Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002
800-332-2667

FORM C-26

NOTICE OF CHANGE OR TERMINATION OF COMPENSATION BENEFITS

This form is used by adjusters to notify workers' compensation claimants of a change or termination in the monetary amount of compensation benefits they will receive. This information must be provided to the Bureau, via EDI, within five (5) business days of the change or termination and to the claimant, using this form, simultaneously with the notice to the Bureau.

State File #: _____ Insurer Claim # _____

Claimant Name _____

Employer Name _____

Date of Injury _____ Date of Disability _____

CHANGE OF BENEFITS

Compensation benefit rate changed from $_____ to $_____

Reason for change: _____

_____

Date of change: _____Date claimant notified: _____

TERMINATION OF BENEFITS

Date benefits terminated _____ Date claimant notified: _____

Reason for termination: _____

_____

_____

INSURER/SELF-INSURER/TPA

_____

Adjuster Name (printed) Phone #

_____

Adjuster Email Address Date