NOTICE OF CLAIM STATUS

Injured Worker:		**Social Security Number:**
Worker's Address:	**City, State:**	**ZIP:**
Date of Injury:		
Employer:		
Insurance Company:		

This is to notify you of the denial or change of status of your workers' compensation claim as indicated in the statement checked below:

☐ **Your claim is denied. Reason:**

☐ **Your benefit payments will be:**

☐ **Reduced** ☐ **Increased** **Effective Date:** **Reason:**

☐ **Your benefit payments will be stopped.**

Effective Date: **Reason:**

☐ **Your claim is being investigated. A decision should be made by .**

☐ **Other:** **Effective Date:**

Explanation:

☐ **See attached medical reports.**

Signature of insurance company adjuster examiner.

Name (Typed or Printed): **Date:**