

KATHY TOPETE
503 2ND AVE SW APT #1
PIPESTONE, MN 56164



February 13, 2008

KATHY TOPETE
503 2ND AVE SW APT #1
PIPESTONE, MN 56164

RE: Employee: KATHY TOPETE
Employer: Corporate Management Group Inc
Date of Injury: 12/24/2007
Claim Number: 1000024346

The Minnesota Assigned Risk Plan (ARP) insures Corporate Management Group Inc. Berkeley Risk Administrators Company (BRAC) administers the Workers' Compensation claims.

We have understand you have returned to work (on date) at reduced wages. As a result, you are eligible for Temporary Partial Disability (TPD) benefit payments.

By law, TPD benefits are calculated by first subtracting you gross wage for the pay period from your pre-injury average weekly wage (\$506.87 per week), then multiplying that amount by two-thirds. You or your employer needs to send us a copy of your pay stub showing gross earnings so we can calculate your benefit.

This benefit applies to wages lost due to your injury but not to wages lost for other illnesses or personal time off. Please include an explanation when you work less than the scheduled hours or those authorized by your medical provider.

Sincerely,

Geri Wilkening
WC Examiner
(612)766-3443

cc: Corporate Management Group Inc

MANDATORY FRAUD NOTICE

A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime. Minnesota Statute 60A.955.

Notice of Intention to Discontinue Workers' Compensation Benefits



Please PRINT or TYPE your responses.
Enter dates in MM/DD/YYYY format.

DO NOT USE THIS SPACE

SOCIAL SECURITY NUMBER 605-24-0354	DATE OF INJURY 12/24/2007
EMPLOYEE KATHY TOPETE	EMPLOYER Corporate Mgmt Group Inc.
EMPLOYEE ADDRESS 502 2 ND AVE SW APT #1	
CITY PIPESTONE, MN 56164	STATE ZIP CODE
INSURER CLAIM NUMBER 1000024346	

Your benefits for (check one) TEMPORARY TOTAL TEMPORARY PARTIAL PERMANENT TOTAL disability are being discontinued for the following reasons:

- You have returned to work on _____ (date) at full wage.
- You have returned to work on 2/8/2008 (date) at reduced hours or wages.
Temporary partial will will not be paid. Temporary partial is usually based on the difference between your wage of \$ 506.87 at the time of the injury and your current weekly wage.
- Reasons other than return to work. Payment will be made through _____ (date).
Give reasons and facts below: (Appropriate medical reports must be attached.)

Reasonable medical expenses and any permanent partial disability due will still be paid, unless your claim has been denied.

INSTRUCTIONS TO EMPLOYEE – THIS REQUIRES YOUR IMMEDIATE ATTENTION

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 OR THAT THE REDUCTION OF BENEFITS IS PROPER.

If **Box 1 or 2** is checked above and you believe that your benefits should be reinstated due to an occurrence during the initial 14 calendar days after your return to work, you may request a conference. Your request must be received by the Workers' Compensation Division within 30 calendar days after the date that you returned to work.

If **Box 3** is checked above and you think the reason for stopping your benefits is incorrect, or you disagree with the proposed discontinuance, you may request a conference. Your request must be received within 12 calendar days after this notice is received by the Workers' Compensation Division.

TO REQUEST A CONFERENCE, YOU MUST MAIL OR DELIVER THE ATTACHED FORM TO THE WORKERS' COMPENSATION DIVISION SO THAT IT IS RECEIVED WITHIN THE ABOVE TIME LIMITS. TELEPHONE REQUESTS WILL ALSO BE ACCEPTED AT (612) 349-2513 OR 1-800-342-5354.

The conference will be scheduled within 10 calendar days of the date your request is received by the Division. You, your employer and the insurer will be invited to attend. You are not required to bring an attorney, but may bring one if you wish. You should bring to the conference any current reports and return-to-work restrictions, if available.

You may instead file an Objection to Discontinuance with the Division. This is a formal procedure before a compensation judge, which takes longer than the administrative conference process and usually requires an attorney. If you do this, your benefits will stop on the date stated in this notice and will not be paid during the time you wait for the hearing.

If the insurer is denying primary liability for your claim and you disagree with the denial, cannot return to your former employment and would like vocational rehabilitation assistance, contact the Department of Labor and Industry, Vocational Rehabilitation Unit at (651) 284-5038.

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 Customer Assistance Unit at the office nearest you.

