Berkley Risk Administrators Company, LLC
PO Box 59143
Minneapolis, MN 55459-0143

Notice of Benefit Payment

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

NBO1

DO NOT USE THIS SPACE

WID or SSN	DATE OF INJURY
10381192	1/15/2008
EMPLOYEE (last, first, mi)	EMPLOYER
OMAR, NAWA	CORPORATE MANAGEMENT GRO
EMPLOYEE ADDRESS	
1430 4TH AVE. SE	
CITY	STATE ZIP CODE
ROCHESTER MN 55904	
INSURER CLAIM NUMBER	
1000025457	

☐ **THE FOLLOWING PERMANENT PARTIAL DISABILITY BENEFIT WILL BE PAID TO YOU:**

_____ % of whole body according to Minnesota Workers' Compensation Permanent Partial Disability Schedule number(s) _____

The rating is based on the attached medical report of Dr. _____ dated _____

☐ This payment is based on a preliminary rating. If your final disability rating is higher, further payments will be made.

For injuries on or after 10/01/1995 payment will be made at $ 0.00 per week beginning on (date) _____ for a total of 0 weeks and a total amount of $ _____

For injuries on or after 10/01/2000 a total lump sum payment of $ 0.00 , rather than weekly payments will be made as requested by the employee.

For injuries between 01/01/1984 and 09/30/1995 payment will be made as follows:

☐ $ _____ **Impairment compensation** will be paid in a lump sum on _____ (date). (If you are laid off from your job for economic reasons within _____ weeks of the day you returned to work, you may be entitled to monitoring period compensation, in addition to Impairment Compensation.)

☐ **Periodic impairment compensation** or ☐ **Periodic economic recovery compensation** of $ _____ per week beginning on _____ (date) will be paid for up to _____ weeks. If you return to work before this number of weeks, you will receive the balance due in a lump sum after working 30 days.

☐ **26 weeks economic recovery compensation** (M.S. § 176.101, subd. 3t) of $ _____ per week will be paid beginning on _____ (date).

☒ **YOUR FINAL PAYMENT OF** $ $3,000.00 **FOR** AWARD ON STIP **BENEFITS** ☒ **WAS** ☐ **WILL BE ISSUED ON** 2/10/2014 **(DATE) ACCORDING TO:** COSTS PAID.

A. ☒ An award on agreement of the parties dated 2/4/2014

B. ☐ A prior Notice of Benefit Payment for periodic payment of permanent partial disability dated _____

C. ☐ An administrative decision under M.S. § 176.239 dated _____

D. ☐ A judge's decision and order dated _____

Your **monitoring period compensation** has been **discontinued** effective _____ the date that:

☐ you returned to work.

☐ monitoring period benefits were exhausted.

INSTRUCTIONS TO EMPLOYEE

You are responsible for reviewing this form to make sure that you have been properly paid the benefits due you. YOU DO NOT NEED TO TAKE ANY ACTION IF YOU BELIEVE THAT YOU HAVE RECEIVED ALL BENEFITS DUE YOU OR THAT THE REDUCTION OF BENEFITS IS PROPER.

If you have questions about your benefits, you should first contact the claim representative whose telephone number is at the bottom of the page. Be sure to provide that person with any additional information you have to support your claim. If you still have questions, contact the Workers' Compensation Division's Benefit Management and Resolution Unit at the office nearest you.

Minnesota Department of Labor and Industry

525 Lake Avenue South, Suite 330
Duluth, MN 55802-2368
Telephone: (218) 733-7810
1-800-342-5354

443 Lafayette Road North
St. Paul MN 55155-4301
Telephone: (651) 284-5030
1-800-342-5354

Mailing Address
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

THE FOLLOWING BENEFITS HAVE BEEN PAID	FROM	THROUGH	WEEKS	RATE	*TOTAL
☐ Temporary Total Disability or ☐ Permanent Total Disability			0.0000	$ 0.00	$ 0.00
			0.0000	$ 0.00	$ 0.00
			0.0000	$ 0.00	$ 0.00
			0.0000	$ 0.00	$ 0.00
			0.0000	$ 0.00	$ 0.00
Temporary Partial Disability			0.0000 0.0000	varies varies	$ 0.00 $ 0.00
Retraining Benefits			0.0000 0.0000	$ 0.00 $ 0.00	$ 0.00 $ 0.00
Monitoring Period Compensation			0.0000 0.0000	$ 0.00 $ 0.00	$ 0.00 $ 0.00
Permanent Partial Disability _____ % ☐ Injuries on or after 10/01/1995 ☐ Impairment Compensation (injuries 01/01/1984 – 09/30/1995) ☐ Economic Recovery Compensation (injuries 01/01/1984 - 09/30/1995) ☐ _____ [part of body] (injuries before 01/01/1984)			0.0000	$ 0.00	$ 0.00 $ 0.00 $ 0.00

Attorney Fees/Expenses:		Benefit Totals	
M.S. 176.081, subd. 1&3 Paid		*Lump Sum Payment Under Award or Order	$3,000.00 $0.00
M.S. 176.081, subd. 1 & 3 Still Withheld		Attorney Fees Reimbursed to Employee (MS 176.081, subd. 7)	$ 0.00 $0.00
Heaton Fees Paid		Interest Paid	$ 0.00
Roraff Fees Paid		Total Due	$3,000.00
M.S. 176.191 Paid		***TOTAL COMPENSATION PAID**	$3,000.00
Other Fees Paid		Overpayment	$ 0.00
Costs & Disbursements Paid	$122.61	*Total Supplementary Benefits	
		Total Medical Expenses Paid to Date	$627.27

INSURER/SELF-INSURER/TPA	CLAIM REPRESENTATIVE NAME	
Berkley Risk Administrators Company, LLC	GERI WILKENING, Claim Examiner	
ADDRESS 222 South Ninth Street, Suite 1300	PHONE NUMBER (include area code) 6127663443	EXTENSION
CITY STATE ZIP CODE Minneapolis, MN 55402-3332	DATE SERVED ON EMPLOYEE 2/11/2014	DATE SERVED ON ATTORNEY 2/11/2014

*Include attorney fees in these totals.

Distribution: Workers' Compensation Division, Employer, Employee, Insurer