Official Form 142

# STATEMENT OF SUSPENSION OF BENEFITS

Revised 7/2024

TO BE COMPLETED BY INSURANCE CARRIER OR SELF-INSURED EMPLOYER

**NOTICE TO INJURED WORKER:** This form is to notify you, the injured worker, of Suspension of Benefits of your industrial accident or occupational disease claim. If you have questions please contact the adjuster assigned to your claim as listed below. If further assistance is required you may then contact the Labor Commission, Division of Industrial Accidents.

**INJURED WORKER INFORMATION:**

| | | | | |
|---|---|---|---|---|
| Name: | | Phone: | | |
| Address: | | City: | State: | Zip: |
| SSN: | Claim Number: | Date of Injury: | | |
| Employer: | | Phone: | | |
| Employer Address: | | City: | State: | Zip: |
| Insurance Carrier: | | Claim Administrator: | | |
| Adjuster: | Phone: | Adjuster Email: | | |
| Adjuster Address: | | City: | State: | Zip: |
| Jurisdiction Claim Number (JCN): | | | | |
| Date of Filing: | | Effective Date: | | |

**REASON FOR SUSPENSION:**

| Full Suspension | Partial Suspension |
|---|---|
| ☐ S1- Returned to Work or Medically Determined/Qualified to Return to Work | ☐ P1- Returned to Work or Medically Determined/Qualified to Return to Work |
| ☐ Return/Release Date:_____ | Return/Release Date:_____ |
| ☐ S2- Medical Non-Compliance | ☐ P2- Medical Non-Compliance |
| ☐ S3- Administrative Non-Compliance | ☐ P3- Administrative Non-Compliance |
| ☐ S6- Claimant's Whereabouts Unknown | ☐ P7- Benefits Exhausted |
| ☐ S7- Benefits Exhausted | ☐ PJ- Pending Appeal or Judicial Review |
| ☐ SJ- Pending Appeal or Judicial Review | |

Reason Narrative**:**

**INSTRUCTIONS FOR INSURANCE CARRIER OR SELF-INSURED EMPLOYER:** This form is to be completed by the insurance carrier or self-insured employer according to the time frames listed below. A copy must be sent to the physician, if the physician is involved in any way with suspension of Temporary Total Disability compensation.

**Mandatory Reporting Requirements:**

Suspension Reasons P1 and S1: Carrier must send Form 142 to the injured worker within five (5) days of benefits being suspended.

All Other Suspension Reasons: Carrier must send Form 142 to the injured worker five (5) days before benefits are suspended. The benefits must continue to be paid until five (5) days following this notice being sent to the injured worker.

Labor Commission Filing: On claims with a date of injury of July 1, 2019 and forward the suspension must be filed with the Labor Commission using EDI. Claims prior to this date may be filed using EDI or on paper Form 142 and sent to the Division, if preferred.

UTAH LABOR COMMISSION
Industrial Accidents Division

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