NOTICE OF INTENT TO SUSPEND

Return to: Carrier or Self-Insured Employer Address

Date Mailed:

ICA Claim No.:

Soc. Sec. No.:

SSN not required if correct ICA claim number is provided

Claimant's First Name Last Name

Claimant's Address

Carrier Claim No.

Employer:

Date of Injury:

To the Claimant: You are required to report annually on the anniversary date of your award of permanent compensation benefits ALL OF YOUR EARNINGS for the 12 months prior. This report must be fully and accurately completed and signed by you and promptly returned to the Carrier or Self-Insured Employer at the address shown above. A.R.S. § 23-1047

Payment of further benefits will be suspended unless information called for in the space provided below is received in this office within THIRTY (30) DAYS from this date.

	MO. DAY YEAR		MO. DAY YEAR
Period		Through	

Name and Address of Employer *(Include Self Employment)*	Period Worked From	Through	Total Wages and other Earnings	Describe Work
			$	
			$	
			$	
			$	
			$	

MY TOTAL GROSS EARNINGS FOR THE ABOVE PERIOD WERE: $

Any person who knowingly makes a false statement or representation to obtain any compensation, benefit or payment is guilty of a class 6 felony and is subject to up to one and one-half years in prison, a fifty thousand dollar fine and forfeiture of benefits. By my signature below, I am applying for all benefits to which I may be entitled and I swear that the statements made on this application are true, correct and complete to the best of my knowledge.

Claimant's signature required _____ Date

Email address:

Current Residence

Street

Phone:

City State Zip Code

Address to which mail should be sent:

Street

City State Zip Code

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE