YOUR CLAIM FILE NO. _____

**STATE OF IOWA -- WORKERS' COMPENSATION COMMISSIONER**
PAYMENT ACTIVITY REPORT
(COMPLETE FORM IN ENTIRETY)

W.C. COMM. NO. _____

A)
INSURANCE COMPANY:_____

_____

Employee: _____

Social Security Number: _____

Employer: _____

_____

_____

B) COMMENTS:

_____

_____

_____

_____

_____

C) RATE CALCULATION - Section 85.36( )

Injury Date _____ Total Exemptions _____ Weekly Rate _____

Marital Status _____ Gross Weekly Wage _____ PPD Weekly Rate_____

D) THIS SECTION IS FOR INDICATING WHETHER OR NOT DISABILITY BENEFITS ARE BEING PAID (PAYMENT NOTICE OR DENIAL):

D1) ☐ Check here if this is a Commencement of Payment Notice (enter Date of First Payment: _____, Date Disability Began _____ )

D2) ☐ Check here if this is a Denial of Liability

D3) ☐ Check here if benefits are not being paid - reason? ☐ Insufficient lost time ☐ Other (explain: _____ )

E) THIS SECTION IS FOR REPORTING BENEFITS PAID TO DATE (PAYMENT REPORT):

E1) Check type of Payment Report:

| | |
|---|---|
| ☐ Final Report<br>Enter Date of Last Payment: | ☐ Interim Report<br>Enter Estimated Completion Date: |

E2) Payment(s) for period(s) of disability:

| TYPE OF PAYMENT (CHECK) | PERIOD(S) OF DISABILITY DATE BEGAN (thru) DATE ENDED | WEEKS/DAYS PAYABLE | AMOUNT EARNED | IF TPD AMOUNT PAID |
|---|---|---|---|---|
| ☐ TTD/HP ☐ PTD ☐ TPD ☐ DEA | | WEEKS DAYS $ | $ | |
| ☐ TTD/HP ☐ PTD ☐ TPD ☐ DEA | | WEEKS DAYS $ | $ | |

E3) Payment for PPD:

| PART OF BODY (SPECIFY) | % PPD | NO. OF WEEKS | AMOUNT PAID | TYPE OF BENEFIT |
|---|---|---|---|---|
| | | | | MEDICAL (85.27) |

E4) Other benefit payments:

| AMOUNT PAID | TYPE OF BENEFIT | AMOUNT PAID |
|---|---|---|
| | VOC REHAB (85.70) | |
| BURIAL | PENALTY (86.13) | |
| | MISC (SPECIFY) | |

E5) Settlement/Commutation approved by W.C. Comm. (85.28)

| TYPE | DATE APPROVED | AMOUNT | INTEREST |
|---|---|---|---|
| | | (85.30) | |

E6) ☐ Check here if a Medical Report is attached

**FORM PAR** -- 14-0147 (10-10) Prepared by: _____ Date Prepared: _____

**LEGEND:** TTD = Temporary Total Disability HP = Healing Period TPD = Temporary Partial Disability PTD = Permanent Total Disability PPD = Permanent Partial Disability DEA = Death Benefits

**STATE OF IOWA - WORKERS' COMPENSATION COMMISSIONER**

PAYMENT ACTIVITY REPORT (FORM PAR)

INSTRUCTIONS

This form is designed to assist with meeting the various filing requirements of the Iowa Workers' Compensation Act and Administrative Rules. The form (or photocopy of the front side) is to not be filed with the Iowa Workers' Compensation Commissioner's Office, except to support settlement applications.

**THE INFORMATION PROVIDED WILL BE OPEN FOR PUBLIC INSPECTION UNDER IOWA CODE § 22.11.**

## SECTION A - NAMES AND ADDRESSES OF THE PARTIES:

This section is to be used to provide the complete names and addresses of the insurer (or adjusting company), employee, and employer.

## SECTION B - REPORT OF CHANGE IN PAYMENT STATUS/COMMENTS:

This section is to be used to provide information concerning any changes in payment status or any comments pertinent to the handling of the claim.

## SECTION C - RATE CALCULATION:

This section is to be used to verify the employee's weekly compensation rate. If the information upon which the compensation rate is based is the same as the information reflected on the Employer's First Report of Injury, this form may be filed as a "Rate Agreement." If the information upon which the rate is based differs from the information reflected on the Employer's First Report of Injury, a Form 2B must be filed as a "Rate Agreement."

## SECTION D - COMMENCEMENT OF PAYMENT NOTICE OR DENIAL:

This section is to be used by the insurer to indicate whether or not payment of disability benefits to the employee have been initiated.

D1. Check this box if this is a "Commencement of Payment Notice" pursuant to 86.13.

D2. Check this box if this is "Denial of Liability" pursuant to 85.26.

D3. Check this box if payment of disability benefits is not being made for reasons other than Denial, then check Insufficient Lost Time (if disability is 3 days or less), or Other (and include an explanation).

## SECTION E - PAYMENT REPORT:

This section is to be used by the insurer to report the benefits paid to date, and to indicate whether an "Interim Report" or "Final Report" is being filed pursuant to Rule 876 - 3.1(2). Attach a separate sheet if necessary.

E1. Check and complete the appropriate box for the type of "Payment Report" being made.

"Final Report" - Disability benefits have been terminated. Enter the Date of Last Payment.

"Interim Report" - Disability benefits are continuing. Enter the Estimated Completion Date when termination of benefits is anticipated.

E2. Enter the payment(s) for the period(s) of disability:

TYPE OF PAYMENT - Check if TTD/HP, TPD, PTD, or DEA benefits.

DATE BEGAN - Enter the first date of disability for the type and period being reported.

DATE ENDED - Enter the last date of disability for the type and period being reported.

WEEKS/DAYS PAYABLE - Enter the number of weeks and days payable during the period.

Example: The period from May 1st thru May 8th is 8 days of disability, which if subject to the three day waiting period is 5 days payable, or .714 weeks.

TPD AMOUNT EARNED - If TYPE OF PAYMENT checked is TPD, enter the actual amount of wages earned from the employer during the period being reported.

AMOUNT PAID - Enter the amount paid for the period.

Example: To calculate TTD/HP, PTD, or DEA multiply the WEEKLY RATE times the decimal equivalent of the WEEKS/ DAYS PAYABLE.

To calculate TPD multiply the GROSS WEEKLY WAGE times the WEEKS/DAYS PAYABLE minus the TPD AMOUNT EARNED during the period times .66667.

Conversion Rule 876 - 8.6

1 day = .143 week 2 days = .286 week
3 days = .429 week 4 days = .571 week
5 days = .714 week 6 days = .857 week
7 days = 1.000 week

E3. Enter payment for PPD:

PART OF BODY - Enter the part of the body upon which benefits are based.

% PPD - Enter extent of disability as a percentage.

NO. OF WEEKS - Multiply the % PPD times the scheduled number of weeks for the PART OF BODY pursuant to 85.34(2) (a-u).

Example: A 25% loss of an arm equals .25 x 250 weeks or 62.5 weeks.

AMOUNT PAID - Multiply the PPD WEEKLY RATE times the NO. OF WEEKS and enter the amount paid.

E4. Enter other benefit payments:

TYPE OF BENEFIT - Find the appropriate box(es) for other benefits paid. If a type of benefit is not shown, specify the type of benefit in the MISC. box. The number in parentheses under each type of benefit refers to the section of the Iowa Code applicable to these payments.

AMOUNT PAID - Enter the amount paid.

E5 Enter settlement/commutation payment(s) approved by the workers' compensation commissioner:

TYPE - Indicate type
SPCS = Special Case Settlement pursuant to 85.35
AGFS = Agreement for Settlement pursuant to 86.13
FCOMM = Full Commutation pursuant to 85.45 & 85.47.
PCOMM = Partial Commutation pursuant to 85.45 & 85.48.

DATE APPROVED - Enter the date the workers' compensation commissioner approved the settlement/commutation.

AMOUNT - Enter the amount of the settlement/ commutation.

E6 Check this box if a "Medical Report" is attached pursuant to rule 876- 3.1(2). A medical report must be filed if an injury involves PPD or PTD, or if the disability period exceeds 13 weeks on TTD/HP or TPD.

Please sign and date this report where indicated.