NOTIFICATION OF CHANGE IN AMOUNT OF INDEMNITY BENEFIT PAYMENT

DATE:

TO: [NAME OF INJURED EMPLOYEE]
[ADDRESS]
[CITY, STATE, ZIP]

RE [DATE OF INJURY]
[NATURE OF INJURY]
[PART OF BODY INJURED]
[EMPLOYEE SSN]
[CLAIM #]
[CARRIER NAME/TPA NAME]
[CARRIER CLAIM#]
[EMPLOYER NAME]
[EMPLOYER ADDRESS]
[EMPLOYER CITY, STATE, ZIP]

The amount of the (***type of benefits being paid***) you are receiving has (***increased/decreased***) effective (***effective date***) because:

(***Provide Full and complete statement explaining the action taken_____
_____
_____***)

Previous Amount of Weekly Payment $_____
New Amount of Weekly Payment $_____

If you are expected to be paid benefits for a period of eight weeks or more, you may request that we make your benefit payments by electronic funds transfer directly to your bank account. Also, you may request that we change your benefit payments from a weekly payment to a monthly payment.

You remain entitled to reasonable and necessary medical benefits related to this injury.

If you do not agree with the amount of the change or the reason for the change, please contact me:

Adjuster's Name: _____
Toll Free Telephone #: _____
Fax #/E-mail Address: _____

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. You can contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

Cc:

INSTRUCTIONS:

Notification of Change in Amount of Benefit Payment (DWC FORM PLN-8), Rule 124.2(e)(2), and (3), and (f): (MTC: CA, RE)

This letter will be used when the change in benefit amount is the primary reason for the reporting. This will include actions that would normally trigger a Change in Benefit Amount (CA) transaction or an Reduced Earnings (RE) transaction. This notice should be used to report a change in net income benefit payment amount (increase or decrease) to the employee/beneficiary/representative.

EXAMPLES:

- Change/recalculation of Average Weekly Wage
- Change in post-injury earnings
- Refusal of a Bona Fide job offer at less than pre-injury wages
- Return to Work at less than pre-injury wages
- Statutory reduction of benefits from 75% to 70% after 26 weeks of benefit payments
- Recovery of advanced benefits initiated
- Recovery of advanced benefits completed
- Payment of accelerated benefits
- Payment of attorney fees
- Payment of attorney fees completed
- Redistribution of Death Benefits (beneficiary(ies) eligibility change)
- Court Ordered Child Support Lien
- Recovery of overpayment initiated
- Recovery of overpayment completed
- Contribution (weekly payment amount may be adjusted to $0.00 if necessary)
- Subrogation/Third Party Settlement (weekly payment amount may be adjusted to $0.00 if necessary)
- School employee adjustment
- Seasonal employee adjustment

Provide a full and complete statement of the reason(s) the action was taken.

EXAMPLES:

- A Division order for accelerated payment of your IIBs has been received. Therefore, the remaining 26 weeks of benefits will be paid in 20 weeks at the increased amount of $256.98 after the discount is applied.
- Accelerating payment of IIBs pursuant to jurisdiction order.

- We have been notified by your employer, [Name of Employer], that you returned to restricted duty work on April 1, 2002, earning $250.00/week.

- A Division order for an advance of income benefits of $1,500.00 has been received. Therefore, your weekly benefits will be reduced $25.00 per week for 60 weeks in accordance with the Division order.

- We have determined you are entitled to SIBs for the 4th quarter. Your monthly SIBs payments for the 4th quarter have been reduced to (***monthly payment amount***) based on post-injury earnings provided on your application for benefits. **NOTE: This notice does not relieve the insurance carrier from filing the DWC FORM-52 with the injured employee/representative and Division.**

- You were released to return to work with modified duty. The employer sent you a bona fide offer of employment of 20 hours a week at $7.00 per hour. Your refusal of the job offer results in the reduction of your benefits by $98.00 per week.

DO NOT SEND THIS LETTER TO THE TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION