



Claim Reporting Requirements

November 10, 2017



Reporting Requirements - General

Basics



Reporting Requirements - General

Required Reporting to RI Department of Labor and Training (RI DLT):

- Injury or illness - medical only and indemnity
- Indemnity benefits
 - Start
 - Change
 - Stop



Reporting Requirements

First Report of Injury



First Report of Injury

A work-related injury must be reported if:

- The injury requires medical treatment.
- The employee can't work for more than 3 days.
- The injury is fatal.



First Report of Injury

- Fatal injuries must be reported to RIDLT within 48 hours.
- Other injuries must be reported to RIDLT within 10 days.
- Fine of \$250 can be imposed for late filing or failure to file.



First Report of Injury

How to Report an Injury:

- RIDLT mandated electronic reporting March 1, 2015.
- RIDLT uses the IAIABC national standard Claims Release 3.
- Injuries must be reported electronically through the standard EDI process only.
- No paper first report forms are accepted.



First Report of Injury

Who reports?

- The injured worker reports the injury to the employer.
- The employer reports the injury to the claim administrator.
- A **claim administrator** is the party handling a claim, the employer's workers' compensation insurance company or a third party administrator.
- The claim administrator reports the injury to RIDLT using EDI.



First Report of Injury

- A first report of injury in EDI is called a FROI. The FROI is an electronic transaction (EDI).
- See RIDLT's web site for more information on EDI reporting.
- NO paper first report forms are accepted.



Denial

Denial



Denial

- RIDLT has no requirement and no paper form for notice of denial.
- The claim administrator should notify the employee that the claim is denied.
- The claim administrator should notify RI DLT electronically with a First Report of Injury Denial (FROI 04) or a Subsequent Report of Injury Denial (SROI 04).
- The employee may petition the RI Workers' Compensation Court for benefits 21 days after the injury.



Indemnity Claims

Indemnity Claims Reporting



Indemnity Claims – Reporting

- Indemnity events must be reported on a legal document and through EDI.
- Both a legal document (paper form) AND an EDI transaction are required when indemnity benefits:
 - Start
 - Change
 - Stop
 - One-time payment is made



Indemnity Claims – Reporting

Legal Documents:

- **Court Order:** RI Workers' Compensation Court sends court orders (pretrial orders, decisions, decrees, etc.) directly to RI DLT. The Claim Administrator need not send a copy of the order to RI DLT. The Claim Administrator must **also** send the appropriate EDI transaction.
- **Agreement:** The claim administrator must complete and file the appropriate legal document with RI DLT, with a copy to the employee and attorney (if any). Agreements are not valid until filed with RI DLT. The Claim Administrator must **also** send the appropriate EDI transaction.



Indemnity Claims – Reporting

- A legal agreement or court order is required when indemnity benefits start, change and stop.
- A legal agreement must be filed with RI DLT, with a copy to the employee and his or her attorney, if any.
- Indemnity benefits paid without a legal agreement on file at RI DLT may be considered “gratuitous”. Those payments “paid without paper” may not count as workers’ compensation benefits.
- An appropriate legal document is needed to end benefits to be sure liability ends.



Indemnity Claims – Reporting

EDI Transactions:

- Subsequent Report of Injury – SROI
 - Claim Administrator must send a SROI when indemnity benefits:
 - Start
 - Change
 - Stop
 - One-time payment is made
 - And periodic reports are required
- See RIDLT web site for more information on EDI transactions.



Indemnity Claims

Indemnity Claims Legal Agreements and Liability



Indemnity Claims – Legal Agreements

Without Liability – agreements required:

- Benefits Start:
 - Nonprejudicial Agreement Form DWC-20.
 - Wage Statement Form DWC-03.
 - Certificate of Dependency Status Form DWC-04.



Indemnity Claims – Legal Agreements

Without Liability – agreements required:

- Benefits Change:
 - Corrected Nonprejudicial Agreement Form DWC-20
-- OR --
 - Mutual Agreement Form DWC-24



Indemnity Claims – Legal Agreements

Without Liability – agreements required:

- Benefits Stop:
 - Termination of Benefits Form DWC-21.



Indemnity Claims – Legal Agreements

Without Liability

- Claim Administrator may pay without liability for up to 13 weeks.
- After 13 weeks, liability is automatic.
- With liability, Claim Administrator must file a Memorandum of Agreement Form DWC-02.
- The Wage Statement and Dependents forms filed with the Nonprejudicial Agreement will transfer to the Memorandum of Agreement.



Indemnity Claims – Legal Agreements

With Liability – agreements required:

- Benefits Start:
 - Memorandum of Agreement Form DWC-02.
 - Wage Statement Form DWC-03.
 - Certificate of Dependence Status Form DWC-04.



Indemnity Claims – Legal Agreements

With Liability – agreements required:

- Benefits Change:
 - Corrected Memorandum of Agreement Form DWC-02.
 - OR --
 - Mutual Agreement Form DWC-24.



Indemnity Claims – Legal Agreements

With Liability – agreements required:

- Benefits Stop:
 - Suspension Agreement Form DWC-05
 - OR --
 - Wage Transcript Form DWC-30. Employer must certify that employee has two consecutive weeks of earnings greater than or equal to the pre-injury average weekly wage.



Indemnity Claims – Legal Documents

Matching Agreements – file the appropriate liability match.

- Without Liability:
 - Nonprejudicial Agreement Form DWC-20
 - Termination of Benefits Form DWC-21.
- Voluntary Liability:
 - Memorandum of Agreement Form DWC-02
 - AND--
 - Suspension Agreement Form DWC-05
 - OR--
 - Wage Transcript Form DWC-30



Indemnity Claims – Legal Documents

Matching Agreements – file the appropriate match.

- Filing a Suspension Agreement Form DWC-05 to stop benefits paid under a Nonprejudicial Agreement Form DWC-20 may raise the question of liability.
- Filing a Termination of Benefits Form DWC-21 to stop benefits paid under a Memorandum of Agreement Form DWC-02 will not end liability.



Indemnity Claims – Legal Documents

Court Orders:

- RI Workers' Compensation Court may order benefits to start, change or stop.
- RIDLT receives court orders from the RI WC Court. The claim administrator does not have to submit a copy of a court order to RIDLT.
- A court order supersedes an agreement.



Indemnity Claims – Legal Documents

The claim administrator must submit an EDI transaction along with legal agreements when benefits:

- Start
- Change
- Stop



Indemnity Claims

Indemnity Claims Waiting Period



Indemnity Claims – Waiting Period

- Indemnity benefits may begin after a three (3) day waiting period.
- The date of injury is not included in the waiting period.
- The days in the waiting period need not be consecutive.
- Only one waiting period is taken per injury.
- Waiting period is not reimbursed.
- There is no waiting period for fatalities.



Indemnity Claims – Legal Documents

Preparing to Calculate the Compensation Rate



Indemnity Claims – Legal Documents

- Compensation rate is based on wages, marital status, maximum number of allowed exemptions, and date of incapacity.
- The claim administrator must gather the necessary information from the employee and employer(s).
- The information is recorded on the Wage Statement Form DWC-03 and Dependency Form DWC-04.



Indemnity Claims – Legal Documents

- A Wage Statement Form DWC-03 is used to determine the employee's average weekly wage and compensation rate.
- A Certificate of Dependency Status Form DWC-04 is used to verify the employee's marital status, maximum number of allowed exemptions and number of dependents to calculate the compensation rate.



Indemnity Claims – Legal Documents

- A Wage Statement Form DWC-03 and Certificate of Dependency Status Form DWC-04 are required with:
 - Nonprejudicial Agreement Form DWC-20
 - Memorandum of Agreement Form DWC-02
- A Wage Statement may be required under a court order.



Legal Document– Dependency Form

Certificate of Dependency Status (Dependency Form)



Legal Document– Dependency Form

Dependency Form (Certificate of Dependency Status)

- Information on marital status, maximum number of allowed exemptions and dependents is recorded on the Certificate of Dependency Status Form DWC-04 and submitted to RIDLT.
- The claim administrator should complete the top of the form, the employee information, and the claim information.
- The claim administrator or the employer should ask the employee to complete the rest of the Certificate of Dependency Status Form DWC-04.



Legal Document– Dependency Form

Claim Administrator completes the top of the form:

- Correction Box – check the box if this form corrects a previous one.
- Claim Administrator File Number – the claim number or file identification number of the company handling the claim.

Employee's Certificate of Dependency Status

State of Rhode Island

Department of Labor and Training, Division of Workers' Compensation

PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100

Check if this is a corrected report

Claim Administrator File Number:

1. Employee information:

SSN: XXX - XX -

2. Claim information:

Employer name



Legal Document– Dependency Form

2. Claim information:

Employer name _____

Claim Administrator _____

Address _____

City, St, Zip _____

Injury Date _____

Incapacity Date _____

- Enter the business name of the employer.
- Enter name of the company handling the claim.
- Enter the claim administrator's mailing address: street, city, state and zip.
- Injury date: enter the date of injury.
- Incapacity date: enter the first full date the employee was unable to work.



Legal Document– Dependency Form

3. Marital Status	At the time of the injury the employee was	<input type="checkbox"/> Single	<input type="checkbox"/> Married
<input type="checkbox"/> Spouse works	<input type="checkbox"/> Spouse does not work	Spouse's name _____	

The employee fills out this part of the form **or** provides the information:

- Check SINGLE if unmarried, widowed or divorced.
- Check MARRIED if married or separated
- If married, check if spouse works or not. A non-working spouse qualifies as a dependent for workers' compensation.
- If married, enter spouse's name.



Legal Document– Dependency Form

4. Number of Federal Exemptions

Enter the maximum number of Federal Exemptions you are allowed to claim for Federal income tax. Include yourself, your spouse, your dependents, and any other exemptions.

The employee fills out this part of the form **or** provides the information:

- Enter the **MAXIMUM** number of Federal Exemptions the employee is allowed to claim for Federal income tax. The number is **AT LEAST ONE (1)**.
- Count yourself (the employee).
- Count your spouse and dependent children.
- Count any other additional exemptions allowed for taxes.



Legal Document– Dependency Form

5. Dependents			
A dependent for workers' compensation includes children you support who are:			
• Under age 18, or age 18 to 23 and a full time student			
• Mentally or physically incapacitated from earning at any age			
Dependent's Name	Date of Birth	Relationship	Full time student?
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

The employee fills out this part of the form **or** provides the information:

- List each dependent's name, date of birth, and relationship to the employee.
- Check if the dependent is a full-time student.



Legal Document– Dependency Form

Employee's
Signature

Date

DWC-04 (2/13)

The employee signs and dates the form.

The employee returns the form to the claim administrator.

The claim administrator files the form with RIDLT as part of a Nonprejudicial Agreement or Memorandum of Agreement with a copy to the employee and attorney.



Indemnity Claims – Wage Statement

Wage Statement



Indemnity Claims – Wage Statement

- The employee's pre-injury wages are needed to calculate the compensation rate.
- The claim administrator must obtain wage information from the injured worker's employer(s) to determine compensation rate.
- The claim administrator must identify all the injured workers' employers.



Indemnity Claims – Wage Statement

Claim administrator - Discover how many hours the employee was hired to work each week at each job. Hours hired to work determines if the employee is considered to be:

- Full-time - hired for **20 hours or more** per week
- Part-time - hired for **less than 20 hours** per week
- Seasonal - hired for a seasonal job of 16 weeks or less



Legal Document – Wage Statement

- If the employee is full-time and has only one employer, complete a Full-Time Wage Statement Form DWC-03F.
- If the employee is part-time and has only one employer, complete a Part-Time Wage Statement Form DWC-03P. Part-Time is defined as **up to 20 hours** per week.
- If the employee was injured at a seasonal job, complete a Seasonal Wage Statement Form DWC-03S. Seasonal is defined as employed for a period of **up to 16 weeks**.



Legal Document – Wage Statement

- The claim adjuster must work with the injured worker's employer(s) to correctly complete a Wage Statement and calculate the employee's average weekly wage and compensation rate.
- The Excel Auto-Calculate version of the form does calculations for you. It's on our web site: www.dlt.ri.gov
- Here are instructions to complete a Full-Time Wage Statement. Instructions are also on the web site.



Legal Document – Wage Statement

Full-Time Wage Statement



Legal Document - Wage Statement

State of Rhode Island

FULL-TIME WAGE STATEMENT (Hired for 20 hours or more per week)

Department of Labor and Training, Division of Workers' Compensation

PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

PLEASE CHECK IF CORRECTION OF PRIOR REPORT

DWC No. _____

Insurer File No. _____

Claim Administrator completes the top of the form:

- Correction Box – check the box if this form corrects a previous one.
- DWC No. – For RIDLT use only. Leave blank.
- Insurer File Number – the claim number or file number of the company handling the claim (claim administrator).



Legal Document – Wage Statement

1. EMPLOYEE INFORMATION:

SSN _____

Name _____

Hired for _____ hours each week (Approximate)

Are these supplemental wages? Yes No

If yes, supplemental employer name: _____

Maximum no. of exemptions _____ Single Married

- Enter at least the last 4 digits of the employee's SSN. Do **not** use a fictitious number. If SSN is not available, use 999 + date of birth in MMDDYY order.
- Enter employee's first name, middle initial and last name.
- Enter the number of hours per week the employee was hired to work. Check the box if the number is approximate.



Legal Document – Wage Statement

1. EMPLOYEE INFORMATION:

SSN _____

Name _____

Hired for _____ hours each week (Approximate)

Are these supplemental wages? Yes No

If yes, supplemental employer name: _____

Maximum no. of exemptions _____ Single Married

- Supplemental employer: Check YES if these wages are for the employee's other job, not the job where the injury occurred.
- If Yes, enter the supplemental employer's business name.
- Write in the maximum number of allowed exemptions (including employee).
- Check Single (single, unmarried, divorced, widowed) or Married (married or separated).



Legal Document – Wage Statement

2. CLAIM INFORMATION:

Employer _____

Insurance Co. _____

Claim Administrator _____

Injury date _____

Incapacity date _____

Hire date _____

- Enter the business name of the employer.
- Enter the insurance company name.
- Enter name of the company handling the claim.
- Injury date: enter the date of injury.
- Incapacity date: enter the first full date the employee was unable to work.
- Hire date: enter the date the employee was hired. If hired over a year ago, the approximate date is OK.



Legal Document – Wage Statement

3. EMPLOYED LESS THAN 2 WEEKS:

If Yes:	OR:
1. List agreed upon hourly wage _____	
2. Number of hrs. per week for full-time employees _____	Give average weekly for same or similar employment: _____
3. Multiply #1 by #2 for average weekly wage	

If employed less than 2 weeks – **OPTION 1** (left side):

1. List the hourly wage promised to the employee.
2. List the number of hours worked each week for full-time employees.
3. Multiply #1 WAGE by #2 HOURS to give the Average Weekly Wage.



Legal Document – Wage Statement

3. EMPLOYED LESS THAN 2 WEEKS:

If Yes:	OR:
1. List agreed upon hourly wage _____	Give average weekly for same or similar employment: _____
2. Number of hrs. per week for full-time employees _____	
3. Multiply #1 by #2 for average weekly wage _____	

If employed less than 2 weeks: **OPTION 2** (right side)

- Enter the amount of average weekly wage paid for the same type of employment or similar employment.



Legal Document – Wage Statement

4. EMPLOYED MORE THAN 2 WEEKS:

On the left side of the form, list gross wages prior to employee's first full day out of work. **DO NOT** include their week of hire or week of injury *unless* a full week was paid. **DO NOT SKIP WEEKS.** Please calculate any overtime and/or bonus paid **SEPARATELY** on the right side of the form below.

LIST 13 CONSECUTIVE WEEKS:				BONUS AND OVERTIME CALCULATION:	
Week Number	Week Ending Date	No. of standard hrs. worked	Gross Wages (No Overtime)	Number of weeks employed (up to 52)	Block 1
1				Total BONUS amount paid in past 52 weeks	Block 2

- If the injured worker was employed for more than 2 weeks, use weekly earnings to calculate average weekly wage.
- Obtain wages from the employer for 13 weeks before the date of incapacity (first day of waiting period) not before the date of injury.



Legal Document – Wage Statement

4. EMPLOYED MORE THAN 2 WEEKS:

On the left side of the form, list gross wages prior to employee's first full day out of work. **DO NOT** include their week of hire or week of injury *unless* a full week was paid. **DO NOT SKIP WEEKS.** Please calculate any overtime and/or bonus paid **SEPARATELY** on the right side of the form below.

LIST 13 CONSECUTIVE WEEKS:

Week Number	Week Ending Date	No. of standard hrs. worked	Gross Wages (No Overtime)
1			

BONUS AND OVERTIME CALCULATION:

Number of weeks employed (up to 52)	Block 1
Total BONUS amount paid in past 52 weeks	Block 2

- If the employee was not paid for a full week for the week the incapacity began, don't use that week. It's not a **USABLE** week.
- If the employee was not paid for a full week for the week of hire, don't use that week. It's not a **USABLE** week.



Legal Document – Wage Statement

4. EMPLOYED MORE THAN 2 WEEKS:

On the left side of the form, list gross wages prior to employee's first full day out of work. **DO NOT** include their week of hire or week of injury *unless* a full week was paid. **DO NOT SKIP WEEKS.** Please calculate any overtime and/or bonus paid **SEPARATELY** on the right side of the form below.

LIST 13 CONSECUTIVE WEEKS:

Week Number	Week Ending Date	No. of standard hrs. worked	Gross Wages (No Overtime)

BONUS AND OVERTIME CALCULATION:

Number of weeks employed (up to 52)	Block 1
	Block 2

- Determine the week ending date, standard hours and standard amount of wages for 13 weeks before the date of incapacity.
- Overtime is not included in gross wages. Overtime is calculated separately.
- Bonuses are not included in gross wages. Bonuses are calculated separately.
- Commissions, shift differential, Sunday pay, paid holiday, sick pay and vacation pay are included in gross wages.



Legal Document – Wage Statement

4. EMPLOYED MORE THAN 2 WEEKS:

On the left side of the form, list gross wages prior to employee's first full day out of work. **DO NOT** include their week of hire or week of injury *unless* a full week was paid. **DO NOT SKIP WEEKS.** Please calculate any overtime and/or bonus paid **SEPARATELY** on the right side of the form below.

LIST 13 CONSECUTIVE WEEKS:

Week Number	Week Ending Date	No. of standard hrs. worked	Gross Wages (No Overtime)

BONUS AND OVERTIME CALCULATION:

Number of weeks employed (up to 52)	Block 1
	Block 2

- Include any weeks the employee was not paid for plant shutdown or unpaid time off in the list of 13 weeks. Write “UNPAID” for GROSS Wages and 0 (zero) in the Number of Standard Hours worked. Those are UNUSABLE weeks.



Legal Document – Wage Statement

4. EMPLOYED MORE THAN 2 WEEKS:

On the left side of the form, list gross wages prior to employee's first full day out of work. **DO NOT** include their week of hire or week of injury *unless* a full week was paid. **DO NOT SKIP WEEKS.** Please calculate any overtime and/or bonus paid **SEPARATELY** on the right side of the form below.

LIST 13 CONSECUTIVE WEEKS:

Week Number	Week Ending Date	No. of standard hrs. worked	Gross Wages (No Overtime)
-------------	------------------	-----------------------------	---------------------------

BONUS AND OVERTIME CALCULATION:

Number of weeks employed (up to 52)	Block 1
	Block 2

- Weeks must be consecutive. Do not skip weeks.
- If paid bi-weekly, split wages and hours into single week periods and report each week separately. Report 13 weeks, not 12 or 14.
- If the employee worked more than 40 hours in a week at straight-time (not overtime), note “ST” after hours worked.
- If there are fewer than 13 weeks to list, include all full weeks worked.



Legal Document – Wage Statement

LIST 13 CONSECUTIVE WEEKS:

Week Number	Week Ending Date	No. of standard hrs. worked	Gross Wages (No Overtime)
1			
12			
13			
Total number usable weeks:		Total earnings:	

- Add the total number of usable weeks. Exclude any weeks with zero earnings. Write the result in **Total number of usable weeks**.
- Add the gross wages. Write the result in **Total earnings**.



Legal Document – Wage Statement

BONUS AND OVERTIME CALCULATION:

Number of weeks employed (up to 52)	Block 1
Total BONUS amount paid in past 52 weeks	Block 2
Divide Block 2 by Block 1 for average bonus	Block 3

Calculate Average Bonus:

- Enter the number of weeks employed in Block 1. Maximum number is 52 weeks.
- Enter the total amount of bonus paid in the 52 weeks before the first date of incapacity.
- Divide amount of bonus by number of weeks for Average Bonus. Enter it in Block 3.



Legal Document – Wage Statement

BONUS AND OVERTIME CALCULATION:

Number of weeks employed (up to 52)	Block 1
Total BONUS amount paid in past 52 weeks	Block 2
Divide Block 2 by Block 1 for average bonus	Block 3
Total OVERTIME amount paid in past 52 weeks	Block 4
Divide Block 4 by Block 1 for average overtime	Block 5

Calculate Average Overtime:

- Enter the total amount of overtime paid in the 52 weeks before the first date of incapacity.
- Divide amount of bonus by number of weeks employed (maximum 52) (Block 1) for Average Overtime. Enter it in Block 5.



Legal Document – Wage Statement

CALCULATION OF AVERAGE WEEKLY WAGE (AWW):	
1. Total earnings from 13 weeks	_____
2. Total number usable weeks	_____
3. Divide total earnings by number of usable weeks	_____
4. Average bonus (Block 3 in BONUS AND OT)	_____
5. Add 3 and 4 for AWW excluding Overtime	\$ _____
6. Average overtime (Block 5 in BONUS AND OT)	_____
7. Add 5 and 6 for Total Average Weekly Wage	\$ _____

Calculate Average Weekly Wage no Bonus no Overtime (#3):

- Enter total earnings from left side of form in #1.
- Enter number of usable weeks from left side of form in #2.
- Divide total earnings (#1) by usable weeks (#2). Enter result in #3. This is Average Weekly Wage **no Bonus no Overtime**.



Legal Document – Wage Statement

CALCULATION OF AVERAGE WEEKLY WAGE (AWW):	
1. Total earnings from 13 weeks	_____
2. Total number usable weeks	_____
3. Divide total earnings by number of usable weeks	_____
4. Average bonus (Block 3 in BONUS AND OT)	_____
5. Add 3 and 4 for AWW excluding Overtime	\$ _____
6. Average overtime (Block 5 in BONUS AND OT)	_____
7. Add 5 and 6 for Total Average Weekly Wage	\$ _____

Calculate Average Weekly Wage **with** Bonus **no** Overtime (#5):

- Enter Average Bonus from Block 3 above on line 4.
- Add Average Weekly Wage no Bonus no Overtime (line 3) with Average Bonus (line 4). Enter result on line 5.
- The result on line 5 is Average Weekly Wage **with** Bonus **no** Overtime.



Legal Document – Wage Statement

CALCULATION OF AVERAGE WEEKLY WAGE (AWW):	
1. Total earnings from 13 weeks	_____
2. Total number usable weeks	_____
3. Divide total earnings by number of usable weeks	_____
4. Average bonus (Block 3 in BONUS AND OT)	_____
5. Add 3 and 4 for AWW excluding Overtime	\$ _____
6. Average overtime (Block 5 in BONUS AND OT)	_____
7. Add 5 and 6 for Total Average Weekly Wage	\$ _____

Calculate Average Weekly Wage **with Bonus and Overtime (#7)**:

- Enter Average Overtime from Block 5 above onto line 6.
- Add Average Weekly Wage with Bonus no Overtime (line 5) with Average Overtime (line 6). Enter result on line 7.
- The result is Average Weekly Wage **with Bonus and Overtime**, which is used to calculate the compensation rate.



Legal Document – Wage Statement

Average Weekly Wage figures:

- Average Weekly Wage **no** Bonus **no** Overtime
- Average Weekly Wage **with** Bonus **no** Overtime
 - This is the pre-injury Average Weekly Wage. Benefits may be ended with a Wage Transcript Form DWC-30 when post-injury earnings are greater than pre-injury AWW.
- Average Weekly Wage **with** Bonus **and** Overtime
 - Used to calculate the compensation rate.



Legal Document – Wage Statement

Print Preparer Name:	Date:	Print Adjuster Name:	Date:

DWC-03F (01/03)

For instructions visit our web site: www.dlt.ri.gov/wc

- Print the form preparer's name and the date the form was prepared.
- Print the claim adjuster's name and date the adjuster checked the form.



Legal Document – Wage Statement

- Keep a copy of the Wage Statement for your records.
- Use the Average Weekly Wage with bonus and overtime figure to calculate compensation rate.
- Submit the Wage Statement to RI DLT as part of the legal agreement to begin indemnity benefits: Nonprejudicial Agreement Form DWC-20 or Memorandum of Agreement Form DWC-02. Send a copy to the employee and attorney.



Legal Document – Wage Statement

Part-Time Wage Statement



Legal Document – Wage Statement

State of Rhode Island

PART-TIME WAGE STATEMENT (Hired for less than 20 hours per week)

Department of Labor and Training, Division of Workers' Compensation

PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

PLEASE CHECK IF CORRECTION OF PRIOR REPORT

DWC No. _____

Insurer File No. _____

- Use Part-Time Wage Statement Form DWC-03P when the employee has only one job, and it is part-time.
- The employee is considered to be part-time if hired for less than 20 hours per week.
- The instructions for part-time are the same as for full-time, but 26 weeks of wages are used in calculations instead of 13 weeks.



Legal Document – Wage Statement

Seasonal Wage Statement



Legal Document – Wage Statement

State of Rhode Island

SEASONAL WAGE STATEMENT (Hired for 16 weeks or less)

Department of Labor and Training, Division of Workers' Compensation

PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

PLEASE CHECK IF CORRECTION OF PRIOR REPORT

DWC No. _____

Insurer File No.

- If the employee was injured at a seasonal job, use Seasonal Wage Statement Form DWC-03S.
- The employee is considered to be seasonal if hired for a seasonal job lasting no more than 16 weeks.
- The employee's wages from **ALL employers** for the past 52 weeks are needed.



Legal Document – Wage Statement

State of Rhode Island

SEASONAL WAGE STATEMENT (Hired for 16 weeks or less)

Department of Labor and Training, Division of Workers' Compensation

PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

PLEASE CHECK IF CORRECTION OF PRIOR REPORT

DWC No. _____

Insurer File No. _____

Top of the form:

- Correction Box – check the box if this form corrects a previous one.
- DWC No. – For RIDLT use only. Leave blank.
- Insurer File Number – the claim number or file number of the company handling the claim (claim administrator).



Legal Document – Wage Statement

1. EMPLOYEE INFORMATION:

SSN

Name

- Enter at least the last 4 digits of the employee's SSN. Do **not** use a fictitious number. If SSN is not available, use 999 + date of birth in MMDDYY order.
- Enter employee's first name, middle initial and last name.



Legal Document – Wage Statement

1. EMPLOYEE INFORMATION:

SSN _____

Name _____

Maximum no. of exemptions _____ Single Married

Wages for how many employers are listed below? _____

- Write in the maximum number of allowed exemptions including the employee.
- Check **Single** (single, unmarried, divorced, widowed) or **Married** (married or separated).
- Enter the number of employers with wages included on the form. Include wages from all the injurer workers' employers for the past 52 weeks.



Legal Document – Wage Statement

2. CLAIM INFORMATION:

Employer _____

Insurance Co. _____

Claim Administrator _____

Injury date _____

Incapacity date _____

Hire date _____

- Enter the business name of the employer.
- Enter the name of the insurer.
- Enter name of the company handling the claim.
- Injury date: enter the date of injury.
- Incapacity date: enter the first full date the employee was unable to work (first day of waiting period).
- Hire date: enter the date the employee was hired. If hired over a year ago, the approximate date is OK.



Legal Document – Wage Statement

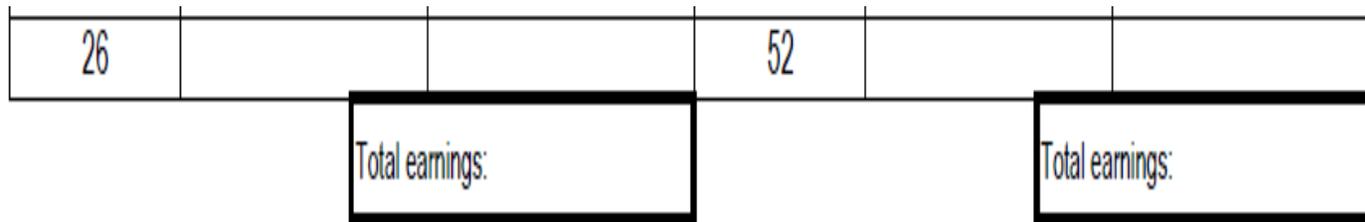
List 52 CONSECUTIVE weeks of gross wages for *any* employment held by this person within the 52 week period.

Week Number	Week Ending Date	Gross Wages	Week Number	Week Ending Date	Gross Wages
1			27		
2			28		
...			...		

- For each of the 52 weeks preceding the date of incapacity, enter the week ending date and total amount of gross wages **for all employers**.
- Include commissions, bonus and overtime.
- Weeks are consecutive. Include every week even if gross wages for that week are zero.



Legal Document – Wage Statement



- Total the earnings for the first 26 weeks and the last 26 weeks.



Legal Document – Wage Statement

1. Combine total earnings listed	_____
2. Divide total earnings by 52	$\div 52$ _____
3. Average Weekly Wage	$\$$ =====

- Add the total earnings for both 26 week periods together.
- Enter the total on line 1.
- Divide total earnings by 52. Always divide by 52 weeks, even if there are weeks with zero earnings.
- Enter the result on line 3. This is the Average Weekly Wage.



Legal Document – Wage Statement

Print Preparer Name:	Date:	Print Adjuster Name:	Date:

DWC-03S (01/03)

For instructions visit our web site: www.dlt.ri.gov/wc

- Print the form preparer's name and the date the form was prepared.
- Print the claim adjuster's name and date the adjuster checked the form.



Legal Document – Wage Statement

- Claim Administrator keeps a copy of the Wage Statement.
- The Average Weekly Wage with Bonus and Overtime is used to calculate the compensation rate.
- Submit the Wage Statement to RI DLT as part of the legal agreement to begin indemnity benefits: Nonprejudicial Agreement Form DWC-20 or Memorandum of Agreement Form DWC-02.
- Send a copy to the employee and attorney.



Wage Statement – Multiple Employers

Multiple Employers



Wage Statement – Multiple Employers

Multiple employers:

- If the employee has more than one job, earnings from all jobs are used to calculate the employee's Average Weekly Wage.
- The employer where the worker was injured is the primary employer and is named as the employer on forms.
- The other employers are called Supplemental Employers.



Wage Statement – Multiple Employers

Multiple employers:

- Calculating Average Weekly Wage for multiple employers can be complicated.
- Average Bonus and Average Overtime must be calculated separately for each employer for the results to be accurate.



Wage Statement – Multiple Employers

Multiple employers – more than one **full-time** job:

- From each employer you need:
 - Date of hire (if employed less than 52 weeks)
 - 13 weeks of wages (without overtime) prior to the first date of incapacity
 - Amount of bonus paid in past 52 weeks
 - Amount of overtime paid in past 52 weeks



Wage Statement – Multiple Employers

Multiple employers – more than one full-time job:

- Calculate Total Average Earnings (also known as Average Weekly Wage **No Bonus No Overtime**):
 - Add the 13 weeks of wages from both employers together to get Total Earnings.
 - Determine the number of usable weeks. Exclude any weeks with zero earnings from both employers.
 - Divide Total Earnings by the number of usable weeks.
 - The result is Total Average Earnings (or AWW no Bonus no OT).



Wage Statement – Multiple Employers

Multiple employers – more than one full-time job:

- Calculate Average Bonus:
 - For the first job, divide the amount of bonus paid for the past 52 weeks at the first job by the number of weeks employed at the first job (up to 52) to get Average Bonus for the first job.
 - Do the same for the second job.
 - Add the Average Bonus amounts for both jobs together to get Total Average Bonus.



Wage Statement – Multiple Employers

Multiple employers – more than one full-time job:

- Calculate Total Average Weekly Wage **with** bonus **no** Overtime:
 - Add Total Average Earnings for both jobs (AWW no Bonus no OT) to Total Average Bonus for both jobs to get Total AWW **with** Bonus **no** Overtime.
 - This is the threshold to determine if the employee's post-injury earnings have recovered to pre-injury levels and benefits may be discontinued.



Wage Statement – Multiple Employers

Multiple employers – more than one full-time job:

- Calculate Average Overtime:
 - For the first job, divide the amount of overtime paid for the past 52 weeks at the first job by the number of weeks employed at the first job (up to 52) to get Average Overtime for the first job. Use date of hire to determine the number of weeks employed.
 - Do the same for the second job.
 - Add the Average Overtime amounts for both jobs together to get Total Average Overtime.



Wage Statement – Multiple Employers

Multiple employers – more than one full-time job:

- Calculate Total Average Weekly Wage **with** bonus **and** Overtime:
 - Add Average Weekly Wage **with** Bonus **no** OT for both jobs to Total Average Overtime for both jobs to get Total AWW **with** Bonus **and** Overtime.
 - This is the average weekly wage figure used to calculate the weekly compensation rate.



Wage Statement – Multiple Employers

Multiple employers – more than one **part-time** job:

- Average weekly wage is calculated the same as for two full-time jobs.
- Use up to 26 weeks of wages before the first date of incapacity instead of using 13 weeks.



Wage Statement – Multiple Employers

Multiple employers – more than one **seasonal** job:

- Wages for the past 52 weeks for ALL EMPLOYERS are used to calculate Average Weekly Wage for a seasonal employee.
- Use the same method for one seasonal job as for more than one.



Wage Statement – Multiple Employers

Multiple employers – injured at full-time job, also has a part-time job:

- Calculated the same as for two full-time jobs.
- Use 13 weeks of wages from the full-time employer.
- Use 13 weeks of wages (not 26) from the part-time employer.



Wage Statement – Multiple Employers

Multiple employers – injured at part-time job, also has a full-time job:

- Use 26 weeks of wages from the part-time employer. Complete the entire wage statement to calculate Average Weekly Wage with Bonus and Overtime for the part-time primary employer.
- Use 13 weeks of wages from the full-time employer. Complete the entire wage statement to calculate Average Weekly Wage with Bonus and Overtime for the full-time supplemental employer.
- Add the Average Weekly Wage with Bonus and Overtime from both employers together.



Wage Statement – Multiple Employers

Multiple employers – full-time and seasonal jobs, injured at either job:

- Use 52 weeks of wages including bonus and overtime from seasonal employer(s). Complete the entire wage statement to calculate Average Weekly Wage.
- Use 13 weeks of wages from full-time employer. Complete the entire wage statement to calculate AWW with Bonus and Overtime for full-time employer.
- Add the seasonal AWW and the full-time AWW with Bonus and OT together.



Wage Statement – Multiple Employers

Multiple employers – part-time and seasonal jobs, injured at either job:

- Use 52 weeks of wages including bonus and overtime from seasonal employer(s). Complete the entire wage statement to calculate Average Weekly Wage.
- Use 26 weeks of wages from part-time employer. Complete the entire wage statement to calculate AWW with Bonus and Overtime for part-time employer.
- Add the seasonal AWW and the part-time AWW with Bonus and OT together.



Compensation Rate

Compensation Rate



Compensation Rate

To calculate the weekly compensation rate you need:

- Average Weekly Wage with Bonus and Overtime from Wage Statement(s).
- Marital Status
- Maximum number of Allowed Exemptions. This is the maximum number of exemptions the employee could claim, not the actual exemptions claimed for tax withholding.
- Incapacity Date (first day of waiting period).



Compensation Rate

Work week:

- RI uses a 7 day week
- Employee's scheduled days off are not considered in calculating compensation.
- The daily compensation rate is one seventh ($1/7$) of the weekly compensation rate.



Compensation Rate

Recurrence – second or subsequent period of incapacity

- If the employee returned to work for 26 weeks before this subsequent incapacity, a new average weekly wage and compensation rate are needed:
 - Calculate a NEW average weekly wage & compensation rate
 - Use the first day of **the second or subsequent** incapacity period as the Incapacity Date for new wages and maximum compensation rate.



Compensation Rate

Weekly compensation rate calculation depends on type of benefit:

- Total incapacity (temporary total) § 28-33-17
- Partial incapacity (temporary partial) § 28-33-18
 - 70% reduction after MMI
 - Reduction based on functional impairment
 - 312 week gate
- Partial incapacity Suitable Alternative Employment § 28-33-18.2
- Loss of Use (permanent partial) § 28-33-19
- Scarring (disfigurement) § 28-33-19
- Death Benefit § 28-33-12



Compensation Rate

Spendable Base Wage
Spendable Earnings



Compensation Rate

For total incapacity, partial incapacity and death benefit compensation rates, you will need to determine the Spendable Base Wage using:

- Average Weekly Wage with Bonus and Overtime from Wage Statements.
- Marital Status
- Maximum number of Allowed Exemptions. This is the maximum number of exemptions the employee could claim, not the actual exemptions claimed for tax withholding.
- Incapacity Date (first day of waiting period).



Compensation Rate

- Spendable Base Wage is the gross wage (average weekly wage with bonus and overtime) converted to net wage per §28-33-17.
- Spendable Earnings is the gross amount an employee earned while on light duty converted to net earnings per §28-33-17.
- Use the RIDLT Chart or formulas available online at <http://www.dlt.ri.gov/wc/infoWages.htm> to find the spendable base wage or spendable net earnings.
- There is a new calculation of spendable tables published each year.
- The **Incapacity Date** dictates which Spendable table year to use.



Compensation Rate

- In recent years, a new spendable publication is effective on May 10 of each year.
- If Incapacity Date is 04/01/2017, use the chart effective 5/10/2016 (through 5/9/2017).
- If Incapacity Date is 06/01/2017, use the chart effective 5/10/2017 (through 5/9/2018).
- Use the chart that is appropriate for the Incapacity Date.



Compensation Rate

- Each spendable publication has:
 - Instructions
 - Formulas
 - Chart for Single
 - Chart for Married
 - Use the chart part of the spendable publication to find the spendable base wage or spendable earnings.



Compensation Rate

- The chart page headers show Single or Married. Excel version has separate sheets (tabs) for Single and Married.
- Go to the part of the chart that matches the employee's marital status.

Avg. Weekly Wage ROUNDED	Single 1 Exemption 5/10/2016	Single 2 Exemptions 5/10/2016	Single 3 Exemptions 5/10/2016	Single 4 Exemptions 5/10/2016	Single 5 Exemptions 5/10/2016	Single 6 Exemptions 5/10/2016
---	---	--	--	--	--	--

Avg. Weekly Wage ROUNDED	Married 2 Exemptions 5/10/2016	Married 3 Exemptions 5/10/2016	Married 4 Exemptions 5/10/2016	Married 5 Exemptions 5/10/2016	Married 6 Exemptions 5/10/2016	Married 7 Exemptions 5/10/2016
---	---	---	---	---	---	---



Compensation Rate

Use the Average Weekly Wage with bonus and overtime to find Spendable Base Wage (SBW):

- Round the employee's Average Weekly Wage with Bonus and Overtime up or down to the nearest dollar.
- Make sure you are in the correct section of the chart for the employee's marital status (single or married).
- Move down the Average Weekly Wage column of the chart until you find the rounded Average Weekly Wage.



Compensation Rate

- Follow the row for the Rounded Average Weekly Wage to the column that matches the employee's maximum number of allowed exemptions.
- The figure in the correct row and column on the chart is the SBW for the employee.
- If the Average Weekly Wage or number of exemptions is outside the range of the chart, please contact a claim analyst at RI DLT to calculate the SBW.



Compensation Rate

Total incapacity
Temporary Total



Compensation Rate

- Total incapacity (temporary total):
 - Convert the employee's Average Weekly Wage with Bonus and Overtime to Spendable Base Wage.
 - Base Comp Rate = 75% of Spendable Base Wage
 - Comp Rate is subject to annual maximum amount based on incapacity date: See <http://www.dlt.ri.gov/wc/maxcomprates.htm>
 - Additional dependency rate of \$15 per week per dependent
 - Base compensation rate plus dependency rate is capped at 80% of Average Weekly Wage.
 - Each year on May 10, if the employee has received total incapacity benefits for a year, the employee will receive a COLA adjustment.



Compensation Rate

Example: Calculate the base weekly compensation rate:

- Multiply the Spendable Base Wage (SBW) by 75%.
- In the past example, SBW = \$2,259.29
- Compensation Rate = $75\% \times \$2,259.29 = \$1,694.47$
- The base compensation rate is subject to a maximum limit.
- The maximum amount changes every year.
- Check our web site for maximum compensation rates:
<http://www.dlt.ri.gov/wc/maxcomprates.htm>



Compensation Rate

Calculate the base weekly compensation rate (continued):

- Maximum weekly compensation rate allowed for incapacity 6/1/2016 is **\$1,076.00** (effective 9/1/2015 – 9/30/2016)

**RI Department of Labor and Training
Workers' Compensation**

DT Labor Market Information Temporary Disability Unemployment Insurance Workers' Compensation Workforce Development Workforce Regulation

WC Home Education Donley Center Injured Worker Employer Insurer/Adjuster Independent Contractor Forms FAQ's

Maximum Weekly Compensation Rates

[Click here](#) for a printer-friendly pdf of the Maximum Weekly Compensation Rate Table
You must have Adobe Reader to view and print this file

Effective Date	Maximum Weekly Rate
October 1, 2016	\$ 1,154.00
September 1, 2015	\$ 1,076.00
September 1, 2014	\$ 1,042.00

Find Coverage
File a Claim
Rehabilitative Services
Report Employers with no Coverage
Report Fraud
Independent Contractor Search + Online Filing
Find Medical Fees
Find Hospital Rates
Become an Adjuster



Compensation Rate

Calculate the dependency rate:

- Base weekly compensation rate is \$1,076.00 (maximum)
- Dependency Rate depends on benefit type:
 - Total incapacity (temporary total): \$15 per week per dependent
 - Partial incapacity (temporary partial): no dependency
 - Death benefit (fatality): \$40 per week per dependent
- Total Compensation Rate (Base Compensation plus Dependency Rate) is capped at 80% of Average Weekly Wage.



Compensation Rate

- Total Compensation Rate is capped at 80% of Average Weekly Wage.
 - The dependency rate is reduced if the base compensation rate plus dependency rate is more than 80% of the employee's Average Weekly Wage.
 - Example:
 - Average Weekly Wage with Bonus and Overtime is \$500
 - Employee is single with 8 dependent children, 9 exemptions (includes employee).
 - Spendable Base Wage for 1/3/2017 date of incapacity is \$456.74
 - Base Compensation Rate = 75% of Spendable Base Wage = \$342.56
 - Weekly Dependency Rate is $8 \times \$15 = \120
 - Total Comp Rate = Base + Dependency = \$462.56
 - 80% of Average Weekly Wage = \$400, so maximum total comp rate is capped at \$400.



Compensation Rate

Partial Incapacity
Temporary Partial
Variable Partial
Working Partial



Compensation Rate

- Partial incapacity (temporary partial) – no earnings:
 - Determine Spendable Base Wage based on Average Weekly Wage with Bonus and Overtime.
 - Base Comp Rate = 75% of Spendable Base Wage
 - Subject to annual maximum amount (based on incapacity date)
 - No additional dependency benefit
 - Subject to gate after 312 weeks of partial incapacity benefits
 - Subject to functional impairment rating to reduce benefits
 - COLA only if employee passes through 312 week gate



Compensation Rate

- Partial incapacity (temporary partial) with weekly earnings:
 - Compensation rate is 75% of the difference between the spendable base wage and the spendable amount earned in a week.
 - Compensation rate must be calculated **separately for each week.**



Compensation Rate

- Partial incapacity (temporary partial) with weekly earnings:
 - The employee's weekly earnings (gross) must be converted to spendable earnings (net).
 - Convert an employee's weekly earnings (gross) to spendable earnings (net) using the spendable chart



Compensation Rate

- Partial incapacity (temporary partial) with weekly earnings:
 - Use the chart to convert Average Weekly Wage with Bonus and Overtime to Spendable Base Wage.
 - Use the chart to convert each week's gross earnings to spendable earnings.
 - $\text{Comp rate} = 75\% * (\text{spendable base wage} - \text{spendable earnings})$
 - Subject to annual maximum amount for total incapacity for the incapacity date
 - No dependency rate



Compensation Rate

- Partial incapacity with earnings (example):
 - AWW = \$900, single, 1 exemption, incapacity date 1/2/2017
 - Convert AWW to spendable (net) SBW = \$698.64
 - Gross amount earned this week = \$400
 - Convert amount earned this week to spendable (net) earnings = \$328.20
 - Compensation Rate this week = $75\% * (698.64 - 328.20)$
 - Compensation Rate this week = \$277.83



Compensation Rate

- Partial incapacity (temporary partial) § 28-33-18 may be modified:
 - 70% reduction after MMI
 - Reduction based on functional impairment
 - 312 week gate
- Consult your legal counsel on these possible modifications.



Compensation Rate

**Partial Incapacity
Suitable Alternative
Employment**



Compensation Rate

- Partial incapacity benefits under suitable alternative employment § 28-33-18.2:
 - Compensation Rate is $66 \frac{2}{3}$ % of the difference between the average weekly wage before the injury and wages from the suitable alternative employment
 - $66 \frac{2}{3}\% * (\text{Avg. Weekly Wage} - \text{S.A.E Earnings})$



Compensation Rate

Loss of Use
Permanent Partial



Compensation Rate

Loss of Use (Permanent Partial)

- Compensation Rate = 50% of Average Weekly Wage
- Maximum \$180 per week
- Minimum \$90 per week



Compensation Rate

Scarring Permanent Partial Disfigurement



Compensation Rate

Scarring (Permanent Partial Disfigurement)

- Compensation Rate = 50% of Average Weekly Wage
- Maximum \$90 per week
- Minimum \$45 per week



Compensation Rate

Death Benefit § 28-33-12

- Calculated as for Total Incapacity
- No waiting period
- Dependency Rate is \$40 per dependent child until age 18, age 23 for full-time student
- COLA: 4% annually on date of death
- If no spouse or children, a one-time payment of \$7,500 is made to Workers' Compensation Administrative Fund.



Indemnity Claims – Benefits Start

Benefits Start



Indemnity Claims – Benefits Start

BOTH are needed when weekly indemnity benefits
START:

- A legal document
- An EDI transaction



Indemnity Claims – Benefits Start

Start weekly indemnity benefit:

- Legal Agreement or Order:
 - Nonprejudicial Agreement Form DWC-20 – **without** liability – to RI DLT, employee and attorney. Include Wage Statement & Dependency Form.
 - Memorandum of Agreement Form DWC-20 – **with** liability – to RI DLT, employee and attorney. Include Wage Statement & Dependency Form.
 - Court order. Include Wage Statement if ordered.
- EDI transaction: Subsequent Report Initial Payment - SROI IP
- Issue check



Non-prejudicial Agreement DWC-20

Non-prejudicial Agreement Form DWC-20



Non-prejudicial Agreement DWC-20

Non-prejudicial Agreement Form DWC-20:

- Claim Administrator Claim Number: enter the number the claim administrator uses to identify the claim or injury record.

Non-Prejudicial Agreement

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

Claim Administrator Claim Number



Non-Prejudicial Agreement

Employee information:

- Enter at least the last 4 digits of the employee's SSN. Do **not** use a fictitious number. If SSN is not available, use 999 + date of birth in MMDDYY order.
- Enter employee's first name, middle initial and last name.
- Enter the employee's mailing address: street address, city, state and zip.
- Enter the employee's date of birth.

Employee Information	
SSN or ID	
Name	
Address	
City, State Zip	
Date of Birth	



Non-Prejudicial Agreement

Employer Information:

- Enter the employer's Federal ID number if available.
- Enter employer's business name.
- Enter the employer's mailing address: street address, city, state and zip.
- Provide the phone number if available.

Employer Information	
FEIN	
Business Name	
Address	
City, State Zip	
Phone	



Non-Prejudicial Agreement

Insurer Information:

- Enter the Federal ID number of the insurance carrier named on policy, if available.
- Enter insurance carrier's full business name.
- Enter the insurer's mailing address: street address, city, state and zip.
- Provide the phone number if available.

Insurer Information	
FEIN	
Business Name	
Address	
City, State Zip	
Phone	



Non-Prejudicial Agreement

Claim Administrator Information:

- Enter the Federal ID number of the claim administrator – the insurer or third party administrator handling the claim.
- Enter claim administrator’s full business name.
- Enter the claim administrator’s mailing address: street address, city, state and zip.
- Provide the claim administrator’s phone number.

Claim Administrator Information (Adjusting Company)	
FEIN	
Business Name	
Address	
City, State Zip	
Phone	



Non-Prejudicial Agreement

Injury Information:

- Enter the date of injury or illness
- State the address or identify where the injury occurred.
- List the injured body part and nature of injury. List multiple parts and natures if applicable.

Injury Information	
Date of Injury	Place where injury occurred
Injured body part & nature of injury	



Non-Prejudicial Agreement

Rate Information:

- Check employee's marital status from information provided on the Dependency Form.
- Enter the MAXIMUM number of allowed exemptions including the employee, spouse, children, and any other exemption that can be claimed for tax purposes.

Rate Information	
Employee's Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married
Number of Exemptions (self, spouse & children)	
Spendable Base Wage	
Weekly Dependency Rate	



Non-Prejudicial Agreement

Rate Information:

- Enter the employee's number of dependents. Include dependent children and non-working spouse. A working spouse is not considered a dependent.
- The number of dependents is always at least one less than number of exemptions, because exemptions includes the employee.

Rate Information			
Employee's Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	Number of Dependents (children & nonworking spouse)
Number of Exemptions (self, spouse & children)			Total Average Weekly Wage



Non-Prejudicial Agreement

Rate Information – From the Wage Statement(s):

- Enter the employee's Total Average Weekly Wage
- Enter the employee's Spendable Base Wage
- Enter the employee's Base Compensation Rate

Number of Exemptions (self, spouse & children)		Total Average Weekly Wage	
Spendable Base Wage		Base Compensation Rate	
Weekly Dependency Rate		Total Weekly Rate	



Non-Prejudicial Agreement

Rate Information – From the Wage Statement(s):

- Enter the employee's Weekly Dependency Rate if paying Total Incapacity or Death Benefits.
- Enter the employee's Total Weekly Compensation Rate.

Number of Exemptions (self, spouse & children)		Total Average Weekly Wage	
Spendable Base Wage		Base Compensation Rate	
Weekly Dependency Rate		Total Weekly Rate	



Non-Prejudicial Agreement

Disability Information:

- Enter the First Payment Issue Date – the date the first benefit check was issued.
- Enter the First Date of Disability – the first date of the waiting period, or the first date of a subsequent period or disability.

Disability Information			
First Payment Issue Date		First Date of Disability	
Temporary Total Start Date		Temporary Partial Start Date	
Permanent Total Start Date		Death Benefits Start Date	
Date of Death		Death Benefits Paid to	



Non-Prejudicial Agreement

Disability Information:

- Enter the start date of indemnity benefits for the type of benefit being paid.
- The start date is the first day after the waiting period or first day of a subsequent disability period.

Disability Information			
First Payment Issue Date		First Date of Disability	
Temporary Total Start Date		Temporary Partial Start Date	
Permanent Total Start Date		Death Benefits Start Date	
Date of Death		Death Benefits Paid to	



Non-Prejudicial Agreement

Disability Information:

- If the employee died, enter the date of death.
- If death benefits are paid, provide the name of the payee.

Disability Information			
First Payment Issue Date		First Date of Disability	
Temporary Total Start Date		Temporary Partial Start Date	
Permanent Total Start Date		Death Benefits Start Date	
Date of Death		Death Benefits Paid to	



Non-Prejudicial Agreement

Other Information:

- Indicate if the employee had additional employers.
- Wages are needed for all employers to calculate compensation rate.
- Attach a completed wage statement for each employer.

Other information			
Does the employee have other employers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Attach a completed wage statement for each employer.
Is this a recurrence of a previous injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Previous disability end date: <input type="text"/>
Did the employee work 26 weeks or more before this recurrence?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If so, a new wage statement is required.



Non-Prejudicial Agreement

Other Information:

- Indicate if this is this a recurrence of a previous injury.
- If so, enter the end date of the previous disability period.

Other information			
Does the employee have other employers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Attach a completed wage statement for each employer.
Is this a recurrence of a previous injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Previous disability end date: <input type="text"/>
Did the employee work 26 weeks or more before this recurrence?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If so, a new wage statement is required.



Non-Prejudicial Agreement

Other Information:

- Indicate if the employee worked for 26 weeks or more before this subsequent disability.
- If so, new wage statements are required to establish a new average weekly wage and a new compensation rate.

Other information			
Does the employee have other employers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Attach a completed wage statement for each employer.
Is this a recurrence of a previous injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Previous disability end date: <input type="text"/>
Did the employee work 26 weeks or more before this recurrence?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If so, a new wage statement is required.



Non-Prejudicial Agreement

Notice to Employee:

- The claim adjuster must sign the form.
- Print the adjuster's name.
- Enter the date the adjuster signed the form.

Signature		
Claims Adjuster Signature	Printed Name	Date



Non-Prejudicial Agreement

Notice:

- States that liability was NOT accepted.
- States the time frame for the employee to petition the court.

Notice to Employees Receiving Worker's Compensation Benefits

ATTENTION: The employer and insurer are NOT accepting legal responsibility for your work injury. You have two (2) years to file a petition at the Workers' Compensation Court to establish liability.

ATENCIÓN: El empleador y la compañía aseguradora NO se hacen legalmente responsables de su lesión en el trabajo. Tiene dos (2) años para entablar una demanda en el Tribunal de Compensación Laboral para establecer la responsabilidad.

DWC-20 06/2014



Non-Prejudicial Agreement

- File the Non-Prejudicial Agreement with the RI DLT. The agreement is not valid until filed.
- Include the Wage Statement and Dependency Form as part of the agreement.
- Claim Administrator sends a copy to the employee and his or her attorney.



Memorandum of Agreement DWC-02

Memorandum of Agreement Form DWC-02



Memorandum of Agreement DWC-02

Memorandum of Agreement Form DWC-02:

- Legal agreement to start indemnity benefits **WITH** liability
- Filed with RI DLT, copy to employee and attorney
- Claim Administrator may file a Memorandum of Agreement at the start of indemnity benefits instead of Non-Prejudicial Agreement.
- Memo of Agreement must be filed if benefits are paid for more than 13 weeks and liability is established.
- Memo of Agreement may be filed before 13 weeks of benefits to establish liability.



Memorandum of Agreement

- Check the box if this is a correction of a previously submitted Memorandum of Agreement.
- DWC No: For DLT Use Only – please leave blank.
- Insurer File No: The claim administrator’s record ID number.

State of Rhode Island
MEMORANDUM OF AGREEMENT

Department of Labor and Training, Division of Workers' Compensation

PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

PLEASE CHECK IF CORRECTION OF PRIOR REPORT

DWC No.

Insurer File No.



Memorandum of Agreement

Employee information:

- Enter at least the last 4 digits of the employee's SSN. Do **not** use a fictitious number. If SSN is not available, use 999 + date of birth in MMDDYY order.
- Enter employee's first name, middle initial and last name.
- Enter the mailing address: street address, city, state and zip.
- Provide the phone number if available.
- Enter the employee's date of birth.

1. EMPLOYEE:		
SSN	<input type="text"/>	
Name	<input type="text"/>	
Address	<input type="text"/>	
Address	<input type="text"/>	
City, State, Zip	<input type="text"/>	
Phone	<input type="text"/>	Date of Birth <input type="text"/>



Memorandum of Agreement

Employer Information:

- Enter the employer's Federal ID number if available.
- Enter employer's business name.
- Enter the employer's mailing address: street address, city, state and zip.
- Provide the phone number if available.

2. EMPLOYER:

FEIN

Name

Address

Address

City, State, Zip

Phone



Memorandum of Agreement

Insurer Information:

- Enter the Federal ID number of the insurance carrier named on policy, if available.
- Enter insurance carrier's full business name.
- Enter the insurer's mailing address: street address, city, state and zip.
- Provide the insurer's phone number if available.
- Insurer license number is not needed.

3. INSURANCE COMPANY NAMED ON WC POLICY:

FEIN	<input type="text"/>
Name	<input type="text"/>
Address	<input type="text"/>
Address	<input type="text"/>
City, State, Zip	<input type="text"/>
Phone	<input type="text"/> Ext. <input type="text"/>
RI License Number	<input type="text"/>



Memorandum of Agreement

Claim Administrator Information:

- Enter the Federal ID number of the claim administrator – the insurer or third party administrator handling the claim.
- Enter claim administrator’s full business name.
- Enter the claim administrator’s mailing address: street address, city, state and zip.
- Provide the claim administrator’s phone number.
- License number is not needed.

4. CLAIM ADMINISTRATOR:	<input type="checkbox"/>	SAME AS BLOCK 3
FEIN	<input type="text"/>	
Name	<input type="text"/>	
Address	<input type="text"/>	
Address	<input type="text"/>	
City, State, Zip	<input type="text"/>	
Phone	<input type="text"/>	Ext. <input type="text"/>
RI License or Self-Insurance Number	<input type="text"/>	



Memorandum of Agreement

Injury Information:

- Enter the date of injury or illness.
- Enter the first date of first disability. This is the first day of the waiting period.
- State the address or identify where the injury occurred.
- List the injured body part(s) and nature(s) of injury.

Injury date:	<input type="text"/>	List injured body parts and nature of injury: <input type="text"/>
First date of first disability:	<input type="text"/>	
Place where injury occurred:	<input type="text"/>	



Memorandum of Agreement

Disability Type:

- Check the type of benefit.
- Enter the first date of that benefit for the disability covered on this agreement.
- For death benefits, include date of death and payee name.

5. DISABILITY TYPE: (check all that apply)

Temporary Total as of _____

Temporary Partial as of _____

Death Benefits/Date of Death _____

Payable to: _____

Permanent Total as of _____



Memorandum of Agreement

Rate Information:

- Indicate if employee is Single (unmarried, divorced, widowed) or Married (married or separated).
- Enter the maximum number of allowed exemptions. Include the employee.
- Enter the Average Weekly Wage **WITH** Bonus **NO** Overtime.
- Enter the amount of Average Overtime from the Wage Statement.

6. RATE INFORMATION:

Single

Married

Number of Exemptions

AWW (include bonus/no OT)

Average Overtime Amount

	<input type="text"/>
	<hr/>
	<input type="text"/>
	<hr/>
	<input type="text"/>
	<hr/>



Memorandum of Agreement

Rate Information:

- Enter the Average Weekly Wage **WITH** Overtime from the Wage Statement.
- Enter the Spendable Base Wage.
- Enter the Base Compensation Rate.

AWW including Overtime

Number of Dependents

Spendable Base Wage

Weekly Dependency Rate

Base Compensation Rate

Total Weekly Rate



Memorandum of Agreement

- Enter the Date of Initial Payment under this Memorandum of Agreement. That is the date of the first check issued under this legal agreement to compensate with liability.
- The claim administrator must issue the first check within 14 days of the agreement.

7. DATE OF INITIAL PAYMENT UNDER MOA:



Memorandum of Agreement

- Indicate if the employee has more than one employer.
- If so, a wage statement is needed from all the employers to calculate the average weekly wage and compensation rate.

Does employee have other employers?

Yes

No

If yes, attach a wage statement from each employer.



Memorandum of Agreement

- Indicate if this is a recurrence of a previous injury.
- If so, enter the end date of the previous disability.
- Indicate if the employee worked 26 weeks or more between disability periods.
- If so, new wage statement(s) and compensation rate are required.

Is this a recurrence of a previous injury? Yes No Previous disability end date: _____

Has the employee worked at least 26 weeks prior to this recurrence? Yes No If yes, a new wage statement is required.



Memorandum of Agreement

Signature and Date:

- Adjuster must sign and date this legal agreement.
- Print the adjuster's name.
- Enter the adjuster's phone number and extension.

Signature:

Date:

Print Name:

RI Adjuster License Number:

Phone & Extension:



Memorandum of Agreement

Notice to Employee:

- Employee must report earnings to Claim Administrator.
- Employee's signature on check affirms eligibility for benefits.
- Benefits are not due while incarcerated after conviction.

