State of Rhode Island

Workers' Compensation Insurance Adjuster Exam Study Outline

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RI Department of Labor and Training
2006

RHODE ISLAND
Insurance Supplement

Examination Content Outline

Effective Date: April 25, 2006

RHODE ISLAND
WORKERS' COMPENSATION
INSURANCE ADJUSTER
CONTENT OUTLINE

(50 scoreable questions)

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**All references relate to the Rhode Island General Laws*

I. Workers' Compensation Insurance, Employer's Liability Insurance, and Related Issues

A. Policy Concepts

What situations would be paid under the comp policy?

Make yourself aware of what's covered under a comp policy vs. other types of insurance

B. Self-Insurance

Traditional Insurance through an insurance company

OR

Self-Insurance certified by the Department of Labor and Training (DLT)

After meeting certain criteria, certain companies can seek to become self-insured but can only do so through DLT

C. Work-Related vs. NOT…

Willful intention

Intoxication or unlawful use of controlled substances

Voluntary participation in employer-sponsored social or nonprofessional athletic activity

D. Fraud Prevention

Within DLT

Documents or evidence are privileged and not open to the public

Employee must be notified that endorsing a benefit check affirms eligibility to compensation

Statutory check endorsement statement must be on all checks

E. Workers' Compensation Court

Mandatory Pretrial conference within 21 days of filing

Payments made within 14 days of the entry of the order

Claim a trial within 5 days

F. WC Administrative Fund

Every self-insured employer and every insurer must pay $7,500 into the Workers' Compensation Administrative Fund for every case of injury causing death in which there is no person entitled to compensation.

G. Preferred Provider Network

If the insurer or self-insured employer has a Preferred Provider Network (PPN), approved by the Medical Advisory Board, any change by the employee from the initial health care provider of record can only come from the PPN. If not in the PPN, approval must be obtained.

H. Health Care Provider Fee Schedules

Medical fees are paid based on ~

Hospital Fee Schedule: In-patient; Emergency Room; Ambulatory surgery

Medical Fee Schedule: All others

NOTES:

II. Workers' Compensation (State)

A. Requirements

1. Forms *(order has been changed for ease of training)*

e. Common Law Rights - Waiver

Claim of common law rights – not to be covered by Workers' Compensation

At the time of his or her contract of hire

Filed with DLT

State of Rhode Island, Department of Labor and Training, Workers' Compensation Unit
P.O. Box 20190, Cranston, RI 02920-0942
Phone (401) 462-8100 TDD 462-8006

NOTICE OF CLAIM OF COMMON LAW RIGHTS PURSUANT TO R.I.G.L. §28-29-17

I,

Name _____ Soc. Sec. No._____

Address_____ Date of Birth _____

_____

_____

an employee of the following business,

Name _____ DBA _____

Address_____ FEIN _____

_____

do hereby give notice in writing that I claim my right of action at common law to recover damages for personal injuries sustained while in the employment of the aforementioned employer. I understand that by claiming this right, I am no longer eligible for nor entitled to workers' compensation coverage or benefits pursuant to Title 28, Chapter 29, of the R.I. Workers' Compensation law.

Under penalties of perjury I declare that I have examined this form and to the best of my knowledge it is true, correct and complete. I further acknowledge that false statements on the within document may subject me to criminal prosecution.

Signature _____ Notary Public Signature _____

Date _____ Date Commission Expires _____

A filing fee of five dollars ($5.00) is required with the submission of this form. Please enclose a check or money order payable to Rhode Island Department of Labor and Training. The employer should retain a copy of this form and send an original to the Department of Labor and Training. For a dated receipt copy, include a copy with the original sent to the Department with a self addressed, stamped envelope. The original and copy will be date stamped. The original will be retained for our files. The stamped copy will be returned in the envelope provided.

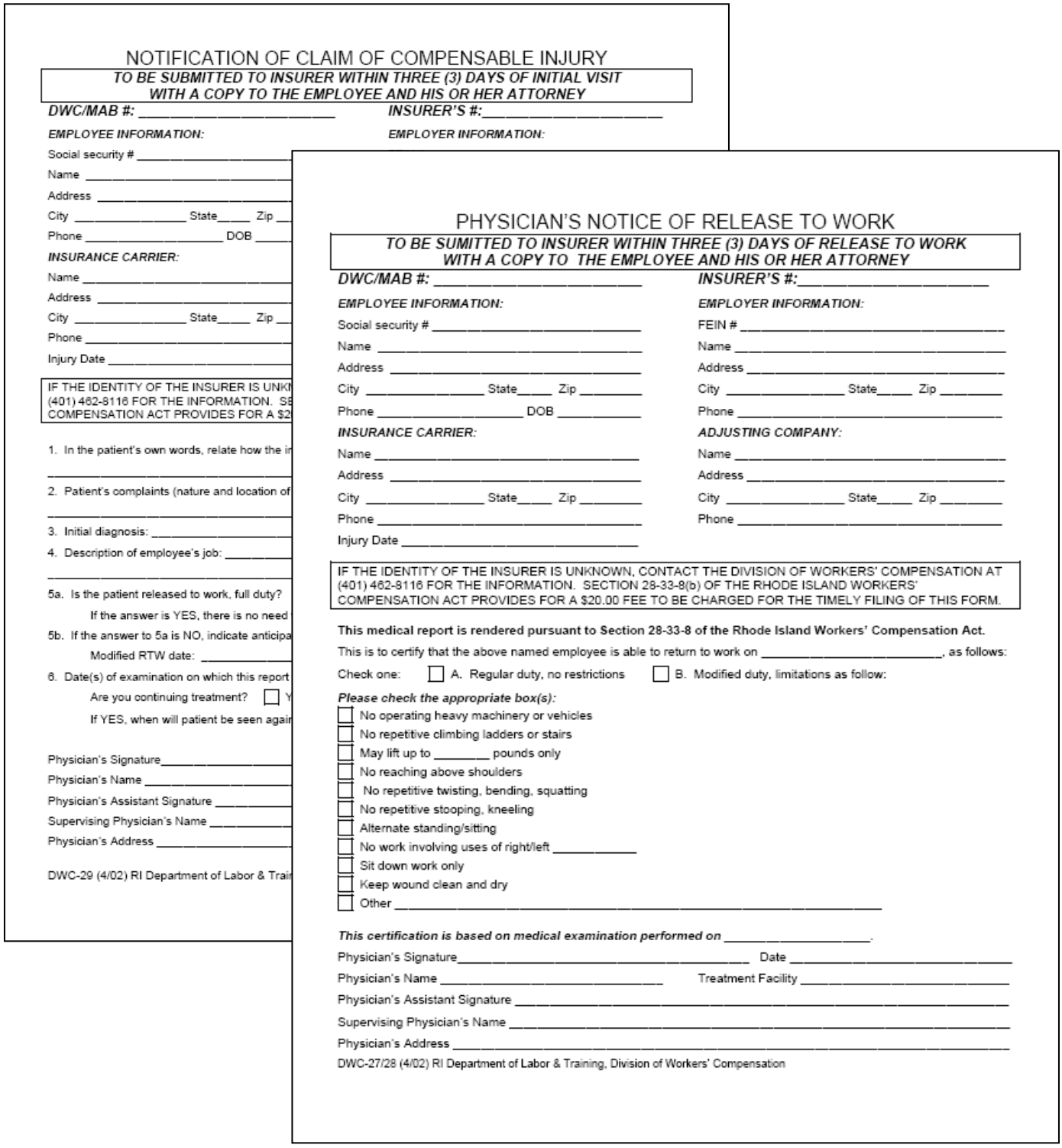
DWC-11 (1/2002)

f. Physician Forms

Notification of Compensable Injury

Notice of Release to Work

Health care provider may charge $20 to the insurer or self-insured employer for the timely filing of these two forms



NOTIFICATION OF CLAIM OF COMPENSABLE INJURY

TO BE SUBMITTED TO INSURER WITHIN THREE (3) DAYS OF INITIAL VISIT WITH A COPY TO THE EMPLOYEE AND HIS OR HER ATTORNEY

DWC/MAB #: _____ *INSURER'S #:*_____

EMPLOYEE INFORMATION:

Social security # _____

Name _____

Address _____

City _____ State_____ Zip __

Phone _____ DOB _____

INSURANCE CARRIER:

Name _____

Address _____

City _____ State_____ Zip __

Phone _____

Injury Date _____

IF THE IDENTITY OF THE INSURER IS UNKI
(401) 462-8116 FOR THE INFORMATION. SE
COMPENSATION ACT PROVIDES FOR A $2

1. In the patient's own words, relate how the in

_____

2. Patient's complaints (nature and location of

_____

3. Initial diagnosis: _____

4. Description of employee's job: _____

_____

5a. Is the patient released to work, full duty?

If the answer is YES, there is no need

5b. If the answer to 5a is NO, indicate anticipa

Modified RTW date: _____

6. Date(s) of examination on which this report

Are you continuing treatment? ☐ Y

If YES, when will patient be seen agair

Physician's Signature_____

Physician's Name _____

Physician's Assistant Signature _____

Supervising Physician's Name _____

Physician's Address _____

DWC-29 (4/02) RI Department of Labor & Trai

PHYSICIAN'S NOTICE OF RELEASE TO WORK

TO BE SUMITTED TO INSURER WITHIN THREE (3) DAYS OF RELEASE TO WORK WITH A COPY TO THE EMPLOYEE AND HIS OR HER ATTORNEY

DWC/MAB #: _____ *INSURER'S #:*_____

EMPLOYEE INFORMATION:

Social security # _____

Name _____

Address _____

City _____ State_____ Zip _____

Phone _____ DOB _____

INSURANCE CARRIER:

Name _____

Address _____

City _____ State_____ Zip _____

Phone _____

Injury Date _____

EMPLOYER INFORMATION:

FEIN # _____

Name _____

Address _____

City _____ State_____ Zip _____

Phone _____

ADJUSTING COMPANY:

Name _____

Address _____

City _____ State_____ Zip _____

Phone _____

IF THE IDENTITY OF THE INSURER IS UNKNOWN, CONTACT THE DIVISION OF WORKERS' COMPENSATION AT (401) 462-8116 FOR THE INFORMATION. SECTION 28-33-8(b) OF THE RHODE ISLAND WORKERS' COMPENSATION ACT PROVIDES FOR A $20.00 FEE TO BE CHARGED FOR THE TIMELY FILING OF THIS FORM.

This medical report is rendered pursuant to Section 28-33-8 of the Rhode Island Workers' Compensation Act.

This is to certify that the above named employee is able to return to work on _____, as follows:

Check one: ☐ A. Regular duty, no restrictions ☐ B. Modified duty, limitations as follow:

Please check the appropriate box(s):

☐ No operating heavy machinery or vehicles
☐ No repetitive climbing ladders or stairs
☐ May lift up to _____ pounds only
☐ No reaching above shoulders
☐ No repetitive twisting, bending, squatting
☐ No repetitive stooping, kneeling
☐ Alternate standing/sitting
☐ No work involving uses of right/left _____
☐ Sit down work only
☐ Keep wound clean and dry
☐ Other _____

This certification is based on medical examination performed on _____.

Physician's Signature_____ Date _____

Physician's Name _____ Treatment Facility _____

Physician's Assistant Signature _____

Supervising Physician's Name _____

Physician's Address _____

DWC-27/28 (4/02) RI Department of Labor & Training, Division of Workers' Compensation

d. Employer's First Report of Injury

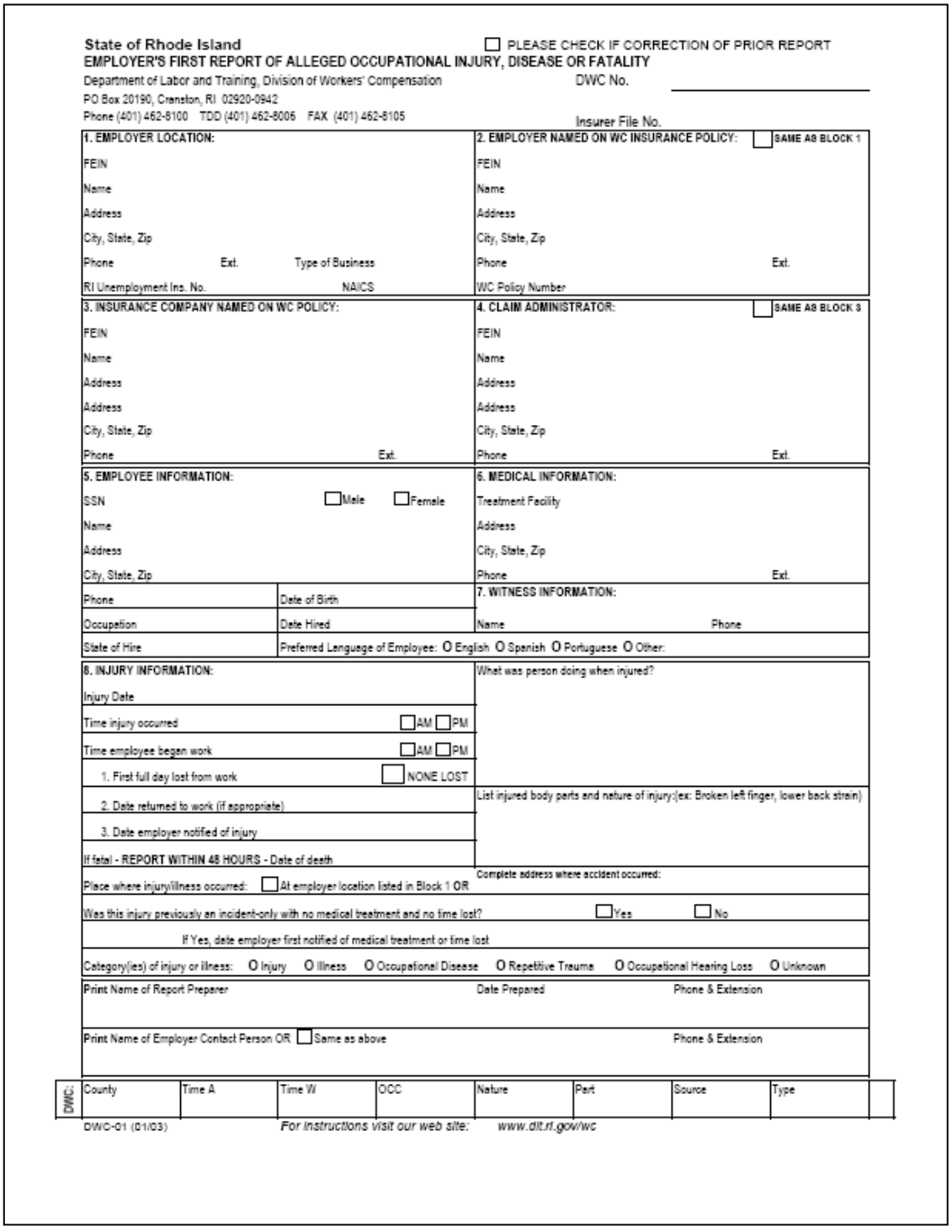
File within 10 days of knowledge

…if injury incapacitates the employee from earning full wages for at least three days

…if medical treatment was required regardless of period of incapacity

File within 48 hours of death

$250 penalty may be assessed for failure to report or late reporting



State of Rhode Island ☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

EMPLOYER'S FIRST REPORT OF ALLEGED OCCUPATIONAL INJURY, DISEASE OR FATALITY

Department of Labor and Training, Division of Workers' Compensation DWC No.

PO Box 20190, Cranston, RI 02920-0942

Phone (401) 462-8100 TDD (401) 462-8006 FAX (401) 462-8105 Insurer File No.

1. EMPLOYER LOCATION:	2. EMPLOYER NAMED ON WC INSURANCE POLICY: ☐ SAME AS BLOCK 1
FEIN	FEIN
Name	Name
Address	Address
City, State, Zip	City, State, Zip
Phone Ext. Type of Business	Phone Ext.
RI Unemployment Ins. No. NAICS	WC Policy Number
3. INSURANCE COMPANY NAMED ON WC POLICY:	**4. CLAIM ADMINISTRATOR:** ☐ SAME AS BLOCK 3
FEIN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Ext.	Phone Ext.
5. EMPLOYEE INFORMATION:	**6. MEDICAL INFORMATION:**
SSN ☐ Male ☐ Female	Treatment Facility
Name	Address
Address	City, State, Zip
City, State, Zip	Phone Ext.
Phone Date of Birth	**7. WITNESS INFORMATION:**
Occupation Date Hired	Name Phone
State of Hire Preferred Language of Employee: O English O Spanish O Portuguese O Other:	
8. INJURY INFORMATION:	What was person doing when injured?
Injury Date	
Time injury occurred ☐ AM ☐ PM	
Time employee began work ☐ AM ☐ PM	
1. First full day lost from work ☐ NONE LOST	
2. Date returned to work (if appropriate)	List injured body parts and nature of injury:(ex: Broken left finger, lower back strain)
3. Date employer notified of injury	
If fatal - REPORT WITHIN 48 HOURS - Date of death	
Place where injury/illness occurred: ☐ At employer location listed in Block 1 OR	Complete address where accident occurred:
Was this injury previously an incident-only with no medical treatment and no time lost? ☐ Yes ☐ No	
If Yes, date employer first notified of medical treatment or time lost	
Category(ies) of injury or illness: O Injury O Illness O Occupational Disease O Repetitive Trauma O Occupational Hearing Loss O Unknown	
Print Name of Report Preparer Date Prepared Phone & Extension	
Print Name of Employer Contact Person OR ☐ Same as above Phone & Extension	

