Reset

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

Notice of Benefit Payment

Print in ink or type
Enter dates in MM/DD/YYYY format

NB01

Do not use this space

WID number or SSN	Date of injury (DOI)	
Employee (last, first, middle initial)	Employer	
Employee address		
City	State	ZIP code
Insurer claim number		

Notes

☐ **The following permanent partial disability benefit will be paid to you:**

_____ % of whole body according to Minnesota Workers' Compensation Permanent Partial Disability Schedule rule number(s):

_____.

The rating is based on the attached medical report of Dr. _____

dated _____, received by the insurer on _____ (date).

☐ This payment is based on the preliminary rating. If your final disability rating is higher, additional payments may be made.

☐ **For injuries on or after 10/01/1995**:

☐ The initial payment of weekly benefits was or will be made on _____ (date). Benefits will be paid at a weekly rate of $ _____ through _____ (date) for a total of $ _____.

☐ A lump-sum payment of $ _____, instead of weekly payments, was or will be made on _____ (date) as requested by the employee on _____ (date).

☐ **For injuries from 01/01/1984 through 09/30/1995** payment of:

☐ $ _____ for **impairment compensation** was or will be paid in a lump sum on _____ (date).

☐ **Periodic impairment compensation** or ☐ **Periodic economic recovery compensation** will be paid at a weekly rate of $ _____ through _____ (date) for a total of $ _____.

☐ **Your final payment of $** _____ **for** _____

benefits was or will be paid on _____ **(date) according to:**

☐ **A.** An award on agreement of the parties served and filed on _____ (date).

☐ **B.** A prior Notice of Benefit Payment form for periodic payment of permanent partial disability dated _____.

☐ **C.** An administrative decision under Minnesota Statutes § 176.239 served and filed on _____ (date).

☐ **D.** A judge's decision and order served and filed on _____ (date).

☐ **Amending payment information only at the request of the Workers' Compensation Division in follow-up to a Notice of Intention to Discontinue Benefits form served on the employee on** _____ **(date).**

INSTRUCTIONS TO EMPLOYEE

Review this form to make sure your benefits have been properly paid. You do not need to take any action if the benefits listed are correct.

If you have questions about your benefits, contact the claim representative whose telephone number is at the bottom of the page. If you still have questions after talking to the claim representative, contact either Workers' Compensation Division office:

525 Lake Ave. S., Suite 330
Duluth, MN 55802
(218) 733-7810 or 1-800-342-5354

443 Lafayette Road N.
St. Paul, MN 55155
(651) 284-5030 or 1-800-342-5354

Average weekly wage at DOI $_____	**Include contingent attorney fees in benefit totals**				
The following benefits have been paid	**From**	**Through**	**Weeks**	**Rate**	**Total**
☐ Temporary total disability or ☐ Permanent total disability Notes ☐ Benefit addendum attached					
Temporary partial disability					
Retraining benefits					
Permanent partial disability _____% ☐ Injuries on or after 10/01/1995 ☐ Impairment compensation (injuries 01/01/1984 through 09/30/1995) ☐ Economic recovery compensation (injuries 01/01/1984 through 09/30/1995) ☐ Part of body_____ (injuries before 01/01/1984)					

Attorney fees/expenses		**Benefit totals**	
M.S. § 176.081, subd. 1, contingent fees paid		Lump-sum payment under award or order (include contingent attorney fees)	
M.S. § 176.081, subd. 1, contingent fees still withheld		Attorney fees reimbursed to employee (M.S. § 176.081, subd. 7)	
Heaton fees paid		Interest paid	
Roraff fees paid		**Total compensation paid** (include contingent attorney fees)	
M.S. § 176.191 fees paid		Total supplementary benefits (include contingent attorney fees)	
Other fees paid		Total medical expenses paid to date	
Costs and disbursements paid			

Insurer/self-insurer/TPA			Claim representative name	
Address			Phone number (include area code)	Extension
City	State	ZIP code	Date served on employee	Date served on employee's attorney

This document can be given to you in Braille, large print or audio. To request, call (651) 284-5032 or 1-800-342-5354.

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 Minnesota Statutes § 609.52, subdivision 3.

Send to: Workers' Compensation Division, employee and the employee's attorney (if any).