Minnesota Department of Labor and Industry	
5 North Third Avenue West, Suite 400 Duluth, MN 55802-1614 Telephone: (218) 733-7810 1-800-365-4584	443 Lafayette Road North St. Paul MN 55155-4301 Telephone: (651) 284-5030 1-800-342-5354

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
<input checked="" type="checkbox"/> Temporary Total Disability or	12/26/2007	2/7/2008	6.4000	\$337.91	\$2,162.62
<input type="checkbox"/> Permanent Total Disability			0.0000	\$0.00	\$ 0.00
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>			0.0000	\$ 0.00	\$ 0.00
			0.0000	\$ 0.00	\$ 0.00
			0.0000	\$ 0.00	\$ 0.00
Temporary Partial Disability			0.0000	varies	\$ 0.00
			0.0000	varies	\$ 0.00
Retraining Benefits			0.0000	\$ 0.00	\$ 0.00
			0.0000	\$ 0.00	\$ 0.00
Monitoring Period Compensation			0.0000	\$ 0.00	\$ 0.00
			0.0000	\$ 0.00	\$ 0.00
Permanent Partial Disability _____ %					\$ 0.00
<input type="checkbox"/> Injuries on or after 10/01/1995			0.0000	\$ 0.00	\$ 0.00
<input type="checkbox"/> Impairment Compensation (injuries 01/01/1984 – 09/30/1995)					
<input type="checkbox"/> Economic Recovery Compensation (injuries 01/01/1984 - 09/30/1995)					
<input type="checkbox"/> _____ [part of body] (injuries before 01/01/1984)					\$ 0.00
Attorney Fees/Expenses:			Benefit Totals		
M.S. 176.081, subd. 1&3 Paid			*Lump Sum Payment Under Award or Order		\$0.00
					\$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		\$2,162.62
M.S. 176.191 Paid			*TOTAL COMPENSATION PAID		\$2,365.30
Other Fees Paid			Overpayment		\$ 202.68
Costs & Disbursements Paid			*Total Supplementary Benefits		
			Total Medical Expenses Paid to Date		\$660.25
INSURER/SELF-INSURER/TPA Berkley Risk Administrators Company, LLC			CLAIM REPRESENTATIVE NAME Geri Wilkening, Claim Examiner		
ADDRESS 222 South Ninth Street, Suite 1300			PHONE NUMBER (include area code) 612-766-3443		
CITY	STATE	ZIP CODE	DATE SERVED ON EMPLOYEE	DATE SERVED ON ATTORNEY	
Minneapolis, MN		55402-3332	2/13/2008		

*Include attorney fees in these totals.

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

Employee's Request for Administrative Conference
Minn. Stat. §176.239, subd. 2



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EMPLOYEE ADDRESS 502 2ND AVE SW APT #1	
CITY PIPESTONE , MN 56164	STATE ZIP
INSURER CLAIM NUMBER 1000024346	INSURANCE/SELF-INSURER/TPA Berkley Risk Administrators Co., LLC
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THIS REQUIRES YOUR IMMEDIATE ATTENTION

Private or confidential data which you supply on this form will be used to process your workers' compensation file. You may refuse to supply the data, but your request may be delayed, or under Minn. Stat. Sec. 176.275, the Department may refuse to accept any formal document that lacks identifying information. This data may be supplied to employers and insurers for the claimed date of injury, the Department of Revenue, the Department of Health and the Workers' Compensation Reinsurance Association. It may also be used in workers' compensation hearings and for state investigations and statistics.

INSTRUCTIONS TO EMPLOYEE

DO NOT COMPLETE THIS FORM IF YOU AGREE THAT YOUR WEEKLY WORKERS' COMPENSATION BENEFITS MAY BE STOPPED OR CHANGED.

HOWEVER, IF YOU DISAGREE THAT YOUR BENEFITS MAY BE STOPPED OR CHANGED, YOU MAY BE ENTITLED TO AN ADMINISTRATIVE CONFERENCE. At the conference, a decision can be made about your right to further weekly benefits.

TO REQUEST A CONFERENCE, MAIL OR DELIVER THIS COMPLETED FORM TO:

DEPARTMENT OF LABOR AND INDUSTRY
 WORKERS' COMPENSATION DIVISION
 443 LAFAYETTE ROAD NORTH
 ST. PAUL, MN 55155-4301

Requests will also be accepted by telephone. Call (612) 349-2513 or 1-800-342-5354

TIME LIMIT TO REQUEST A CONFERENCE

IF BOX 1 OR 2 is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits, your request for a conference must be received by the Workers' Compensation Division **WITHIN 30 DAYS AFTER YOU RETURNED TO WORK.**

IF BOX 3 is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits, your request for a conference must be received **WITHIN 12 DAYS AFTER A COPY OF THE NOTICE OF INTENTION TO DISCONTINUE WORKERS' COMPENSATION BENEFITS IS RECEIVED BY THE WORKERS' COMPENSATION DIVISION.**

EMPLOYEE'S REQUEST FOR ADMINISTRATIVE CONFERENCE

1. BOX (check one) 1 2 3 is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits.

2. My weekly benefits should not be changed/stopped because: _____

(attach separate sheet if more room is needed)

EMPLOYEE SIGNATURE _____ EMPLOYEE PHONE # (include area code) _____ DATE _____

ATTORNEY (if you have one) ATTORNEY # _____ ATTORNEY PHONE # (include area code) _____ QRC (if you have one) _____