

Mail or fax to:
Department of Labor and Industry
Workers' Compensation Division
P.O. Box 64221
St. Paul, MN 55164-0221
(651) 284-5032 or 1-800-342-5354
Fax: (651) 284-5731

Notice of Benefit Payment

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



Do not use this space

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

Notes

The following permanent partial disability benefit will be paid to you:

_____ % of whole body according to Minnesota Workers' Compensation Permanent Partial Disability Schedule rule number(s):

The rating is based on the attached medical report of Dr. _____

dated _____, received by the insurer on _____ (date).

This payment is based on the preliminary rating. If your final disability rating is higher, additional payments may be made.

For injuries on or after 10/01/1995:

The initial payment of weekly benefits was or will be made on _____ (date). Benefits will be paid at a weekly rate of \$ _____ through _____ (date) for a total of \$ _____.

A lump-sum payment of \$ _____, instead of weekly payments, was or will be made on _____ (date) as requested by the employee on _____ (date).

For injuries from 01/01/1984 through 09/30/1995 payment of:

\$ _____ for **impairment compensation** was or will be paid in a lump sum on _____ (date).

Periodic impairment compensation or **Periodic economic recovery compensation** will be paid at a weekly rate of \$ _____ through _____ (date) for a total of \$ _____.

Your final payment of \$ _____ for _____ benefits was or will be paid on _____ (date) according to:

- | |
|--|
| <p><input type="checkbox"/> A. An award on agreement of the parties served and filed on _____ (date).</p> <p><input type="checkbox"/> B. A prior Notice of Benefit Payment form for periodic payment of permanent partial disability dated _____.</p> <p><input type="checkbox"/> C. An administrative decision under Minnesota Statutes § 176.239 served and filed on _____ (date).</p> <p><input type="checkbox"/> D. A judge's decision and order served and filed on _____ (date).</p> |
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Amending payment information only at the request of the Workers' Compensation Division in follow-up to a Notice of Intention to Discontinue Benefits form served on the employee on _____ (date).

INSTRUCTIONS TO EMPLOYEE

Review this form to make sure your benefits have been properly paid. You do not need to take any action if the benefits listed are correct.

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 either Workers' Compensation Division office:

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

443 Lafayette Road N.
St. Paul, MN 55155
(651) 284-5030 or 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
<input type="checkbox"/> Temporary total disability or <input type="checkbox"/> Permanent total disability <div style="border: 1px solid black; padding: 5px; margin: 5px 0;">Notes</div> <input type="checkbox"/> Benefit addendum attached					
Temporary partial disability					
Retraining benefits					
Permanent partial disability _____%					
<input type="checkbox"/> Injuries on or after 10/01/1995 <input type="checkbox"/> Impairment compensation (injuries 01/01/1984 through 09/30/1995) <input type="checkbox"/> Economic recovery compensation (injuries 01/01/1984 through 09/30/1995) <input type="checkbox"/> 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).