Reset

Employee's Request for Administrative Conference on Discontinuance of Workers' Compensation Benefits

EQ05

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	Employer	
Employee address		
City	State	ZIP code
Insurer claim number	Insurer/self-insurer/TPA	

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 Department of Labor and Industry staff members 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 Office of Administrative Hearings; the Workers' Compensation Court of Appeals; the Department of Revenue; the Department of Health; and the Workers' Compensation Reinsurance Association.

THIS REQUIRES YOUR IMMEDIATE ATTENTION

Do not complete this form if you agree that your weekly workers' compensation benefits may be stopped or changed.

If you disagree that your benefits may be stopped or changed, you may request an administrative conference. A decision can be made at the conference about your weekly benefits.

- **If box 1 or 2** is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits form, your request for a conference must be received by the Workers' Compensation Division **within 30 days after you returned to work.**
- **If box 3** is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits form, your request for a conference must be received **within 12 days after a copy of the Notice of Intention to Discontinue Workers' Compensation Benefits form is received by the Workers' Compensation Division.**

Complete this section to request a conference by mail, by fax or in person
(You do not need to complete this section to request a conference by phone)

Box (check one) 1 ☐ 2 ☐ 3 ☐ is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits form.

My weekly benefits should not be stopped or changed because _____

_____

(Attach a separate sheet if needed)

If an interpreter is needed for conference, specify the language/dialect _____

Employee signature	Employee phone number (include area code)	Date
Attorney (if you have one)	Attorney phone number (include area code)	

To request a conference, take one of the following actions:

Call
(651) 361-7901; or
1-800-342-5354, press number 3

Mail this form
Department of Labor and Industry
Workers' Compensation Division
P.O. Box 64221
St. Paul, MN 55164-0221

Fax this form
(651) 284-5731

Deliver this form
Department of Labor and Industry
Workers' Compensation Division
443 Lafayette Road N.
St. Paul, MN 55155

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.