|  |  |
| --- | --- |
| Date Letter Sent | **Notice of Underpayment** |

Enter Claimant Name

Claimant Address Line 1

Claimant Address Line 2

Claimant Address Line 3

RE: Claim Enter Claim Number

Dear Enter Claimant Name,

Information received reveals an underpayment in compensation benefits for the date(s) of Click or tap to enter a date. through Click or tap to enter a date..

Mandatory free text box for explanation.

The amount of the underpayment is $Click or tap here to enter text.. Choose an item.

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.

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/#** |