NOTICE TO EMPLOYEES RECEIVING WORKERS' COMPENSATION BENEFITS:

YOU MUST REPORT ANY EARNINGS you receive to the Claim Administrator that pays your benefits. Failure to report earnings may subject you to civil or criminal liability. Your endorsement on a benefit check is your statement that you are qualified to receive workers' compensation benefits. You are NOT entitled to receive workers' compensation benefits for any time that you are imprisoned as a result of a criminal conviction.



Memorandum of Agreement

- §RIGL 28-33-20: Wage statement “shall be a necessary part of the memorandum of agreement.”
- Submit the wage statement and dependency form with the memorandum of agreement.

ATTACH WAGE STATEMENT(S) AND DEPENDENCY FORM

DWC-02 (01/03)

For instructions visit our web site: www.dlt.ri.gov/wc



Memorandum of Agreement

- File the Memorandum of Agreement with the RI DLT. The agreement is not valid until filed.
- Include the Wage Statement and Dependency Form as part of the agreement.
- Claim Administrator sends a copy to the employee and his or her attorney.



Memorandum of Agreement

- Payments are sometimes made at a provisional or estimate compensation rate if there is a delay in obtaining the correct information for the wage statement.
- When a delayed wage statement becomes available, submit either a corrected Memorandum of Agreement or a Mutual Agreement Form DWC-24 to legally document the change the average weekly wage and compensation rate.



Benefits Change

Benefits Change



Benefits Change

A legal authorization is needed when benefits start, change or stop. When benefits change, authority can be:

- Mutual Agreement
 - Court order
 - A corrected Nonprejudicial Agreement or Memorandum of Agreement.
- And EDI transaction is also required.



Mutual Agreement DWC-24

Mutual Agreement Form DWC-24



Mutual Agreement DWC-24

Mutual Agreement Form DWC-24:

- Claim Administrator Claim Number: enter the number the claim administrator uses to identify the claim or injury record.

Mutual Agreement

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

Claim Administrator Claim Number



Mutual Agreement DWC-24

Employee Information:

- Enter at least the last 4 digits of the employee's SSN. Do **not** use a fictitious number. If SSN is not available, use 999 + date of birth in MMDDYY order.
- Enter the employee's date of birth.

Employee Information		
SSN or ID	Date of Birth	
Last Name	First Name	Initial
Date of Injury	Date of Death	



Mutual Agreement DWC-24

Indicate the change to ongoing indemnity benefits and the effective date.

This form may be used under RIGL § 28-35-6(b) to amend a Memorandum of Agreement, Order or Decree on a workers' compensation claim. This form cannot be used to start or end weekly benefits.

Amendment to Memorandum of Agreement. Indicate the change.			
<input type="checkbox"/> Change employee's marital status to	<input type="checkbox"/> Single	<input type="checkbox"/> Married	effective date: <input type="text"/>
<input type="checkbox"/> Change the total average weekly wage to	\$ <input type="text"/>		effective date: <input type="text"/>
<input type="checkbox"/> Change the weekly spendable base wage to	\$ <input type="text"/>		effective date: <input type="text"/>
<input type="checkbox"/> Change the weekly compensation rate to	\$ <input type="text"/>		effective date: <input type="text"/>
<input type="checkbox"/> Change maximum number of eligible exemptions	to <input type="text"/>		effective date: <input type="text"/>
<input type="checkbox"/> Change number of dependents	to <input type="text"/>		effective date: <input type="text"/>
<input type="checkbox"/> Modify from total to partial incapacity			effective date: <input type="text"/>
<input type="checkbox"/> Modify from partial to total incapacity			effective date: <input type="text"/>
<input type="checkbox"/> Suitable Alternative Employment (offer attached)			effective date: <input type="text"/>
<input type="checkbox"/> Change nature of injury and/or affected body part to	<input type="text"/>		
<input type="checkbox"/> Other (specify)	<input type="text"/>		



Mutual Agreement DWC-24

A Mutual Agreement may be used as the legal authority to pay specific injury benefits:

- Disfigurement (permanent partial disfigurement, scarring)
- Loss-of-use (permanent partial). Specific injury indemnity benefits are paid in a single payment.
- Specific injury benefits are calculated based on weeks and rate but are usually paid as a lump-sum.
- Payment is due within 14 days of the agreement or court order.



Mutual Agreement DWC-24

Loss of Use (Permanent Partial)

- Compensation Rate for Loss of Use injuries on or after January 1, 2012 is 50% of the average weekly wage with a maximum of \$180 and a minimum of \$90 per week.
- Compensation Rate for Loss of Use injuries before January 1, 2012 is 50% of the average weekly wage with a maximum of \$90 and a minimum of \$45 per week.



Mutual Agreement DWC-24

Disfigurement (Permanent Partial Disfigurement) and Hearing Loss (Permanent Partial):

- Compensation Rate for Disfigurement is 50% of the average weekly wage with a maximum of \$90 and a minimum of \$45 per week.
- Compensation Rate for hearing loss is 50% of the average weekly wage with a maximum of \$180 and a minimum of \$90 per week.



Mutual Agreement DWC-24

- Indicate the disfigured body part
- Show the number of weeks calculated for the payment (maximum 500).
- Show the weekly rate (often the maximum, \$90)
- Enter the amount paid for this benefit under Amount Paid.
- Enter the date of the benefit check under Date Paid.

Specific Injury Agreement

The injured worker and the Claims Administrator representing the Insurer and Employer agree on the specific injury or injuries stated here.

Disfigurement: Body Part	Weeks	Weekly Rate	Amount Paid	Date Paid



Mutual Agreement DWC-24

- Indicate the body part for loss-of-use (permanent partial).
- Enter the percent loss.
- Enter the calculated number of weeks for the payment.
- Show the weekly rate (often the maximum, \$180)
- Enter the amount paid for this benefit under Amount Paid.
- Enter the date of the benefit check under Date Paid.

Loss of Use: Body Part	Percent	Weeks	Weekly Rate	Amount Paid	Date Paid
	0.00%				
	0.00%				



Mutual Agreement DWC-24

- For hearing loss, indicate if loss to left, right, or both ears.
- Indicate occupational or traumatic hearing loss.
- Enter the percent of the hearing loss.
- Enter the calculated number of weeks for the payment.
- Show the weekly rate.
- Enter the amount paid for this benefit under Amount Paid.
- Enter the date of the benefit check under Date Paid.

Body Part	Type of Hearing Loss		Percent	Weeks	Weekly Rate	Amount Paid	Date Paid
<input type="checkbox"/> Left	<input type="checkbox"/> Occupational	<input type="checkbox"/> Traumatic	0.00%				
<input type="checkbox"/> Right	<input type="checkbox"/> Occupational	<input type="checkbox"/> Traumatic	0.00%				
<input type="checkbox"/> Both	<input type="checkbox"/> Occupational	<input type="checkbox"/> Traumatic	0.00%				



Mutual Agreement DWC-24

- The Employee must sign and date this agreement.
- The Claim Adjuster must sign and date this agreement.
- The agreement must be filed with RI Department of Labor & Training, with copy to employee, attorney and claim administrator.

Signatures of Parties to this Agreement			
Employee Signature		Claim Adjuster Signature	
Date		Date	



Benefits Stop

Benefits Stop



Benefits Stop

BOTH are needed when weekly indemnity benefits
STOP:

- A legal document
- An EDI transaction



Benefits Stop

Stop weekly indemnity benefit:

- Legal Agreement or Order:
 - If benefits were paid **without** liability under a Nonprejudicial Agreement Form DWC-20, a Termination of Benefits Form DWC-21 is required.
 - If benefits were paid **with** liability under a Memorandum of Agreement Form DWC-20 , a Suspension Agreement Form DWC-05 is required to end liability.
 - Benefits paid with liability can also be ended with a Wage Transcript Form DWC-30 showing 2 weeks of earnings at or above the pre-injury average weekly wage (AWW with bonus no overtime).
 - Court order may stop benefits regardless of the legal agreement to start.



Benefits Stop

Stop weekly indemnity benefit:

- EDI transaction: Subsequent Report Suspension. There are several EDI suspension codes. These are two common codes:
 - S1 – Suspended, returned to work
 - SJ – Suspended, Directed by Jurisdiction (court order)
- The EDI Subsequent Report Suspension (SROI S1) is not the same as the Suspension Agreement Form DWC-05 legal document. An EDI suspension AND an appropriate legal document are required when benefits stop.



Termination of Benefits DWC-21

Termination of Benefits Form DWC-21



Termination of Benefits DWC-21

Termination of Benefits Form DWC-21:

- Claim Administrator Claim Number: enter the number the claim administrator uses to identify the claim or injury record.

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

Claim Administrator Claim Number



Termination of Benefits DWC-21

Employee information:

- Enter at least the last 4 digits of the employee's Social Security Number. Do **not** use a fictitious number. If SSN is not available, use 999 + date of birth in MMDDYY order.
- Enter the employee's date of birth.
- Enter employee's last name, first name, and middle initial.

Employee Information		
SSN or ID	Date of Birth	
Last Name	First Name	Initial



Termination of Benefits DWC-21

Employee information:

- Enter the employee's mailing address including, city, state and zip code.
- Enter the employee's date of injury.
- If the employee died, enter date of death.

Address		
City	State	Zip
Date of Injury	Date of Death	



Termination of Benefits DWC-21

Employer Information:

- Enter the employer's Federal ID number if available.
- Enter employer's business name.
- Enter the employer's mailing address: street address, city, state and zip.
- Provide the phone number if available.

Employer Information		
Employer FEIN		
Employer Business Name		
Address		
City	State	Zip
Employer Phone		



Termination of Benefits DWC-21

Insurer Information:

- Enter the Federal ID number of the insurance carrier named on policy, if available.
- Enter insurance carrier's full business name.
- Enter the insurer's mailing address: street address, city, state and zip.
- Provide the phone number if available.

Insurer Information		
Insurer FEIN		
Insurer Business Name		
Address		
City	State	Zip
Insurer Phone		



Termination of Benefits DWC-21

Claim Administrator Information:

- Enter the Federal ID number of the claim administrator – the insurer or third party administrator handling the claim.
- Enter claim administrator’s full business name.
- Enter the claim administrator’s mailing address: street address, city, state and zip.
- Provide the claim administrator’s phone number.

Claim Administrator Information		
Claims Administrator FEIN		
Claim Administrator Business Name		
Address		
City	State	Zip
Claim Administrator Phone		



Termination of Benefits DWC-21

Incapacity Information:

- Enter the date disability began. This is the first date of this disability period. If this is the first disability period, this is the first day of the waiting period.
- Enter the last date of this disability period.

