DLT Department of Labor and Training
RHODE ISLAND

Termination of Benefits

RI Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 www.dlt.ri.gov/wc
Phone: (401) 462-8100 Fax: (401) 462-8105 TTY (Relay RI): 711

Claim Administrator Claim Number

Employee Information			Employer Information		
SSN or ID (Last four digits only) XXX-XX-	Date of Birth		Employer FEIN		
Last Name	First Name	Initial	Employer Business Name		
Address			Address		
City	State	Zip	City	State	Zip
Date of Injury	Date of Death		Employer Phone		
Insurer Information			**Claim Administrator Information**		
Insurer FEIN			Claims Administrator FEIN		
Insurer Business Name			Claim Administrator Business Name		
Address			Address		
City	State	Zip	City	State	Zip
Insurer Phone			Claim Administrator Phone		

Incapacity Information	
Date Disability Began	Date Disability Ended

Notice to Employees Receiving Workers' Compensation Benefits:

Weekly compensation payments have ended. The employer and insurer have not accepted liability for this claim. To protect any rights you may have to future weekly compensation payments and payment for medical expenses, a petition must be filed with the Workers' Compensation Court within two (2) years of the first date of incapacity.

Claims Adjuster Signature	Printed Name	Date

The Termination of Benefits is a legal document required when weekly indemnity benefits paid **without liability** under a Non-prejudicial Agreement are stopped. RIGL § 28-35-8 requires the insurer to send a Termination of Benefits form to the employee, his or her attorney, and The Department of Labor and Training (DLT) within 10 days of the date benefits end. If benefits were paid **with liability** under a Memorandum of Agreement, file a Suspension Agreement and Receipt Form DWC-05 instead of a Termination of Benefits Form DWC-21.

The insurer must also submit a Subsequent Report of Injury (DWC-52 or electronic) with payment details to DLT when benefits end.

Claim Administrator Claim 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 or ID: provide ***at most*** 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: enter the employee's last name, first name and middle initial.
- Address: enter the employee's mailing address including city, state and zip.
- 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 information: Please provide the employer's Federal Employer Identification Number, employer business name, employer business address and phone number.

Insurer information: Provide information for the licensed insurer named on the workers' compensation policy or the self-insured employer's name. Include the insurer business name, insurer business address and phone number.

Claim Administrator information: Supply information for the company handling the claim. Provide the claim administrator business name, address, and phone number.

Incapacity Information: Provide information for this period of disability.

- Date disability began: enter the first date of this disability period. If this is the first disability period, this is the first day of the waiting period.
- Date disability ended: provide the last date for which the employee was paid benefits for this disability period.

Signature Block. The claim adjuster must sign this document, print his or her name, and date the 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.**

Send the document to the employee, the employee's attorney, and the DLT within 10 days of the end of payments.

Revised 01/2021