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| --- | --- |
| Date Letter Sent | **Assessment of Overpayment** |

Claimant Name

Address Line 1

Address Line 2

Address Line 3

RE: Claim Claim Number

Dear Enter Claimant Name,

Information received reveals an overpayment in compensation benefits for the date(s) of Click or tap to enter a date through Click or tap to enter a date. The amount of the overpayment is $Enter amount of overpayment. Self-Insurers can assess overpayments in accordance with RCW 51.32.240. Overpayments can be deducted from future time-loss compensation or permanent partial disability benefits.

Mandatory free text box for explanation

Choose an item.

If you have questions about the action being taken, or have additional information you’d like to provide, please contact me at the phone number listed below. At that time, we can also make arrangements to repay the overpayment amount.

Sincerely,

|  |  |  |
| --- | --- | --- |
| Name |  | Enter Phone Number |
| Name |  | Phone Number |

|  |
| --- |
| **If you dispute the action being taken, you may write the Department of Labor & Industries within 60 days at:****Department of Labor & Industries****PO Box 44892****Olympia WA 98504-4892****Fax: 360-902-6900****Or go to: https://secure.Lni.wa.gov/ReportSelfInsuredEmployer/#** |