Non-Prejudicial Agreement

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

Claim Administrator Claim Number

Employee Information	Employer Information
SSN or ID	FEIN
Name	Business Name
Address	Address
City, State Zip	City, State Zip
Date of Birth	Phone
Insurer Information	**Claim Administrator Information (Adjusting Company)**
FEIN	FEIN
Business Name	Business Name
Address	Address
City, State Zip	City, State Zip
Phone	Phone

Injury Information	
Date of Injury	Place where injury occurred
Injured body part & nature of injury	

Rate Information	
Employee's Marital Status ☐ Single ☐ Married	Number of Dependents (children & nonworking spouse)
Number of Exemptions (self, spouse & children)	Total Average Weekly Wage
Spendable Base Wage	Base Compensation Rate
Weekly Dependency Rate	Total Weekly Rate

Disability Information	
First Payment Issue Date	First Date of Disability
Temporary Total Start Date	Temporary Partial Start Date
Permanent Total Start Date	Death Benefits Start Date
Date of Death	Death Benefits Paid to

Other information		
Does the employee have other employers? ☐ Yes ☐ No	Attach a completed wage statement for each employer.	
Is this a recurrence of a previous injury? ☐ Yes ☐ No	Previous disability end date:	
Did the employee work 26 weeks or more before this recurrence? ☐ Yes ☐ No	If so, a new wage statement is required.	

Signature		
Claims Adjuster Signature	Printed Name	Date

Notice to Employees Receiving Worker's Compensation Benefits

ATTENTION: The employer and insurer are NOT accepting legal responsibility for your work injury. You have two (2) years to file a petition at the Workers' Compensation Court to establish liability.

ATENCION: El empleador y la compañía aseguradora NO se hacen legalmente responsables de su lesión en el trabajo. Tiene dos (2) años para entablar una demanda en el Tribunal de Compensación Laboral para establecer la responsabilidad.

DWC-20 04/2019

RIGL § 28-35-8 requires the insurer to file a Non-Prejudicial Agreement with The Department of Labor and Training (DLT) when indemnity benefits are paid voluntarily **without liability**. A Wage Statement (DWC-03) and Certificate of Dependency Status (DWC-04) must be submitted as part of the agreement. A copy of the agreement must also be sent to the employee and his or her attorney. As of March 1, 2015, the insurer must also submit an electronic Subsequent Report of Injury to DLT when benefits begin.

Claim Administrator Claim Number: Provide the claim number or file identification number for the company handling the claim: the insurer, self-insured employer or third party administrator.

Employee information:

- SSN or ID: Provide at least the last 4 digits of the employee's social security number or the employee ID number assigned by DLT. DO NOT use a fictitious number. Please contact RI DLT to obtain an assigned employee ID number.
- Name: enter the employee's first name, middle initial and last name.
- Address: give the employee's mailing address, city, state and zip.
- Date of birth: enter the employee's date of birth.

Employer information: Please provide the employer's Federal Employer Identification Number, employer business name, employer business mailing address and phone number.

Insurer information: Provide the information for the licensed insurer named on the workers' compensation policy or the self-insured employer's name. Include the insurer business name, insurer mailing address and phone number.

Claim Administrator information: Supply information for the company handling the claim. Provide the claim administrator business name, mailing address, and phone number.

Injury Information:

- Date of injury: enter the date of the injury or start of illness.
- Place where injury occurred: enter the city and state where the injury occurred.
- Injured body part & nature of injury: list the nature of each injury and the employee's injured body parts. Examples: cut right index finger, fractured right wrist or sprained lower back.

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 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.
- 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.

- Total Average Weekly Wage: enter the amount of the total average weekly wage (AWW) as calculated on the Wage Statement (DWC-03).
- Spendable Base Wage: calculate the Spendable Base Wage using the formulas or tables on the DLT web site.
- 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.
- 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).
- Total Weekly Rate: Enter the total weekly compensation rate including dependency.

Disability Information:

- First Payment Issue Date: Enter the date the first indemnity payment was issued for this disability period.
- First Date of Disability: Enter the start date of the first disability period for this injury including the waiting period (the first day of the waiting period).
- Temporary Total Start Date: Enter the first date the employee is owed temporary total disability benefits for this period of disability. If this is the first period of disability, this would be the first day after the waiting period. If this is a subsequent period of disability, this is the first day of this subsequent period.
- Temporary Partial Start Date: Enter the first date the employee is owed temporary partial disability benefits for this period of disability. If this is the first period of disability, this would be the first day after the waiting period. If this is a subsequent period of disability, this is the first day of this subsequent period.
- Death Benefits Start Date: Enter the first date the employee's survivors are due death benefits.
- Date of Death: If the employee has died, enter the date of death.
- Death Benefits Paid to: Enter the name of the primary survivor receiving death benefits.

Other Information:

- 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 or no.
- 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.
- Did the employee work 26 weeks or more before this recurrence? Check yes or no. If yes, a new wage statement must be completed based on this new disability date.

Signature Block. The claim adjuster must sign this document, print name and date the form.

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

Revised 04/2019