

Sample Forms

The following sample represents one type of claim that, initially, does not accept liability by using a Non-Prejudicial Agreement. The claim then accepts liability with a Memorandum of Agreement. Please understand that when a claim is closed without accepting liability, you will use a Report of Indemnity Payment (DWC-22) with the *Termination of Benefits under Non-Prejudicial Agreement* box checked.

This representation is meant to give you a sample of what various forms should look like when completed. Please refer to the Flow Chart and individual form instructions for more information.

State of Rhode Island

PLEASE CHECK IF CORRECTION OF PRIOR REPORT

EMPLOYER'S FIRST REPORT OF ALLEGED OCCUPATIONAL INJURY OR DISEASE

Department of Labor and Training, Division of Workers' Compensation

DWC No.

This number is assigned by DLT

PO Box 20190, Cranston, RI 02920-0942

If the insurer has a file number,

Phone (401) 462-8100 TDD (401) 462-8006 FAX (401) 462-8105

it can be put here.

Insurer File No.

1. EMPLOYER LOCATION:		2. EMPLOYER NAMED ON WC INSURANCE POLICY: <input type="checkbox"/> SAME AS BLOCK 1	
FEIN	05-1234567	FEIN	<p>If there is a company other than who is listed in Block 1 that is the employer named on the WC policy (ex: parent company), you must complete this entire section. If it is the same as Block 1, simply check the appropriate box in this section -- IN EITHER CASE, list the WC policy number.</p>
Name	ABC, Incorporated	Name	
Address	222 Main Street	Address	
City, State, Zip	Pleasantville, RI 02000	City, State, Zip	
Phone (401) 555-1000 Ext. 333	Type of Business Costume Jewelry Mfg.	Phone	
RI Unemployment Ins. No. 0007654321	NAICS 339914	WC Policy Number	0000098765

3. INSURANCE COMPANY NAMED ON WC POLICY:		4. CLAIM ADMINISTRATOR: <input type="checkbox"/> SAME AS BLOCK 3	
FEIN	05-2727272	FEIN	05-111222333
Name	Proper Insurance Company	Name	XYZ Adjusting Company
Address	333 Oak Road	Address	890 Elm Street, Suite 555
Address	Suite 001	Address	
City, State, Zip	Wherever, RI 02000	City, State, Zip	Somewhere, RI 02000
Phone (401) 555-0001	Ext. 456	Phone	(401) 555-1111

Note: Block 3 is for information on the actual insurance carrier named on the policy only.

5. EMPLOYEE INFORMATION:		6. MEDICAL INFORMATION:	
SSN	123-45-6789	<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Treatment Facility
Name	O. Sean State		Address
Address	123 Red Maple Lane		City, State, Zip
City, State, Zip	Anytown, RI 02000		Phone
Phone (401) 555-1234	Date of Birth	01/01/1950	Ext.
Occupation	Shipping Mgr.	Date Hired	3/3/2003
State of Hire	Rhode Island	Preferred Language of Employee: <input checked="" type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Portuguese <input type="checkbox"/> Other:	

If this information is available, please be sure to include.

7. WITNESS INFORMATION:		Include if available.	
Name		Phone	

8. INJURY INFORMATION:		What was person doing when injured?	
Injury Date	7/1/2003	Employee was loading boxes on a pallet when several boxes fell on top of him. Employee landed on left arm.	
Time injury occurred	2:30 <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		
Time employee began work	8:00 <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM		
1. First full day lost from work	7/2/2003 <input type="checkbox"/> NONE LOST	List injured body parts and nature of injury:(ex: Broken left finger, lower back strain)	
2. Date returned to work (if appropriate)			
3. Date employer notified of injury	7/1/2003		
If fatal - REPORT WITHIN 48 HOURS - Date of death		Broken Left Arm	

Complete address where accident occurred:

Place where injury/illness occurred: At employer location listed in Block 1 OR

Was this injury previously an incident-only with no medical treatment and no time lost? Yes No

If Yes, date employer first notified of medical treatment or time lost

Category(ies) of injury or illness: Injury Illness Occupational Disease Repetitive Trauma Occupational Hearing Loss Unknown

Print Name of Report Preparer	Date Prepared	Phone & Extension
Jane Smith	7/5/2003	(401) 555-1000 Ext. 333
Print Name of Employer Contact Person OR <input checked="" type="checkbox"/> Same as above		Phone & Extension

DWC	County	Time A	Time W	OCC	Nature	Part	Source	Type
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**State of Rhode Island
NON-PREJUDICIAL 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. This number is assigned by DLT
If the insurer has a file number, it can be put here.
Insurer File No. _____

