Reset

Department of Labor and Industry
Workers' Compensation Division
651-284-5032 or 800-342-5354
Fax: 651-284-5731

Notice of Intention to Discontinue Workers' Compensation Benefits

ND01

DO NOT USE THIS SPACE

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

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

Notes

Your benefits for (check one) ☐ temporary total disability ☐ temporary partial disability ☐ permanent total disability are being discontinued or reduced for the following reason(s):

☐ 1. You returned to work at full wage on _____ (date).

☐ 2. You returned to work at reduced hours or wage on _____ (date).

Temporary partial disability benefits ☐ will be paid or ☐ will not be paid. Temporary partial disability benefits are usually two-thirds of the difference between your average weekly wage at the time of the injury and your current weekly wage.

☐ 3. For reasons other than return to work as stated below. (Relevant medical reports or other documents must be attached.) Payment will be made through _____ (date).

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

Review this form to make sure your benefits have been properly paid.

You do not need to take any action if you agree the discontinuance or the reduction of benefits is proper.

If box 1 or 2 above is checked, you may request a conference if you think your benefits should be reinstated due to occurrences during the initial 14 calendar days after your return to work. Your request must be received by the Workers' Compensation Division within 30 calendar days after the date you returned to work.

If box 3 above is checked, you may request a conference if you think the reason for stopping your benefits is incorrect or you disagree with the proposed discontinuance. Your request must be received within 12 calendar days after this Notice of Intention to Discontinue Workers' Compensation Benefits form is received by the Workers' Compensation Division.

If the insurer is denying liability for your claim and you disagree with the denial, cannot return to your former employment and would like vocational rehabilitation assistance, call the Department of Labor and Industry, Vocational Rehabilitation unit, at (651) 284-5038 for information.

To request a conference, you must mail or deliver the attached form to the Workers' Compensation Division so it is received within these time limits. You may also request a conference by calling (651) 361-7901 (Office of Administrative Hearings) or 1-800-342-5354 (Department of Labor and Industry).

The conference will be scheduled within 10 calendar days after your request is received. You, your employer and the insurer will be invited to attend. You are not required to have an attorney for this conference. If you have an attorney, the attorney will also be invited. Bring any reports and return-to-work restrictions that show why your benefits should not be discontinued.

Instead of requesting a conference, you or your attorney may request a formal hearing by filing an Objection to Discontinuance form with the Workers' Compensation Division. A formal hearing process takes longer than the conference process. You may want to talk with an attorney.

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 the Workers' Compensation Division office:

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

443 Lafayette Road N.
St. Paul, MN 55155
(651) 284-5030
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).