LAB500

THE STATE OF NEW HAMPSHIRE
DEPARTMENT OF LABOR
CONCORD, NEW HAMPSHIRE

NOTICE OF INTENTION TO SUSPEND PAYMENT OF WORKERS' COMPENSATION BENEFITS

_____
DATE

TO: _____ **DOI:**_____
Name of Employee

_____ _____
Last known address Employer Name

_____
Employee's last telephone number

Dear _____

According to our records, we mailed a form WC53 requesting verification of your employment to you on _____. You had 30 days to return this form to us, but to date we have not received it.

Enclosed is a blank copy of the form. Please complete the form and return it to us no later than 15 days from the date of this letter which is _____.

Under the law, failure to return the completed form by the date listed above may result in the suspension of payment of your benefit until such time as the form is completed and returned to this company.

If you have any questions, you may call _____
(name of carrier/name or self-insured employer)
at _____, and ask for _____.
(Telephone number) (Name of Insurance Carrier Representative or Employer Rep. If self-insured)

You may also contact the New Hampshire Department of Labor at (603) 271-3176 or 1-800-272-4353 and ask for Workers' Compensation claims.

Very truly yours,

Adjuster's Name
_____
Carrier or TPA Name
_____
Address
_____ _____ _____
City State Zip
_____
Phone Number

cc: Commissioner of Labor

53-A WC (12/2000)