State of Rhode Island
EMPLOYEE'S OBJECTION TO WAGE TRANSCRIPT

☐ 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. _____

1. EMPLOYEE INFORMATION:

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

2. CLAIM INFORMATION:

Employer _____
Insurance Co. _____
Claim Administrator _____
Injury date _____
Incapacity date _____

The employee objects to the discontinuance or reduction of workers' compensation benefits pursuant to RIGL Section 28-35-47 and requests a review by the Workers' Compensation Court, pursuant to RIGL Section 28-35-51.

Employee: Date:

RIGL § 28-35-47 allows indemnity benefits to be discontinued upon filing of a wage transcript showing the employee returned to work for at least two consecutive weeks and earned as much or more than earnings at the time of the injury, excluding overtime. The employee may file this objection within two weeks of the wage transcript to refer the matter to court.

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.

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.
   - Phone: Provide the employee's phone number if available.

2. Claim Information. The claim administrator completes section 2.
   - Employer: enter the company name of the injured worker's employer at the time of the injury.
   - Insurance Co: enter the name of the licensed insurance company or self-insured employer.
   - Claim Administrator: enter the company name of the party handling the claim.
   - Injury Date: enter the injury date.
   - Incapacity Date: enter the incapacity date, which is the first full day that the employee was unable to work.

Signature. The employee must sign and date the form.