

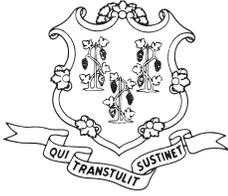


# IMPORTANT



Rev. 7-13-2009

# 36



State of Connecticut Workers' Compensation Commission

## Notice of Intention to Reduce or Discontinue Payments

Please TYPE or PRINT IN INK

You are hereby notified that the employer/insurer intends to **REDUCE OR DISCONTINUE** your compensation payments on

\_\_\_\_\_ for the following reason(s):  
(date)

*(Employer/insurer to explain and attach supporting medical documentation.)*

WCC File #

Date filed in District

(for WCC use only)

**IF YOU OBJECT** to the reduction or discontinuation of benefits as stated, **YOU MUST REQUEST A HEARING WITHIN 15 DAYS** after your receipt of this notice, **OR THIS NOTICE WILL AUTOMATICALLY BE APPROVED.**

**TO REQUEST AN INFORMAL HEARING**, call the Workers' Compensation District Office in which your case is pending:

*(Employer/insurer to check appropriate box.)*

- |   |                      |                |  |                     |                |
|---|----------------------|----------------|--|---------------------|----------------|
| <input type="checkbox"/> 1 — Hartford   | 999 Asylum Avenue    | (860) 566-4154 | <input type="checkbox"/> 5 — Waterbury   | 55 West Main Street | (203) 596-4207 |
| <input type="checkbox"/> 2 — Norwich    | 55 Main Street       | (860) 823-3900 | <input type="checkbox"/> 6 — New Britain | 233 Main Street     | (860) 827-7180 |
| <input type="checkbox"/> 3 — New Haven  | 700 State Street     | (203) 789-7512 | <input type="checkbox"/> 7 — Stamford    | 111 High Ridge Road | (203) 325-3881 |
| <input type="checkbox"/> 4 — Bridgeport | 350 Fairfield Avenue | (203) 382-5600 | <input type="checkbox"/> 8 — Middletown  | 90 Court Street     | (860) 344-7453 |

Be prepared to provide medical and other documentation to support your objection. For your protection, note the date when you received this notice.

### EMPLOYEE

Name \_\_\_\_\_

D.O.B. (required) \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Tel.# \_\_\_\_\_

### INJURY

Date of Injury \_\_\_\_\_

City/Town of Injury \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

Body Part \_\_\_\_\_

Nature of Injury \_\_\_\_\_

Cause of Injury \_\_\_\_\_

### ATTORNEY OR REPRESENTATIVE OF EMPLOYEE

Name \_\_\_\_\_

Name of Firm \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Tel.# \_\_\_\_\_

### INSURER

Claim Number \_\_\_\_\_

Voluntary Agreement Issued?  YES  NO

Name \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_

Contact Person \_\_\_\_\_

Tel.# \_\_\_\_\_

Date Mailed \_\_\_\_\_

### EMPLOYER

Name \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Tel.# \_\_\_\_\_