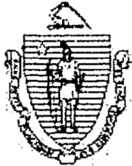
FORM 101



The Commonwealth of Massachusetts
Department of Industrial Accidents - Department 101
600 Washington Street - 7th Floor, Boston, Massachusetts 021 11
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.state.ma.us/dia

DIA USE ONLY

EMPLOYER'S FIRST REPORT OF INJURY OR FATALITY

THIS FORM MUST BE FILED BY THE *EMPLOYER* IN THE EVENT OF AN INJURY THAT RESULTS IN DEATH OR FIVE OR MORE CALENDAR DAYS OF TOTAL OR PARTIAL INCAPACITY FROM EARNING WAGES.

INSTRUCTIONS AND CODES ON THE REVERSE SIDE - **Please Print Legibly or Type - Unreadable forms will be returned.**

EMPLOYEE

1. Employee's Name (Last, First, MI):	2. Home Telephone Number:	3. Social Security Number*:	4. Sex: ☐ M ☐ F
5. Home Address (No., Street, City, State & Zip Code):		6. Marital Status: ☐ M ☐ S	7. No. of Dependents:
8. Date of Hire (mm/dd/yyyy):	9. Date of Birth (mm/dd/yyyy):	1 0. Average Weekly Wage: $ ☐ Estimated ☐ Actual	

EMPLOYER

11. Employer's Name:	12. Federal Tax I.D. Number:
13. Employer's Address (No., Street, City, State & Zip Code):	14. Employer's Telephone Number:
	15. Industry Code (See Reverse Side):
16. Workers' Compensation Insurance Carrier and Tel. No. (NOT LOCAL AGENT/ADMINISTRATOR)	17. W.C. Policy Number:
18. Self-Insured? ☐ Yes ☐ No If Yes, Self-Insurer Number:	19. Business Type : ☐ Service ☐ Wholesale ☐ Mfg. ☐ Retail ☐ Other ________

INJURY INFORMATION

20. DATE OF INJURY (mm/dd/yyyy):

21. Was Employee Injured on Employer's Premises? ☐ Yes ☐ No	22. Location of Injury if not on Employer's Premises:	
23. FIRST day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):	**24. FIFTH day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):**	
25. If Employee has Died, Date of Death (mm/dd/yyyy):	26. Source of Injury (Chemicals, Machinery, etc.)-	
27. Briefly Describe How Injury/Exposure Occurred and Body Part(s) involved:		
28. Person to Whom Injury was Reported (list position):	29. Date Reported (mm/dd/yyyy):	30. Date Reported as work related (mm/dd/yyyy):
3 1. Injury Code(s) Body Part Code(s) a. to body part a. b. to body part b. c. to body part c.	32. Witness(es) to Injury - Give Full Name(s), if none state as such:	
33. Has Employee Returned to Work? ☐ Yes ☐ No	34. Date Employee Returned to Work (mm/dd/yyyy):	
35. Employee's Regular Occupation:	36. Has Employee Returned to Regular Occupation: ☐ Yes ☐ No	
37. EMPLOYER'S Name (SEE INSTRUCTIONS ON REVERSE SIDE):	38. Title:	
39. EMPLOYER'S Signature (SEE INSTRUCTIONS ON REVERSE SIDE)	40. Date Prepared (mm/dd/yyyy):	

*Disclosure of Social Security Number is Voluntary. It will aid in the processing of your report.

THIS FORM DOES NOT CONSTITUTE AN EMPLOYEE'S CLAIM FOR BENEFITS UNDER WORKERS' COMPENSATION.

FORM 103

The Commonwealth of Massachusetts
Department of Industrial Accidents - Department 103

600 Washington Street - 7th Floor, Boston, Massachusetts 021 11
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.state.ma.us/dia

DIA Board #
(If Known):

INSURER'S NOTIFICATION OF PAYMENT

FILE THIS FORM WHEN WEEKLY BENEFITS ARE PAID WITHIN 14 DAYS OF INSURER'S RECEIPT OF A FIRST REPORT OF INJURY (FORM 101) OR AN INITIAL WRITTEN CLAIM FOR WEEKLY BENEFITS.
DO NOT FILE THIS FORM FOR MEDICAL ONLY CLAIMS

IMPORTANT INSTRUCTIONS AND CODES ON THE REVERSE SIDE- Please Print Legibly or Type -Unreadable forms will be returned.

