

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 Reinstatement

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



Do not use this space

WID number or SSN	Date of injury (DOI)	Date of death (if applicable)
Employee (last, first, MI)		
Employer		
Insurer/self-insurer/TPA		
Insurer claim number		

**This is notification that workers' compensation benefits have been reinstated or changed.**

Date of new payment	Amount of payment	Type of benefit	Time period covered with this payment	Compensation rate
		<input type="checkbox"/> TTD <input type="checkbox"/> TPD <input type="checkbox"/> PTD <input type="checkbox"/> DEP	Date from _____ Date through _____	

**Insurer: Check the appropriate box(es) and enter date(s).**

1. Payment resumed voluntarily. First date of new period of time lost \_\_\_\_\_  
 Date of notice to employer of new period of time lost \_\_\_\_\_

2. Payment resumed pursuant to order served and filed on \_\_\_\_\_  
 M.S. § 176.239 decision    OR     Other decision (OAH, WCCA or Supreme Court)

3. TPD changed to TTD effective \_\_\_\_\_

4. Full wage continuation changed to TTD effective \_\_\_\_\_

**Provide the following pre-injury wage information *only* if it differs from prior submissions.**

Average weekly wage at DOI	Weekly value of:	Meals	Lodging	Second income

**Explain below the reason for the change and attach a 26-week wage statement.**

Claim representative name	Phone number (include area code)	Date