Department of Labor
Workers' Compensation Division
5 Green Mountain Drive, PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286; TDD 800-650-4152
www.labor.vermont.gov

DOL Form 27 Rev. 5/18
State File No.: _____
Ins. Co. File No.: _____
Date of Injury: _____

EMPLOYER'S NOTICE OF INTENTION TO DISCONTINUE PAYMENTS

TO THE INSURANCE ADJUSTER: Please review the accompanying instructions carefully. If you fail either to submit required documentation and/or to provide proper notice, the discontinuance will be rejected.

Employee Name: _____ Employer: _____

Employee Address: _____

Employee's Attorney (if represented): _____ Employee has been out of work: _____ days

TO THE INJURED WORKER: Your workers' compensation benefits are about to be discontinued.

Effective _____ you will stop receiving the following benefits:

☐ Temporary Total Disability ☐ Temporary Partial Disability

☐ Specific medical treatment as follows: _____

Your weekly wage replacement benefits are stopping because:

☐ According to the attached medical report, dated _____ , you have reached an end medical result for your work injury.
☐ You have failed to accept a suitable offer to return to work.
☐ You have failed to conduct a good faith search for suitable work.
☐ You have failed to attend a scheduled independent medical examination.
☐ Other: _____

Your medical benefits are stopping because:

☐ According to the attached medical report, dated _____ , the medical treatment specified above:
☐ is not medically necessary and/or ☐ is not causally related to your work injury.
☐ Other: _____

Notice to Injured Worker: You have the right to object to this discontinuance and may request an extension of benefits of 14 days (21 V.S.A. §643a). If you wish to do so, follow the attached instructions for injured workers. To ensure proper processing, please include your state file number on all filings.

Insurance Adjuster	Insurance Carrier Name	Insurance Carrier Address
Insurance Adjuster Phone Number	Insurance Adjuster Signature	Date Notice Mailed
Date Reviewed	Commissioner or Designee Signature	

NOTICE OF POTENTIAL ELIGIBILITY FOR UNEMPLOYMENT INSURANCE BENEFITS

Notice to Injured Worker: If the insurance company is proposing to discontinue your TTD benefits you may be eligible for unemployment insurance benefits, provided that you have a work capacity and are able and available for work. To explore your potential eligibility, you must contact the Unemployment Initial Claims Line at 1-877-214-3330 within 6 months from the date when your benefits ended [21 VSA §1343(d)]. You can find more information about unemployment benefits on-line at www.labor.vermont.gov under the "Workers - Unemployed" section. If you are found eligible, you will only be paid for weeks claimed in a timely manner and made with certification of where you have searched for work you are qualified and able to perform.

INSTRUCTIONS FOR COMPLETING THE NOTICE OF INTENTION TO DISCONTINUE PAYMENTS (FORM 27)

To the insurance adjuster: Please review these instructions carefully. IF YOU FAIL EITHER TO SUBMIT REQUIRED DOCUMENTATION AND/OR TO PROVIDE PROPER NOTICE, THE DISCONTINUANCE WILL BE REJECTED.

1. The Form 27 Discontinuance Notice must be received by the injured worker, his or her attorney if represented, and the Department **at least 7 days prior to its EFFECTIVE DATE**. 21 V.S.A. §643a.
2. You **must include** with the Form 27 **ALL RELEVANT EVIDENCE** not already submitted to the injured worker, his or her attorney if represented, and the Department. This includes evidence that supports the proposed discontinuance **as well as** evidence that supports continuing benefits. 21 V.S.A. §643a.
3. **For discontinuances based on end medical result**, please refer to Workers' Compensation Rule 12.1200. You **MUST ATTACH** medical report(s) documenting that the injured worker has reached an end medical result. "End medical result" is defined as "the point at which a person has reached a substantial plateau in the medical recovery process, such that significant further improvement is not expected, regardless of treatment." The fact that an injured worker has reached an end medical result **IS NOT** an appropriate basis for discontinuing medical or vocational rehabilitation benefits.
4. **For discontinuances based on the injured worker's failure either to accept a suitable offer to return to work or to conduct a good faith search for suitable work**, please refer to Workers' Compensation Rule 12.1300. You **MUST ATTACH** written documentation of the following:

   (a) That the injured worker has been medically released to return to work, either with or without restrictions; **AND**
   (b) That the injured worker has been notified both of the fact of his or her release **AND** his or her obligation to conduct a good faith search for suitable work; **AND**
   (c) That the injured worker has either failed to conduct a good faith search for suitable work and/or has refused a written offer of suitable work once notified.

   Medical benefits **CANNOT be discontinued** based solely on the above criteria.
5. **For discontinuances based on an injured worker's failure to attend a scheduled independent medical exam**, you **MUST ATTACH** a copy of the scheduling notice sent to the injured worker **as well as** written notice from the examiner documenting that the injured worker failed to attend.
6. **If the injured worker has been out of work for at least 90 days**, you **MUST ATTACH** written verification that he or she has been offered vocational rehabilitation screening and/or services. 21 V.S.A. §§641 and 643a.

INSTRUCTIONS FOR OBJECTING TO A FORM 27 AND REQUESTING AN EXTENSION OF BENEFITS

To the injured worker: Please review these instructions carefully and ensure that you submit all required documentation. See 21 V.S.A. §643a; Workers' Compensation and Occupational Disease Rules, Rule 12.1900.

If you wish to dispute the Form 27 Discontinuance, you must submit a written notice of objection. This written notice must specifically identify the reason(s) why the proposed discontinuance is objectionable and must be accompanied by supporting evidence. The notice of objection must be filed with the Department and a copy sent to the employer or insurance carrier.

You may also request an extension of the effective date of the Discontinuance by 14 days so that you can continue to receive benefits while you gather the necessary evidence to support your notice of objection. A request for extension must be filed with the Department **within 7 calendar days** after receipt of the Form 27 and be accompanied by supporting evidence. A copy of this filing must also be sent to the employer or insurance carrier. The request for extension shall be reviewed promptly upon receipt by the Department and will either be approved or denied. The Department extension decision shall not be subject to reconsideration or appeal. If approved, the expectation is that the injured worker will file supplemental evidence within the extension period. Note: If the discontinuance is subsequently determined to be supported, the employer or insurance carrier may request an offset of any payments made during the extended period. **See 21 V.S.A. §643a; Workers' Compensation and Occupational Disease Rules, Rule 12.2010.**