PRINT CARRIER NAME HERE

SROI - MTC:AP, CA, CB, CD, EP, ER, IP, PY, RB, RE, S1, S2, S4, S5, S7, SD, SJ, SA

NOTICE THAT PAYMENT OF COMPENSATION HAS BEEN STOPPED OR MODIFIED

DN0004 DN0058 (Code 9), DN0059 DN0058 (Code 9), DN0059

CHECK TYPE OF CASE: ☐ WORKERS' COMPENSATION ☐ VOLUNTEER FIREFIGHTER ☐ VOLUNTEER AMBULANCE WORKER

ANSWER ALL QUESTIONS FULLY - TYPEWRITER OR COMPUTER PREPARATION IS REQUIRED

ALL COMMUNICATIONS SHOULD REFER TO THESE NUMBERS

1. W C B Case Number	2. Carrier Case Number	3. Carrier Code	4. Date of Injury	5. Social Security Number
DN0005	DN0015	DN0006	DN0031	DN0042, DN0270

Name		Address to which notices should be sent
6. Claimant/Name of Deceased	DN0043-0045, 0255	DN0046-0051 (FROI only)
7. Employer *	DN0016	DN0165-0170 (FROI only)
8. Carrier	DN0006	DN0010-0014, DN0136, DN0137, DN0188

* In VF and VAW benefit cases, the liable political subdivision (or unaffiliated ambulance service as defined in Sec. 30 VAWBL) is deemed to be the "EMPLOYER"

9. County Where Injury Occurred	10. Date Disability Began or Date of Death	11. Average Weekly Wage	12. Date First Payment Mailed	13. Date Most Recent Payment Mailed
DN0118 (FROI only)	DN0056 or DN0057/0055	$ DN0286	DN0192,0195 (MTC IP)	DN0192, 0195, 0077

14. Description (Diagnosis) of Injury DN0038 (Available on FROI only)

15. SUMMARY OF BENEFIT PAYMENTS

Indicate Type of Disability		Period(s) of Payment		Less Days Worked	Number of Weeks	Weekly Rate	Amount
TOTAL/PARTIAL	PERM./TEMP.	From	To				$
DN0085	DN0085	DN0088	DN0089	DN0091	DN0090	DN0134	DN0086
		DN0219	DN0220	DN0212		DN0087	DN0218
DN0092		DN0094	DN0125			DN0093	
					DN0175	DN0174	

DISFIGUREMENT..... DN0085 (Type - 090 or 590)

LUMP SUM PAYMENT (Include Lump Sum Non-Schedule Adjustment or Lump Sum Advance on a Schedule Loss Award)..... MTC-PY - DN0293

DEATH BENEFITS

From	To	Paid To Or For	
DN0088	DN0089	DN0097, 0216, 0217	DN0086
		DN0082	

Lump Sum Death Benefit (VFBL and VAWBL only)..... MTC-PY (DN0097, 0216, 0217) DN0086

Funeral Expenses..... DN0216 (Other Benefit Type-300) DN0086

State Treasurer (Sections 15-9, 25-a or 26-a)..... DN0185, 0217 DN0086

Payment made into Aggregate Trust Fund - Date: DN0195

TOTAL AWARD $ DN0218

PENALTY PAYMENT TO CLAIMANT..... DN0216 (Other Benefit Type-311) $ DN0215

LESS: a. Fees to representative: DN0216 (Other Benefit Type-340), DN0217 $ DN0215

b. Reimbursement to: DN0217 DN0226 $ DN0215 DN0225

c. Other (specify): DN0217, DN0222 DN0126-0129 DN0130-0133 $ DN0215

TOTAL DEDUCTIONS (a+b+c) $

BALANCE TO CLAIMANT $ DN0086

16 . Have benefits been paid in full in accordance with an award of the WCB? ☐ Yes ☐ No If "No," check and complete items a-d, as appropriate:

a. ☐ Claimant returned to work. Date of return: DN68, 72, 144, 145, 189, 224, 0228 ☐ At pre-injury wages ☐ At reduced wages DN0124, 0202

b. ☐ There is a change in condition and/or earnings. (A medical report or other supporting documentation must be attached.) DN0224, DN0002MTC-RE DN0002(with MTC)

c. ☐ Carrier has proof of incarceration upon conviction of a felony. (Attach proof of incarceration.) MTC - S5

d. ☐ Payments stopped or modified for other reason. (Explain below and/or attach explanation/documentation.) DN0002 (with MTC)

