

Termination of Benefits

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:

Soc. Sec. No _____ M ___ F
 Name _____
 Address _____
 City, State, Zip _____
 Phone _____ Date of birth _____
 No. of dependents _____
 Maximum no. of exemptions ___ ___ Single ___ Married

CLAIM INFORMATION:

Employer _____
 Insurance Co. _____
 Adjusting Co. _____
 Injury date _____
 Incapacity date _____
 Date of death _____

RATE INFORMATION:

AWW including overtime _____
 Spendable base wage _____
 Base compensation rate _____

Cost of living adjustment _____
 Dependency rate _____
 Total weekly compensation rate _____

WEEKLY COMPENSATION:

Indicate Payment type	Payment period Date from	Payment period Date through	Number of weeks & days	If partial, amount earned	Total weekly rate	Compensation paid
__TI __PI __DB						
__TI __PI __DB						
__TI __PI __DB						

OTHER PAYMENTS: Indicate total paid to date.

Payment type	Amount paid	Payment type	Amount paid	Payment type	Amount paid
Medical		Penalty		Other _____	

NOTICE TO EMPLOYEES

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, which is usually the first day out of work due to the injury.

 Insurer Signature

 Date

A copy of this form must be sent to the employee and his/her attorney within 10 days of the termination of payments.