the employee or employer. <input type="checkbox"/> C. Other reason (include legal and factual basis): <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div> |
|----------------|---|

3. Primary liability is DENIED for the claimed work related injury and/or death. (Check one or both)

| |
|--|
| Reason for denial (include legal and factual basis): |
|--|

| | | | |
|--|--------------|-----------|---------------------------------|
| NAME OF THE PERSON MAKING THIS DETERMINATION (print) | PHONE NUMBER | EXTENSION | DATE SERVED (must be completed) |
|--|--------------|-----------|---------------------------------|

INSTRUCTIONS TO EMPLOYEE/HEIRS AND DEPENDENTS

PLEASE KEEP A COPY OF THIS NOTICE FOR YOUR RECORDS

General Information

This liability determination is the opinion of the insurer. If the claim has been denied, this opinion may not be final. If you have questions about any of the information on this form, you should first contact the person making this determination (see name and phone number on the front side of this form). If you still have questions, contact the Department of Labor and Industry (DLI), Workers' Compensation Division's Benefit Management and Resolution Unit at the office nearest you (listed below). For the hearing impaired, please call our Telecommunication Device for the Deaf (TDD) at (651) 297-4198. If there are problems with your claim, there are several options available to resolve them informally.

Minnesota Department of Labor and Industry

5 North Third Avenue West, Suite 400
Duluth, MN 55802-1614
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

Time Limitations

If the injury claim has been denied, you may lose your right to benefits if you do not commence legal proceedings within three years after your employer/insurer filed a written report of your claimed injury with DLI, not to exceed six years after the date of the claimed injury. If you have an occupational disease, you have three years to begin legal proceedings from the date you learned that the cause of the disease might be work related and the disease first caused disability.

If the death claim has been denied, you may lose your right to benefits if you do not commence legal proceedings within three years after the employer/insurer filed the written notice of death with DLI, except that:

- 1) For claims where the employer/insurer did not pay benefits for the injury, commencement of legal proceedings cannot exceed six years from the **date of injury** resulting in the death.
- 2) For claims where the employer/insurer did pay benefits for the injury, commencement of legal proceedings cannot exceed six years from the **date of death**.

In very rare circumstances, there may be exceptions to the time limits noted above.

Vocational Rehabilitation

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

Instructions to Insurer/Claims Administrator

1. If the claim is a fatality with dependents and payment is being made, attach dependent information.
2. The reason for a denial must be clear and specific, and state a legal and factual basis in language which is easily understood. If the reason for a denial is based on medical information, attach medical reports or summary of any health care provider contacts that support your reason for denial.
3. This form may be filed more than once if your liability determination changes. (Examples: when you initially deny primary liability, but later accept liability; when you initially accept a claim and pay wage loss benefits, but later deny primary liability within 60 days pursuant to M.S. § 176.221, subd 1; when you accept liability, but are unable to pay TPD benefits until verification of wage loss is received, but later issue the first TPD check.)
4. If you file this form more than once, check the Amended box in the upper left-hand corner for each subsequent filing.
5. Do not use this form to reinstate benefits. Use the Notice of Benefit Reinstatement (NOBR) form.
6. If you indicate that the employer paid "full wage," you must also file a Notice of Intention to Discontinue (NOID) at the appropriate time showing the date of return to work or other reason for discontinuance and the payment data on the back of the form as required by M.S. § 176.221, subd. 9.
7. The date served must be completed each time you file this form.
8. The boxes (in the upper left-hand corner on the front of the form) containing claim identifying information must be fully completed each time you file the form. The boxes containing the dates of lost time, notice, and initial return to work, and the average weekly wage must also be completed, if applicable, each time you file the form, regardless of your liability determination.

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 Middle of the Story – Indemnity Benefits

Remember Pat Williams? Pat had a low back injury at work on March 21, 2007 and lost two hours on the date of injury to go to the emergency room. Pat initially returned to work on March 26th, but on March 27th Pat returned to the doctor half way through the work day and has been off work as of that date. Pat normally works Monday through Friday, eight hours per day at \$15.00 per hour, with an average weekly wage of \$600 on the date of injury.

The doctor has released Pat to return to work light duty four hours per day on April 9, 2007. The employer can accommodate the light duty work and Pat goes back to work on April 9th, at light duty four hours per day.