DWC:	County	Time A	Time W	OCC	Nature	Part	Source	Type	

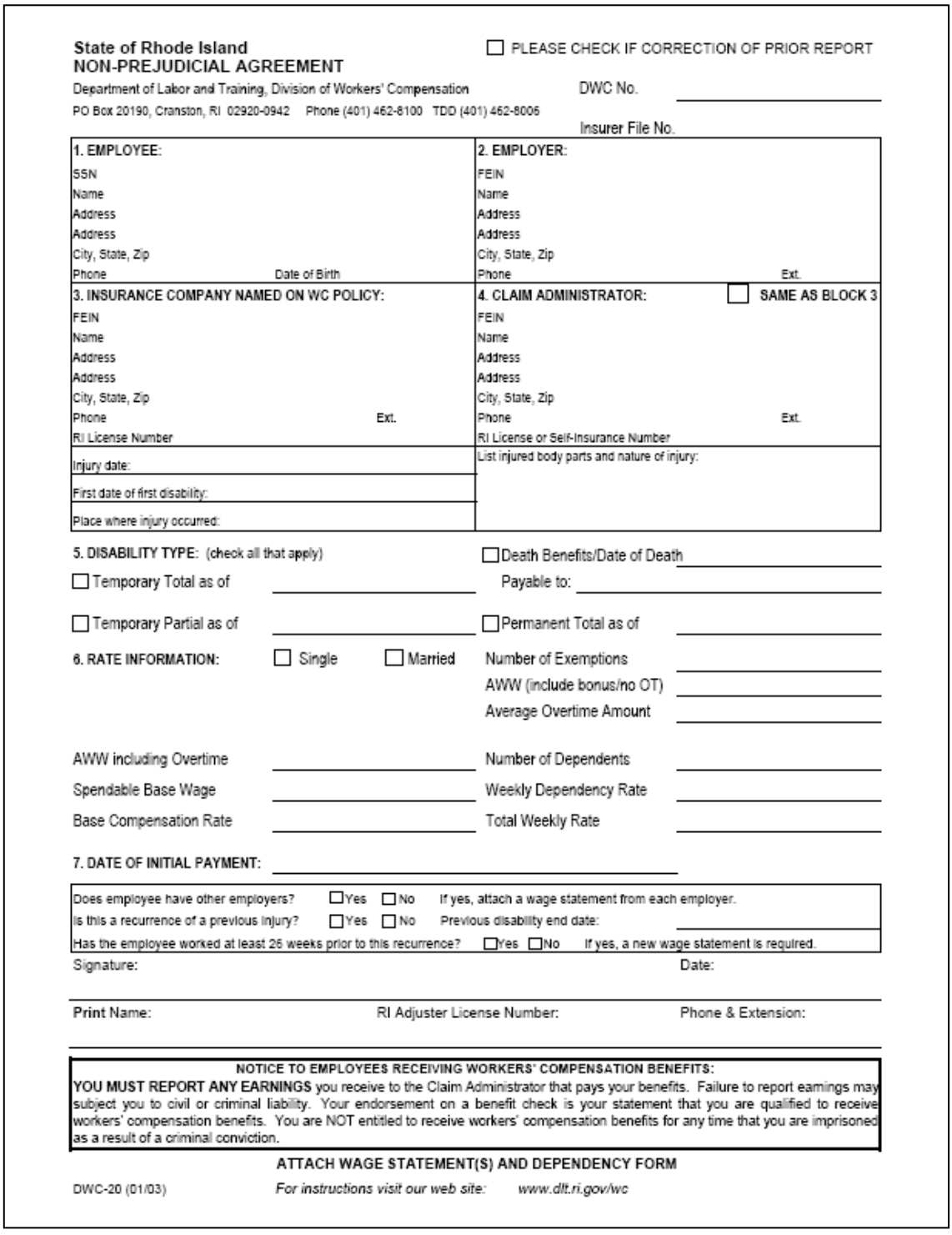
DWC-01 (01/03) *For instructions visit our web site: www.dlt.ri.gov/wc*

a. Non-prejudicial Agreement

Allows for payments for up to 13 weeks without accepting liability

If the payment of compensation is terminated, notice must be given to the employee and his or her attorney within 10 days of the termination

If payments are made for more than 13 weeks, a Memorandum of Agreement (MOA) must be filed with DLT within 10 days



State of Rhode Island
NON-PREJUDICIAL AGREEMENT

☐ 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.

1. EMPLOYEE:	2. EMPLOYER:
SSN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Date of Birth	Phone Ext.
3. INSURANCE COMPANY NAMED ON WC POLICY:	**4. CLAIM ADMINISTRATOR:** ☐ SAME AS BLOCK 3
FEIN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Ext.	Phone Ext.
RI License Number	RI License or Self-Insurance Number
Injury date:	List injured body parts and nature of injury:
First date of first disability:	
Place where injury occurred:	

5. DISABILITY TYPE: (check all that apply)

☐ Temporary Total as of _____

☐ Temporary Partial as of _____

☐ Death Benefits/Date of Death _____
Payable to: _____

☐ Permanent Total as of _____

6. RATE INFORMATION: ☐ Single ☐ Married

Number of Exemptions _____
AWW (include bonus/no OT) _____
Average Overtime Amount _____

AWW including Overtime _____
Spendable Base Wage _____
Base Compensation Rate _____

Number of Dependents _____
Weekly Dependency Rate _____
Total Weekly Rate _____

7. DATE OF INITIAL PAYMENT: _____

Does employee have other employers? ☐Yes ☐No If yes, attach a wage statement from each employer.
Is this a recurrence of a previous injury? ☐Yes ☐No Previous disability end date: _____
Has the employee worked at least 26 weeks prior to this recurrence? ☐Yes ☐No If yes, a new wage statement is required.

