NEW JERSEY BENEFIT STATUS LETTER – Indemnity

[Claim Administrator Letterhead] [Claim Administrator Address]

Date of notice:

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

Date of Injury: Insurance Claim #: Agency Claim #:

Dear [Injured Worker Name],

I am handling your claim for workers' compensation benefits. In accordance with [Jurisdiction {New Jersey}] law, I am sending you a summary of your claim and benefits paid to date. The information contained in this notice has been provided to the state in an electronic format. Only the boxes checked or information provided applies to your workers' compensation claim.

This notice is with reference to the following status of your workers' compensation claim:

( ) You were released to return to work on ( ) Your injury reached maximum medical improvement status on ( ) Your injury was assigned a permanent impairment rating as follows:

[**Permanent Impairment Percent**] of the [**Permanent Impairment Body Part**]

( ) This workers' compensation claim involves a fatality that occurred on _____ and we [have/have not] been providing death benefits on this claim.

According to our records, your injury occurred while you were working for:

Name of Employer: Employer's Address:

At the time of the injury, your average weekly wage was $0000.00. Items such as overtime, lodging, uniforms, etc. [were/were not] applicable to the average weekly wage calculation, pursuant to jurisdictional requirements. Based on your average weekly wage, your weekly benefit rate was calculated at $0000.00

*****If maximum medical improvement box was checked above, insert this paragraph:*

Once maximum medical improvement has been reached, you are no longer eligible for temporary disability benefits; but if you sustained a permanent disability, you may be entitled to permanent benefits. The weekly benefit is defined by statute with a value based upon degree of impairment.

*****If the employer continued salary during the temporary disability benefit period (Release 1: DN0067 Salary Continued Y/N = Yes or Release 3: DN0273 Employer Paid Salary in Lieu of Compensation=Y). Include the following paragraph.*

Your employer elected to continue paying your salary during your temporary disability period and in lieu of workers' compensation benefits except for the following benefits we provided and that are listed below.

To date, we have provided the following workers' compensation indemnity benefits for your injury:

Benefit Description	Paid To Date	From/Through Dates	# Weeks	# Days
(***insert printout of benefits paid by benefit type*****)**				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If you do not agree with the information contained in this letter, please contact me via one of the methods below:

Adjuster's Name:
Telephone #:
Fax #:
E-Mail Address:

Or you may write to the NJ Division of Workers' Compensation at PO Box 381, Trenton, NJ 08625-038, attn: EDI Coordinator. A copy of your letter must be sent to the insurance carrier.