Reset

Mail completed copy to:
Department of Labor and Industry
Special Compensation Fund
PO Box 64229
St. Paul, MN 55164-0229
(651) 284-5045 or 1-800-342-5354

Permanent Total Disability Agreement

(Effective Only for Dates of Injuries Prior to 10/01/1995)

PRINT IN INK or TYPE YOUR RESPONSES
ALL DATES MUST BE ENTERED in MM/DD/YYYY

PA04

DO NOT USE THIS SPACE

WID or SSN	DATE OF INJURY
EMPLOYEE NAME	
EMPLOYEE ADDRESS	
CITY STATE ZIP CODE	

INSURER/SELF-INSURER	
EMPLOYER NAME	INSURER ADDRESS
INSURER CLAIM NUMBER	CITY STATE ZIP CODE

1. **Attach any medical reports pertinent to the issue of permanent total disability** whether pro or con, that have not been previously filed with the Workers' Compensation Division. (see Minn. Rule 5222.0400, subp. 4) The parties are relying primarily upon medical reports by:

Health Care Provider(s)	Date of report(s)

2. The status of rehabilitation: ☐ Continuing ☐ Closed ☐ Not assigned
   Attach rehabilitation reports to support this claim. (see Minn. Rule 5222.0400, subp. 5).
3. Total disability benefits have been paid to the employee without substantial interruption since the proposed date of permanent total disability. (see Minn. Rule 5222.0300.A) ☐ Yes ☐ No
4. Date the employee began receiving government disability benefits or government old age benefits: (see Minn. Rule 5222.0300.B) Date
5. The employee is receiving or will receive supplementary benefits after an offset for government disability benefits or government old age benefits is taken. (see Minn. Rule 5222.0300.C) ☐ Yes ☐ No
6. Has the issue of permanent total disability for the time period proposed been determined in a judicial or administrative proceeding? (see Minn. Rule 5222.0300.D) ☐ Yes ☐ No
7. Will the offset provision of M.S. § 176.101, subd. 4 result in an overpayment of benefits to the employee? ☐ Yes ☐ No

If yes, explain why there is an overpayment, the amount, and how it will be recovered.

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.

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.

WEEKLY BENEFIT CHANGE ANALYSIS

Proposed Effective Dates:

Permanent Total Disability	$25,000 Offset Date Reached	Date Supplementary Benefits Payable

Before $25,000

	Before PTD Date	*		As of PTD Date	*
TTD	$	*	PTD	$	*
SSDI	$		SSDI	$	
SB	$		SB	$	
Subtotal	$		Subtotal	$	
OPC	$		OPC	$	
TOTAL	$		**TOTAL**	$	

After $25,000

	SB NOT Payable	*		When SB Payable	*
PTD	$	*	PTD	$	*
SSDI	$		SSDI	$	
SB	$		SB	$	
Subtotal	$		Subtotal	$	
OPC	$		OPC	$	
TOTAL	$		**TOTAL**	$	

***enter "F" for full benefit, "R" for reduced benefit**

Workers' compensation benefits must be coordinated with most government benefits. When a person is receiving more than one form of benefit, either the government benefit or the workers' compensation benefit may be reduced. If you are not currently receiving government benefits, your workers' compensation benefits may be affected in the future. After a specific waiting period, supplementary benefits will be paid, if necessary, to assure the employee's compensation benefits are not less than 65% of the state-wide average weekly wage. If you have questions call Claims Services and Investigations.

KEY

PTD - permanent total disability
SB - supplementary benefits
SSDI - social security disability income; include old age, PERA, etc.
TTD - temporary total disability
OPC - overpayment credit

AGREEMENT

Based on the information provided, the insurer/employer and employee agree that the employee's total disability is permanent as of _____ for purposes of the employer/insurer obtaining reimbursement of supplementary benefits under Minn. Rules 5222.0100 to 5222.1000.

All parties understand that a substantial error in the information on this form may be basis to vacate the agreement.

Employee Signature		Phone	Date
Employee Attorney Signature (If applicable)		Phone	Date
Claim Representative Signature		Phone	Date
Workers' Compensation Division Signature	☐ Approved ☐ Rejected	Phone	Date
Reason rejected:			