



DIA Board #  
(If Known):

**AGREEMENT TO EXTEND 180 DAY**  
**PAYMENT WITHOUT PREJUDICE PERIOD**

**FILE THIS FORM ONLY IF THE INSURER HAS PAID WEEKLY BENEFITS WITHIN 14 DAYS OF THE RECEIPT OF THE EMPLOYER'S FIRST REPORT OF INJURY (FORM 101) OR A CLAIM FOR WEEKLY BENEFITS (FORM 110)**  
 Please Print Legibly or Type - Unreadable forms will be returned.

<b>I N S U R E R</b>	1. Insurance Carrier's Name and Address:		2. Self-insured?: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes Please Give Self-insurer Number:	
	3. Claims Representative's Name:		4. Claims Representative's Tel. Number & Ext. :	
	5. Insurer's Case File Number:		6. Did Insurer Receive First Report of Injury (Form 101): <input type="checkbox"/> Yes <input type="checkbox"/> No - If Yes - Date Received (mm/dd/yyyy)	
<b>E M P L O Y E E</b>	7. Employee's Name (Last, First, MI):		8. Employee's Social Security Number*:	
	9. Employee's Address (No. and Street, City, State, Zip Code):		10. Date of Birth (mm/dd/yyyy):	
	11. Employer's Name :			
	<b>12. Date of Injury (mm/dd/yyyy):</b>			
<b>C O M P.</b>	13. First Day of Total or Partial Incapacity to Earn Wages:		14. Fifth Day of Total or Partial Incapacity to Earn Wages:	
	15. Has Insurer Made All Payments Since the First Date of Total or Partial Incapacity to Earn Wages?: <input type="checkbox"/> Yes <input type="checkbox"/> No			
	16. Last Day Payment Can Be Made Pursuant to This Extension - NOT TO EXCEED 1 YEAR from 1st day of incapacity per c. 152 Sec. 8(6) - (mm/dd/yyyy):			
<b>S I G N A T U R E S</b>	17. Preparer for Insurer (Please Print or Type):			
	18. Insurer's Signature ("On-File" is NOT acceptable. Must have signature.):		19. Date (mm/dd/yyyy):	
	20. Name and Address of Employee's Attorney:			
	21. Signature of Employee's Attorney:		22. Date (mm/dd/yyyy):	
	23. Employee's Signature:		24. Date (mm/dd/yyyy):	
<b>THIS AGREEMENT APPROVED AS NOT DETRIMENTAL TO THE EMPLOYEE'S CASE</b>				
25. Signature of Judge or Conciliator:			26. Date (mm/dd/yyyy):	