

Mutual Agreement

State of Rhode Island
Department of Labor and Training
Division of Workers' Compensation
P.O. Box 20190
Cranston, RI 02920-0942
Phone: (401) 462-8100 TDD: (401) 462-8084

DWC No: _____

Insurer's No: _____

EMPLOYEE INFORMATION:

S.S.N. _____ M ___ F
Name _____
Address _____
City, State, Zip _____
Phone _____ Date of birth _____

EMPLOYER INFORMATION:

FEIN _____
Name _____
Address _____
City, State, Zip _____
Phone _____ Ext. _____

INSURANCE CARRIER:

FEIN _____
Name _____
Address _____
City, State, Zip _____
Phone _____ Ext. _____

ADJUSTING COMPANY:

FEIN _____
Name _____
Address _____
City, State, Zip _____
Phone _____ Ext. _____

INJURY INFORMATION:

Date of injury _____

Date of incapacity _____

This form may be used pursuant to RIGL § 28-35-6(b) to amend a Memorandum of Agreement, Order or Decree regarding a Workers' Compensation claim. This form cannot be used for commencement or termination of weekly benefits. Complete in detail; type or print legibly; attach all necessary documentation.

INDICATE THE ACTION(S) OF THIS MUTUAL AGREEMENT:

- Change in total average weekly wage from \$ _____ to \$ _____
- Change in weekly spendable base wage to \$ _____ as of _____ (date)
- Change in weekly compensation rate to \$ _____ as of _____ (date)
- Change in marital status to _____ single _____ married as of _____ (date)
- Change in maximum number of exemptions to _____ as of _____ (date)
- Change in number of dependents to _____ as of _____ (date)
- Change in nature of injury and/or affected body part to _____
- Modify from total to partial incapacity as of _____ (date) Attach interim Report of Payment
- Modify from partial to total incapacity as of _____ (date) Attach interim Report of Payment
- Other (specify) _____

If disfigurement or loss of use, attach a Report of Payment (DWC-22)

Employee Signature
DWC-24 (06/00)

Date

Employer/Insurer Signature

Date