Incapacity Information

Date Disability Began

Date Disability Ended



Termination of Benefits DWC-21

Notice to Employee states employee's rights.

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.



Termination of Benefits DWC-21

Signature & Distribution:

- The adjuster must sign, print his or her name, and date the form.
- The form is filed with RIDLT with a copy to the employee and attorney.

Claims Adjuster Signature	Printed Name	Date



Suspension Agreement DWC-05

Suspension Agreement Form DWC-05



Suspension Agreement DWC-05

Suspension Agreement Form DWC-05:

- Check the box if this is a correction of a previously submitted Suspension Agreement.
- DWC No: For DLT Use Only – please leave blank.
- Insurer File No: The claim administrator’s record ID number.

State of Rhode Island
SUSPENSION AGREEMENT AND RECEIPT

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.



Suspension Agreement DWC-05

Employee information:

- Enter at least the last 4 digits of the employee's Social Security Number. Do **not** use a fictitious number. If SSN is not available, use 999 + date of birth in MMDDYY order.
- Enter employee's last name, first name, and middle initial.
- Enter the employee's address, including city, state, zip.
- Include the phone if available.

1. EMPLOYEE INFORMATION:

SSN

Name

Address

City, State, Zip

Phone



Suspension Agreement DWC-05

Claim Information:

- Enter employer's business name.
- Enter the insurance company name.
- Enter the claim administrator name – the company handling the claim.
- Enter the date of the injury.
- Enter the date of incapacity – the first date of this disability including the waiting period if this is the first disability.

2. CLAIM INFORMATION:

Employer

Insurance Co.

Claim Administrator

Injury date

Incapacity date



Suspension Agreement DWC-05

Agreement:

- Enter the date of incapacity: first day of this disability period including any waiting period.
- Enter the date paid through: the last date for which indemnity benefits were due.

We agree that weekly compensation which began on _____(date of incapacity) will end as of _____(date paid through). Payment of medical bills related to this injury may continue. Completing and signing this form does not prevent the employee from claiming future weekly compensation benefits in the event that the employee is unable to work due to this injury.



Suspension Agreement DWC-05

Signatures:

- The employee must sign and date the form.
- A representative from the claim administrator must sign and date the form on behalf of the employer or insurer.

Employee Signature:

Date:

Employer or Insurer Signature:

Date:



Suspension Agreement DWC-05

- The form is not valid until it is filed with RI DLT.
- The claim administrator sends a copy to the employee and his or her attorney, if any.



Wage Transcript DWC-30

Wage Transcript DWC-30



Wage Transcript DWC-30

Wage Transcript DWC-30:

- The claim administrator and the employer complete a Wage Transcript to discontinue benefits paid with liability if a Suspension Agreement is not available.
- The claim administrator completes the top of the form through section 3.
- The employer completes section 4, signs the form, and returns it to the claim administrator.



Wage Transcript DWC-30

Claim Administrator:

- Check the box if this is a correction of a previously submitted Wage Transcript.
- DWC No: For DLT Use Only – please leave blank.
- Insurer File No: The claim administrator’s record ID number.

**State of Rhode Island
WAGE TRANSCRIPT**

Department of Labor and Training, Division of Workers' Compensation

PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

PLEASE CHECK IF CORRECTION OF PRIOR REPORT

DWC No.

Insurer File No.



Wage Transcript DWC-30

Claim Administrator:

- Check the box if this is a correction of a previously submitted Wage Transcript.
- DWC No: For DLT Use Only – please leave blank.
- Insurer File No: The claim administrator’s record ID number.

**State of Rhode Island
WAGE TRANSCRIPT**

Department of Labor and Training, Division of Workers' Compensation

PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

PLEASE CHECK IF CORRECTION OF PRIOR REPORT

DWC No.

Insurer File No.



Wage Transcript DWC-30

Employee information:

- Enter at least the last 4 digits of the employee's Social Security Number. Do **not** use a fictitious number. If SSN is not available, use 999 + date of birth in MMDDYY order.
- Enter employee's last name, first name, and middle initial.
- Enter the employee's address, including city, state, zip.
- Include the phone if available.

1. EMPLOYEE INFORMATION:

SSN

Name

Address

City, State, Zip

Phone



Wage Transcript DWC-30

Claim Information:

- Enter employer's business name.
- Enter the insurance company name.
- Enter the claim administrator name – the company handling the claim.
- Enter the date of the injury.
- Enter the date of incapacity – the first date of this disability including the waiting period if this is the first disability.

2. CLAIM INFORMATION:

Employer

Insurance Co.

Claim Administrator

Injury date

Incapacity date



Wage Transcript DWC-30

Check “Discontinuation of Benefits”.

3. INSURER COMPLETE:

This wage transcript is submitted to support a:

- Discontinuation of benefits.** The employee has returned to work at a wage equal or greater than he or she earned at the time of the injury.

- Reduction of benefits.** The employee has returned to work at a wage less than he or she earned at the time of the injury.



Wage Transcript DWC-30

Enter the last date for which benefits were paid.

Enter the average weekly wage with overtime no bonus from the Wage Statement filed as part of the Memorandum of Agreement.

Date benefits were discontinued or reduced:

Pre-injury average weekly wage, **not** including overtime:



Wage Transcript DWC-30

- The claim administrator sends the partially completed form to the employer to complete the rest.
- The employer provides information for two consecutive weeks of earnings above the pre-injury average weekly wage with bonus no overtime.

4. EMPLOYER COMPLETE:

Post-Injury Earning Information -- WEEKS MUST BE CONSECUTIVE

	Period Start Date	Period End Date	Number of Hours Worked	Payment Rate	Amount of Earnings



Wage Transcript DWC-30

- For each consecutive week enter:
 - Week start date and end date
 - Number of hours worked in that week
 - Rate the employee was paid
 - Amount earned in each week

Post-Injury Earning Information -- WEEKS MUST BE CONSECUTIVE

	Period Start Date	Period End Date	Number of Hours Worked	Payment Rate	Amount of Earnings
Week 1					
Week 2					



Benefits Stop

Benefits Stop Special Circumstances



Benefits Stop

- Employee dies while receiving benefits, and death is not related to the claim.
 - Alert the RI DLT that employee died, include date of death.
 - Submit an EDI Suspension – Claimant Death (SROI S4).
- Employee is incarcerated after a conviction.
 - Alert the RI DLT that the employee is incarcerated.
 - Submit an EDI Suspension – Incarcerated (SROI S5).



Benefits Stop

- Partial Incapacity Gate.
 - § 28-35-46.1 requires an Itemized Statement Form DWC-50 be filed when benefits end at the Partial Incapacity Gate.
 - ONLY benefits ended at the PI Gate require an Itemized Statement. Do not submit for other circumstances.
 - Submit an EDI Suspension – Benefits Exhausted (SROI S7).



Benefits Stop

- Change of Jurisdiction.
 - Benefits paid under RI WC will in future be paid under a different jurisdiction – Massachusetts, Connecticut, Longshore, etc.
 - If RI court order, RIDLT will receive
 - If other, notify RIDLT
 - Submit an EDI Suspension –Jurisdiction Change (SROI S8).



Benefits Stop

- Whereabouts Unknown.
 - Claim administrator is unable to locate the claimant to pay benefits.
 - Consult your legal counsel.
 - Notify RIDLT.
 - Submit an EDI Suspension –Whereabouts unknown (SROI S6).



Benefits Reduced on Retirement

- Indemnity benefits may be reduced on retirement as per RIGL § 28-33-45.
 - Submit a Coordination of Benefits Form DWC-36.
 - Submit an EDI Change in Benefit Amount (SROI CA).



Periodic Reports

Periodic Reports



Periodic Reports

- Periodic EDI transactions are required:
 - **Sub-annual: SROI SA** is required at six-month intervals from the date of injury while the claim is open in the claim administrator's claim system.
 - **Final: SROI FN** is required when the claim administrator closes the claim.
- Periodic EDI transactions are required on ALL claims.
 - Notice only, Medical Only, Denied, Indemnity claims ALL REQUIRE periodic SROI SA when open and SROI FN closed.



Periodic Reports

- There are no paper periodic reports required.
 - Interim Report of Payment Form DWC-22 was retired and replaced by the SROI SA.
 - Final Report of Payment Form DWC-22 was retired and replaced by SROI Suspension.



Special Notes

- Legal Suspension Agreement Form DWC-05 is NOT the same as an EDI SROI Suspension.
 - Suspension Agreement Form DWC-05 is a legal document that ends liability.
 - SROI Suspension reports that indemnity benefits have ended.
 - Both may be required.



Special Notes

- Final Report of Payment Form DWC-22 is NOT the same as an EDI SROI Final.
 - Final Report of Indemnity Payment Form DWC-22 is no longer accepted. The form provided notice that weekly indemnity benefits stopped. It was replaced by the EDI SROI Suspension (SROI S1, SROI S2,
 - EDI SROI Final (SROI FN) is a notice that the claim is closed.



More Information

Claim forms and instructions are on RI DLT web site

- <http://www.dlt.ri.gov/wc/>
- Click on **Forms**
- Click on **Claim Forms**

General Instructions

- Claim Filing Instructions – download this document from the website that explains legal document filing



More Information

Claim forms page also has:

- Brief instructions on when to use each form
- Link to fillable PDF forms with instructions
- Wage Statements are Excel documents not PDF
 - Full-Time, Part-Time, Seasonal Forms
 - Instructions for each form
 - Instructions for multiple employers



More Information

Workers' Compensation Claims

- Rosemary Brown, Claim Unit Manager
- 401-462-8087
- Rosemary.Brown@dlt.ri.gov



More Information

EDI information is available on our web site:

- <http://www.dlt.ri.gov/wc/>
- Click on EDI information from the WC home page
- EDI page explains the EDI process
- There are links to the EDI website <http://ridltedi.info/>
- Training information available on the DLT EDI page and EDI website
 - EDI Basics for Claim Adjusters



More Information

EDI Information

- Contact RI DLT EDI Team by email
- RIDLTEDI@iso.com

General workers' compensation: Education Unit

- 401-462-8100 option 1
- DLT.WCEdcUnit@dlt.ri.gov