State of Rhode Island
MEMORANDUM OF AGREEMENT

☐ 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 TTY (Relay RI): 711

DWC No. _____

Insurer File No.

1. EMPLOYEE:	**2. EMPLOYER:**
SSN or ID Last four digits only XXX-XX-	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Date of Birth	Phone Ext.
3. INSURANCE COMPANY NAMED ON WC POLICY:	**4. CLAIM ADMINISTRATOR:** ☐ **SAME AS BLOCK 3**
FEIN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Ext.	Phone Ext.
RI License Number	RI License or Self-Insurance Number
Injury date:	List injured body parts and nature of injury:
First date of first disability:	
Place where injury occurred:	

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 _____

6. RATE INFORMATION: ☐ Single ☐ Married

Number of Exemptions _____

AWW (include bonus/no OT) _____

Average Overtime Amount _____

AWW including Overtime _____

Spendable Base Wage _____

Base Compensation Rate _____

Number of Dependents _____

Weekly Dependency Rate _____

Total Weekly Rate _____

7. DATE OF INITIAL PAYMENT UNDER MOA: _____

Does employee have other employers? ☐ Yes ☐ No If yes, attach a wage statement from each employer.

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.

Signature: Date:

Print Name: RI Adjuster License Number: Phone & Extension:

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.

ATTACH WAGE STATEMENT(S) AND DEPENDENCY FORM

Rate Information:

- Employee's marital status: check **single** if the employee is unmarried, divorced or widowed. Check **married** if the employee is married or separated.
- Number of Exemptions: enter the maximum number of personal exemptions the employee may claim for workers' compensation purposes. Count the employee and his or her dependents and any other person who qualifies as a personal exemption for workers' compensation purposes. The number of exemptions must be equal to at least one (the employee). Please refer to the Employee's Certificate of Dependency Status (DWC-04) for additional guidelines in making this determination.
- AWW (include bonus/no OT): enter the amount calculated from the wage statement for average weekly wage **with** average bonus and **without** average overtime.
- Average Overtime Amount: enter the averaged amount of overtime from the wage statement
- AWW including Overtime: enter the total average weekly wage including bonus and overtime.
- Number of Dependents: enter the number of employee's dependents including non-working spouse and dependent children. A child is dependent through age 18, or through age 23 if a full-time student. A disabled child is dependent at any age. See RIGL § 28-35-1.
- Spendable Base Wage: calculate the Spendable Base Wage using the formulas or tables on the DLT web site.
- Weekly Dependency Rate: Enter the total weekly amount of dependency allowance, up to 80% of total AWW as allowed in RIGL § 28-33-17 (c) (1). Dependency is $15 per dependent for temporary total and $40 per dependent for death benefits.
- Base Compensation Rate: Multiply the Spendable Base Wage by 75% to calculate the base compensation rate. The rate can be no higher than the annual maximum compensation rate.
- Total Weekly Rate: Enter the total weekly compensation rate including dependency.

Other Information:

- Date of initial payment under MOA: Enter the date of the first check made under this Memorandum of Agreement.
- Does the employee have other employers? Check yes or no. A wage statement from each employer is needed.
- Is this a recurrence of a previous injury? Check yes if this is a recurrence, meaning this is not the first period of disability. Check no (not a recurrence) if this is the first period of disability.
- Previous disability end date: enter the last date of the previous disability to show if 26 weeks have passed since the previous disability period ended.
- Has the employee worked at least 26 weeks before this recurrence? Check yes or no. If yes, a new wage statement must be completed based on this new disability date.

Claim Adjuster Signature and Information

- Signature: The claim adjuster must sign this document.
- Date: Write the date the document was signed.
- Printed name: Print the claim adjuster's name.
- Phone number: Provide the direct phone number for the claim adjuster.

Send the document to the employee, the employee's attorney, and the DLT within 10 days of the first payment issue date.