



NOTICE OF DENIAL OF BENEFITS

State Form 53914 (R2 / 7-12)

WORKER'S COMPENSATION BOARD
402 West Washington Street, Room W196
Indianapolis, IN 46204-2753

* This agency is requesting disclosure of Social Security Number in accordance with IC 22-3-4-13; disclosure is voluntary and you will not be penalized for refusal.

- INSTRUCTIONS:**
1. *Notice of Denial of Benefits must be made in writing and received by the Workers Compensation Board not later than thirty (30) days after the employer's knowledge of the injury. (IC 22-3-3-7)*
 2. *Mail to the Worker's Compensation Board at the above address.*

Date of injury (month, day, year)	Date employer notified of injury (month, day, year)	Date of employer notified of work restriction or prohibition (month, day, year)	Accident number
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CLAIM INFORMATION

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

NOTICE OF DENIAL

☐ Claim deemed not compensable, no benefits paid.	☐ Medical care only claim from ____, 20__ to ____, 20__; compensation denied.
Explanation:	Explanation:

NOTICE TO EMPLOYEES

By filing this form, your employer or its insurance carrier has indicated to the Indiana Workers' Compensation Board that it has cause to deny workers compensation benefits for your reported injury. You may or may not agree with this denial of benefits.

If you disagree with the denial of benefits, you should discuss the reason for denial with your employer or your employer's insurance carrier. If, after having this discussion, you are not satisfied that benefits were properly denied, you may contact an attorney for legal advice, or contact an ombudsman at the Indiana Workers' Compensation Board for information at (317) 232-3808. Additional information can also be found at www.in.gov/wcb.

EMPLOYER CERTIFICATION

Employer must sign below to certify service of this notice.	
Signature of employer	Date (month, day, year)
Printed name	By: ☐ US Mail ☐ Personal service