WORKERS' COMPENSATION COMMISSION

INSURER'S TERMINATION OF TEMPORARY TOTAL DISABILITY BENEFITS

Pursuant to LE §9-733(b), Annotated Code of Maryland, this form must be sent to the claimant. A copy must also be sent to the Workers' Compensation Commission and claimant's attorney.

WCC Claim Number _____

Claimant _____

Employer _____

Insurer _____

This is your last temporary total disability compensation check/payment and includes benefits through: _____ **(date).**

The insurer/employer has terminated your payments for the following reason(s):

- ☐ 1. You returned to work on _____ . **(date)**
- ☐ 2. There is no medical evidence or documentation to support continuing payment.
- ☐ 3. You failed to keep the medical appointment scheduled for _____ . **(date)**
- ☐ 4. You have reached maximum medical improvement.
- ☐ 5.

For further information contact:

_____ **at** _____

Insurer Representative — Telephone Number

After contacting the insurance representative, if you are in disagreement or are dissatisfied, you have the right to request a hearing before the Workers' Compensation Commission. Please include a copy of this form with your request for a hearing on the MD WCC "Issues" form (H24R) selecting the appropriate Temporary Total Disability issue (#13 or #17).

INSURER CERTIFICATION OF SERVICE

I hereby certify that on the _____ day of _____ , 2020 , I mailed, postage prepaid, a copy of the foregoing "INSURER'S TERMINATION OF TEMPORARY TOTAL DISABILITY BENEFITS" and any attached documentation to all parties and their attorneys.

Signature _____

Name _____ Date _____

Telephone Number _____

Click to Clear Form

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