

# Correcting Notice of Closure

Worker \_\_\_\_\_

① Date of closure (mailing date):

Worker name:

Date of injury:

Social Security no.:

Insurer's claim no.:

WCD file no.:

Employer:

**This is to advise you that your workers' compensation claim is now closed. As your insurer, we have reviewed medical and other information about your *accepted conditions* and have determined the extent of your disability. This closure applies to the most recent opening of your claim. If you have questions about this, you can call us or any of the contacts listed on the back of this notice.**

*Time loss and disability are determined based on Oregon law.*

② Date of NOC being corrected:

③

**Overpaid Workers' Compensation benefits may be deducted from any current or future Workers' Compensation benefits due a worker in accordance with ORS 656.268.**

④ Your condition became medically stationary on:

or

⑤ Date your claim qualified for closure for reasons other than becoming medically stationary:

⑥ Your aggravation rights end:

**⑦ IMPORTANT NOTICE: You and your insurer have the right to appeal this Notice of Closure by requesting reconsideration. You must make your request within 60 days from the mailing date of this notice *only* for those changes made by this notice. See the back of this notice for information on how to appeal. Your insurer's request for review is limited to the impairment findings (if changed by this order) and must be made within seven (7) days of the mailing date of this order. This correction becomes a part of and should be attached to the \_\_\_\_\_ Notice of Closure, which remains the same in all other respects. Your aggravation rights remain unchanged unless corrected by this order.**

cc:  Worker – regular mail       Employer       DCBS  
 Worker – certified mail (return receipt requested)       Insurer       Other:

***Important legal document. Keep in a safe place.***  
**See "NOTICE TO WORKER" on the back of this form.**

**1644c**

# NOTICE TO WORKER

THIS “CORRECTING NOTICE OF CLOSURE” IS A LEGAL DOCUMENT THAT CLOSES YOUR CLAIM. IT TELLS YOU THE PERIODS OF TIME YOU QUALIFIED FOR TEMPORARY DISABILITY (TIME LOSS) AND HOW MUCH PERMANENT DISABILITY YOU HAVE, IF ANY.

**APPEAL RIGHTS:** IF YOU DISAGREE WITH THIS CORRECTING NOTICE OF CLOSURE, YOU HAVE THE RIGHT TO APPEAL THE CLOSURE OF YOUR CLAIM BY ASKING FOR A RECONSIDERATION WITHIN 60 DAYS FROM THE MAILING DATE PRINTED IN BOX ① ON THE FRONT OF THIS FORM. IF YOU DO NOT APPEAL WITHIN 60 DAYS, YOU WILL LOSE ALL RIGHTS TO APPEAL YOUR CLAIM CLOSURE. FORM 2223A, “WORKER REQUEST FOR RECONSIDERATION,” IS AVAILABLE FROM THE WORKERS’ COMPENSATION DIVISION IN SALEM. CALL (503) 947-7816 OR WRITE TO THE WORKERS’ COMPENSATION DIVISION, APPELLATE REVIEW UNIT, 350 WINTER ST NE, P.O. BOX 14480, SALEM, OR 97309-0405. THIS FORM ALSO MAY BE ACCESSED FROM THE DIVISION’S WEB SITE: [HTTP://WCD.OREGON.GOV/POLICY/BULLETINS/FORMSBYNO.HTML](http://wcd.oregon.gov/policy/bulletins/formsbyno.html). AFTER COMPLETING THE FORM, MAIL IT OR DELIVER IT TO:

WORKERS’ COMPENSATION DIVISION, APPELLATE REVIEW UNIT, 350 WINTER ST. NE, P.O. BOX 14480, SALEM, OR 97309-0405

YOU HAVE THE RIGHT TO HAVE AN ATTORNEY REPRESENT YOU DURING THE APPEAL PROCESS.

## Frequently asked questions:

### What are “scheduled” and “unscheduled” disability?

*Scheduled disability* is the loss of use or function of an arm, hand, leg, or foot, or the loss of visual or hearing ability. These body parts are listed on a “schedule” in the Oregon law with specific dollar amounts allowed for each part or for a percentage of loss of use for each part.

*Unscheduled disability* involves impairment of body parts or systems (such as the back, hip, or respiratory system). In addition to impairment, the calculation of unscheduled disability may include factors such as age, education, work history, and current ability to perform work.

### What if I still need medical care?

The insurer is responsible for future medical services with some limitations. Your insurer or doctor should be able to tell you which medical services will be covered.

### How is a permanent disability award paid?

If an award is less than \$6,000, the insurer will pay the entire sum, less any overpayment it recovers, within 30 days from the mailing date of this notice. If the award is greater than \$6,000, it will be paid in monthly payments after the insurer recovers any overpayment. These payments will begin within 30 days of the mailing date of this notice. If you want the whole award paid to you at one time, you may ask the insurer for a “lump sum payment.” NOTE: If you ask for and accept a lump sum payment of an award that is greater than \$6,000, you waive your right to request reconsideration of your permanent disability award.

## More questions?

- If you have questions about either this Correcting Notice of Closure or your rights and responsibilities, contact the insurer at the address or phone number printed on the front of this notice.
- **THE OMBUDSMAN FOR INJURED WORKERS CAN HELP YOU UNDERSTAND YOUR RIGHTS. YOU MAY CALL THE OMBUDSMAN AT (503) 378-3351, TOLL-FREE (800) 927-1271, TTY (503) 947-7189, TO GET HELP OR TO SET UP AN APPOINTMENT.**
- You may also contact a benefit consultant at the Workers’ Compensation Division, (503) 947-7585, or toll-free in Oregon, (800) 452-0288.
  - ◆ There is no charge for assistance from the Ombudsman’s office or the Workers’ Compensation Division.
- You should have received the brochure *Understanding Claim Closure and Your Rights* with this Notice of Closure. Another brochure, *What happens if I’m hurt on the job?*, will give you additional information. To order these brochures, call (503) 947-7627.