FORM 106

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 106
600 Washington Street – 7th Floor, Boston, Massachusetts 02111
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
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: