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 TTY (Relay RI): 711

DWC No. _____

Insurer File No. _____

1. EMPLOYEE INFORMATION:

SSN or ID
Last four digits only XXX-XX-_____

Name _____

Address _____

City, State, Zip _____

Phone _____

2. CLAIM INFORMATION:

Employer _____

Insurance Co. _____

Claim Administrator _____

Injury date _____

Incapacity date _____

We agree that weekly compensation which began on _____(date of incapacity) will end as of _____(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: Date:

Employer or Insurer Signature: Date:

Under RIGL § 28-35-7.1 , if the employee and insurer agree to end workers' compensation benefits paid **with liability**, the parties must sign Suspension Agreement and Receipt (form DWC-05). The Suspension Agreement and Receipt must be filed with The Department of Labor and Training (DLT) with copies to each of the parties. The Suspension Agreement and Receipt is binding upon filing with The Department of Labor and Training. If benefits were paid **without liability** under a Nonprejudicial Agreement, file a Termination of Benefits Form DWC-21 instead of a Suspension Agreement and Receipt Form DWC-05.

DLT also requires an electronic Subsequent Report of Injury (SROI) suspension form be submitted detailing the benefits paid to date.

Top of form:

- Correction Box: Check if this document is correcting a document previously filed.
- DWC No: For RI DLT use only. Please leave blank.
- Insurer File Number: Provide the claim number or file identification number for the company handling the claim: the insurer, self-insured employer or third party administrator.

Employee information:

- SSN: provide ***at most*** the last 4 digits of the employee's social security number or the employee ID number assigned by RIDLT. DO NOT USE A FICTITIOUS NUMBER. Please contact RI DLT to obtain an assigned employee ID number.
- Name: enter the employee's first name, middle initial and last name.
- Address: give the employee's mailing address, city, state and zip.
- Phone: provide the employee's telephone number if known.

Claim Information:

- Employer: enter the employer's business name
- Insurance Co.: enter the name of the licensed insurer named on the workers' compensation policy or the self-insured employer's name
- Claim Administrator: give the name of the company handling the claim
- Injury date: provide the date of injury
- Incapacity date: provide the first date the employee was unable to work due to the injury

Agreement:

- Date of incapacity: provide the first date the employee was unable to work due to the injury including any waiting period.
- Date paid through: provide the last date through which the employee is due benefits for this injury.
- The employee must sign and date this form.
- The employer or insurer must sign and date this form.

RIDLT accepts any digital signature solutions that conform to current standards for integrity and authenticity. However, typed names in lieu of signatures do not meet this standard **and will not be accepted.**