FORM 106

The Commonwealth of Massachusetts

Department of Industrial Accidents – Department 106
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 TERMINATION OR MODIFICATION OF WEEKLY COMPENSATION DURING PAYMENT WITHOUT PREJUDICE PERIOD

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

FILE ONLY WHEN PAYMENT HAS BEEN MADE WITHIN 14 DAYS. AT LEAST 7 DAYS WRITTEN NOTICE MUST BE GIVEN TO EMPLOYEE OF THE INTENT TO STOP PAYMENTS, UNLESS BASED ON ACTUAL INCOME OF EMPLOYEE

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. Employer's Federal Tax ID #:

18. Employee Returned to Work: ☐ Yes ☐ No (If Yes - 7 days written notice not required)
If Yes - Date of Return (mm/dd/yyyy): Employee's Income $_____

GROUNDS

19. Specify grounds for termination and give a brief statement of the specific facts supporting the grounds for termination.
Failure to do so may cause loss of defenses under M.G.L. c 152, Sections 7(1) and 7(2).

A. ☐ No Personal Injury _____
B. ☐ No Injury Arising Out of and in the Course of Employment _____
C. ☐ No Disability _____
D. ☐ No Causal Relationship Between Personal Injury and Disability _____
G. ☐ Lack of Jurisdiction _____
X. ☐ Lack of Notice _____
Y. ☐ Late Claim _____
H. ☐ Other (Specify) _____

Use additional space on back of form if needed.

20. Last Date Through Which Payment Will Be Made (mm/dd/yyyy):

21. Date of Notification of Termination or Modification to the Employee (mm/dd/yyyy):

22. If this is a Modification rather than a Termination, please state the grounds and factual basis for the Modification and the prior rate(s) of weekly compensation paid and the Modification rate(s) of weekly compensation.

Basis for Modification (use reverse side if needed).

Prior Rate(s): **$**_____ **$**_____ _____

Modified Rate(s): **$**_____ **$**_____ _____

23. Insurer's Signature:

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

***Disclosure of Social Security Number is Voluntary. It will aid in the processing of documents.**
Please Print Clearly or Type. Unreadable forms will be returned.

Explanation of Box 19 or Box 22 continued: