

REPORT OF SPECIFIC PAYMENT (DWC-51)

General Instructions:

- Completed by: Claim Administrator
- Time Frame: The Report of Specific Payment should be filed with the Department of Labor and Training (DLT) within 10 days of payment. Payment must be mailed to claimant within 14 days of the entry of a decree, order, or agreement of the parties.
- Distribution: Original to DLT.
- Attachments: None.

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check if sending in an amended form.
 - *YOU MUST CHECK ONE OF THE FOLLOWING:*
 - *Lost Time:* Check if claimant received any weekly indemnity payments.
 - *No Lost Time:* Check if claimant did not receive any weekly indemnity payments.
 - *Federal Jurisdiction:* Check if claim was paid under Federal jurisdiction.
- 1. Employee:**
- *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.
 - *Date of Birth:* Date the employee was born.
- 2. Employer:**
- *FEIN:* Employer's Federal Employer Identification Number.
 - *Name:* Employer's actual name where the employee was employed at the time of the injury.
 - *Address (including city, state, zip):* Address of the employer's actual location.
 - *Phone/Ext:* Phone number and extension (if necessary) of the employer's facility.
- 3. Insurance company named on WC Policy:**
- *FEIN:* WC Insurance company's Federal Employer Identification Number.
 - *Name:* Name of the worker's compensation insurer OR 'Self-Insured' if the company has been certified as self-insured by DLT.
 - *Address (including city, state, zip):* Mailing address of the WC insurance carrier named on the WC Insurance Policy.
 - *Phone/Ext:* Phone number and extension (if necessary) of the named WC insurance carrier.
 - *RI License Number:* License number issued by the RI Department of Business Regulation (DBR).
- 4. Claim Administrator:** If this information is identical to the information in Block 3, check the 'Same' box. If different, proceed below.
- *FEIN:* Federal Employer Identification Number of the company administering the claim.
 - *Name:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
 - *Address (including city, state, zip):* Mailing address of the claim administrator.
 - *Phone/Ext:* Phone number and extension (if necessary) of the claim administrator.
 - *RI License or Self-Insurance Number:* License number issued by DBR or Self-Insurance Certificate number issued by DLT.
- 5. Claim Information:**
- *Injury date:* Date that the accident happened.
 - *Incapacity Date(if appropriate):* First full day that the employee lost from work (include weekends and holidays).
 - *Average Weekly Wage (including OT):* Claimant's total average weekly wage.
 - *Weekly Specific Rate:* Weekly rate used to pay specific.
 - *Specific paid by:*
 - *Pretrial Order or Decree/Date/Number:* Check appropriate box and enter date and Court-assigned number of document.
 - *Agreement of the Parties:* Check if appropriate.
 - *Description of Injury/Specific:* Describe what the specific payment is being made for.
- 6. Specific Payment Information:**
- *Indicate Payment Type/disfigurement or loss of use:* Check appropriate box(es).
 - *Body Part:* Enter appropriate part of body.
 - *Percent of Loss:* Enter percentage of loss.
 - *Number of Weeks:* Enter number of weeks being paid for that entry.
 - *Amount Paid:* Total amount paid for that entry.
 - *Date Paid:* Enter payment date for that entry.

 - *Hearing Loss/ Left/Right Ear-Occupational/Traumatic:* Check appropriate box(es).
 - *Total/Partial Deafness:* Check appropriate box(es).
 - *Number of Weeks:* Enter number of weeks being paid for that entry.
 - *Amount Paid:* Total amount paid for that entry.
 - *Date Paid:* Enter payment date for that entry.

 - *Employee Signature(Not required for Court Order)/Date:* If the Report has been paid by *Agreement of Parties*, this area is for the claimant to sign and date.
 - *Employer/Insurer Signature/Date:* Signature of employer or insurer and date prepared.