Signature: Date:

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

NOTICE TO EMPLOYEES RECEIVING WORKERS' COMPENSATION BENEFITS:
YOU MUST REPORT ANY EARNINGS you receive to the Claim Administrator that pays your benefits. Failure to report earnings may subject you to civil or criminal liability. Your endorsement on a benefit check is your statement that you are qualified to receive workers' compensation benefits. You are NOT entitled to receive workers' compensation benefits for any time that you are imprisoned as a result of a criminal conviction.

ATTACH WAGE STATEMENT(S) AND DEPENDENCY FORM

DWC-20 (01/03) *For instructions visit our web site: www.dlt.ri.gov/wc*

b. Memorandum of Agreement

Accepts liability

A copy of the MOA must be filed with DLT within 10 days of the initial payment with a Report of Indemnity Payment (DWC-22) attached

State of Rhode Island
MEMORANDUM OF AGREEMENT

☐ 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.

1. EMPLOYEE:	2. EMPLOYER:
SSN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Date of Birth	Phone Ext.
3. INSURANCE COMPANY NAMED ON WC POLICY:	**4. CLAIM ADMINISTRATOR:** ☐ **SAME AS BLOCK 3**
FEIN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Ext.	Phone Ext.
RI License Number	RI License or Self-Insurance Number
Injury date:	List injured body parts and nature of injury:
First date of first disability:	
Place where injury occurred:	

5. DISABILITY TYPE: (check all that apply)

☐ Temporary Total as of _____

☐ Temporary Partial as of _____

☐ Death Benefits/Date of Death _____
Payable to: _____

☐ Permanent Total as of _____

6. RATE INFORMATION: ☐ Single ☐ Married

Number of Exemptions _____
AWW (include bonus/no OT) _____
Average Overtime Amount _____

AWW including Overtime _____
Spendable Base Wage _____
Base Compensation Rate _____

Number of Dependents _____
Weekly Dependency Rate _____
Total Weekly Rate _____

7. DATE OF INITIAL PAYMENT UNDER MOA: _____

Does employee have other employers? ☐Yes ☐No If yes, attach a wage statement from each employer.
Is this a recurrence of a previous injury? ☐Yes ☐No Previous disability end date: _____
Has the employee worked at least 26 weeks prior to this recurrence? ☐Yes ☐No If yes, a new wage statement is required.

Signature: Date:

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

NOTICE TO EMPLOYEES RECEIVING WORKERS' COMPENSATION BENEFITS:
YOU MUST REPORT ANY EARNINGS you receive to the Claim Administrator that pays your benefits. Failure to report earnings may subject you to civil or criminal liability. Your endorsement on a benefit check is your statement that you are qualified to receive workers' compensation benefits. You are NOT entitled to receive workers' compensation benefits for any time that you are imprisoned as a result of a criminal conviction.

ATTACH WAGE STATEMENT(S) AND DEPENDENCY FORM

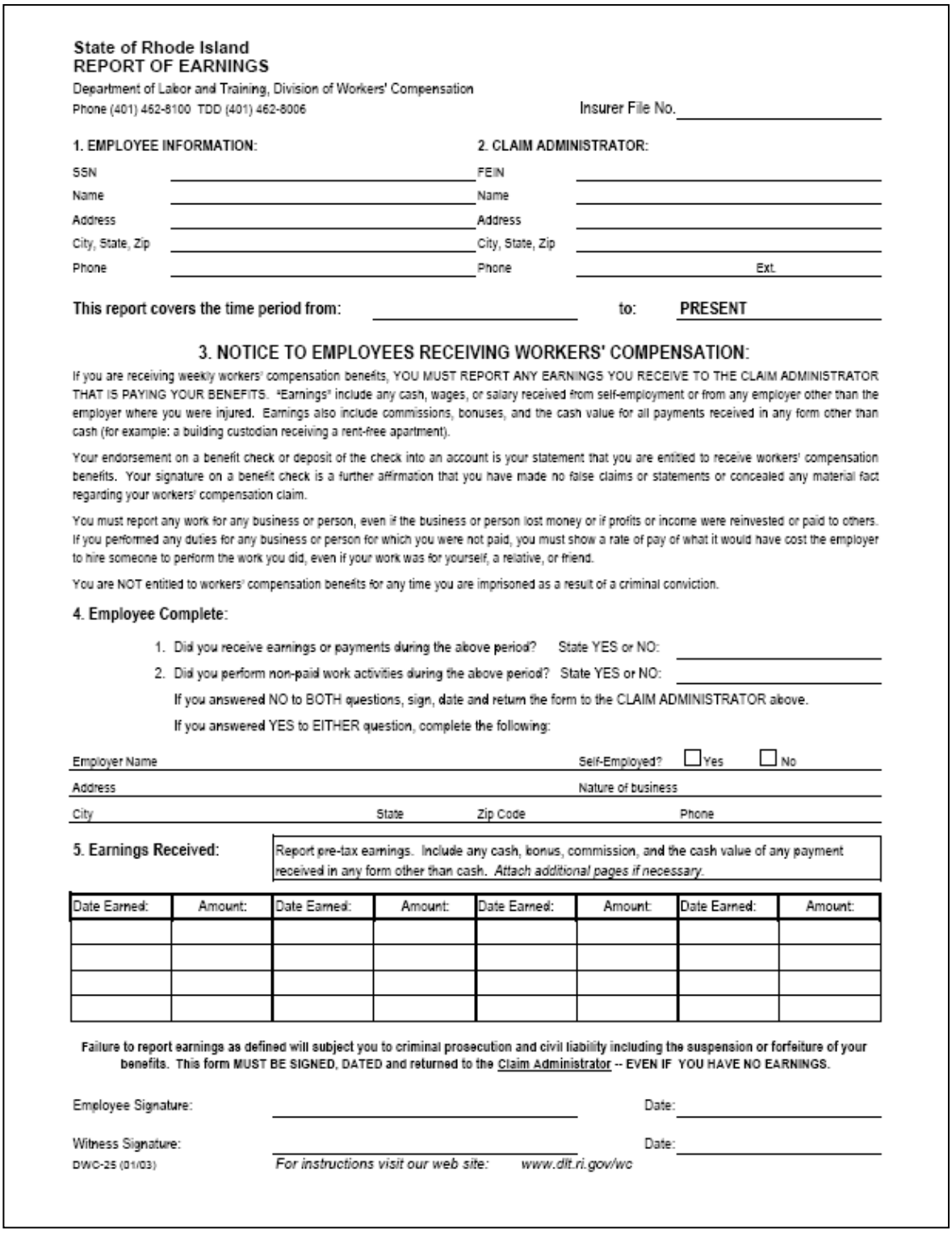
DWC-02 (01/03) *For instructions visit our web site: www.dlt.ri.gov/wc*

g. Report of Earnings

Between insurer and employee

Regular intervals

Cannot be used to delay payments to an employee



State of Rhode Island
REPORT OF EARNINGS

Department of Labor and Training, Division of Workers' Compensation
Phone (401) 462-8100 TDD (401) 462-8006

Insurer File No. _____

1. EMPLOYEE INFORMATION:

SSN _____
Name _____
Address _____
City, State, Zip _____
Phone _____

2. CLAIM ADMINISTRATOR:

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

This report covers the time period from: _____ **to:** **PRESENT**

3. NOTICE TO EMPLOYEES RECEIVING WORKERS' COMPENSATION:

If you are receiving weekly workers' compensation benefits, YOU MUST REPORT ANY EARNINGS YOU RECEIVE TO THE CLAIM ADMINISTRATOR THAT IS PAYING YOUR BENEFITS. "Earnings" include any cash, wages, or salary received from self-employment or from any employer other than the employer where you were injured. Earnings also include commissions, bonuses, and the cash value for all payments received in any form other than cash (for example: a building custodian receiving a rent-free apartment).

Your endorsement on a benefit check or deposit of the check into an account is your statement that you are entitled to receive workers' compensation benefits. Your signature on a benefit check is a further affirmation that you have made no false claims or statements or concealed any material fact regarding your workers' compensation claim.

You must report any work for any business or person, even if the business or person lost money or if profits or income were reinvested or paid to others. If you performed any duties for any business or person for which you were not paid, you must show a rate of pay of what it would have cost the employer to hire someone to perform the work you did, even if your work was for yourself, a relative, or friend.

You are NOT entitled to workers' compensation benefits for any time you are imprisoned as a result of a criminal conviction.

4. Employee Complete:

1. Did you receive earnings or payments during the above period? State YES or NO: _____
2. Did you perform non-paid work activities during the above period? State YES or NO: _____

If you answered NO to BOTH questions, sign, date and return the form to the CLAIM ADMINISTRATOR above.

If you answered YES to EITHER question, complete the following:

Employer Name _____ Self-Employed? ☐ Yes ☐ No

Address _____ Nature of business _____

City _____ State _____ Zip Code _____ Phone _____

5. Earnings Received: Report pre-tax earnings. Include any cash, bonus, commission, and the cash value of any payment received in any form other than cash. *Attach additional pages if necessary.*

Date Earned:	Amount:	Date Earned:	Amount:	Date Earned:	Amount:	Date Earned:	Amount:

Failure to report earnings as defined will subject you to criminal prosecution and civil liability including the suspension or forfeiture of your benefits. This form MUST BE SIGNED, DATED and returned to the Claim Administrator -- EVEN IF YOU HAVE NO EARNINGS.

Employee Signature: _____ Date: _____

Witness Signature: _____ Date: _____

DWC-25 (01/03) *For instructions visit our web site: www.dlt.ri.gov/wc*

c. Termination of Payment—Accounting

Within 60 days after the discontinuance or suspension of compensation payments, DLT requires an itemized accounting of a claim, including medical, from the insurer.

State of Rhode Island ☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

ITEMIZED STATEMENT OF COMPENSATION

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. _____

1. EMPLOYEE INFORMATION:

SSN _____
Name _____
Address _____
City, State, Zip _____

2. CLAIM INFORMATION:

Employer _____
Insurance Co. _____
Claim Administrator _____
Injury date _____ Incapacity date _____
Date of death _____ ☐ Work-related OR Not ☐

3. ☐ **Incident Only**--No payments made. Complete Section 8 and return to DLT *only* at above address. ***All others continue below.***

4. NONPAYMENT OF WEEKLY INDEMNITY ONLY: Check correct box and complete appropriate information on remainder of form.

☐ **Medical Only*** *Payment info must be listed below ☐ **Federal Jurisdiction** ☐ **Salary Continuation** ☐ **Denied** — Do NOT use *Other* if claim is *Denied*

☐ **Death**--Liability established; no dependents. Payment made to WCAF ☐ **Other:**

5. DIAGNOSIS:

Primary Written Diagnosis	ICD Code:
Secondary Written Diagnosis	ICD Code:

6. PAYMENT INFORMATION: (List total amount paid for each appropriate item in both columns) **DATE OF FIRST INDEMNITY PAYMENT:** _____

Temporary Partial		Hospital/Treatment Center	
Temporary Total		Independent Medical Exams	
Permanent Total		Pharmaceutical	
Weekly Death Benefits		Chiropractic	
Burial		Diagnostic Testing	
Specific - Disfigurement		Attorney Fees Awarded by Court	
Specific - Loss of Use		Penalties/Interest	
Vocational Rehabilitation		WC Administrative Fund (WCAF)	
Physical Therapy		Settlement	
Occupational Therapy		Deny & Dismiss	
Psychological Services		Other Payments:	
Physicians		Subrogation	☐ Yes ☐ No