1. What is the TTD rate? Fill in the payment information you left blank on the NOPLD you started in “The Beginning of the Story – Liability Determination”.
2. What benefits are owed through the return to work on April 9th?
3. Fill out the NOID.

The return to work is again unsuccessful as symptoms continue to worsen. Pat returns to Dr. Crunch and is taken off work again as of April 13, 2007.

4. Fill out the NOBR.

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 | 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:

1. You have returned to work on _____ (date) at full wage.
2. 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.
3. 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) 361-7912 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.

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 St. Paul, MN 55155-4301
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Mailing Address
 Workers' Compensation Division
 PO Box 64221
 St. Paul, MN 55164-0221

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| 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) | | | |
| CITY | STATE | ZIP CODE | DATE SERVED ON EMPLOYEE | DATE SERVED ON ATTORNEY | |

*Include attorney fees in these totals.

Employee's Request for Administrative Conference

Minn. Stat. § 176.239, subd. 2



DO NOT USE THIS SPACE

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

| | |
|--|--------------------------|
| WID or SSN | DATE OF INJURY |
| EMPLOYEE | EMPLOYER |
| EMPLOYEE ADDRESS | |
| CITY | STATE ZIP CODE |
| INSURER CLAIM NUMBER | INSURER/SELF-INSURER/TPA |
| <p>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.</p> | |
| <p><i>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.</i></p> | |

THIS REQUIRES YOUR IMMEDIATE ATTENTION

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 re-insurance association.

INSTRUCTIONS TO EMPLOYEE

DO NOT COMPLETE THIS FORM IF YOU AGREE THAT YOUR WEEKLY WORKERS' COMPENSATION BENEFITS MAY BE STOPPED OR CHANGED.

HOWEVER, IF YOU DISAGREE THAT YOUR BENEFITS MAY BE STOPPED OR CHANGED, YOU MAY BE ENTITLED TO AN ADMINISTRATIVE CONFERENCE. At the conference, a decision can be made about your right to further weekly benefits.

TO REQUEST A CONFERENCE, MAIL OR DELIVER THIS COMPLETED FORM TO:

DEPARTMENT OF LABOR AND INDUSTRY
WORKERS' COMPENSATION DIVISION
PO BOX 64218
ST PAUL, MN 55164-0218

Requests will also be accepted by telephone. Call (651) 361-7912 or 1-800-342-5354

TIME LIMIT TO REQUEST A CONFERENCE

IF BOX 1 OR 2 is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits, your request for a conference must be received by the Workers' Compensation Division **WITHIN 30 DAYS AFTER YOU RETURNED TO WORK.**

IF BOX 3 is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits, your request for a conference must be received **WITHIN 12 DAYS AFTER A COPY OF THE NOTICE OF INTENTION TO DISCONTINUE WORKERS' COMPENSATION BENEFITS IS RECEIVED BY THE WORKERS' COMPENSATION DIVISION.**

EMPLOYEE'S REQUEST FOR ADMINISTRATIVE CONFERENCE

1. BOX (check one) 1 2 3 is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits.

2. My weekly benefits should not be changed/stopped because: _____

(attach separate sheet if more room is needed)

EMPLOYEE SIGNATURE

EMPLOYEE PHONE # (include area code)

DATE

ATTORNEY (if you have one)

ATTORNEY #

ATTORNEY PHONE # (include area code)

QRC (if you have one)

