

MUTUAL AGREEMENT (DWC-24)

General Instructions:

- Completed by: Employer/Insurer and Employee.
- Time Frame: No set time frame. Use whenever appropriate.
- Distribution: Original to Department of Labor and Training. Copy to each of the parties.
- Attachments: A completed Report of Indemnity Payment (DWC-22).

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check if sending in an amended form.

1. Employee Information:

- *SSN:* Employee's Social Security Number.
- *Name:* Employee's full name.
- *Address (including city, state, zip):* Employee's current mailing address.
- *Phone:* Employee's current home telephone number.

2. Claim Information:

- *Employer:* Employer's actual name where the employee was employed at the time of the injury.
- *Insurance Co.:* Name of the worker's compensation insurer OR 'Self-Insured' if the company has been certified as self-insured by DLT.
- *Claim Administrator:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
- *Injury Date:* Date that the accident happened.
- *Incapacity Date:* First full day that the employee lost from work (include weekends and holidays).

3. Indicate the action(s) of this Mutual Agreement:

- Check the appropriate box and enter requested information.
- **Note:** This form is no longer used for disfigurement or loss of use. See the [Report of Specific Payment \(DWC-51\)](#).
- *Employee Signature/Date – Employer/Insurer Signature/Date:* Both parties must sign and date this form.