1. EMPLOYEE: SSN <u>123-45-6789</u> Name <u>O. Sean State</u> Address <u>123 Red Maple Lane</u> Address _____ City, State, Zip <u>Anytown, RI 02000</u> Phone <u>(401) 555-1234</u> Date of Birth <u>01/01/1950</u>		2. EMPLOYER: FEIN <u>05-1234567</u> Name <u>ABC, Incorporated</u> Address <u>222 Main Street</u> Address _____ City, State, Zip <u>Pleasantville, RI 02000</u> Phone <u>(401) 555-1000</u> Ext. <u>333</u>	
3. INSURANCE COMPANY NAMED ON WC POLICY: FEIN <u>05-2727272</u> Name <u>Proper Insurance Company</u> Address <u>333 Oak Rd</u> Address <u>Suite 001</u> City, State, Zip <u>Wherever, RI 02000</u> Phone <u>(401) 555-0001</u> Ext. <u>456</u> RI License Number <u>0009876</u>		4. CLAIM ADMINISTRATOR: <input type="checkbox"/> SAME AS BLOCK 3 FEIN <u>05-111222333</u> Name <u>XYZ Adjusting Company</u> Address <u>890 Elm Street, Suite 555</u> Address _____ City, State, Zip <u>Somewhere, RI 02000</u> Phone <u>(401) 555-1111</u> Ext. <u>555</u> RI License or Self-Insurance Number <u>001234</u>	
Injury date: <u>7/1/2003</u> First date of first disability: <u>7/2/2003</u> Place where injury occurred: <u>Same as Block 2</u>		List injured body parts and nature of injury: <u>Compound fracture of left forearm</u>	

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

Temporary Partial as of 7/2/2003 Permanent Total as of _____

6. RATE INFORMATION: Single Married
 Number of Exemptions 4
 AWW (include bonus/no OT) \$534.52
 Average Overtime Amount \$22.14

AWW including Overtime \$556.66 Number of Dependents 2
 Spendable Base Wage \$494.67 Weekly Dependency Rate N/A
 Base Compensation Rate \$371.00 Total Weekly Rate \$371.00

7. DATE OF INITIAL PAYMENT: 7/15/2003

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

Signature: (Signature of Sally Seashell) Date: 7/14/2003

Print Name: Sally Seashell **RI Adjuster License Number:** (Do not use SSN - get another number from DBR) **Phone & Extension:** (401) 555-1111 ext. 555

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

Employee's Certificate of Dependency Status

Check if this is a corrected report

State of Rhode Island
 Department of Labor and Training
 Division of Workers' Compensation
 P. O. Box 20190
 Cranston, RI 02920-0942
 Phone (401) 462-8100 www.dlt.ri.gov/wc

DWC claim number **This number is assigned by DLT**

Claim Administrator **Put the insurer's or adjusting company's file number here**
 File Number

1. Employee information:		2. Claim information:	
SSN: XXX-XX- 6789	<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Employer name	ABC, incorporated
Name	O. Sean State	Claim Administrator	XYZ Adjusting Company
Address	123 Red Maple Lane	Address	890 Elm St, Ste 555
City, ST Zip	Anytown, RI 02000	City, ST Zip	Somewhere, RI 02900
Phone (401) 555-1234	Date of Birth 1/1/1950	Injury Date 7/1/2003	Incapacity Date 7/2/2003

Employee: complete this form and return it to the Claim Administrator.
 This information is needed to calculate your compensation rate.

3. Marital Status At the time of the injury the employee was Single Married
 Spouse works Spouse does not work Spouse's name Hope State

4. Number of Federal Exemptions Enter the maximum number of Federal Exemptions you are allowed to claim for Federal income tax. Include yourself, your spouse, your dependents, and any other exemptions.

5. Dependents A dependent for workers' compensation includes children you support who are:

- Under age 18, or age 18 to 23 and a full time student
- Mentally or physically incapacitated from earning at any age

Dependent's Name	Date of Birth	Relationship	Full time student?
Violet State	2/2/1984	Daughter	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Bowen State	3/3/1989		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Employee's Signature	(Signature of O. Sean State)	Date	7/2/2003
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State of Rhode Island
FULL-TIME WAGE STATEMENT (Hired for 20 hours or more per week)

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. This number is assigned by DLT
 Insurer File No. If the insurer has a file number, it can be put here.

