

Mutual Agreement (DWC-24)

A Mutual Agreement is a legal document that memorializes an agreement between the parties to change a Memorandum of Agreement as specified in RIGL § 28-35-6(b). A copy is provided to each party and filed with RI Department of Labor and Training, Division of Workers' Compensation.

Instructions:

Claim Administrator Claim number: provide the claim handler's claim number or file identification number.

Employee information:

- SSN or ID: provide the last 4 digits of the employee's social security number or the employee ID number assigned by DLT. DO NOT use a fictitious number.
- Date of birth: please enter the employee's date of birth.
- Name: provide the employee's last name, first name, and middle initial.
- Date of injury: enter the date of the injury or start of illness.
- Date of death: if the employee has died, enter the date of death.

Employer, Insurer and Claim Administrator information:

- Employer Business Name: enter the name of the employer's business.
- Insurer Business Name: enter the name of the licensed insurance company or self-insured employer.
- Claim Administrator: enter the business name of the company handling the claim, either the insurer or a third party administrator.

Amendment to Memorandum of Agreement.

- Indicate the agreed upon changes using the options listed on the form.
- Provide complete information for each change including amounts and dates as indicated
- Indicate any other amendment not listed on the form and specify the change.

Specific Injury Agreement

- Provide the details of any agreement on compensation for specific injuries. Use a separate line for each body part.
- Disfigurement: provide the disfigured body part, number of weeks of payment, weekly payment rate, total amount of the payment, and the date the payment is made.
- Loss of use: indicate the affected body part, percent of loss, number of weeks of payment, weekly payment rate, total amount of the payment, and the date the payment is made.
- Hearing Loss: indicate if hearing loss is for left, right or both ears. Specify the type of hearing loss as occupational or traumatic. Provide the percent of loss, number of weeks of payment, weekly payment rate, total amount of the payment, and the date the payment is made.

Signature Block. Both the employee and a representative for the claims administrator on behalf of the employer must sign this document and date the form.

A copy of the form must be provided to each party and filed with RI Department of Labor and Training, Division of Workers' Compensation.