Reset Form

NOTICE OF SUSPENSION OF COMPENSATION AND/OR BENEFITS

State Form 54217 (R / 3-13)

INDIANA WORKER'S COMPENSATION BOARD
402 W Washington Street, Room W196
Indianapolis, IN 46204

Jurisdiction claim number

* PRIVACY NOTICE: This agency is requesting disclosure of your Social Security number in accordance with IC 22-3-4-13. This disclosure is not mandatory and you will not be penalized for refusing.

NOTICE is hereby given that the employer intends to suspend compensation and/or benefits for a compensable injury under the Indiana Worker's Compensation Act for the reason listed below.

EMPLOYER AND CARRIER INFORMATION

Name of employer	Federal Identification number
Address *(number and street, city, state, and ZIP code)*	
Name of Insurance Carrier / Third Party Administrator	Claim number of insurer
Address *(number and street, city, state, and ZIP code)*	

ADJUSTER / ATTORNEY INFORMATION

Name of adjuster / attorney *(typed or printed)*		
Address (*number and street, city, state, and ZIP code*)		
Telephone number ( )	Fax number ( )	E-mail address
Signature of adjuster / attorney		Date signed *(month, day, year)*

EMPLOYEE INFORMATION

Injured workers shall not receive temporary total or partial disability payments, death benefits, employer directed treatment, or partial impairment payments, reimbursement for unauthorized medical care, and may not be entitled to have a case heard, until such refusal ceases.

Name of employee	Social Security number*
Address (*number and street, city, state, and ZIP code*)	Telephone number ( )
Date suspension initiated *(month, day, year)*	Date of injury *(month, day, year)*

Reason compensation and/or benefits are being suspended:

- ☐ Refusal of treatment, services and supplies (IC 22-3-3-4(c)) / (IC 22-3-3-7)
- ☐ Refusal or obstruction of examination (IC 22-3-3-6(a))
- ☐ Refusal to accept suitable employment (IC 22-3-3-11)
- ☐ Refusal of Board ordered autopsy (IC 22-3-3-6(h))

Actions required to have compensation and/or benefits reinstated

Signature of employee acknowledging receipt	Date signed *(month, day, year)*