Gallagher Bassett Services, Inc.

August 25, 2015

Hellen Ocheng
1281 Hazelwood St Apt 305
St. Paul, MN 55106

RE: Employer: Employer Solutions Staffing
Date of Injury: 05/14/2015
Claim Number: 011260-043138-WC-01

Dear Ms. Ocheng:

We have been notified that you have recently returned to work but that your current weekly earnings will be less than your Average Weekly Wage (AWW) at the time of your injury. As a result, you are eligible for Temporary Partial Disability (TPD) benefits. These benefits compensate employees who have a wage loss due to a work-related injury and will be paid during your period of partial disability and according to current law.

In order to calculate the TPD benefits due, your gross wage is subtracted from your AWW (which has been calculated to be $313.62). This difference is then multiplied by two-thirds and paid at that amount.

Verified wage information is required before any TPD benefits can be paid. It is your responsibility to submit the required information. **Please mail or fax all of the following together**: (1) A copy of your paycheck stub for the same pay period showing gross wages earned and paid; and (2) An explanation of any light-duty hours scheduled but not worked, for example, personal illness, sick child, doctor appointment, etc.

All lost time or reduced hours must be authorized by your treating physician in writing at the time of the disability. Please allow 5 to 10 business days, from when your information is received, for your TPD check to be sent. If you have any questions, please contact me at (763) 416-8913.

Sincerely,

Alanna Vetsch
Resolution Associate, Level II
DD: 763-416-8913
Fax: 866-451-0423
E-mail: alanna_vetsch@gbtpa.com

PO BOX 1300
Maple Grove, MN 55311
Direct Dial: 763-416-8904
Direct Fax: 1-866-741-2850

Minnesota Department of Labor and Industry
Workers' Compensation Division
www.dli.mn.gov/wc/wcforms.asp

Notice of Intention to Discontinue Workers' Compensation Benefits

N D 0 1

DO NOT USE THIS SPACE

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

WID or SSN	DATE OF INJURY
157-11-6972	05/14/2015
EMPLOYEE (last, first, mi)	EMPLOYER
OCHENG, HELLEN	EMPLOYER SOLUTIONS STAFF

EMPLOYEE ADDRESS
1281 HAZELWOOD ST APT 305

CITY	STATE	ZIP CODE
ST. PAUL	MN	55106

INSURER CLAIM NUMBER
011260-043138-WC-01

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

1. ☐ You have returned to work on _____ (date) at full wage.
2. ☑ You have returned to work on 08/25/2015 (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 $313.62 at the time of the injury and your current weekly wage.
3. ☐ 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 (651) 361-7901 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 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	05/14/2015	08/24/2015	14.6	$209.08	$3,052.57
☐ Permanent Total Disability					
☐ Benefit Addendum Attached					
Temporary Partial Disability					
Retraining Benefits					
Permanent Partial Disability _____% ☐ Injuries on or after 10/01/95 ☐ 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)					

Attorney Fees/Expenses		Benefit Totals	
M.S. 176.081, subd. 1 & 3 Paid		*Lump sum Payment Under Award or Order	
M.S. 176.081, subd. 1 & 3 Still Withheld		Attorney Fees Reimbursed to Employee (M.S. 176.081, subd. 7)	
Heaton Fees Paid		Interest Paid	
Roraff Fees Paid		***TOTAL COMPENSATION PAID**	$3,052.57
M.S. 176.191 Paid		*Total Supplementary Benefits	
Other Fees Paid		**Total Medical Expenses Paid to Date**	$13,038.37
Costs & Disbursements Paid			

INSURER/SELF-INSURER/TPA	CLAIM REPRESENTATIVE NAME	
GALLAGHER BASSETT SERVICES	ALANNA VETSCH	
ADDRESS PO BOX 1300	PHONE NUMBER (include area code) (763) 416-8913	EXTENSION
CITY / STATE / ZIP CODE MAPLE GROVE / MN / 55311	DATE SERVED ON EMPLOYEE 08/25/2015	DATE SERVED ON ATTORNEY

*Include attorney fees in these totals.

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