7. RETURN TO EMPLOYMENT: Did the employee return to employment? ☐ Yes ☐ No ☐ Unknown

If yes, was it with the ☐ same employer OR a ☐ different employer ☐ Unknown Date Returned: ☐ Unknown

8. THIS REPORT WAS PREPARED BY: **PLEASE PRINT**

Name	RI Adjuster License Number	
Company Name		
Address		
City	State	Zip Code
Telephone	Extension	Email

Signature _____ Date _____

Distribution: DLT, Division of Workers' Compensation; Employee and Attorney; Employer

DWC-50 (01/03) *For instructions visit our web site: www.dlt.ri.gov/wc*

2. Sole Proprietors and Partners – Excluded

3. Employment Covered

WC insurance is mandatory for employers with one or more employees

Jurisdiction for those hired or injured in RI

Partial list of **exclusions**:
Members of fire and police departments
Sole proprietors and Partners
Independent contractors
Volunteers
Certain real estate persons and farm laborers

4. Penalties

$250 penalty may be assessed for failure to report or late reporting

B. Benefits

Reasonable Medical for Injury or Occupational Disease/Illness
Percentage of Lost Wages
Dependency Benefits if Total
Specific Damages
Rehabilitation
Death Benefits

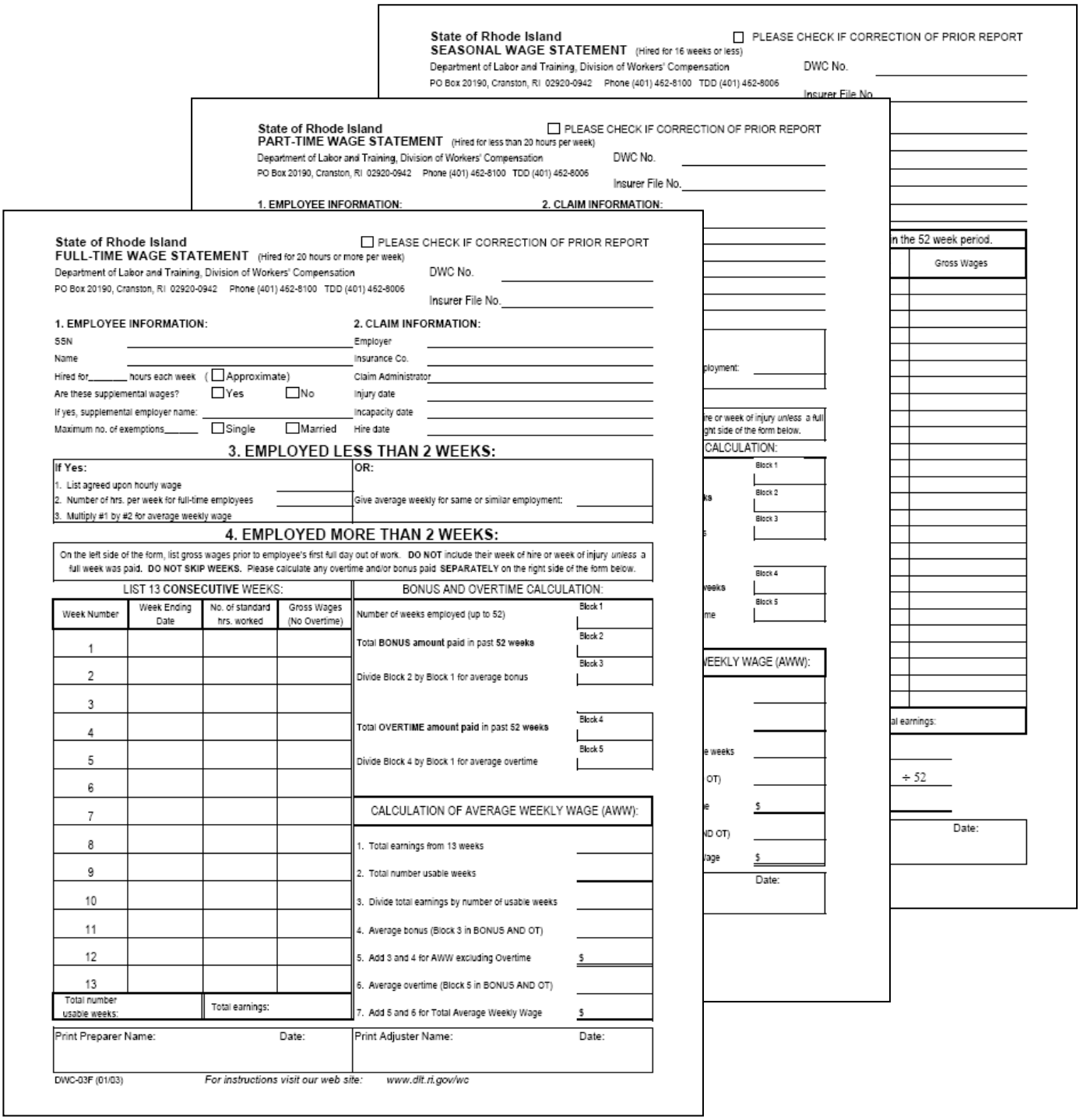
1. Waiting Period

Three-day waiting period – no retro

NOTES:

2. Computation of Earnings

Bonus and Overtime included; separately
Wages from concurrent employment included
Full Time – 13 weeks
Part Time – 26 weeks
Seasonal – 12 months
Recurrence – If employee returned to employment for 26 weeks or more, new average weekly wage is calculated



State of Rhode Island
SEASONAL WAGE STATEMENT (Hired for 16 weeks or less)
Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006
☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT
DWC No.
Insurer File No.

