

Date 10-6-198
Employee Rick A. Hollifield
Address 1042-A South Anza Street
City, State, Zip El Cajon, CA. 92020
Date of Injury 8-28-96

Claims Administrator ARGONAUT INSURANCE COMPANY
Address 9191 TOWNE CENTRE DRIVE, SUITE 375
City, State, Zip SAN DIEGO, CA. 92122
Telephone Number 619-657-0805

Claim Number 62x103499

Employer KAVVAS CONSTRUCTION CO., INC.

NOTICE REGARDING TEMPORARY DISABILITY BENEFITS

ARGONAUT INSURANCE COMPANY (Claims Administrator's Name)

is handling your workers' compensation claim on behalf of _____
KAVVAS CONSTRUCTION CO (Employer). This notice is to advise you of the status of **temporary disability**
payments for your workers' compensation injury of 8-28-96
Only the items completed below concern your benefits at this time.

Payments are beginning being resumed for temporary disability for the period from _____
through _____

The first payment is enclosed sent separately included in your paycheck. Your weekly compensation
rate is \$ _____ based on your earnings of \$ _____ per week. You may receive less
if you are earning partial wages. Payments will be sent to you every two weeks on _____
and will continue until you are able to return to work or your medical condition becomes permanent and stationary.

Although liability for your workers' compensation injury has been accepted, I cannot pay you temporary
disability benefits at this time because _____

Payments are ending because because are permanent and stationary and a qualified
injured worker.

Benefits paid to you total \$ 53,550.00. Benefits were paid to you as: temporary total disability

salary continuation temporary partial disability:

From 8-29-96 through 10-2-98 at \$ 490.00 per week

From _____ through _____ at \$ _____ per week

Please see the attached for (additional) periods paid.

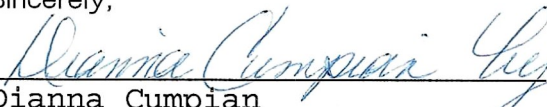
Additionally, you have received 10% self-imposed increases totalling \$ _____

Included in this amount is an overpayment totalling \$ _____. We are asserting credit for
the overpayment against _____

The State of California requires that you be given the following information: If you disagree with the decision,
you may consult with a State Information and Assistance Officer at 1-800-736-7401 or call your local Information
and Assistance Officer at _____. You may also consult with and be represented by an
attorney, and/or apply to have your case heard by the Workers' Compensation Appeals Board.

If you have questions, call me at 619-657-0805

Sincerely,



Dianna Cumpian, Claims Examiner

Enc: Benefits Pamphlet Explanation of salary continuation
 TD Fact Sheet Payment Record
 Employee Claim Form _____

cc: Applicant's Attorney
KAVVAS Construction
file/jd