



# NOTICE OF DENIAL OF BENEFITS

State Form 53914 (4-09)

**WORKER'S COMPENSATION BOARD**  
402 West Washington Street, Room W196  
Indianapolis, IN 46204-2753

\* This agency is requesting disclosure of Social Security Number in accordance with IC 22-3-4-13; disclosure is voluntary and you will not be penalized for refusal.

- INSTRUCTIONS:**
1. *Notice of Denial of Benefits must be made in writing and mailed not later than thirty (30) days after the employer's knowledge of the injury. (IC 22-3-3-7)*
  2. *Mail to the Worker's Compensation Board at the above address.*

Date of injury (month, day, year)	Accident number
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### CLAIM INFORMATION

Name of employer	Federal identification number	Telephone number (      )
Address (number and street, city, state, and ZIP code)		
Name of insurer	Insurer claim number	
Address (number and street, city, state, and ZIP code)		
Name of adjuster / case manager	Telephone number (      )	E-mail address
Name of employee	Social Security Number *	
Address (number and street, city, state, and ZIP code)		
Telephone number (      )	E-mail address	

### NOTICE OF DENIAL

Claim deemed not compensable, no compensation paid.
Explanation
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### EMPLOYER CERTIFICATION

Employer must sign below to certify service of this notice.	
Signature of employer	Date (month, day, year)
Printed name	By: <input type="checkbox"/> US Mail <input type="checkbox"/> Personal service