FORM 104

The Commonwealth of Massachusetts
Department of Industrial Accidents - Department 104
Lafayette City Center , 2 Avenue De Lafayette, Boston, MA 02111-1750
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www mass.gov/dia

DIA Board # (If Known): **7460-20**

Trans. ID: 660295

INSURER'S NOTIFICATION OF DENIAL

THIS FORM MUST BE FILED WITH THE DIA WHEN WEEKLY BENEFITS ARE DENIED TO A CLAIMANT. A COPY OF THIS FORM MUST ALSO BE SENT TO THE CLAIMANT BY CERTIFIED MAIL.

***IMPORTANT - INSTRUCTIONS ON THE REVERSE SIDE*- Please Print Legibly or Type - Unreadable forms will be returned.**

INSURER

1. Insurance Carrier's Name and Address:
TRAVELERS INDEMNITY COMPANY
TRAVELERS INSURANCE & CONSTITUTION STATE SERVICES INC, P (
BUFFALO, NY 14240

2. Self-Insured? ☐ Yes ☒ No
If Yes Please Give Self-insurer Number:

3. Name, Address, and Board of Bar Overseers Number of Insurer's Attorney:
NONE

4. Telephone Number of Insurer's Attorney:
NA

5. Claim Representative's Name:
[redacted]

6. Claim Representative's Tel. Number & Ext. :
[redacted]

7. Insurer's Case File Number:
[redacted]

8. Did Insurer Receive First Report of Injury (Form 101):
☐ Yes ☒ No - If Yes - Date Received (mm/dd/yyyy):

EMPLOYEE

9. Employee's Name (Last, First, MI):
[redacted] , [redacted]

10. Employee's Social Security Number*:
[redacted]

11. Employee's Address (No. and Street, City, State, & Zip Code):
[redacted]

12. Date of Birth (mm/dd/yyyy):
[redacted]

13. Employer's Name:
SELECT REHABILITATION INC

14. Employer's Address (No. and Street, City, State, & Zip Code):
2600 COMPASS RD
GLENVIEW, IL 60025

15. Date of Alleged Injury (mm/dd/yyyy): 03/20/2020

16. If Employee has Died, Date of Death (mm/dd/yyyy):

GROUNDS FOR DENIAL

17. Specify grounds for denial and give a brief statement of the specific facts supporting the grounds for denial.
Failure to do so may cause loss of defenses under M.G.L. c 152, Sections 7(1) and 7(2).

A. ☒ No Personal Injury INSUFFICIENT CREDIBLE EVIDENCE TO PROVE ANY ALLEGED PERSONAL INJURY SUSTAINED AS DEFINED UNDER SECTION 1(7A); ALL S. 1(7A) DEFENSES RAISED AND ALL OTHERS NOT YET DISCOVERED ARE I

B. ☒ No Injury Arising Out of and in the Course of Employment INSUFFICIENT CREDIBLE EVIDENCE TO PROVE ANY ALLEGED INJURY SUSTAINED IN THE COURSE AND SCOPE OF EMPLOYMENT. ALL S. 1(7A) DEFENSES RAISED AND

C. ☒ No Disability INSUFFICIENT CREDIBLE EVIDENCE TO PROVE ANY ALLEGED DISABILITY HAS RESULTED FROM OR IS CAUSED BY ANY ALLEGED PERSONAL INJURY, ALL S1(7A) DEFENSES RAISED AND ALL OTHERS NOT YET DISCO

D. ☒ No Causal Relationship Between Personal Injury and Disability INSUFFICIENT CREDIBLE EVIDENCE TO PROVE ANY CAUSAL RELATIONSHIP BETWEEN THE ALLEGED PERSONAL INJURY AND THE ALLEGED DISABILITY. ALL S1(7A) DE

E. ☐ Incorrect Insurer

F. ☐ Not an Employee

G. ☐ Lack of Jurisdiction

X. ☐ Lack of Notice

Y. ☐ Late Claim

H. ☒ Other (Specify) NATURE OF EMPLOYMENT IS SUCH THAT HAZARD OF CONTRACTING THE DISEASE IS NOT INHERENT IN EMPLOYMENT. SPECIFIC JOB DOES NOT MAKE THE CHANCES OF CONTRACTING DISEASE MATERIALLY GREATER T

18. Insurer's Signature:
[redacted]@TRAVELERS.COM

19. Date Prepared (mm/dd/yyyy):
04/23/2020

***Disclosure of Social Security Number is Voluntary. It will aid in the processing of documents.** Form 104 - Revised 8/2001 - **Reproduce as needed.**
An Employee/Claimant seeking to secure benefits must use Department of Industrial Accidents Form 110 when filing a claim.