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

WCC File #

Date filed in District

(for WCC use only)

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.)

***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.)

☐ 1 — Hartford	999 Asylum Avenue	(860) 566-4154	☐ 5 — Waterbury	55 West Main Street	(203) 596-4207
☐ 2 — Norwich	55 Main Street	(860) 823-3900	☐ 6 — New Britain	233 Main Street	(860) 827-7180
☐ 3 — New Haven	700 State Street	(203) 789-7512	☐ 7 — Stamford	111 High Ridge Road	(203) 325-3881
☐ 4 — Bridgeport	350 Fairfield Avenue	(203) 382-5600	☐ 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.# _____

EMPLOYER

Name _____

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 _____

THIS NOTICE MUST BE SERVED UPON THE COMMISSIONER AND EMPLOYEE BY PERSONAL PRESENTATION OR BY REGISTERED OR CERTIFIED MAIL. IF THE CLAIMANT IS REPRESENTED BY AN ATTORNEY, A COPY SHOULD ALSO BE SENT TO THE CLAIMANT'S ATTORNEY.