INSURER

1. Insurance Carrier's Name and Address:	2. Self-insured?: ☐ Yes ☐ No
	3. Self-insurer Number:
4. Claim Representative's Name:	5. Claim Representative's Tel. Number & Ext. :
6. Insurer's Case File Number:	7. Did Insurer Receive First Report of Injury (Form 1 0 1): ☐ Yes ☐ No If Yes - Date Received (mm/dd/yyyy):

8. Did Insurer Receive a Written Claim for Benefits from the Employee?: ☐ Yes ☐ No If Yes - Date Received (mm/dd/yyyy):

EMPLOYEE

9. Employee's Name (Last, First, MI):	10. Employee's Social Security Number*:
11. Employee's Address (No. and Street, City, State, Zip Code):	12. Date of Birth (mm/dd/yyyy):

13. Employer's Name:

14. Employer's Address (No. and Street, City, State, Zip Code):

INJURY

15. DATE OF INJURY (mm/dd/yyyy):		16. Injury Code(s) / Body Part Code(s)
17. FIRST day of total or Partial Incapacity to Earn Wages (mm/dd/yyyy):	18. FIFTH day of total or Partial Incapacity to Earn Wages (mm/dd/yyyy):	a. to body part a. b. to body part b. c. to body part c.
19. If Employee has Died Date of Death:	20. Description (left leg ... lower back ... etc.)-	

COMPENSATION

21. ☐ ACCEPTED ☐ PAID WITHOUT PREJUDICE

Average Weekly Wage $ __________ ☐ Estimated ☐ Actual
(See M.G.L. Chapter 152, Section 1(1) for definition.)

Date Insurer Mailed First Payment (mm/dd/yyyy): __________ Amount Paid to Date: $ __________

Paid Through (mm/dd/yyyy): __________

	Type of Weekly Compensation	Weekly Compensation Paid
a. ☐	Total, Temporary Incapacity - Section 34	$ __________
b. ☐	Permanent & Total Incapacity - Section 34A	$ __________
c. ☐	Partial Incapacity - Section 35	$ __________
d. ☐	Dependency Coverage - Section 35A	$ __________
e. ☐	Survivor's Benefits - Section 31	$ __________

22. Insurer's Signature :	23. Date Prepared (mm/dd/yyyy):

*Disclosure of Social Security Number is Voluntary. It will aid in the processing of documents.

FORM 104

The Commonwealth of Massachusetts
Department of Industrial Accidents - Department 104
600 Washington Street - 7th Floor, Boston, Massachusetts 02111
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.state.ma.us/dia

DIA Board # (If Known):

INSURER'S NOTIFICATION OF DENIAL

THIS FORM MUST BE FILED WITH THE DIA WHEN WEEKLY BENEFITS ARE DENIED TO A CLAIMANT. A COPY OF THIS FORM MUST ALSO BE SENT TO THE CLAIMANT BY CERTIFIED MAIL.

IMPORTANT - INSTRUCTIONS ON THE REVERSE SIDE- **Please Print Legibly or Type - Unreadable forms will be returned.**

INSURER

1. Insurance Carrier's Name and Address:	2. Self-insured?: ☐Yes ☐No If Yes Please Give Self-insurer Number:
3. Name, Address and Board of Bar Overseers Number of Insurer's Attorney:	4. Telephone Number of Insurer's Attorney:
5. Claim Representative's Name:	6. Claim Representative's Tel. Number & Ext. :
7. Insurer's Case File Number:	8. Did Insurer Receive First Report of Injury (Form 101): ☐Yes ☐No - If Yes - Date Received (mm/dd/yyyy)

EMPLOYEE

9. Employee's Name (Last, First, M):	10. Employee's Social Security Number*:
11. Employee's Address (No. and Street, City, State, Zip Code):	12. Date of Birth (mm/dd/yyyy):
13. Employer's Name:	
14. Employer's Address (No. and Street, City, State, Zip Code):	
15. Date of Alleged Injury (mm/dd/yyyy):	16. If Employee has Died, Date of Death (mm/dd/yyyy):

GROUNDS FOR DENIAL

17. Specify grounds for denial and give a brief statement of the specific facts supporting the grounds for denial.
Failure to do so may cause loss of defenses under M.G.L. c 152, Sections 7(l) and 7(2).

A. ☐ No Personal Injury ____________________

B. ☐ No Injury Arising Out of and in the Course of Employment ____________________

C. ☐ No Disability ____________________

D. ☐ No Causal Relationship Between Personal Injury and Disability ____________________

G. ☐ Lack of Jurisdiction ____________________

X. ☐ Lack of Notice ____________________

Y. ☐ Late Claim ____________________

H. ☐ Other (Specify) ____________________

18. Insurer's Signature :	**19. Date Prepared (mm/dd/yyyy):**

*Disclosure of Social Security Number is Voluntary. It will aid in the processing of documents.

An Employee/Claimant seeking to secure benefits must use Department of Industrial Accidents Form 110 when filing a claim.

FORM 106

The Commonwealth of Massachusetts

Department of Industrial Accidents - Department 106
600 Washington Street - 7th Floor, Boston, Massachusetts 021 11
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.state.ma.us/dia

DIA Board #
(If Known):

INSURER'S NOTIFICATION OF TERMINATION OR MODIFICATION OF WEEKLY COMPENSATION DURING PAYMENT WITHOUT PREJUDICE PERIOD

CHECK ONE BOX: *TERMINATION* ☐ *MODIFICATION* ☐

FILE ONLY WHEN PAYMENT HAS BEEN MADE WITHIN 14 DAYS. AT LEAST 7 DAYS WRITTEN NOTICE MUST BE GIVEN TO EMPLOYEE OF THE INTENT TO STOP PAYMENTS, UNLESS BASED ON ACTUAL INCOME OF EMPLOYEE

INSURER

1. Insurance Carrier's Name and Address:	2. Self-insured?: ☐ Yes ☐ No If Yes Please Give Self-insurer Number:
3. Name & Address of Insurer's Attorney:	4. Telephone Number of Insurer's Attorney:
5. Claim Representative's Name:	6. Claim Representative's Tel. Number & Ext.:
7. Insurer's Case File Number:	8. Did Insurer Receive First Report of Injury (Form 101); ☐ Yes ☐ No - If Yes - Date Received (mm/dd/yyyy):

EMPLOYEE

9. Employee's Name (Last, First, MI):	10. Employee's Social Security Number*:
11. Employee's Address (No. and Street, City, State, Zip Code):	12. Date of Birth (mm/dd/yyyy): 13. Date of Injury (mm/dd/yyyy):
14. First Day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):	15. Fifth Day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):
16. Employer's Name & Address (No. and Street, City, State, Zip Code):	
17. Employer's Federal Tax ID #-	18. Employee Returned to Work: ☐ Yes ☐ No (If Yes - 7 days written notice not required) If Yes - Date of Return (mm/dd/yyyy): Employee's Income $______

GROUNDS

19. Specify grounds for termination and give a brief statement of the specific facts supporting the grounds for termination.
Failure to do so may cause loss of defenses under M.G.L. c 152, Sections 7(l) and 7(2).

A. ☐ No Personal Injury ______
B. ☐ No Injury Arising Out of and in the Course of Employment ______
C. ☐ No Disability ______
D. ☐ No Causal Relationship Between Personal Injury and Disability ______
G. ☐ Lack of Jurisdiction ______
X. ☐ Lack of Notice ______
Y. ☐ Late Claim ______
H. ☐ Other (Specify) ______

Use additional space on back of form if needed.

20. Last Date Through Which Payment Will Be Made (mm/dd/yyyy):	**21. Date of Notification of Termination or Modification to the Employee (mm/dd/yyyy):**

22. If this is a Modification rather than a Termination, please state the grounds and factual basis for the Modification and the prior rate(s) of weekly compensation paid and the Modification rate(s) of weekly compensation. ***Basis for Modification (use reverse side if needed).***

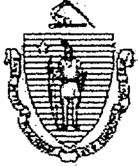
Prior Rate(s): $______ $______ ______

Modified Rate(s): $______ $______ ______

23. Insurer's Signature:	24. Date Prepared (mm/dd/yyyy):

***Disclosure of Social Security Number is Voluntary. It will aid in the processing of documents.**
Please Print Clearly or Type. Unreadable forms will be returned.

FORM 107



The Commonwealth of Massachusetts
Department of Industrial Accidents - Department 107

600 Washington Street - 7th Floor, Boston, Massachusetts 021 11
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.state.ma.us/dia

DIA Board # (If Known):

INSURER'S NOTIFICATION OF ACCEPTANCE, RESUMPTION OR TERMINATION OR MODIFICATION OF WEEKLY COMPENSATION

CHECK ONE BOX. ☐ *ACCEPTANCE* ☐ *RESUMPTION* ☐ *TERMINATION* ☐ *MODIFICATION*

USE FORM 106 AS NOTICE TO TERMINATE OR MODIFY WEEKLY PAYMENTS BEING MADE WITHOUT PREJUDICE UNDER M.G.L., CHAPTER 152 §8(1). *Please Print or Type.*

INSURER

1. Insurance Carrier's Name and Address:	2. Self-insured?: ☐ Yes ☐ No If Yes Please Give Self-insurer Number:
3. Name & Address of Insurer's Attorney:	4. Telephone Number of Insurer's Attorney:
5. Claim Representative's Name:	6. Claim Representative's Tel. Number & Ext.:
7. Insurer's Case File Number:	8. Did Insurer Receive First Report of Injury (Form 101); ☐ Yes ☐ No - If Yes - Date Received (mm/dd/yyyy):

EMPLOYEE

9. Employee's Name (Last, First, MI):	10. Employee's Social Security Number*:
11. Employee's Address (No. and Street, City, State, Zip Code):	12. Date of Birth (mm/dd/yyyy). **13. Date of Injury (mm/dd/yyyy):**
14. First Day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):	**15. Fifth Day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):**
16. Employer's Name & Address (No. and Street, City, State, Zip Code):	17. Employee's Average Weekly Wage: $______ ☐ Actual ☐ Estimated
18. Employee Returned to Work: ☐ Yes ☐ No If Yes - Date of Return (mm/dd/yyyy):	19. Date of Resumption, Modification, or Termination (mm/dd/yyyy)

BENEFITS

19. ☐ This is a Notice of Initial Acceptance of a Claim (ATTACH FORM 113).
☐ This is a Resumption/Modification of Payment of a Case Previously Accepted.
☐ This is a Resumption of Payment of a Case within the Payment Without Prejudice Period.
☐ This is a Resumption/Modification of Payment under §30G.

Type of Compensation Resumed or Modified	Former Weekly Compensation Rate	Resumed or Modified Weekly Compensation Rate
A. ☐ Temporary, Total Incapacity (§34)	$______	$______
B. ☐ Permanent & Total Incapacity (§34A)	$______	$______
C. ☐ Partial Incapacity (§35)	$______	$______
D. ☐ Dependency Coverage (§35A)	$______	$______
E. ☐ Survivor's Benefits (§31)	$______	$______

20. If the Insurer is Terminating or Suspending Payment of Weekly Benefits without the Assent of the Employee or the Dept. of Industrial Accidents, set out the Applicable Statutory Section and Factual Basis Therefore (continue on the reverse side if needed):

______

______

______

21. If the Insurer is Terminating or Modifying with the Assent of the Compensation Recipient, the Recipient's Signature is Required.

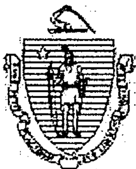
Signature of Recipient: ______

22. Insurer's Signature :	**23. Date Prepared (mm/dd/yyyy):**

***Disclosure of Social Security Number is Voluntary. It will aid in the processing of documents. Please Print Clearly or Type. Unreadable forms will be returned.**

Form 107 - Revised 8/2001 - **Reproduce as needed.**

FORM 108



The Commonwealth of Massachusetts
Department of Industrial Accidents - Department 108
600 Washington Street - 7th Floor, Boston, Massachusetts 02111
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.state.ma.us/dia

DIA Board # (If Known):

INSURER'S COMPLAINT FOR MODIFICATION, DISCONTINUANCE OR RECOUPMENT OF COMPENSATION

CHECK ONE BOX: ☐ *MODIFICATION* ☐ *DISCONTINUANCE* ☐ *RECOUPMENT*

INSURER MUST SEND A COPY OF THIS NOTICE TO THE EMPLOYEE AND THE EMPLOYEE'S REPRESENTATIVE

INSURER

1. Insurance Carrier's Name and Address:	2. Self-insured?: ☐ Yes ☐ No If Yes Please Give Self-insurer Number:
3. Name & Address of Insurer's Attorney:	4. Telephone Number of Insurer's Attorney:
5. Claim Representative's Name:	6. Claim Representative's Tel. Number & Ext.:
7. Insurer's Case File Number:	8. Did Insurer Receive First Report of Injury (Form 101); ☐ Yes ☐ No - If Yes - Date Received (mm/dd/yyyy):

EMPLOYEE

9. Employee's Name (Last, First, MI):	10. Employee's Social Security Number*:
11. Employee's Address (No. and Street, City, State, Zip Code):	12. Date of Birth (mm/dd/yyyy):
13. Date of Injury (mm/dd/yyyy):	14. First Day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):
15. Name, Address & Telephone Number of Employee's Attorney: Tel. Number -	
16. Employer's Name & Address (No. and Street, City, State, Zip Code):	

GROUNDS

17. This is the Insurer's Request to MODIFY Weekly Compensation ☐ Attach Proper Documents Under 452 CMR 1.07(I)

This is the Insurer's Request to DISCONTINUE Weekly Compensation ☐ Attach Proper Documents Under 452 CMR 1.07(J)

This is the Insurer's Request to RECOUP Weekly Compensation ☐ Attach Proper Documents Under 452 CMR 1.07(K)

18. Give Specific Basis for Complaint (continue on reverse side if necessary):

23. Insurer's Signature :	24. Date Prepared (mm/dd/yyyy):

*Disclosure of Social Security Number is Voluntary. It will aid in the processing of documents.
Please Print Clearly or Type. Unreadable forms will be returned.