Disability Status Report

Filed as required by Minn. Rules 5220.0110, subp. 7



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

DO NOT USE THIS SPACE

| | | | |
|--|-------------------|--|---|
| 1. WID or SSN | 2. DATE OF INJURY | | |
| 3. EMPLOYEE NAME | | | |
| 4. EMPLOYEE ADDRESS | | | |
| CITY | STATE | ZIP CODE | 5. EMPLOYEE PHONE # |
| 6. EMPLOYER | | 7. EMPLOYER CONTACT PERSON | 8. PHONE # |
| 9. INSURER/SELF-INSURER/TPA | | 12. TITLE OF JOB AT DATE OF INJURY | |
| 10. INSURER ADDRESS | | 13. AVERAGE WEEKLY WAGE AT DATE OF INJURY | 14. JOB AT DATE OF INJURY <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME |
| CITY | STATE | ZIP CODE | 15. NUMBER OF DAYS OF DISABILITY |
| 11. INSURER CLAIM NUMBER | | 16. IS THE EMPLOYEE CURRENTLY WORKING? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 11. INSURER CLAIM NUMBER | | 17. WILL THE DISABILITY LIKELY EXTEND BEYOND 13 WEEKS? (see instructions on back) <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 18. REASON FOR FILING THE DISABILITY STATUS REPORT: (Check A or B) Was a consultation requested? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, consultation requested by: <input type="checkbox"/> Insurer <input type="checkbox"/> Employer <input type="checkbox"/> Employee on _____ (date of request) <input type="checkbox"/> A. The employee is being referred for a rehabilitation consultation. (Insurer must send a copy of this Disability Status Report, the First Report of Injury, and the treating physician's Report of Work Ability to the QRC before the rehabilitation consultation.) Name of QRC _____ <input type="checkbox"/> B. A waiver of the rehabilitation consultation is being requested. (An offer of suitable gainful employment signed by the date-of-injury employer and the Report of Work Ability must be attached.) Projected return to work date _____ | | | |

| | | | |
|--|--------------|-----------|-------------------------|
| Name of insurer representative completing form | Phone number | Extension | Date served on employee |
|--|--------------|-----------|-------------------------|

Instructions to Insurer

The Disability Status Report (DSR) is used to notify parties that you are either referring the injured worker for a rehabilitation consultation or requesting a waiver of the consultation. The DSR, with a Report of Work Ability (RWA), must be mailed to the injured worker and filed with the Department of Labor and Industry:

- Within 14 calendar days of knowledge that the employee's temporary total disability is likely to exceed 13 cumulative weeks; or
- Within 90 calendar days of the date of injury when the employee has not returned to work following a work injury; or
- Within 14 calendar days after receiving a request for a rehabilitation consultation, whichever is earlier; or
- Within 14 calendar days of expiration of an approved waiver of rehabilitation services.

To Refer for a Rehabilitation Consultation:

If you are referring the injured worker for a rehabilitation consultation, check Box 18A. Send a copy of the DSR form, the First Report of Injury and the treating physician's Report of Work Ability to the QRC prior to the consultation. Fill in the name of the QRC on the form and indicate which party requested the consultation. If the employee requested the consultation, fill in the date of the request.

To Request a Waiver of a Rehabilitation Consultation:

M.S. § 176.102, subd. 4 and Minn. Rules 5220.0110 and 5220.0120 provide that the commissioner may grant a waiver of a rehabilitation consultation to an otherwise qualified employee if there is documentation that the employee will return to suitable gainful employment with the date-of-injury employer within 90 calendar days after the request for waiver is filed. A waiver will not be granted unless documentation is submitted that a suitable job offer within the treating doctor's restrictions has been made.

If you are requesting a waiver, check Box 18B and attach the following documentation:

- Report of Work Ability or other medical report with the same information from the treating doctor which indicates that the employee will be released to return to work within 90 calendar days after the request for waiver is filed and specifying the employee's work restrictions in functional terms.
- Written offer of suitable gainful employment signed by the employer that is within the treating doctor's restrictions to which the employee will return within the timeframe indicated above. Include one of the following:
 - If the employer is offering the employee his/her date-of-injury job, any modifications of the job to accommodate the employee's restrictions must be noted.
 - If the written offer of suitable gainful employment (which does not include temporary, light-duty) is for a different job with the date-of-injury employer, the offer must include the job title, job environment, work tasks, weekly wage, physical, mental and educational demands of the job, and/or employer modifications of the job to accommodate the employee's restrictions.

Instructions to Employee

If you do not agree with the insurer's recommendation for a rehabilitation consultation or a waiver of rehabilitation consultation, you may file a Rehabilitation Request with the Department of Labor and Industry. If you have questions call the Benefit Management and Resolution Unit at 1-800-342-5354 or 651-284-5032.

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 Middle of the Story – Medical Benefits

As you recall, Pat Williams has back pain related to the work injury. Pat has been receiving passive chiropractic care from Dr. Crunch since March 27th.

1. Dr. Crunch must evaluate whether Pat is making progressive improvement with the treatment plan. What are the criteria for progressive improvement?
2. Pat has had eight weeks of passive chiropractic care. If Pat continues to demonstrate progressive improvement, how many more weeks of passive care is allowed under the rules without prior notification?
3. If Pat is having pain and is unable to work after eight weeks of treatment, what treatment should be considered?
4. If Dr. Crunch requests a departure from the treatment parameters, how many days do you have to respond to this request? What happens if you fail to respond?

