MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

INSTRUCTIONS FOR COMPLETING NOTICE OF COMMENCEMENT/ TERMINATION OF COMPENSATION

This form has been designed as a tool to help calculate lost time benefits. It is password protected and you will not be able to make changes to the typed text headings or formulas. The lost time calculations will be automatically performed based upon the information you enter. There are several new fields added to this form which make calculating the lost time benefits feasible. Instructions for these fields are listed below.

If you have problems accessing the form or using its calculations please call 573-526-2700

Injury Number: Please enter one digit of the Division assigned injury number in each box.

Box No. 1A. SSN: Please enter the last four digits of employee's Social Security Number in Box 1A.

Box No. 2. Date of Accident: Please enter the date of the accident in Box 2. The State determined maximum rate of compensation will be automatically displayed in Box 6B based on this date.

Box No. 5. Average Weekly Wage (AWW): Please enter the AWW for the employee in Box 5. The rate of compensation will be automatically calculated and displayed in Box 6C.

Box No. 6. Max AWW: If the injured employee should be receiving the State determined maximum compensation amount based on the AWW entered in Box 5, the indicator in Box 6A will be set to "Y" and the maximum rate in 6B and the rate of compensation in Box 6C will be the same. If the rate of compensation in Box 6C is calculated at a lower rate than the State determined maximum rate based on the AWW, this indicator will automatically toggle to "N."

Box No. 8. Type of Lost Time (LT): This form is designed to automatically calculate the amount of compensation benefits paid to an employee, and contains separate fields for Temporary Total Disability (TTD) [Box 12], and Temporary Partial Disability (TPD) [Box 13] benefits. In order to arrive at the correct calculations you will need to indicate which type of lost time each date range represents. In Box 8 type TTD for temporary total disability or TPD for temporary partial disability. The correct calculations will be automatically performed and displayed based upon this information. Up to 10 different date ranges may be entered per form.

Box No. 9. Disability Began: This is the first day that the employee is entitled to disability benefits.
Note: If the employee was off work for more than 14 days and you **ARE** paying for the three day waiting period, the first day of the waiting period needs to be the date in this box. **Please enter the date as follows: mm/dd/yy. Example for January 1, 2017, you would enter 01/01/17. Please make sure you use the slash (/).**

Box No. 10. Disability Ended: This the last day disability benefits were paid to the employee. **Please enter the date as follows mm/dd/yy. Example for March 15, 2017, you would enter 03/15/17. Please make sure you use the slash (/).**

Total Days and Total Weeks: The total number of days and total number of weeks are automatically calculated for the date range that is entered. Please note that all fields are protected fields that cannot be changed.

Box No. 11. Total Weeks of Compensation: The total weeks of compensation for the injured employee will be automatically calculated. The resulting number of weeks will reflect the TTD and/or TPD date ranges that you entered.

Box No. 12. Temporary Total Disability Benefits Paid to Date: The dollar amount of the TTD benefit will be automatically calculated based upon the number of weeks that TTD benefits were paid and the rate of compensation. Please note that the TTD amount **does not** reflect salary or TPD benefits paid.

Box No. 13. Temporary Partial Disability Benefits Paid to Date: The Division does not calculate the amount of TPD paid to the injured employee. You will need to type in the amount of TPD benefits paid to the injured employee.

Box No. 14. Temporary Total Salary (TTS) Benefits Paid to Date: The Division does not calculate the amount of TTS paid to the injured employee. You will need to type in the amount of TTS benefits paid to the injured employee.

Box No. 15 and 16. Statutory Penalties: The penalty reductions, if any, are automatically calculated. However, only one amount appears on the form. If you enter a dollar amount and a percentage, the form will pick up the dollar amount before the percentage. It is best to only enter either the dollar amount or the percentage. The calculations in Boxes 12 and 14 will reflect the reduction once you have entered the reduction amount.

Box No. 26. If benefits are being paid to a dependent, please list each dependent's name, address, relationship to the deceased employee and dollar amount being paid. You may attach a separate sheet as a pdf document or a Word document.

