Reset

Notice of Insurer's Primary Liability Determination

See instructions on reverse side.
PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

N L 0 1
DO NOT USE THIS SPACE

☐ **Amended**

WID or SSN	DATE OF INJURY	DATE OF DEATH (if applicable)

EMPLOYEE (last, first, mi)

EMPLOYER

INSURER/SELF-INSURER/TPA

INSURER CLAIM NUMBER

First date of lost time	Date employer notified of this lost time	Initial date of return to work	Average weekly wage at date of injury

If the initial return to work was followed by a new period of lost time, complete the following information:
First date of new period of lost time: _____ Date employer notified of this lost time: _____

☐ **1. Your claim is ACCEPTED and wage loss benefits will be paid.**

Benefit type: ☐ Temporary Total (TTD) ☐ Temporary Partial (TPD) ☐ Permanent Total (PTD) ☐ Dependency (DEP)

Date of payment	Amount of payment	Time period covered with this payment Date from — Date through	Compensation rate

Any ongoing payments will be made on _____ (day of week) at _____ (weekly, biweekly, etc.) intervals.

Check all that apply

- ☐ Full wage continuation by the employer under M.S. § 176.221, subd. 9.
- ☐ TPD payment made according to the wage loss verification received by the insurer on _____(date).
- ☐ Fatality with dependents. Payment is being made according to dependent information, which must be **ATTACHED**.
- ☐ Fatality with no dependents. Payment is being made to the estate or the Special Compensation Fund.

☐ **2. Your claim is ACCEPTED. However,** wage loss benefits will not be paid at this time for the following reason:

Check only one

- ☐ A. Injury did not cause lost time from work beyond the three calendar day waiting period. If employee's work schedule is not Monday through Friday, explain: _____
- ☐ B. Verification of reduced wages for TPD has not been received from the employee or employer.
- ☐ C. Other reason (include legal and factual basis):

☐ **3. Primary liability is DENIED** for the claimed work related ☐ injury and/or ☐ death. (Check one or both)

Reason for denial (include legal and factual basis):

NAME OF THE PERSON MAKING THIS DETERMINATION (print)	PHONE NUMBER (area code)	EXTENSION	DATE SERVED (must be completed)

INSTRUCTIONS TO EMPLOYEE/HEIRS AND DEPENDENTS

PLEASE KEEP A COPY OF THIS NOTICE FOR YOUR RECORDS

General Information

This liability determination is the opinion of the insurer. If the claim has been denied, this opinion may not be final. If you have questions about any of the information on this form, you should first contact the person making this determination (see name and phone number on the front side of this form). If you still have questions, contact the Department of Labor and Industry (DLI), Workers' Compensation Division's Benefit Management and Resolution Unit at the office nearest you (listed below). For the hearing impaired, please call our Telecommunication Device for the Deaf (TDD) at (651) 297-4198. If there are problems with your claim, there are several options available to resolve them informally.

Minnesota Department of Labor and Industry

525 Lake Avenue South, Suite 330	443 Lafayette Road North	Mailing Address
Duluth, MN 55802-2368	St. Paul, MN 55155-4301	Workers' Compensation Division
Telephone: (218) 733-7810	Telephone: (651) 284-5030	PO Box 64221
1-800-342-5354	1-800-342-5354	St. Paul, MN 55164-0221

Time Limitations

If the injury claim has been denied, you may lose your right to benefits if you do not commence legal proceedings within three years after your employer/insurer filed a written report of your claimed injury with DLI, not to exceed six years after the date of the claimed injury. If you have an occupational disease, you have three years to begin legal proceedings from the date you learned that the cause of the disease might be work related and the disease first caused disability.

If the death claim has been denied, you may lose your right to benefits if you do not commence legal proceedings within three years after the employer/insurer filed the written notice of death with DLI, except that:

1) For claims where the employer/insurer did not pay benefits for the injury, commencement of legal proceedings cannot exceed six years from the **date of injury** resulting in the death.
2) For claims where the employer/insurer did pay benefits for the injury, commencement of legal proceedings cannot exceed six years from the **date of death**.

In very rare circumstances, there may be exceptions to the time limits noted above.

Vocational Rehabilitation

If the insurer is denying primary liability for your claim and you disagree, cannot return to your former employment, and would like vocational rehabilitation assistance, contact DLI, Vocational Rehabilitation Unit at (651) 284-5038.

Instructions to Insurer/Claims Administrator

1. If the claim is a fatality with dependents and payment is being made, attach dependent information.
2. The reason for a denial must be clear and specific, and state a legal and factual basis in language which is easily understood. If the reason for a denial is based on medical information, attach medical reports or summary of any health care provider contacts that support your reason for denial.
3. This form may be filed more than once if your liability determination changes. (Examples: when you initially deny primary liability, but later accept liability; when you initially accept a claim and pay wage loss benefits, but later deny primary liability within 60 days pursuant to M.S. § 176.221, subd 1; when you accept liability, but are unable to pay TPD benefits until verification of wage loss is received, but later issue the first TPD check.)
4. If you file this form more than once, check the Amended box in the upper left-hand corner for each subsequent filing.
5. Do not use this form to reinstate benefits. Use the Notice of Benefit Reinstatement (NOBR) form.
6. If you indicate that the employer paid "full wage," you must also file a Notice of Intention to Discontinue (NOID) at the appropriate time showing the date of return to work or other reason for discontinuance and the payment data on the back of the form as required by M.S. § 176.221, subd. 9.
7. The date served must be completed each time you file this form.
8. The boxes (in the upper left-hand corner on the front of the form) containing claim identifying information must be fully completed each time you file the form. The boxes containing the dates of lost time, notice, and initial return to work, and the average weekly wage must also be completed, if applicable, each time you file the form, regardless of your liability determination.

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.