LAB 500

Memo of Denial of Workers' Compensation Benefits

Claimant's Name Social Security No.

Employer Identification No.

Date of Accident Date First Report Received

YOUR CLAIM TO WORKERS' COMPENSATION BENEFITS IS HEREBY DENIED BY EMPLOYER OR CARRIER FOR REASONS INDICATED BELOW. IF YOU SO ELECT, YOU MAY PETITION THE COMMISSIONER OF LABOR, 95 PLEASANT ST., CONCORD NEW HAMPSHIRE, 03301, IN WRITING FOR A HEARING. YOU MUST REQUEST A HEARING WITHIN 18 MONTHS OF THE DENIAL

REASONS

1. ❑ No Employer-Employee Relationship (par. VI, VII, VIII, IX, RSA 281-A:2)
2. ❑ No Causal Relationship to Employment (pars. XI, XIII, RSA 281-A:2)
3. ❑ Employee's Fault (RSA 281-A:14)
4. ❑ Improper Notice of Injury by Employee (RSA 281-A:19, 20, 21)

Explanation

Authorized Representative

Insurance Carrier and Number

Carrier's Address

Phone # ______________________________________Email Address

Date

<u>THIS FORM IS NOT TO BE USED TO DENY MEDICAL BILLS ON AN ACCEPTED CLAIM</u>

9 WCA-1 (9/2015)