Office of Administrative Hearings
Workers' Compensation Division
PO Box 64620
St. Paul, MN 55164-0620
(651) 361-7900

Reset

Employee's Objection To Discontinuance

of Temporary Total, Temporary Partial or Permanent Total Disability Benefits

PRINT IN INK or TYPE
ENTER DATES in MM/DD/YYYY FORMAT

ED02

DO NOT USE THIS SPACE

WID or SSN	DATE(S) OF CLAIMED INJURY
EMPLOYER AND	
INSURER AND	
EMPLOYEE VS.	

Private or confidential data you supply on this form, and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by the office of administrative hearings (OAH) and the department of labor and industry staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.

TO THE OFFICE OF ADMINISTRATIVE HEARINGS

1. The Objection to Discontinuance is filed in response to:

   ☐ An administrative decision issued under Minn. Stat. § 176.239 by _____ served
   Name of Judge
   and filed on _____

   or ☐ A Notice of Intention to Discontinue Benefits dated _____ (Check only if no administrative decision has been issued on this discontinuance.)

   or ☐ Other _____

2. The employee alleges that he/she is entitled to the following additional benefits:

   a. Temporary Total from _____ to _____

   b. Temporary Partial from _____ to _____

   c. Permanent Total from _____ to _____

3. Trial Data:

   a. Requested place of: Pretrial _____ Trial _____

   b. Estimated hours to present evidence: _____

   c. If an interpreter is requested for a hearing or conference, specify the language/dialect: _____

   d. If a reasonable accommodation of disability is requested for a hearing or conference, describe: _____

WHEREFORE, the Employee objects to the discontinuance of compensation benefits and requests that this matter be set for hearing in accordance with Minn. Stat. § 176.238.

EMPLOYEE SIGNATURE			ATTORNEY FOR EMPLOYEE SIGNATURE		
ADDRESS			ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
TELEPHONE			ATTORNEY REGISTRATION #	TELEPHONE	

STATE OF MINNESOTA }
} ss.
COUNTY OF _____ }

AFFIDAVIT OF SERVICE

I, _____, being first duly sworn, state that on _____, I served a true and correct copy of this document, enclosed in a properly addressed envelope, by depositing the same, with postage prepaid, in the United States mail at _____, Minnesota, addressed as follows:

NAMES AND ADDRESSES

Subscribed and sworn to before me
this _____ day of _____
Notary Public _____
My Commission expires _____

_____
Signature

INSTRUCTIONS

1. The hearing will be expedited if the Objection to Discontinuance is within 60 calendar days after a Notice of Intention to Discontinue Benefits has been filed (if no administrative decision has been issued) or within 60 days after a decision concerning the discontinuance has been issued pursuant to Minn. Stat. § 176.239.
2. Failure to properly and fully fill out this form, with appropriate documentation, in accordance with workers' compensation rules of practice, is not considered proper filing. The Office of Administrative Hearings may refuse to accept this form if it lacks any of the following: employee's name, date of injury, WID or social security number, or name of employer/insurer.
3. The claim must be presented in terms of the Minnesota Workers' Compensation Act.
4. If you have more defendants or more injuries than can be listed, this form may be modified accordingly.
5. A doctor's report or other information supporting the claim MUST be filed with this form.
6. A copy of this form must be served on the employer and the insurer, their attorney, potential intervenors, and the Special Compensation Fund, if applicable, by first class mail or personally.

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.

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.