Termination of Benefits/Request for IME

State Form 38911 (R8 / 1-14)

INDIANA WORKER'S COMPENSATION BOARD
402 West Washington Street, Room W196
Indianapolis, IN 46204
Telephone: (317) 232-3808
www.in.gov/wcb

Date of Injury (month, day, year)	Jurisdiction Claim Number

CLAIM INFORMATION

Name of Injured Worker	Name of Employer
Address (number and street, city, state, and ZIP code)	Address (number and street, city, state, and ZIP code)
Telephone Number	Name of Claim Administrator
E-mail Address	Administrator Claim Number

CLAIMS ADJUSTER INFORMATION

Name of Claims Adjuster	Telephone Number
Address (number and street, city, state, and ZIP code)	
E-mail Address	

BENEFIT TERMINATION *(check all that apply)*

* If termination is NOT due to one of the 5 reasons enumerated in IC 22-3-3-7 (d), 4 additional days of TTD are owed. In accordance with IC-22-3-3-7(d), TTD/TPD benefits have been/will be terminated due to the following:

S1	☐ The injured worker has returned to any employment*; **OR** has been released by the treating physician to return to work;
S2	☐ The injured worker has refused to undergo a medical examination under Section 6 (IC 22-3-3-6)*;
S3	☐ The injured worker has refused to accept suitable employment under Section 11 (IC 22-3-3-11)*;
S4	☐ The injured worker has died*;
S5/S6	☐ The injured worker is unable or unavailable to work for reason unrelated to the compensable injury*;
S7	☐ The injured worker has received five hundred (500) weeks of TTD/TPD benefits or has been paid the maximum compensation allowed under IC 22-3-3-22*;
S8	☐ The injured worker has changed jurisdiction to a state other than Indiana;

Explanation:

DISPUTE OF BENEFIT TERMINATION AND/OR REQUEST FOR AN INDEPENDENT MEDICAL EXAMINATION (IME)

If the injured worker disagrees with proposed benefit termination, the injured worker must complete, sign and send a copy of this notice to the **Worker's Compensation Board** and **the employer** within **seven (7) days** of receipt. Preferably, this notice may be filed via the **Dispute Termination of Benefits** link on the Board's website. **PLEASE DO NOT MAIL THIS FORM TO THE BOARD UNLESS THE INJURED WORKER HAS NO ACCESS TO THE INTERNET.**

Please check all that apply:

☐ Employee disagrees with the termination of benefits ☐ Employee requires further medical care

☐ Employee believes an independent medical examination (IME) may be helpful to resolve this dispute

Reason for Objection

Signature of Employee	Date Received (month, day, year)
Printed Name	By (check one): ☐ US Mail ☐ Electronic Service

CERTIFICATION OF SERVICE

Employer must sign below to certify service.

I certify that this information is true and that a copy of the relevant medical documentation is attached.

Signature of Employer	Date of Service (month, day, year)
Printed Name	By (check one): ☐ US Mail ☐ Electronic Service