

Memo of Denial of Workers' Compensation Benefits

Claimant's Name _____ Social Security No. _____

Employer _____ Identification No. _____

Date of Accident _____ Date First Report Received _____

YOUR CLAIM TO WORKERS' COMPENSATION BENEFITS IS HEREBY DENIED BY EMPLOYER OR CARRIER FOR REASONS INDICATED BELOW. IF YOU SO ELECT, YOU MAY PETITION THE COMMISSIONER OF LABOR, 95 PLEASANT ST., CONCORD NEW HAMPSHIRE, 03301, IN WRITING FOR A HEARING. YOU MUST REQUEST A HEARING WITHIN 18 MONTHS OF THE DENIAL.

REASONS

1. No Employer-Employee Relationship (pars. VII, VIII, IX, RSA 281-A:2)
2. No Causal Relationship to Employment (pars. XI, XIII, RSA 281-A:2)
3. Employee's Fault (RSA 281-A:14)
4. Improper Notice of Injury by Employee (RSA 281-A:19, 20, 21)

Explanation

Authorized Representative _____

Insurance Carrier and Number _____

Carrier's Address and Phone # _____

Date _____