Reset

Notice of Discontinuance of Workers' Compensation Dependency Benefits

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DO NOT USE THIS SPACE

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

WID or SSN	DATE OF INJURY
EMPLOYEE (last, first, mi)	EMPLOYER
INSURER CLAIM NUMBER	

DEPENDENT NAME(S)		
DEPENDENT ADDRESS		
CITY	STATE	ZIP CODE

THIS IS YOUR NOTICE THAT DEPENDENCY BENEFITS ARE BEING DISCONTINUED ON _____ (DATE)
FOR THE FOLLOWING REASON(S):

INSTRUCTIONS TO HEIRS AND DEPENDENTS REGARDING DISCONTINUANCE

You are responsible for reviewing this form to make sure that you have been properly paid the benefits due you. YOU DO NOT NEED TO TAKE ANY ACTION if you believe that you have received all benefits due.

If you have questions about the discontinuance of these benefits, you should first contact the claim representative whose telephone number is listed on the back of this form. If you still have questions, contact the Workers' Compensation Division's Benefit Management and Resolution Unit at the office nearest you.

Minnesota Department of Labor and Industry

525 Lake Avenue South, Suite 330
Duluth, MN 55802-2368
Telephone: (218) 733-7810
1-800-342-5354

443 Lafayette Road North
St. Paul, MN 55155-4301
Telephone: (651) 284-5030
1-800-342-5354

Mailing Address
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221

THE FOLLOWING BENEFITS HAVE BEEN PAID	FROM	THROUGH	WEEKS	RATE	TOTAL
Dependency Benefits (please attach a copy of worksheet)					

Interest Paid		Dependency Benefits Lump Sum (other than award for death prior to 10/01/1983)	
Attorney Fees Paid		Lump Sum Paid Per Award	
Attorney Fees Still Withheld		Total Dependency Benefits Paid	
Total Burial Expenses Paid		Additional Payment to SCF (if applicable)	
		Additional Payment to Estate or Dependents (If applicable)	
INSURER/SELF-INSURER/TPA		CLAIM REPRESENTATIVE NAME	
ADDRESS		PHONE NUMBER (include area code)	EXTENSION
CITY STATE ZIP CODE		DATE SERVED ON DEPENDENT(S)	

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI) 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.

Distribution: Workers' Compensation Division, Employer, Insurer, Dependents (one to each household)