FORM 105

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 105
Lafayette City Center, 2 Avenue de Lafayette, Boston, MA 02111-1750
Info. Line: (800) 323-3249 (Inside Mass.) / (857) 321-7470 (Outside Mass.)
www.mass.gov/dia

DIA Board # (If Known):

AGREEMENT TO EXTEND 180 DAY PAYMENT WITHOUT PREJUDICE PERIOD

FILE THIS FORM ONLY IF THE INSURER HAS PAID WEEKLY BENEFITS WITHIN 14 DAYS OF THE RECEIPT OF THE EMPLOYER'S FIRST REPORT OF INJURY (FORM 101) OR A CLAIM FOR WEEKLY BENEFITS (FORM 110)

Please Print Legibly or Type - Unreadable forms will be returned.

INSURER

1. Insurance Carrier's Name and Address:

2. Self-insured?: ☐ Yes ☐ No
If Yes Please Give Self-insurer Number:

3. Claims Representative's Name:

4. Claims Representative's Tel. Number & Ext. :

5. Insurer's Case File Number:

6. Did Insurer Receive First Report of Injury (Form 101):
☐ Yes ☐ No - If Yes - Date Received (mm/dd/yyyy)

EMPLOYEE

7. Employee's Name (Last, First, MI):

8. Employee's Social Security Number*:

9. Employee's Address (No. and Street, City, State, Zip Code):

10. Date of Birth (mm/dd/yyyy):

11. Employer's Name :

12. Date of Injury (mm/dd/yyyy):

COMP.

13. First Day of Total or Partial Incapacity to Earn Wages:

14. Fifth Day of Total or Partial Incapacity to Earn Wages:

15. Has Insurer Made All Payments Since the First Date of Total or Partial Incapacity to Earn Wages?: ☐ Yes ☐ No

16. Last Day Payment Can Be Made Pursuant to This Extension - NOT TO EXCEED 1 YEAR from 1st day of incapacity per c. 152 Sec. 8(6) - (mm/dd/yyyy):

SIGNATURES

17. Preparer for Insurer (Please Print or Type):

18. Insurer's Signature ("On-File" is NOT acceptable. Must have signature.):

19. Date (mm/dd/yyyy):

20. Name and Address of Employee's Attorney:

21. Signature of Employee's Attorney:

22. Date (mm/dd/yyyy):

23. Employee's Signature:

24. Date (mm/dd/yyyy):

THIS AGREEMENT APPROVED AS NOT DETRIMENTAL TO THE EMPLOYEE'S CASE. SIGNING THIS FORM DOES NOT GUARANTEE CONTINUED WORKERS' COMPENSATION PAYMENTS FOR AN ADDITIONAL 180 DAYS AND BENEFITS MAY BE TERMINATED UNILATERALLY BY THE INSURANCE COMPANY AT ANY TIME PRIOR TO THE DATE NOTED IN BOX 16, WITH PROPER NOTICE.

25. Signature of Judge or Conciliator:

26. Date (mm/dd/yyyy):

***Disclosure of Social Security Number is Voluntary. It will aid in the processing of documents.**