FORM 108-A

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 108-A

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 REQUEST FOR POST-LUMP SUM MEDICAL MEDIATION

INSURER MUST SEND A COPY OF THIS NOTICE TO THE EMPLOYEE AND THE EMPLOYEE'S REPRESENTATIVE

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. Date of Lump Sum Approval (mm/dd/yyyy):
EMPLOYEE	9. Employee's Name (Last, First, Middle):	10. Employee's Social Security number*:
	11. Employee's Address (No., 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. Name, Address & Telephone Number of Employee's Attorney: Tel. Number:	
	16. Employer's Name & Address (No., Street, City, State, Zip Code):	
GROUNDS	17. **REQUIRED:** Please provide the specific reasons for the request:	
	18. Insurer's Signature :	**19. 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.