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 | 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:

1. You have returned to work on _____ (date) at full wage.
2. 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.
3. 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

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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) 361-7912 OR 1-800-342-5354.

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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.

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| 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) | | | |
| CITY | STATE | ZIP CODE | DATE SERVED ON EMPLOYEE | DATE SERVED ON ATTORNEY | |

*Include attorney fees in these totals.

Employee's Request for Administrative Conference

Minn. Stat. § 176.239, subd. 2



DO NOT USE THIS SPACE

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

| | |
|--|--------------------------|
| WID or SSN | DATE OF INJURY |
| EMPLOYEE | EMPLOYER |
| EMPLOYEE ADDRESS | |
| CITY | STATE ZIP CODE |
| INSURER CLAIM NUMBER | INSURER/SELF-INSURER/TPA |
| <p>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.</p> | |
| <p><i>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.</i></p> | |

THIS REQUIRES YOUR IMMEDIATE ATTENTION

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 re-insurance association.

INSTRUCTIONS TO EMPLOYEE

DO NOT COMPLETE THIS FORM IF YOU AGREE THAT YOUR WEEKLY WORKERS' COMPENSATION BENEFITS MAY BE STOPPED OR CHANGED.

HOWEVER, IF YOU DISAGREE THAT YOUR BENEFITS MAY BE STOPPED OR CHANGED, YOU MAY BE ENTITLED TO AN ADMINISTRATIVE CONFERENCE. At the conference, a decision can be made about your right to further weekly benefits.

TO REQUEST A CONFERENCE, MAIL OR DELIVER THIS COMPLETED FORM TO:

DEPARTMENT OF LABOR AND INDUSTRY
WORKERS' COMPENSATION DIVISION
PO BOX 64218
ST PAUL, MN 55164-0218

Requests will also be accepted by telephone. Call (651) 361-7912 or 1-800-342-5354

TIME LIMIT TO REQUEST A CONFERENCE

IF BOX 1 OR 2 is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits, your request for a conference must be received by the Workers' Compensation Division **WITHIN 30 DAYS AFTER YOU RETURNED TO WORK.**

IF BOX 3 is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits, your request for a conference must be received **WITHIN 12 DAYS AFTER A COPY OF THE NOTICE OF INTENTION TO DISCONTINUE WORKERS' COMPENSATION BENEFITS IS RECEIVED BY THE WORKERS' COMPENSATION DIVISION.**

| EMPLOYEE'S REQUEST FOR ADMINISTRATIVE CONFERENCE | | | |
|--|--------------------------------------|--------------------------------------|---|
| 1. BOX (check one) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits. |
| 2. My weekly benefits should not be changed/stopped because: _____ | | | |
| (attach separate sheet if more room is needed) | | | |
| EMPLOYEE SIGNATURE | EMPLOYEE PHONE # (include area code) | DATE | |
| ATTORNEY (if you have one) | ATTORNEY # | ATTORNEY PHONE # (include area code) | QRC (if you have one) |

Notice of Benefit Payment



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

DO NOT USE THIS SPACE

| | | |
|----------------------|----------------|----------|
| WID or SSN | DATE OF INJURY | |
| EMPLOYEE | 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 number(s) _____
The rating is based on the attached medical report of Dr. _____ dated _____

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

For injuries on or after 10/01/1995 payment will be made at \$ _____ per week beginning on (date) _____ for a total of _____ weeks and a total amount of \$ _____

For injuries on or after 10/01/2000 a total lump sum payment of \$ _____, rather than weekly payments will be made as requested by the employee.

For injuries between 01/01/1984 and 09/30/1995 payment will be made as follows:

\$ _____ **Impairment compensation** will be paid in a lump sum on _____ (date).
(if you are laid off from your job for economic reasons within _____ weeks of the day your returned to work, you may be entitled to monitoring period compensation, in addition to Impairment Compensation.)

Periodic impairment compensation or **Periodic economic recovery compensation** of \$ _____ per week beginning on _____ (date) will be paid for up to _____ weeks. If you return to work before this number of weeks, you will receive the balance due in a lump sum after working 30 days.

26 weeks economic recovery compensation (M.S. § 176.101, subd. 3t) of \$ _____ per week will be paid beginning on _____ (date).

YOUR FINAL PAYMENT OF \$ _____ FOR _____ BENEFITS WAS WILL BE ISSUED ON _____ (DATE) ACCORDING TO:

- A. An award on agreement of the parties dated _____
- B. A prior Notice of Benefit Payment for periodic payment of permanent partial disability dated _____
- C. An administrative decision under M.S. § 176.239 dated _____
- D. A judge's decision and order dated _____

INSTRUCTIONS TO EMPLOYEE

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 YOU OR THAT THE REDUCTION OF BENEFITS IS PROPER.

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

5 North Third Avenue West, Suite 400
 Duluth, MN 55802-1614
 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

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|--|----------------------------------|----------------|-------------------------|--|--------|
| <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 | |
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| 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) | | | | |
| CITY | STATE | ZIP CODE | DATE SERVED ON EMPLOYEE | DATE SERVED ON ATTORNEY | |

*Include attorney fees in these totals.

Notice of Benefit Payment



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

DO NOT USE THIS SPACE

| | | |
|----------------------|----------------|----------|
| WID or SSN | DATE OF INJURY | |
| EMPLOYEE | 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 number(s) _____
The rating is based on the attached medical report of Dr. _____ dated _____

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

For injuries on or after 10/01/1995 payment will be made at \$ _____ per week beginning on (date) _____ for a total of _____ weeks and a total amount of \$ _____

For injuries on or after 10/01/2000 a total lump sum payment of \$ _____, rather than weekly payments will be made as requested by the employee.

For injuries between 01/01/1984 and 09/30/1995 payment will be made as follows:

- \$ _____ **Impairment compensation** will be paid in a lump sum on _____ (date).
(if you are laid off from your job for economic reasons within _____ weeks of the day your returned to work, you may be entitled to monitoring period compensation, in addition to Impairment Compensation.)
- Periodic impairment compensation** or **Periodic economic recovery compensation** of \$ _____ per week beginning on _____ (date) will be paid for up to _____ weeks. If you return to work before this number of weeks, you will receive the balance due in a lump sum after working 30 days.
- 26 weeks economic recovery compensation** (M.S. § 176.101, subd. 3t) of \$ _____ per week will be paid beginning on _____ (date).

YOUR FINAL PAYMENT OF \$ _____ FOR _____ BENEFITS **WAS** **WILL BE ISSUED ON _____ (DATE) ACCORDING TO:**

- A. An award on agreement of the parties dated _____
- B. A prior Notice of Benefit Payment for periodic payment of permanent partial disability dated _____
- C. An administrative decision under M.S. § 176.239 dated _____
- D. A judge's decision and order dated _____

INSTRUCTIONS TO EMPLOYEE

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Minnesota Department of Labor and Industry

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

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| 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 | |
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| 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) | | | | |
| CITY | STATE | ZIP CODE | DATE SERVED ON EMPLOYEE | DATE SERVED ON ATTORNEY | |

*Include attorney fees in these totals.

Interim Status Report



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

DO NOT USE THIS SPACE

| | | |
|----------------------|----------------|----------|
| WID or SSN | DATE OF INJURY | |
| EMPLOYEE | EMPLOYER | |
| EMPLOYEE ADDRESS | | |
| CITY | STATE | ZIP CODE |
| INSURER CLAIM NUMBER | | |

THE FORM MUST BE SUBMITTED ANNUALLY ON ALL CLAIMS OF CONTINUING DISABILITY, SUPPLEMENTARY OR DEPENDENCY BENEFITS. Please provide additional information on the Benefit Addendum (BA01).

| | FROM | THROUGH | WEEKS | RATE | *TOTAL |
|--|------|---------|-------|------|--------|
| <input type="checkbox"/> Temporary Total* <input type="checkbox"/> Permanent Total* Balance Carried Forward | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| TOTAL: | | | | | |
| Temporary Partial Balance Carried Forward | | | | | |
| | | | | | |
| | | | | | |
| TOTAL: | | | | | |
| Permanent Partial 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) | | | | | |
| TOTAL: | | | | | |

*These areas need not be completed if this form is being attached to and filed with the **Annual Claim for Reimbursement of Supplementary Benefits.**

| | FROM | THROUGH | WEEKS | RATE | TOTAL |
|---|------|---------|-------|------|-------|
| Retraining Benefits Balance Carried Forward | | | | | |
| | | | | | |

