FORM 107

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 107
1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017
Info. Line 800-323-3249 ext. 7470 in Mass. Outside Mass. - 617-727-4900 ext. 7470
http://www.mass.gov/dia

DIA Board #
(If Known):

INSURER'S NOTIFICATION OF ACCEPTANCE, RESUMPTION OR TERMINATION OR MODIFICATION OF WEEKLY COMPENSATION

*CHECK ONE BOX***:** ☐ *ACCEPTANCE* ☐ *RESUMPTION* ☐ *TERMINATION* ☐ *MODIFICATION*

USE FORM 106 AS NOTICE TO TERMINATE OR MODIFY WEEKLY PAYMENTS BEING MADE WITHOUT PREJUDICE
UNDER M.G.L., CHAPTER 152 §8(1). *Please Print or Type*.

INSURER

1. Insurance Carrier's Name and Address:

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

3. Name & Address of Insurer's Attorney:

4. Telephone Number of Insurer's Attorney:

5. Claim Representative's Name:

6. Claim Representative's Tel. Number & Ext.:

7. Insurer's Case File Number:

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

EMPLOYEE

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

10. Employee's Social Security Number*:

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

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

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

14. First Day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):

15. Fifth Day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):

16. Employer's Name & Address (No. and Street, City, State, Zip Code):

17. Employee's Average Weekly Wage:
$_____ ☐ Actual ☐ Estimated

18. Employee Returned to Work: ☐ Yes ☐ No
If Yes - Date of Return (mm/dd/yyyy):

19. Date of Resumption, Modification or Termination (mm/dd/yyyy):

BENEFITS

20. ☐ This is a Notice of Initial Acceptance of a Claim (ATTACH FORM 113).
☐ This is a Resumption/Modification of Payment of a Case Previously Accepted.
☐ This is a Resumption of Payment of a Case within the Payment Without Prejudice Period.
☐ This is a Resumption/Modification of Payment under §30G.

Type of Compensation Resumed or Modified	Former Weekly Compensation Rate	Resumed or Modified Weekly Compensation Rate
A. ☐ Temporary, Total Incapacity (§34)	$_____	$_____
B. ☐ Permanent & Total Incapacity (§34A)	$_____	$_____
C. ☐ Partial Incapacity (§35)	$_____	$_____
D. ☐ Dependency Coverage (§35A)	$_____	$_____
E. ☐ Survivor's Benefits (§31)	$_____	$

21. If the Insurer is Terminating or Suspending Payment of Weekly Benefits without the Assent of the Employee or the Dept. of Industrial Accidents, set out the Applicable Statutory Section and Factual Basis Therefore (continue on the reverse side if needed):

_____
_____
_____

22. If the Insurer is Terminating or Modifying with the Assent of the Compensation Recipient, the Recipient's Signature is Required.

Signature of Recipient: _____

23. Insurer's Signature :

24. Date Prepared (mm/dd/yyyy):

Explanation of Box 21 continued:

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