## SAMPLE NOTICE - English

# Notice of Underpayment of Income Benefits

**Send form to workers' compensation insurance carrier**

### I. INJURED EMPLOYEE INFORMATION

| | |
|---|---|
| **1. Employee's Name** (First, Middle, Last) | **2. Employee's Social Security Number** (last four digits) **xxx-xx-** |
| **3. Employee's Address** (Street or PO Box, City State Zip) | **4. Date of Injury** (mm/dd/yyyy) |
| **5. Employee's Telephone Number ( )** | **6. Employee's Email Address** (Optional) |
| **7. Attorney/Representative's Name** (if applicable) | **8. Attorney/Representative's Address** (Street or PO Box, City State Zip) |

### II. EMPLOYER INFORMATION (at the time of the injury)

| | |
|---|---|
| **9. Employer's Name** | **10. Employer's Address** (Street or PO Box, City State Zip) |

### III. INSURANCE CARRIER INFORMATION

| | |
|---|---|
| **11. Insurance Carrier's Name** | **12. Insurance Carrier Claim Number** |

### IV. EMPLOYEE'S EXPLANATION REGARDING UNDERPAYMENT

| | |
|---|---|
| **13. Provide a detailed explanation which shows that the insurance carrier has not paid you the full amount of income benefits due. Attach any supporting documentation.** | |
| **14. Signature of Injured Employee or Injured Employee's Representative / Attorney** | |
| **15. Printed Name of Injured Employee or Injured Employee's Representative / Attorney** | **16. Date of Signature** |