Rescission of Agreement for Electronic Payment of Workers' Compensation Benefits

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

Claim Administrator Claim Number

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

RIGL § 28-35-40 allows for workers' compensation benefits to be paid by an electronic fund transfer or the issuance of an electronic access device if mutually agreed upon by both the employee and the employer or its insurer. Such agreement may be rescinded at any time by either party.

BY SIGNING THIS FORM THE EMPLOYEE OR THE EMPLOYER/INSURER IS ELECTING TO RESCIND THE AGREEMENT THAT ALLOWS FOR ELECTRONIC PAYMENT OF BENEFITS.

(Either party may rescind the agreement at any time)

Employee Signature Date: (mm/dd/yyyy)

Print Name:

Employees completing this form must send it to the Claims Administrator who is paying benefits.

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

Print Name:

This form does not control eligibility to receive benefits. It only refers to the method of payments.

The Employer/Insurer is required to file this completed form with the RI Department of Labor and Training. Please allow at least fourteen (14) days from the date that this Agreement is returned by you to your Claim Adjuster in order to process this rescission. You may continue to receive electronic payments during this processing period.