DN0193, 0233

☐ **NOTICE OF TERMINATION OF TEMPORARY PAYMENTS OF COMPENSATION AND PRESCRIBED MEDICINE (Sec. 21-a WCL)**

17 . Employer or carrier is ceasing payment of temporary compensation and prescribed medicine. See special information box on reverse. Last payment was made on DN0192,0195. Reason for termination of payments: DN0233

Prepared by DN0138-0140 Dated DN0003

Official Title Telephone No. & Extension DN0137

C-8/8.6 (1-11) Prescribed by Chair Workers' Compensation Board State of New York **SEE IMPORTANT INFORMATION TO CLAIMANT AND CARRIER ON REVERSE.**

This notice must be filed with the CHAIR, Workers' Compensation Board, by the Insurance Company or Self-Insured Employer within 16 days after the date on which benefit payments were stopped or modified. **(Please note: if this form serves as a notice of termination of temporary payment of compensation and prescribed medicine pursuant to Section 21-a WCL, it must be delivered within five days after the last payment.)** This notice should be sent to the Board office in the district where the injury occurred. (See district office addresses below.) A copy of this notice must also be mailed to the CLAIMANT, to his or her REPRESENTATIVE, if any, at the same time it is filed with the Chair.

TO THE CLAIMANT

1. This notice shows that your employer or its insurance company has stopped paying benefits to you or has modified the rate at which benefits are being paid.
2. The stopping or modification of payments may have been made because:
   a. a decision or award was made by the Workers' Compensation Board, or
   b. you have returned to work, or
   c. your employer or its insurance company contends that your disability has ended or lessened, or
   d. the carrier has proof of incarceration upon conviction of a felony.
3. Item 16 on the front of this form shows the reason why your employer or its insurance carrier has stopped or modified your benefits.
   a. If the case has been closed, and all payments awarded have been made, no further action will usually be necessary unless the decision has been appealed.
   b. If the case has not been closed, the Board will determine if additional benefits are due and notify you in writing of any further action taken on your claim.
4. If you have not received the payments awarded by the W.C. Law Judge or the Board, or shown in item 15 on the front of this form, or have not received the benefits agreed to as the result of a conciliation agreement, contact the insurance carrier and the nearest office of the Workers' Compensation Board.
5. The filing of this notice by the insurance carrier does not affect your right to medical care related to your injury or occupational disease. Only the Board may determine if medical care may be terminated.

IF ITEM 17 IS CHECKED - NOTICE OF TERMINATION OF TEMPORARY PAYMENTS OF COMPENSATION AND PRESCRIBED MEDICINE If item 17 on the front of this form is checked, disregard the information given in numbers 1-5 above. This form serves as notice that your employer or its insurance carrier is stopping temporary payment of compensation and prescribed medicine, which was begun voluntarily without an award from the Workers' Compensation Board. **The payment of such compensation and prescribed medicine is not an admission by the employer of liability for your injury.** Upon the ending of these payments, you and your employer retain all original rights, defenses and obligations under the Workers' Compensation Law without regard for the temporary payment of compensation and prescribed medicine. If the employer or carrier is now accepting liability for your claim, Form C-669 must be sent to you simultaneously with this notice. If the employer or carrier is now disputing your claim, Form C-7 must be sent to you simultaneously with this notice, or within ten days after delivery of this notice. If you do not receive one of these forms when your temporary compensation is stopped, notify the Workers' Compensation Board immediately.

VOLUNTEER AMBULANCE WORKERS AND VOLUNTEER FIREFIGHTERS

In volunteer ambulance workers' and volunteer firefighters' benefit cases, the liable political subdivision (or unaffiliated ambulance service as defined in the Volunteer Ambulance Workers' Benefit Law) is considered the "employer," with respect to the information given in items 1-5 above.

BE SURE TO NOTIFY THE WORKERS' COMPENSATION BOARD AND THE INSURANCE COMPANY OF ANY CHANGE IN YOUR ADDRESS

IF YOU HAVE ANY QUESTIONS CONCERNING THIS NOTICE OR YOUR CASE, OR WITH RESPECT TO YOUR RIGHTS UNDER THE WORKERS' COMPENSATION LAW, OR THE VOLUNTEER FIREFIGHTERS' OR VOLUNTEER AMBULANCE WORKERS' LAWS, YOU SHOULD CONSULT THE NEAREST OFFICE OF THE BOARD FOR ADVICE. **ALWAYS USE THE CASE NUMBERS SHOWN ON THE OTHER SIDE OF THIS NOTICE,** OR ON OTHER PAPERS RECEIVED BY YOU, IF YOU FIND IT NECESSARY TO WRITE OR CALL THE BOARD.

SI USTED TIENE DUDAS EN RELACIÓN A ESTA NOTIFICACIÓN O SOBRE SU CASO, O EN RELACIÓN A SUS DERECHOS BAJO LA LEY DE COMPENCACIÓN OBRERA, O LAS LEYES DE BENEFICIOS DE LOS BOMBEROS VOLUNTARIOS O DE LOS VOLUNTARIOS DE CUERPOS DE AMBULANCIA, O LAS LEYES DE BENEFICIO POR INCAPACIDAD, DEBE ASESORARSE CON LA OFICINA DE LA JUNTA MAS CERCANA. CUANDO SE COMUNIQUE CON LA JUNTA **CITE SIEMPRE LOS NÚMEROS DE CASOS QUE APARECEN AL DORSO** O EN LOS OTROS DOCUMENTOS QUE HAYA RECIBIDO.

TO THE CARRIER

Except in the case of temporary payment of compensation and prescribed medicine under Section 21-a, the filing of a Form C-8/8.6, in a case where the carrier has begun payment without awaiting an award of the Board, is not authority to suspend or reduce payments in an open and pending claim unless supporting evidence accompanies the notice, such as: (1) a copy of a payroll report if the benefit rate is not based on information contained in the Report of Injury and is below the maximum, and/or (2) claimant's medical and other reports (including notice of return to work), or by indicating on the Form C-8/8.6 the name and date of the claimant's medical or other reports, if they have been previously filed.

See 12NYCRR300.23 of Board's Rules for other requirements controlling the right to suspend or modify payments.

See 12NYCRR300.22 (d) of Board's Rules for other requirements regarding temporary payments of compensation without prejudice and without admitting liability under Sec. 21-a WCL.

Section 114 of the Workers' Compensation Law provides, in part, that any employer or carrier, or any employee, agent, or person acting on behalf of an employer or carrier, who knowingly makes a false statement or representation as to a material fact for the purpose of avoiding provision of any payment or benefit under this chapter shall be guilty of a felony.

WORKERS' COMPENSATION BOARD DISTRICT OFFICES

DOWNSTATE CENTRALIZED MAILING
(for New York City, Hempstead, Hauppauge & Peekskill Districts)
PO Box 5205 Binghamton, NY 13902-5205
NYC(800)877-1373 HEMP(866)805-3630 HAUP(866)681-5354 PEEK(866)746-0552

100 Broadway
Menands
ALBANY 12241
(866) 750-5157

State Office Building
44 Hawley Street
BINGHAMTON 13901
(866) 802-3604

295 Main Street
Suite 400
BUFFALO 14203
(866) 211-0645

130 Main Street W.
ROCHESTER 14614
(866) 211-0644

935 James St.
SYRACUSE 13203
(866) 802-3730

Statewide Fax Line: 877-533-0337