MAIL TO:
OFFICE OF WORKERS' COMPENSATION
POST OFFICE BOX 94040
BATON ROUGE, LA 70804-9040
(225) 342-7565 TOLL FREE (800) 201-3457

1. Social Security No. ______-______-______

2. Date of Injury/Illness ______-______-______

NOTICE OF PAYMENT

This form is to be completed by the Employer/Insurer and sent to the injured employee with the first check or within 10 days of suspension/modification and/or change to SEB. A copy must be sent to the Office of Workers' Compensation Administration within 10 days of the effective date.

3. Purpose of Form (check one):
__ Payment __ Modification __ Suspension __ Change to SEB

4. Employee Name ____

5. _____ - _____ - _____
Effective Date

6. Part(s) of Body Injured ____

7. Nature of Injury ____

8. Compensation is paid as follows:

__ A. Weekly payments of $ _______ based on an average weekly wage of $ _________ have begun.

__ B. Payments re-started at $ ________ per week.

__ C. Payments reduced by $ _________ due to:
__ Social Security Benefits __ Other Workers' Compensation Benefits
__ Employer Disability Benefits __ Unemployment Insurance Benefits
__ Third Party Recovery __ Refused Rehabilitation
__ Other:____

__ D. Permanent Partial Benefits of $ ________________ will be paid for __________________ weeks.

__ E. Supplemental Earnings Benefits of $ __________________ will begin _______________
The exact amount received weekly may vary.

__ F. Death Benefits have begun in the amount of $__________________ per week, representing ________% of wages.

__ G. Payment suspended due to employee failing to cooperate.

__ H. Other reasons or explanations____

9. Submitted by:

Preparer's Name: ______________________________ Employee Name: ______________________________
Employer/Insurer: ______________________________ Employer: ______________________________
Address: ______________________________ Address: ______________________________
______________________________ ______________________________
Phone: ( ) ______________________________ Phone : ( ) ______________________________
Employer/Insurer NCCI Number: ______________________

LWC-WC-1002
REV. 07/08