LAB 500

THE STATE OF NEW HAMPSHIRE

DEPARTMENT OF LABOR

CONCORD, NH 03301

MEMO OF PAYMENT OF DISABILITY COMPENSATION

You are required to pay total disability compensation and to file, with the department, copy to employee, memorandum of payment in accordance with RSA 281-A:40, 41 and 42 **as soon as possible after date of knowledge of disability of four or more days, but no later than seven days thereafter.** Filing shall also be made upon making provisional payment, upon adjusting such payment, upon making last payment, and upon making payment resulting from departmental hearing. **Failure to pay and to file memorandum promptly, in the absence of a legitimate denial of benefit, shall render a carrier liable to a civil penalty of up to $2,500.**

Employee _____ _____
(Name) (Soc. Sec. No.)

Employer _____ _____
(Name) (Federal Identification No.)

Carrier _____ _____
(Name) (Carrier Number Assigned by DOL)

Date of:

Injury	Disability/Recurrence*	First or Sup. Rep. R'cd	First Payment	Last Payment

*Recurrence refers to subsequent periods of disability

1

Compensation at the rate of $_____ per week
Beginning _____ Avg. WKly. Wage of $_____

Check box if compensation payment results from department hearing decision ☐
Chck box if memo indicating provision payment already filed ☐
Check box if memo indicating adjustment in total disability – RSA 281-A:29 ☐
SEE ATTACHED WAGE SCHEDULE, EXCEPT IF DISABILITY OF LESS THAN FOURTEEN DAYS

2

Missing Wage Schedule

When Expected _____

Provisional Payment of $ _____ Subject to Later Adjustment

3

Total Compensation Paid $ _____ Ending Date _____

Date of Return to Work _____ Earning after R.T.W._____

Name of Employer (New or same) _____

(Date) (Signature)

Dept. Approval

9 WCA (6/1994)