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 www.dlt.ri.gov

NOTICE OF CLAIM AGAINST RHODE ISLAND

UNINSURED PROTECTION FUND PURSUANT TO RIGL §28-53-7

Instructions - For injuries on or after September 1, 2019

1) Complete entire 3-page form, with attachments, and submit to the Division of Workers' Compensation Fraud and Compliance Unit at the above address or by e-mail to dlt.wcfraud@dlt.ri.gov
2) Fraud & Compliance Unit will investigate and determine if the employer is uninsured.
3) If the employer is found to be uninsured, a Certificate of No Insurance will be issued.
4) Claimant/Attorney may file a petition at the Workers' Compensation Court with the Certificate of No Insurance.

Questions should be directed to an Education Unit Representative at (401) 462-8100

EMPLOYEE INFORMATION:

Employee Name:	Date of Birth (mm/dd/yyyy):
Address:	
Address:	
City/St/Zip	
Telephone & e-mail contact:	

EMPLOYER INFORMATION:

Business Name:	FEIN (if known):
Address:	
City/St/Zip:	
Telephone/Contact Information:	
Does this business go by any other names?	
How many employees work for this business?	
Describe work the Employees of this Business do:	
Owners Name:	Name of Supervisor/Boss:
Your date of hire (mm/dd/yyyy):	Name of person that hired you:
Additional information about this employer?	

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ADDITIONAL INFORMATION:

How are/were you paid: (circle one) CASH CHECK DIRECT DEPOSIT OTHER (list):	
ATTACH MOST RECENT PROOF OF WAGES FROM EMPLOYER LISTED FOR THIS INJURY	
Did you receive medical treatment: YES NO (circle one)	If yes, what date (mm/dd/yyyy):
Name of treatment provider(s):	
ATTACH OUT OF WORK SLIP AND/OR MEDICAL REPORT(S)	

INJURY:

Date of Injury (mm/dd/yyyy):	Time of Injury: AM PM (circle one)
Address/place where injury happened:	
Was this injury reported to the employer: YES NO (circle one)	If yes, date and time:
To whom was the injury reported:	
Describe how the incident/injury happened:	
Type of Injury and Body Part: (example: Broken Left Hand)	

DISABILITY:

Occupation/Job Title when injured:	
Gross weekly wages before injury: $	# of weekly hours worked:
Did injury cause lost time out of work: YES NO (circle one)	If yes, last date worked:
Has employer paid for lost wages: YES NO (circle one)	If yes, what was paid:
Has the employee returned to work: YES NO (circle one)	If yes, date returned:
If yes, name of current employer:	
Does injured worker have other wages: YES NO (circle one) If yes, list employer(s) and amount of wages:	
Other Employer Name:	Gross weekly wage $

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WITNESS: List all witnesses to injury and contact information: Add additional pages if needed

1. Witness Name:	**2. Witness Name:**
Address:	Address:
City/St/Zip	City/St/Zip
Telephone:	Telephone:
Is this witness a co-worker? YES NO (circle one)	Is this witness a co-worker? YES NO (circle one)

3. Witness Name:	**4. Witness Name:**
Address:	Address:
City/St/Zip	City/St/Zip
Telephone:	Telephone:
Is this witness a co-worker? YES NO (circle one)	Is this witness a co-worker? YES NO (circle one)

EMPLOYEE REPRESENTATION:

Attorney Name:
Address:
Address:
City/St/Zip
Telephone & e-mail contact:

LITIGATION: List any litigation related to this injury

By signing this form, I verify that all information, to the best of my knowledge, is true, complete and correct.

Employee Signature:

Employee Signature:	Date:(mm/dd/yyyy):

Attorney Signature:

Signature: Bar #:_____	Date:(mm/dd/yyyy):