

NOTIFICATION OF SUSPENSION OF INDEMNITY BENEFIT PAYMENT

DATE:

TO: [NAME OF INJURED EMPLOYEE]
[ADDRESS]
[CITY, STATE, ZIP]

RE: [DATE OF INJURY]
[NATURE OF INJURY]
[PART OF BODY INJURED]
[EMPLOYEE SSN]
[CLAIM #]
[CARRIER NAME/TPA NAME]
[CARRIER CLAIM#]
[EMPLOYER NAME]
[EMPLOYER ADDRESS]
[EMPLOYER CITY, STATE, ZIP]

We have suspended payment of (**type of benefit**) effective (**effective date**) because:

(**Provide Full and complete statement explaining action taken _____
_____**)

You remain entitled to reasonable and necessary medical benefits related to this injury.

If you do not agree with the suspension of benefit payments, please contact me:

Adjuster's Name: _____
Toll Free Telephone #: _____
Fax #/E-mail Address: _____

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. You can contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

Cc:



INSTRUCTIONS:

Notification of Suspension of Indemnity Benefit Payments (DWC FORM PLN-9), Rule 124.2(e)(6); (MTC: S1, S3, S4, S5, S6, S7, S8, SJ)

This letter will be used to notify the employee of suspension of income/indemnity benefits, except when benefits are suspended due to a 0% IR, which would be reported via the "Notification of MMI/IR". This notice should be used to report the suspension of payment of income/death benefits to the employee/beneficiary/representative.

EXAMPLES:

- Employee Return to Work at Full Wages
- Bona Fide Job Offer
- Employee Death (NOT RELATED TO INJURY)
- Benefits Exhausted (IR/IIBs paid out, 4 quarters of non-entitlement to SIBs, etc)
- Division Order (Interlocutory Order paid out)
- Jurisdiction Change
- Re-marriage
- Change in Beneficiary Eligibility Status
- Division Order for Suspension of TIBs based on a RME
- Non-compliance, i.e. Division Order, RME or DD

Provide a full and complete statement of the reason(s) the action was taken.

EXAMPLES:

- Employee was released to return to work by treating doctor with no restrictions per conversation with treating doctor Dr. Jones on 4/31/02. Employee returned to work 5/1/02 earning full pre-injury wages.
- Employee was released to return to work with modified duties on 4/15/02. A written bona fide offer of employment was mailed to the employee on 4/16/02. The offer was for return to work duties that met the restrictions of the release, and the offered wages were equal to the full amount of pre-injury wages. The offer was effective for 10 days from date of delivery to the employee. The employee did not and has not contacted the employer regarding the offer as of today's date.

DO NOT SEND THIS LETTER TO THE TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION

