## Agreement For Electronic Payment of Workers' Compensation Benefits

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

Claim Administrator Claim Number

| Employee Information | | | Employer, Insurer & Claim Administrator |
|---|---|---|---|
| SSN or ID (Last four digits only) XXX-XX- | Date of Birth mm/dd/yyyy | | Employer Name |
| Last Name | First Name | Initial | Insurer Name |
| Date of Injury | Date of Incap | | Claim Administrator Name |

RIGL § 28-35-40 allows for workers' compensation benefits to be paid by an electronic fund transfer or the issuance of an electronic access device if mutually agreed upon by both the employee and the employer or its insurer. By signing below, the employee and employer/insurer mutually agree to such electronic payment of workers' compensation benefits. This agreement may be rescinded at will by either party by signing the rescission form (DWC-EB2).

| Employee Signature Date (mm/dd/yyyy) | Signature of Employer/Insurer by its Claim Adjuster Date (mm/dd/yyyy) |
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| | |

**(Employee signature also required below)**

**NOTICE TO EMPLOYEES REGARDING THE EFFECT OF SIGNING THIS AGREEMENT FOR THE ELECTRONIC PAYMENT OF WORKERS' COMPENSATION BENEFITS:**

You are hereby advised that by signing this agreement, you are certifying that each time you accept an electronic payment you are entitled to receive workers' compensation benefits under the Workers' Compensation Act and have made no false claims or statements or concealed any material fact in connection therewith. You are NOT ENTITLED to receive workers' compensation benefits for any time that you are imprisoned as a result of a criminal conviction.

Furthermore, any injured worker receiving workers' compensation benefits who returns to work and receives earnings, which include wages, salary, commissions, bonuses, cash and/or any other compensation other than money, MUST REPORT SUCH EARNINGS TO THE EMPLOYER'S CLAIM ADMINISTRATOR IMMEDIATELY. ANYONE WHO FAILS TO REPORT SUCH EARNINGS, MAY BE CRIMINALLY PROSECUTED AND SENT TO PRISON, DISQUALIFIED FROM RECEIVING FUTURE BENEFITS AND/OR BE SUBJECT TO OTHER PENALTIES, INCLUDING REPAYMENT OF BENEFITS.

I UNDERSTAND THAT EXECUTION OF THIS AGREEMENT AND ACCEPTANCE OF ELECTRONIC PAYMENT OF WORKERS' COMPENSATION BENEFITS CONSTITUTES MY AFFIRMATION THAT I AM RECEIVING SUCH WORKERS' COMPENSATION BENEFITS PURSUANT TO LAW, THAT I HAVE MADE NO FALSE CLAIMS OR STATEMENTS OR CONCEALED ANY MATERIAL FACT IN ORDER TO RECEIVE SUCH BENEFITS, AND THAT DOING SO WOULD MAKE ME LIABLE FOR CIVIL AND CRIMINAL PENALTIES, INCLUDING JAIL.

Accepted and agreed to by:

Employee Signature Date: (mm/dd/yyyy)

The Employee should return this form to the Claim Administrator. The Employer/Insurer is required to file this completed form with the RI DLT. Please allow at least fourteen (14) days from the date that this Agreement is returned by you to your Claim Adjuster in order to establish your electronic payment. You may continue to receive payment by check during this processing period.

Thisformdoesnotcontroleligibilitytoreceivebenefits.Itonlyreferstothemethodofpayments.