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
P.O. BOX 58, JEFFERSON CITY, MO 65102-0058

INJURY NUMBER

NOTICE OF COMMENCEMENT/ TERMINATION OF COMPENSATION

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[ ][ ] - [ ][ ][ ][ ][ ][ ]

INSURER'S OR SELF-INSURED EMPLOYER'S NAME	CLAIM NO.
ADDRESS	ZIP CODE

THIS FORM NEEDS TO BE COMPLETED IF THE EMPLOYEE RECEIVED COMPENSATION BENEFITS AFTER THE THREE DAY WAITING PERIOD AND AS REQUIRED BY §§287.380; 287.170 AND 287.180, RSMo, AND 8 CSR 50-2.010. SEND ORIGINAL TO THE DIVISION AND ONE COPY TO THE EMPLOYEE.

TO EMPLOYERS/INSURERS/THIRD PARTY ADMINISTRATOR: BE SURE TO COMPLETE THE COST OF MEDICAL AID AND ALL OTHER DATA ITEMS. EMPLOYER MUST NOTIFY EMPLOYEE OF TERMINATION OF BENEFITS WITHIN 10 DAYS OF WHEN BENEFITS WERE DUE.

(THIS FORM IS REQUIRED TO BE FILED WITHIN 30 DAYS OF THE DATE OF THE ORIGINAL NOTIFICATION OF THE INJURY. THIS FORM MUST BE UPDATED AND REFILED WITHIN 10 DAYS AFTER TERMINATION OF COMPENSATION UNDER §287.203.)

1. EMPLOYEE NAME	1A. SSN	2. DATE OF ACCIDENT	3. COST OF MEDICAL AID
	XXX-XX-		
4. EMPLOYEE ADDRESS			ZIP CODE

5. AVERAGE WEEKLY WAGE	6A. MAX AWW	6B. MAX RATE	6C. RATE OF COMPENSATION	7. WAITING PERIOD DATES
	N			

8. Type of LT	9. DISABILITY BEGAN	10. DISABILITY ENDED	Total Days	Total Weeks	11. TOTAL WEEKS OF COMPENSATION
					12. CUMULATIVE TEMPORARY TOTAL DISABILITY BENEFITS PAID TO DATE
					13. CUMULATIVE TEMPORARY PARTIAL DISABILITY BENEFITS PAID TO DATE
					14. TEMPORARY TOTAL SALARY (TTS) BENEFITS PAID TO DATE
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THE INFORMATION YOU VOLUNTARILY PROVIDE IN BOXES 15 & 16 BASED UPON SB 1 & 130 EFFECTIVE AUGUST 28, 2005, IS FOR STATISTICAL PURPOSES ONLY.

15. HAS STATUTORY PENALTY BEEN ASSESSED FOR:

SAFETY VIOLATION: ☐ YES ☐ NO

DRUG/ALCOHOL VIOLATION ☐ YES ☐ NO

16. I F YOU CHECKED YES IN BOX 15, PLEASE INDICATE THE FOLLOWING:

	AMOUNT REDUCED	PERCENTAGE REDUCED
MEDICAL		
TTD/TPD		

DISABILITY PAYMENT

17. DATE FIRST PAYMENT WAS MADE TO EMPLOYEE BASED UPON CURRENT DISABILITY PERIOD BEING REPORTED

18. FIRST DAY OF PERIOD COVERED BY PAYMENT FOR CURRENT DISABILITY PERIOD BEING REPORTED

NOTICE OF TERMINATION OF COMPENSATION

19. THIS IS TO NOTIFY THE DIVISION OF WORKERS' COMPENSATION AND THE EMPLOYEE THAT COMPENSATION PAYMENTS IN THE ABOVE MATTER HAVE TERMINATED, THE LAST PAYMENT HAVING BEEN MADE ON _____ 20 ____ FOR THE FOLLOWING REASON (MUST BE STATED) _____

PLEASE INDICATE WHETHER EMPLOYEE'S "POST-INJURY MISCONDUCT" SET FORTH IN SECTION §287.170.4 RSMO EFFECTIVE AUGUST 28, 2005, RESULTED IN TERMINATION OF TTD/TPD DISABILITY BENEFITS ☐ YES ☐ NO

20. RETURN TO WORK DATE	21. PREPARED BY	22. PREPARER'S PHONE NUMBER

23. EMPLOYER/INSURER/THIRD PARTY ADMINISTRATOR SIGNATURE	24. DATE	25. PREPARER'S EMAIL ADDRESS

DEATH BENEFIT PAYMENT (IF MORE THAN ONE DEPENDENT, USE ADDITIONAL SHEET)

26. NAME OF DEPENDENT TO WHOM PAID	27. WEEKLY AMOUNT PAID
28. ADDRESS OF DEPENDENT	29. RELATIONSHIP TO DECEASED

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