State of Rhode Island

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

EMPLOYEE'S OBJECTION TO WAGE TRANSCRIPT

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

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 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.
   - 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.

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.**