Reset

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 Reinstatement

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

NC01

Do not use this space

WID number or SSN	Date of injury (DOI)	Date of death (if applicable)
Employee (last, first, MI)		
Employer		
Insurer/self-insurer/TPA		
Insurer claim number		

This is notification that workers' compensation benefits have been reinstated or changed.

Date of new payment	Amount of payment	Type of benefit	Time period covered with this payment	Compensation rate
		☐ TTD ☐ TPD ☐ PTD ☐ DEP	Date from - Date through	

Insurer: Check the appropriate box(es) and enter date(s).

☐ 1. Payment resumed voluntarily. First date of new period of time lost _____

Date of notice to employer of new period of time lost _____

☐ 2. Payment resumed pursuant to order served and filed on _____

☐ M.S. § 176.239 decision OR ☐ Other decision (OAH, WCCA or Supreme Court)

☐ 3. TPD changed to TTD effective _____

☐ 4. Full wage continuation changed to TTD effective _____

Provide the following pre-injury wage information *only* if it differs from prior submissions.

Average weekly wage at DOI	Weekly value of:	Meals	Lodging	Second income

Explain below the reason for the change and attach a 26-week wage statement.

Claim representative name	Phone number (include area code)	Date

Send to: Workers' Compensation Division, insurer