State of Rhode Island
PART-TIME WAGE STATEMENT (Hired for less than 20 hours per week)
Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006
☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT
DWC No.
Insurer File No.
1. EMPLOYEE INFORMATION:
2. CLAIM INFORMATION:

State of Rhode Island
FULL-TIME WAGE STATEMENT (Hired for 20 hours or more per week)
Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006
☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT
DWC No.
Insurer File No.

1. EMPLOYEE INFORMATION:
SSN
Name
Hired for_____ hours each week (☐ Approximate)
Are these supplemental wages? ☐ Yes ☐ No
If yes, supplemental employer name:
Maximum no. of exemptions_____ ☐ Single ☐ Married

2. CLAIM INFORMATION:
Employer
Insurance Co.
Claim Administrator
Injury date
Incapacity date
Hire date

3. EMPLOYED LESS THAN 2 WEEKS:

If Yes:	OR:
1. List agreed upon hourly wage	
2. Number of hrs. per week for full-time employees	Give average weekly for same or similar employment:
3. Multiply #1 by #2 for average weekly wage	

4. EMPLOYED MORE THAN 2 WEEKS:

On the left side of the form, list gross wages prior to employee's first full day out of work. **DO NOT** include their week of hire or week of injury *unless* a full week was paid. **DO NOT SKIP WEEKS.** Please calculate any overtime and/or bonus paid **SEPARATELY** on the right side of the form below.

LIST 13 **CONSECUTIVE** WEEKS:

Week Number	Week Ending Date	No. of standard hrs. worked	Gross Wages (No Overtime)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
Total number usable weeks:		Total earnings:	

BONUS AND OVERTIME CALCULATION:

Number of weeks employed (up to 52)	Block 1
Total **BONUS amount paid** in past **52 weeks**	Block 2
Divide Block 2 by Block 1 for average bonus	Block 3
Total **OVERTIME amount paid** in past **52 weeks**	Block 4
Divide Block 4 by Block 1 for average overtime	Block 5

CALCULATION OF AVERAGE WEEKLY WAGE (AWW):

1. Total earnings from 13 weeks	
2. Total number usable weeks	
3. Divide total earnings by number of usable weeks	
4. Average bonus (Block 3 in BONUS AND OT)	
5. Add 3 and 4 for AWW excluding Overtime	$
6. Average overtime (Block 5 in BONUS AND OT)	
7. Add 5 and 6 for Total Average Weekly Wage	$

Print Preparer Name: Date:
Print Adjuster Name: Date:

DWC-03F (01/03) *For instructions visit our web site: www.dlt.ri.gov/wc*

3. Medical and Vocational Rehabilitation

Dr. John E. Donley Rehabilitation Center
Within DLT offering physical, vocational and psychological services
Rehabilitation evaluation available after receiving compensation for more than 3 months
While participating in an approved rehab program, compensation cannot be reduced or terminated

4. Choice of Physician

An injured worker shall have the freedom of choice to obtain health care, diagnosis, and treatment from any qualified health care provider initially.

Examination or treatment at a facility providing emergency care or by a physician under contract with the employer or insurer shall not constitute the employee's initial choice to obtain health care, diagnosis, or treatment.

5. Total vs. Partial

Total Incapacity
Same calculation for compensation rate
Payment for dependents
COLA as of May 10 if total for 52 weeks
No set time limit

Partial Incapacity
Same calculation for compensation rate
NO dependency
No COLA unless passage through the "Gate" at the end of 312 week time limit
Insurer/Employer must send a notice of intention to terminate to employee and DLT at least 26 weeks prior

6. Death

Every self-insured employer and every insurer must pay $7,500 into the Workers' Compensation Administrative Fund for every case of injury causing death in which there is no person entitled to compensation.

Burial Benefit on regular death claim is $15,000

7. Specific Injuries

Payment is mailed within 14 days of the entry of a decree, order, or agreement of the parties

8. Reinstatement

Employers with ten or more
Employees capable of pre-injury job tasks with or without reasonable accommodation
Subject to ADA and collective bargaining agreement
Position is "available" even if filled by replacement worker
Disputes are heard by WC Court

Reinstatement does <u>not</u> apply to a worker…:

hired on a temporary basis
in a seasonal occupation
who is on a probationary period of less than 91days
who works out of a hiring hall operating pursuant to a collective bargaining agreement

9. Dependency

Dependency is not paid on Partial Incapacity claims
$15 per week - Total Incapacity
$40 per week - Death Claim

C. Definitions

Part-time
Hired for less than 20 hours per week

Full-time
Hired for 20 hours or more per week

Seasonal
Hired for 16 weeks or less

Occupational Disease is covered under RI Law

III. RHODE ISLAND LAWS, RULES AND REGULATIONS

A. Powers and Duties of Insurance Commissioner

Licensing is handled by the RI Department of Business Regulation
Ability to rescind a license
Promulgate rules and regulations
Investigate violators
Administer penalties

B. Denial, Suspension and Revocation of license

Violations by adjusters can prompt a variety of consequences

C. Child Support Intercept Act

Within 30 days prior to making a payment to a claimant equal to or above $3,000, any WC carrier must review information provided by the RI Department of Administration, Division of Taxation to see whether or not that claimant owes back child support.

D. Complaint Handling Procedures

Insurers must maintain a complete record of all complaints it receives, including:
Total number
Classification by line of insurance
Nature of each
Disposition of each
Time it took to process complaint

Miscellaneous Adjuster Licensing Issues:

Handled by the Rhode Island Department of Business Regulation (DBR)
(401) 222-2223
www.dbr.state.ri.us

Reciprocal States
CT, KY, NC, NH, ME, MI, OK, SC, TX, VT
NONRESIDENTS— Exempt from taking exam if they are licensed in their home state for the same lines being requested in RI and if their state is reciprocal. Same fees apply; see application requirements.

NOTES: