State of Rhode Island
REPORT OF EARNINGS

Department of Labor and Training, Division of Workers' Compensation
Phone (401) 462-8100 TDD (401) 462-8006

Insurer File No. ____________

1. EMPLOYEE INFORMATION:

SSN ____________
Name ____________
Address ____________
City, State, Zip ____________
Phone ____________

2. CLAIM ADMINISTRATOR:

FEIN ____________
Name ____________
Address ____________
City, State, Zip ____________
Phone ____________ Ext.

This report covers the time period from: ____________ **to:** **PRESENT**

3. NOTICE TO EMPLOYEES RECEIVING WORKERS' COMPENSATION:

If you are receiving weekly workers' compensation benefits, YOU MUST REPORT ANY EARNINGS YOU RECEIVE TO THE CLAIM ADMINISTRATOR THAT IS PAYING YOUR BENEFITS. "Earnings" include any cash, wages, or salary received from self-employment or from any employer other than the employer where you were injured. Earnings also include commissions, bonuses, and the cash value for all payments received in any form other than cash (for example: a building custodian receiving a rent-free apartment).

Your endorsement on a benefit check or deposit of the check into an account is your statement that you are entitled to receive workers' compensation benefits. Your signature on a benefit check is a further affirmation that you have made no false claims or statements or concealed any material fact regarding your workers' compensation claim.

You must report any work for any business or person, even if the business or person lost money or if profits or income were reinvested or paid to others. If you performed any duties for any business or person for which you were not paid, you must show a rate of pay of what it would have cost the employer to hire someone to perform the work you did, even if your work was for yourself, a relative, or friend.

You are NOT entitled to workers' compensation benefits for any time you are imprisoned as a result of a criminal conviction.

4. Employee Complete:

1. Did you receive earnings or payments during the above period? State YES or NO: ____________
2. Did you perform non-paid work activities during the above period? State YES or NO: ____________

If you answered NO to BOTH questions, sign, date and return the form to the CLAIM ADMINISTRATOR above.

If you answered YES to EITHER question, complete the following:

Employer Name ____________ Self-Employed? ☐ Yes ☐ No
Address ____________ Nature of business ____________
City ____________ State ____________ Zip Code ____________ Phone ____________

5. Earnings Received:

Report pre-tax earnings. Include any cash, bonus, commission, and the cash value of any payment received in any form other than cash. *Attach additional pages if necessary.*

Date Earned:	Amount:	Date Earned:	Amount:	Date Earned:	Amount:	Date Earned:	Amount:

Failure to report earnings as defined will subject you to criminal prosecution and civil liability including the suspension or forfeiture of your benefits. This form MUST BE SIGNED, DATED and returned to the Claim Administrator -- EVEN IF YOU HAVE NO EARNINGS.

Employee Signature: ____________ Date: ____________

Witness Signature: ____________ Date: ____________

DWC-25 (01/03) *For instructions visit our web site: www.dlt.ri.gov/wc*

The claim administrator (the company handling the claim: the insurer, self-insured employer or third party administrator) sends the form to the employee to complete at the beginning of a claim, at reasonable intervals throughout the claim, and at the end of a claim. The employee completes the form and **returns it to the claim administrator.**

Top of form:

- 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.

1. Employee Information. The claim administrator completes section 1.
   - SSN: enter at least 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.
   - Name: enter the employee's first name, middle initial and last name.
   - Address: complete the employee's street address, city, state and zip code.
   - Provide the employee's phone number if available.

2. Claim Administrator Information. The claim administrator completes section 2.
   - Complete the information for the company handling the claim. Provide the claim administrator business name, mailing address, and phone number.
   - Reporting period. From date: enter the first day the employee lost time from work due to the injury (incapacity date).

3. Notice to Employees Receiving Workers' Compensation: Employee should read the complete notice.

4. Employee Complete:
   - Read the questions and WRITE IN either YES or NO.
   - If you answered NO to BOTH questions, sign and date the form. Return the completed form to the **claim administrator** (not to RI Department of Labor and Training).
   - If you answered YES to either question, complete the employer and earnings information.
   - Employer information: give the business name and address of the employer that provided the earnings.

5. The employee reports earnings received: give the date of earnings and amount received. Attach another page if needed.

Signature:

- The employee must sign and date the form.
- A witness to the employee's signature must sign and date the form.

Return the form to the **<u>CLAIM ADMINISTRATOR</u>**, not to the Department of Labor & Training.