1. EMPLOYEE INFORMATION:

SSN 123-45-6789
 Name O. Sean State
 Hired for 40 hours each week (Approximate)
 Are these supplemental wages? Yes No
 If yes, supplemental employer name: _____
 Maximum no. of exemptions 4 Single Married

2. CLAIM INFORMATION:

Employer ABC, Incorporated
 Insurance Co. Proper Insurance Company
 Claim Administrator XYZ Adjusting Company
 Injury date 07/01/2003
 Incapacity date 07/02/2003
 Hire date 3/3/2003

3. EMPLOYED LESS THAN 2 WEEKS:

<p>If Yes:</p> <p>1. List agreed upon hourly wage _____</p> <p>2. Number of hrs. per week for full-time employees _____</p> <p>3. Multiply #1 by #2 for average weekly wage _____</p>	<p>OR:</p> <p>Give average weekly for same or similar employment: _____</p>
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4. EMPLOYED MORE THAN 2 WEEKS:

On the left side of the form, list gross wages prior to employee's first full day out of work. DO NOT include their week of hire or week of injury *unless* a full week was worked. DO NOT SKIP WEEKS. Please calculate any overtime and/or bonus paid SEPARATELY on the right side of the form below.

LIST 13 CONSECUTIVE WEEKS:				BONUS AND OVERTIME CALCULATION:	
Week Number	Week Ending Date	No. of standard hrs. worked	Gross Wages (No Overtime)		
1	6/28/2003	38	560.88	Number of weeks employed (up to 52)	Block 1 17
2	6/21/2003	VAC	UNPAID	Total BONUS amount paid in past 52 weeks	Block 2 \$1,050.00
3	6/14/2003	10	147.60	Divide Block 2 by Block 1 for average bonus	Block 3 \$61.76
4	6/7/2003	44 NO OT	649.44	Total OVERTIME amount paid in past 52 weeks	Block 4 \$376.38
5	5/31/2003	40	590.40	Divide Block 4 by Block 1 for average overtime	Block 5 \$22.14
6	5/24/2003	40	590.40		
7	5/17/2003	SICK	590.40		
8	5/10/2003	16	236.16		
9	5/3/2003	VAC	300.00		
10	4/26/2003	32	472.32		
11	4/19/2003	0	0.00		
12	4/12/2003	32	472.32		
13	4/5/2003	40	590.40		
Total number usable weeks: 11		Total earnings: \$5,200.32		CALCULATION OF AVERAGE WEEKLY WAGE (AWW):	
				1. Total earnings from 13 weeks	\$5,200.32
				2. Total number usable weeks	11
				3. Divide total earnings by number of usable weeks	\$472.76
				4. Average bonus (Block 3 in BONUS AND OT)	\$61.76
				5. Add 3 and 4 for AWW excluding Overtime	\$534.52
				6. Average overtime (Block 5 in BONUS AND OT)	\$22.14
				7. Add 5 and 6 for Total Average Weekly Wage	\$556.66

Print Preparer Name: John Doe	Date: 7/7/2003	Print Adjuster Name: Sally Seashell	Date: 7/11/2003
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**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. This number is assigned by DLT
If the insurer has a file number, Insurer File No. it can be put here.

1. EMPLOYEE: SSN <u>123-45-6789</u> Name <u>O. Sean State</u> Address <u>123 Red Maple Lane</u> Address City, State, Zip <u>Anytown, RI 02000</u> Phone <u>(401) 555-1234</u> Date of Birth <u>01/01/1950</u>		2. EMPLOYER: FEIN <u>05-1234567</u> Name <u>ABC, Incorporated</u> Address <u>222 Main Street</u> Address City, State, Zip <u>Pleasantville, RI 02000</u> Phone <u>(401) 555-1000</u> Ext. <u>333</u>	
3. INSURANCE COMPANY NAMED ON WC POLICY: FEIN <u>05-2727272</u> Name <u>Proper Insurance Company</u> Address <u>333 Oak Rd</u> Block 3 is for information on the actual insurance carrier named on the policy. Address <u>Suite 001</u> City, State, Zip <u>Wherever, RI 02000</u> Phone <u>(401) 555-0001</u> Ext. <u>456</u> RI License Number <u>0009876</u>		4. CLAIM ADMINISTRATOR: <input type="checkbox"/> SAME AS BLOCK 3 FEIN <u>05-111222333</u> Name <u>XYZ Adjusting Company</u> Address <u>890 Elm Street, Suite 555</u> Address City, State, Zip <u>Somewhere, RI 02000</u> Phone <u>(401) 555-1111</u> Ext. <u>555</u> RI License or Self-Insurance Number <u>001234</u>	
Injury date: <u>7/1/2003</u>		List injured body parts and nature of injury: <u>Compound fracture of left forearm</u>	
First date of first disability: <u>7/2/2003</u>			
Place where injury occurred: <u>Same as Block 2</u>			

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

Temporary Partial as of 7/2/2003 Permanent Total as of _____

6. RATE INFORMATION: Single Married Number of Exemptions 4
 AWW (include bonus/no OT) \$534.52
 Average Overtime Amount \$22.14

AWW including Overtime \$556.66 Number of Dependents 2
 Spendable Base Wage \$494.67 Weekly Dependency Rate N/A
 Base Compensation Rate \$371.00 Total Weekly Rate \$371.00

7. DATE OF INITIAL PAYMENT UNDER MOA: 7/25/2003

Does employee have other employers? <input type="checkbox"/> Yes <input checked="" 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 checked="" 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: (Signature of Sally Seashell) Date: 7/25/2003

Print Name: Sally Seashell RI Adjuster License Number: (Do not use SSN - get another number from DBR) Phone & Extension: (401) 555-1111 ext. 555

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

State of Rhode Island
SUSPENSION AGREEMENT AND RECEIPT

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. This number is assigned by DLT
Insurer File No. If the insurer has a file number, it can be put here.

1. EMPLOYEE INFORMATION:

SSN 123-45-6789
Name O. Sean State
Address 123 Red Maple Lane
City, State, Zip Anytown, RI 02000
Phone (401) 555-1234

2. CLAIM INFORMATION:

Employer ABC, Incorporated
Insurance Co. Proper Insurance Company
Claim Administrator XYZ Adjusting Company
Injury date 07/01/2003
Incapacity date 07/02/2003

We agree that weekly compensation which began on July 2, 2003 (date of incapacity) will end as of August 16, 2003 (date paid through). Payment of medical bills related to this injury may continue. Completing and signing this form does not prevent the employee from claiming future weekly compensation benefits in the event that the employee is unable to work due to this injury.

Employee Signature:

(Signature of O. Sean State)

Date:

August 19, 2003

Employer/Insurer Signature:

(Signature of Sally Seashell)

Date:

August 19, 2003

**State of Rhode Island
REPORT OF SPECIFIC PAYMENT**

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. This number is assigned by DLT
Insurer File No. If the insurer has a file number, it can be put here.

YOU **MUST** CHECK ONE OF THE FOLLOWING:

LOST TIME **NO LOST TIME** **FEDERAL JURISDICTION**

1. EMPLOYEE: SSN <u>123-45-6789</u> Name <u>O. Sean State</u> Address <u>123 Red Maple Lane</u> Address City, State, Zip <u>Anytown, RI 02000</u> Phone <u>(401) 555-1234</u> Date of Birth <u>01/01/1950</u>		2. EMPLOYER: FEIN <u>05-1234567</u> Name <u>ABC, Incorporated</u> Address <u>222 Main Street</u> Address City, State, Zip <u>Pleasantville, RI 02000</u> Phone <u>(401) 555-1000</u> Ext. <u>333</u>	
3. INSURANCE COMPANY NAMED ON WC POLICY: FEIN <u>05-2727272</u> Name <u>Proper Insurance Company</u> Address <u>333 Oak Rd</u> Address <u>Suite 001</u> City, State, Zip <u>Wherever, RI 02000</u> Phone <u>(401) 555-0001</u> Ext. <u>456</u> RI License Number <u>0009876</u>		4. CLAIM ADMINISTRATOR: <input type="checkbox"/> SAME AS BLOCK 3 FEIN <u>05-111222333</u> Name <u>XYZ Adjusting Company</u> Address <u>890 Elm Street, Suite 555</u> Address City, State, Zip <u>Somewhere, RI 02000</u> Phone <u>(401) 555-1111</u> Ext. <u>555</u> RI License or Self-Insurance Number <u>001234</u>	

5. CLAIM INFORMATION:

Injury date 7/1/2003 Incapacity date (if appropriate) 7/2/2003
 Average Weekly Wage(including OT) \$556.66 Weekly Specific Rate \$90.00
 Specific paid by: Court Order Date: _____ Number: _____ OR Agreement of the Parties
 Description of Injury/Specific: 3 inch scar to left forearm

Attorney Fee: _____

6. SPECIFIC PAYMENT INFORMATION:

Indicate Payment Type	Body Part	Percent of Loss	Number of Weeks	Amount Paid	Date Paid
<input checked="" type="checkbox"/> disfigurement <input type="checkbox"/> loss of use	<u>Left Arm</u>		<u>30</u>	<u>\$2,700.00</u>	<u>11/20/2003</u>
<input type="checkbox"/> disfigurement <input type="checkbox"/> loss of use					
<input type="checkbox"/> disfigurement <input type="checkbox"/> loss of use					

Hearing Loss		Total/Partial Deafness	Number of Weeks	Amount Paid	Date Paid
Left Ear	<input type="checkbox"/> occupational <input type="checkbox"/> traumatic	<input type="checkbox"/> total <input type="checkbox"/> partial			
Right Ear	<input type="checkbox"/> occupational <input type="checkbox"/> traumatic	<input type="checkbox"/> total <input type="checkbox"/> partial			

Employee Signature: (Not required for Court Order) <u>(Signature of O. Sean State)</u>	Date: <u>11/20/2003</u>	Employer/Insurer Signature: <u>(Signature of Sally Seashell)</u>	Date: <u>11/20/2003</u>
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