Department of Labor
Workers' Compensation Division
5 Green Mountain Drive, PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286
www.labor.vermont.gov

DOL Form 27 Rev. 6/10

State File No.: _____

Ins. Co. File No.: _____

Date of Injury: _____

EMPLOYER'S NOTICE OF INTENTION TO DISCONTINUE PAYMENTS

THIS FORM MUST INCLUDE ALL RELEVANT EVIDENCE* TO THE CLAIM **AND MUST BE RECEIVED** BY THE CLAIMANT, AND THEIR ATTORNEY IF REPRESENTED, AND THE DIVISION OF WORKERS' COMPENSATION **AT LEAST 7 DAYS PRIOR TO THE EFFECTIVE DATE** pursuant to 21 V.S.A. §643a.

Employee Name: _____ Employer: _____

Employee Address: _____

Employee's Attorney (if represented): _____

This employee has been out of work _____ days.

☐ The insurer verifies that if the employee has been out of work for 90 days the employee has been offered vocational rehabilitation screening and/or services (21 V.S.A. §643a and 641). Copy of the offer and any screening is attached.

Effective _____ the following benefits will be DISCONTINUED for the reasons checked below:

☐ Temporary Total Disability ☐ Temporary Partial Disability ☐ Vocational Rehabilitation

☐ Medical Benefits (MUST identify the specific treatment below):

TREATMENT being Discontinued: _____

Attach additional pages if necessary

☐ Claimant has reached medical end result. Medical report of _____ attached.

"End Medical Result" or "Medical End Result" is defined under Rule 2.1200 as "the point at which a person has reached a substantial plateau in the medical recovery process, such that significant further improvement is not expected, regardless of treatment." Medical End Result is basis for stopping Temporary Total or Temporary Partial Disability compensation regardless of work status. **IT IS NOT** a basis for stopping medical benefits or vocational rehabilitation benefits.

☐ Claimant has been released to return to work but has failed to accept a suitable offer of employment or has failed to provide evidence of verifiable, good faith job search information. ALL of the following evidence must be provided pursuant to Rule 18.1300:

18.1310 That the claimant has been medically released to work, either with or without restrictions; AND
18.1320 That the claimant has been notified both of the fact of his or her release and his or her obligation to conduct a good faith job search for suitable work; AND
18.1330 That the claimant has either failed to conduct a good faith search for suitable work and/or has refused an offer of suitable work once notified.

MEDICAL BENEFITS CAN NOT BE DISCONTINUED BASED ON RULE 18.1300 CRITERIA.

☐ Claimant has failed to attend a scheduled Independent Medical Exam (IME). Evidence must include copy of the scheduling notice sent to claimant and written evidence from the examiner that claimant failed to attend.

Pursuant to 21 V.S.A. §655 "If an employee refuses to submit himself to or in any way obstructs such examination, his right to take or prosecute any proceeding under the provisions of this chapter shall be suspended until such refusal or obstruction ceases, and compensation shall not be payable for the period during which such refusal or obstruction continues."

☐ Other: Explain reason and identify evidence relied on.

Evidence relied on: _____

Attach additional sheets if necessary.

*Please note: The insurer/employer is required to submit all relevant evidence in its possession, including evidence that does not support its position, with the discontinuance unless that evidence already has been submitted to the Division of Workers' Compensation and the employee/employee's attorney (21 V.S.A. §643a).

Insurance Carrier

Date Notice Mailed

Insurance Adjuster (Print Name)

Date Reviewed

Insurance Carrier Address

Commissioner or Designee Signature

Insurance Carrier Phone Number

Insurance Adjuster Signature

Insurance Carrier's Attorney (if represented) _____

NOTICE TO EMPLOYEE'S OF RIGHT TO APPEAL

IF YOU DISAGREE WITH THE NOTICE TO DISCONTINUE BENEFITS, you may request a hearing IN WRITING to the Division of Workers' Compensation at the address above. ATTACH medical documentation and any other information to support your appeal. **PLEASE BE SURE TO PUT YOUR STATE FILE NUMBER ON YOUR HEARING REQUEST.**

NOTICE OF POTENTIAL ELIGIBILITY FOR UNEMPLOYMENT INSURANCE BENEFITS

The insurance company is proposing to discontinue your TTD benefits. If you have a work capacity and are able and available for work, you may be eligible for Unemployment Insurance benefits. To explore your potential eligibility, you must contact the Unemployment Initial claims line at 1-877-214-3330 within 6 months of the date your temporary total disability benefits ended. Further information about unemployment benefits may be found on-line at www.labor.vermont.gov under the "Workers - Unemployed" section. If you are found eligible, you will only be paid for weeks claimed in a timely manner, made with certification of where you have searched for work you're qualified and able to perform.