

Mail or fax 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
 Fax: (651) 284-5731

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

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)
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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 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.

WEEKLY BENEFIT CHANGE ANALYSIS

Proposed Effective Dates:

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

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

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	<input type="checkbox"/> Approved <input type="checkbox"/> Rejected	Date
Reason rejected:		