

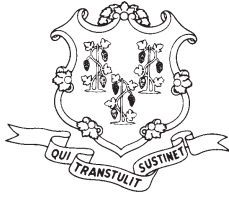


IMPORTANT



Rev. 10-01-2021

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)

WCC File #

Date filed in District

(for WCC use only)

(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.)

- | | | | | | |
|---|----------------------|----------------|--|-----------------------|----------------|
| <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 | 24 Washington 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 | 649 South Main 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. _____

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.# _____