

**State of Rhode Island  
MEMORANDUM OF AGREEMENT**

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. \_\_\_\_\_

Insurer File No. \_\_\_\_\_

<b>1. EMPLOYEE:</b> SSN _____ Name _____ Address _____ Address _____ City, State, Zip _____ Phone _____ Date of Birth _____	<b>2. EMPLOYER:</b> FEIN _____ Name _____ Address _____ Address _____ City, State, Zip _____ Phone _____ Ext. _____
<b>3. INSURANCE COMPANY NAMED ON WC POLICY:</b> FEIN _____ Name _____ Address _____ Address _____ City, State, Zip _____ Phone _____ Ext. _____ RI License Number _____	<b>4. CLAIM ADMINISTRATOR:</b> <input type="checkbox"/> SAME AS BLOCK 3 FEIN _____ Name _____ Address _____ Address _____ City, State, Zip _____ Phone _____ Ext. _____ RI License or Self-Insurance Number _____
Injury date: _____ First date of first disability: _____ Place where injury occurred: _____	List injured body parts and nature of injury: _____

**5. DISABILITY TYPE:** (check all that apply)  Temporary Total as of \_\_\_\_\_  Temporary Partial as of \_\_\_\_\_  Death Benefits/Date of Death \_\_\_\_\_ Payable to: \_\_\_\_\_

Permanent Total as of \_\_\_\_\_

**6. RATE INFORMATION:**  Single  Married Number of Exemptions \_\_\_\_\_  
 AWW (include bonus/no OT) \_\_\_\_\_  
 Average Overtime Amount \_\_\_\_\_

AWW including Overtime \_\_\_\_\_ Number of Dependents \_\_\_\_\_  
 Spendable Base Wage \_\_\_\_\_ Weekly Dependency Rate \_\_\_\_\_  
 Base Compensation Rate \_\_\_\_\_ Total Weekly Rate \_\_\_\_\_

**7. DATE OF INITIAL PAYMENT UNDER MOA:** \_\_\_\_\_

Does employee have other employers?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, attach a wage statement from each employer.
Is this a recurrence of a previous injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Previous disability end date: _____
Has the employee worked at least 26 weeks prior to this recurrence?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, a new wage statement is required.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **RI Adjuster License Number:** \_\_\_\_\_ **Phone & Extension:** \_\_\_\_\_

**NOTICE TO EMPLOYEES RECEIVING WORKERS' COMPENSATION BENEFITS:**  
**YOU MUST REPORT ANY EARNINGS** you receive to the Claim Administrator that pays your benefits. Failure to report earnings may subject you to civil or criminal liability. Your endorsement on a benefit check is your statement that you are qualified to receive workers' compensation benefits. You are NOT entitled to receive workers' compensation benefits for any time that you are imprisoned as a result of a criminal conviction.

**ATTACH WAGE STATEMENT(S) AND DEPENDENCY FORM**