State of Rhode Island
REPORT OF INDEMNITY PAYMENT

☐ 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.

YOU ***MUST*** CHECK ONE OF THE FOLLOWING:	YOU ***MUST*** CHECK ONE OF THE FOLLOWING:
☐ TERMINATION OF BENEFITS UNDER NON-PREJUDICIAL AGREEMENT*	☐ INTERIM
☐ PAYMENT UNDER MEMO OF AGREEMENT, ORDER OR DECREE	☐ FINAL: Date of last weekly indemnity payment: _____

1. EMPLOYEE INFORMATION:

SSN _____
Name _____
Address _____
City, State, Zip _____
Phone _____ Date of Birth _____
Maximum no. of exemptions _____ ☐ Single ☐ Married

2. CLAIM INFORMATION:

Employer _____
Insurance Co. _____
Claim Administrator _____
Injury date _____
Incapacity date _____
Date of death _____ ☐ NOT work-related

3. RATE INFORMATION:

AWW including Overtime _____ AWW (include bonus/no OT) _____
Spendable Base Wage _____ Total Cost of Living Adjustment(s) _____
Base Compensation Rate _____ Weekly Dependency Rate _____

4. WEEKLY COMPENSATION:

Indicate Payment Type	Payment period Date from	Payment period Date through	Number of Weeks & Days	Total Weekly Rate	Variable Partial Total Spendable	Compensation Paid	☐ Settlement ☐ Deny&Dismiss
☐TI ☐PI ☐DB							Amount:
☐TI ☐PI ☐DB							Decree No.
☐TI ☐PI ☐DB							Decree Date

5. WEEKLY COMPENSATION for Variable Partial Payments: (Complete information above also)

Week Ending	Gross Earnings	Spendable Earnings	Amount Paid	Week Ending	Gross Earnings	Spendable Earnings	Amount Paid

Signature: _____ Date: _____

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

***THE FOLLOWING NOTICE IS FOR EMPLOYEES TERMINATED UNDER A NON-PREJUDICIAL AGREEMENT ONLY**

Weekly compensation payments have stopped. The insurer/employer has not accepted liability for this claim. If you wish to protect any rights you may have under the Workers' Compensation Act, including possible entitlement to continued or future weekly compensation payments or payment of medical expenses, a petition must be filed with the Workers' Compensation Court within two (2) years from the first date of incapacity.