TERMINATION OF BENEFITS/REQUEST FOR IME

State Form 38911 (R9 / TBD)

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