State of Rhode Island
COORDINATION OF RETIREMENT BENEFITS

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. ____________

Claim Administrator Complete 1-6

Insurer File No.

1. EMPLOYEE:	2. EMPLOYER:
SSN	FEIN
Name	Name
Address	Address
City, State, Zip	City, State, Zip
Phone Date of Birth	Phone Ext.
3. INSURANCE COMPANY NAMED ON WC POLICY:	**4. CLAIM ADMINISTRATOR:** ☐ SAME AS BLOCK 3
FEIN	FEIN
Name	Name
Address	Address
City, State, Zip	City, State, Zip
Phone Ext.	Phone Ext.

5. INJURY INFORMATION:

Injury date: ____________ Age at the time of injury: ____________ Incapacity date: ____________

6. RATE INFORMATION:

Weekly workers' compensation indemnity amount: ____________

Employee/Employer Complete:

Please verify that the information above is correct. Complete this section, with signatures, and return entire form to claim administrator listed in Section 4 above.

7. RETIREMENT INFORMATION:	Retirement Benefits Paid By:
Retirement Date:	Company Name: Phone:
Total amount of <u>employee</u> contribution:	Address:
Weekly retirement amount:	City: State: Zip:

The information listed in Section 7 for the named employee is a true and accurate statement of retirement benefits to the best of my knowledge and ability.

Employer Signature: ______________________________ Date: ____________

Employee Signature: ______________________________ Date: ____________

Claim Administrator completes appropriate Section(s) below after completion of Section 7 by Employee/Employer

The offset provided for pursuant to RIGL §28-33-45 shall not be applicable to those collecting retirement benefits while collecting compensation benefits for an injury sustained before the age of fifty-five (55) years <u>and</u> more than five (5) years prior to the date of retirement. An employee shall not collect any indemnity benefits after his or her retirement for any injury sustained less than two (2) years prior to his or her retirement.

8. Based on the above, this employee is not eligible for continued workers' compensation benefits. ☐ *Check if appropriate*

9. EMPLOYEE DID CONTRIBUTE TO RETIREMENT:	10. EMPLOYEE DID <u>NOT</u> CONTRIBUTE *OR* OFFSET CALCULATION AFTER EMPLOYEE CONTRIBUTION:
Total amount of <u>employee</u> contribution: ____________	Weekly workers' compensation amount: ____________
Weekly retirement amount: ____________	Weekly retirement amount: ____________
Divide contribution by weekly retirement amount*: ____________	Subtract retirement from workers' compensation*: ____________
Dividing the employee contribution amount by the weekly retirement amount will result in the number of weeks **without any offset or reduction to the workers' compensation weekly indemnity amount. At <u>no</u> time is the retirement amount altered.*	**If the retirement amount is greater, the employee receives <u>no</u> workers' compensation monies. If the workers' compensation amount is greater, the employee receives the difference as their workers' compensation amount. At <u>no</u> time is the retirement amount altered.*

Print Adjuster Name: ______________________________ Date: ____________

A copy of this completed form shall be forwarded by the claim administrator to the RI Department of Labor and Training, Division of Workers' Compensation, the employer, and the employee and his or her attorney within ten (10) working days of the receipt of the form. Either party has a right to a review of any decision regarding coordination of benefits by the Workers' Compensation Court, pursuant to RIGL §28-35-11.