



The Commonwealth of Massachusetts

Division of Industrial Accidents

Leverett Saltonstall Building, Government Center

100 Cambridge Street, Boston 02202

I.A.B. FILE NO.
ATTENTION OF:

May 16, 1985

CIRCULAR LETTER NO. 216 - AMENDING IN PART
CIRCULAR LETTER NO. 215.

TO: ALL INSURANCE COMPANIES, ALL SELF-INSURERS, AND
WORKMEN'S COMPENSATION AGENTS OF DEPARTMENTS OF
THE COMMONWEALTH AND COUNTIES, CITIES, TOWNS
AND DISTRICTS SUBJECT TO THE WORKMEN'S COMPENSATION
LAW (GENERAL LAWS, CHAPTER 152, AS AMENDED).

RE: General Laws, Chapter 152, Section 29, requires that
the insurer shall file a written application for
discontinuance of compensation with a recent medical
report in support thereof or stating such other reason
which may justify such discontinuance, and shall furnish
a copy of such application and supporting medical report
or statement of reason to the employee or his attorney.

Paragraph Three, on Page 2 of Circular Letter No. 215
is amended in that it gives General Instructions that
no supporting doctor reports, medicals or other documents
need be submitted at the time of an Application for
Discontinuance. Insurers must follow General Laws,
Chapter 152, Section 29.

Very truly yours,

Francis J. Joyce
Francis J. Joyce
Secretary

FJJ/mpv

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 100 Cambridge Street, Boston 02202

APPLICATION FOR DISCONTINUANCE OF COMPENSATION PAYMENTS

EMPLOYEE	BOARD NUMBER	
EMPLOYEE ADDRESS	INSURER'S CLAIM NUMBER	
EMPLOYER	POLICY NUMBER	
INSURER OR SELF INSURER	POLICY EFFECTIVE DATE	
NATURE OF INJURY		
	DATE OF INJURY	DATE OF LAST PAYMENT

Note: No application for permission to terminate compensation payments will be considered unless the agreement in regard to compensation has been filed with the Division.

The insurer hereby applies to the Division or a member thereof, as provided by General Laws (Ter. Ed.) Chapter 152, Section 29, as amended, for permission to discontinue compensation payments in the above named case.

This application is based on the following:

NAME OF INSURER OR SELF INSURER _____

Attachments: All hospital and medical reports not previously filed with the division

By _____
 AUTHORIZED REPRESENTATIVE SIGNATURE

DISPOSITION	DATE
<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved	
REMARKS	

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