Reset Form

REPORT OF TEMPORARY TOTAL DISABILITY (TTD) / TEMPORARY PARTIAL DISABILITY (TPD) TERMINATION

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

* Your Social Security number is being requested by this state agency in accordance with IC 22-3-4-13; disclosure is voluntary, and you will not be penalized for refusal.

INSTRUCTIONS: 1. *You must report all compensation payments on this prescribed form. (IC 22-3-3-7)*
2. *Mail to the Worker's Compensation Board at the above address.*

Date of injury *(month, day, year)*	Accident number

CLAIM INFORMATION

Name of employer	Federal identification number	Telephone number ( )
Address of employer *(number and street, city, state, and ZIP code)*		
Name of insurer		Insurer claim number
Address of insurer *(number and street, city, state, and ZIP code)*		
Name of adjuster / case manager	Telephone number ( )	E-mail address
Name of employee		Employee Social Security number *
Address of employee *(number and street, city, state, and ZIP code)*		
Telephone number ( )	E-mail address	

BENEFIT TERMINATION / REDUCTION *(check all that apply)*

☐ In accordance with IC 22-3-3-7 (c), TTD/TPD benefits have been terminated due to the following *(check all that apply)*:
- ☐ The employee has returned to **ANY** employment;
- ☐ The employee has died;
- ☐ The employee has refused to accept suitable employment under Section 11 (IC 22-3-3-11);
- ☐ The employee has refused to undergo a medical examination under Section 6 (IC 22-3-3-6);
- ☐ The employee has received five hundred (500) weeks of TTD benefits or has been paid the maximum compensation allowed under IC 22-3-3-22;
- ☐ The employee is unable or unavailable to work for reasons unrelated to the compensable injury.
- ☐ Other ***(IF CHECKED, MEDICAL DOCUMENTATION MUST BE SERVED ON INJURED PARTY.)***
  - ☐ TTD benefits shall be terminated and Temporary Partial Disability (TPD) begun because employee has been released to part time work suitable to employee's disability.
  - ☐ Employer intends to terminate TTD/TPD benefits on _____ *(must be at least four (4) days after mailing or two (2) days after personal service)* because:
    - ☐ Treating physician has released employee to full time light duty work and employer has appropriate light duty work available.
    - ☐ Treating physician finds employee has reached MMI and/or employee is released to full time work *(check one)*:
      - ☐ With restrictions ☐ Without restrictions

Explanation

COMPENSATION PAYMENTS

Average weekly wage	Number of weeks paid	Weekly rate	Start date of payments (*month, day, year*)	End date (*month, day, year*)
$		$		
Total amount paid $	*Check one.* ☐ Employee ☐ Dependent		Reason(s) for ending payments	

EMPLOYEE'S OBJECTION TO TERMINATION OF TTD BENEFITS

If the employee disagrees with the proposed benefit termination, the employee must complete, sign and return a copy of this notice to the **Worker's Compensation Board** and **the employer** within **seven (7) days** after receipt. This notice can also be filed via the Dispute Termination of Benefits link on the Board's website.

Please check all that apply.
☐ Employee disagrees with the termination / reduction of benefits. ☐ Employee requires further medical care.
☐ Employee believes an independent medical examination (IME) may be helpful to resolve this dispute.

Explanation

EMPLOYER CERTIFICATION / RECEIPT OF EMPLOYEE / DEPENDENT

Employer and employee must sign below to certify service or acknowledge receipt of this notice.
I certify that the foregoing 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 ☐ Personal service
Signature of employee	Date received (*month, day, year*)
Printed name	By *(check one)*: ☐ US Mail ☐ Personal service