TOTAL:

| | | | | | |
|---|--|--|--|--|--|
| Dependency Benefits Balance Carried Forward | | | | | |
| | | | | | |

TOTAL:

| | | | | | |
|---|--|--|--|--|--|
| Supplementary Benefits* Balance Carried Forward | | | | | |
| | | | | | |
| | | | | | |

TOTAL:

Social Security Benefits or Other Government Benefits* Retirement Disability

Name of Program: _____

| FROM | THROUGH | PER WEEK |
|------|---------|----------|
| | | |
| | | |

*These areas need not be completed if this form is being attached to and filed with the **Annual Claim for Reimbursement of Supplementary Benefits.**

| | | | |
|---|-------|--|-------------|
| Attorney Fees Paid | | Interest Paid | |
| Attorney Fees Still Withheld | | Lump Sum Payment Under Award or Order | |
| Attorney Fees Reimbursed to Employee M.S. 176.081, subd. 7 | | Total Compensation Paid to Employee | |
| | | Total Dependency Benefits Paid (Please attached copy of worksheet) | |
| INSURER/SELF-INSURER/TPA | | CLAIM REPRESENTATIVE NAME | |
| ADDRESS | | PHONE NUMBER (include area code) | |
| CITY | STATE | ZIP CODE | DATE SERVED |

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.

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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 | 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:

1. You have returned to work on _____ (date) at full wage.
2. 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.
3. 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) 361-7912 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.

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|--|-------|----------------------------------|--|-------------------------|--------|
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| <input type="checkbox"/> Benefit Addendum Attached | | | | | |
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| 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) | | | |
| CITY | STATE | ZIP CODE | DATE SERVED ON EMPLOYEE | DATE SERVED ON ATTORNEY | |

*Include attorney fees in these totals.

Employee's Request for Administrative Conference

Minn. Stat. § 176.239, subd. 2



DO NOT USE THIS SPACE

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

| | | |
|--|--------------------------|----------|
| WID or SSN | DATE OF INJURY | |
| EMPLOYEE | EMPLOYER | |
| EMPLOYEE ADDRESS | | |
| CITY | STATE | ZIP CODE |
| INSURER CLAIM NUMBER | INSURER/SELF-INSURER/TPA | |
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| <p><i>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.</i></p> | | |

THIS REQUIRES YOUR IMMEDIATE ATTENTION

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 re-insurance association.

INSTRUCTIONS TO EMPLOYEE

DO NOT COMPLETE THIS FORM IF YOU AGREE THAT YOUR WEEKLY WORKERS' COMPENSATION BENEFITS MAY BE STOPPED OR CHANGED.

HOWEVER, IF YOU DISAGREE THAT YOUR BENEFITS MAY BE STOPPED OR CHANGED, YOU MAY BE ENTITLED TO AN ADMINISTRATIVE CONFERENCE. At the conference, a decision can be made about your right to further weekly benefits.

TO REQUEST A CONFERENCE, MAIL OR DELIVER THIS COMPLETED FORM TO:

DEPARTMENT OF LABOR AND INDUSTRY
WORKERS' COMPENSATION DIVISION
PO BOX 64218
ST PAUL, MN 55164-0218

Requests will also be accepted by telephone. Call (651) 361-7912 or 1-800-342-5354

TIME LIMIT TO REQUEST A CONFERENCE

IF BOX 1 OR 2 is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits, your request for a conference must be received by the Workers' Compensation Division **WITHIN 30 DAYS AFTER YOU RETURNED TO WORK.**

IF BOX 3 is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits, your request for a conference must be received **WITHIN 12 DAYS AFTER A COPY OF THE NOTICE OF INTENTION TO DISCONTINUE WORKERS' COMPENSATION BENEFITS IS RECEIVED BY THE WORKERS' COMPENSATION DIVISION.**

| EMPLOYEE'S REQUEST FOR ADMINISTRATIVE CONFERENCE | | | |
|--|---|---|---|
| 1. BOX (check one) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits. |
| 2. My weekly benefits should not be changed/stopped because: _____ | | | |
| (attach separate sheet if more room is needed) | | | |
| _____ EMPLOYEE SIGNATURE | _____ EMPLOYEE PHONE # (include area code) | _____ DATE | |
| _____ ATTORNEY (if you have one) | _____ ATTORNEY # | _____ ATTORNEY PHONE # (include area code) | _____ QRC (if you have one) |

