A.I.M. Mutual
Insurance Companies
since 1989

A.I.M. Mutual Insurance Company
Associated Employers Insurance Company
Massachusetts Employers Insurance Company
New Hampshire Employers Insurance Company





Claim **Kit**

in
partnership
with
you

A.I.M. Mutual Insurance Company
Massachusetts Employers Insurance Company
New Hampshire Employers Insurance Company
Associated Employers Insurance Company

As your new workers' compensation insurance carrier, we ask that you report all accidents to us as soon as possible after they occur. Your prompt notification, together with a complete accident report, will help us handle your claims fairly and efficiently. This will also help you avoid fines for late reporting

Here is a supply of the necessary forms along with instructions for their use. You can also find them online at www.aimmutual.com. Please feel free to contact us at any time with your questions or service requests.

A.I.M. MUTUAL INSURANCE COMPANIES

54 Third Avenue, Burlington, MA 01803

Workers' Compensation
Rhode Island Claim Reporting Options

In the event of a serious accident, call us immediately at 1-866-270-3354
(toll free 24-hour/7 day a week claim reporting)

Choose from several different ways to report your workers' compensation claim to us.

On-Line:

Log on to www.aimmutual.com. Select Report A Claim / Report A Claim RI

You will be prompted to answer a series of questions similar to the information necessary to complete a Form DWC-01. After answering all of the questions and clicking on SEND, you will receive a message stating your claim has been submitted. It will also state that a Claim Acknowledgement letter containing the claim number and assigned claim representative will be mailed to your company after registration has been completed. Click Print for a copy of the information you sent. We will file Form DWC-01 with the State of Rhode Island Department of Labor and Training. Even if the claim is for first-aid only injury claims, submit the Form DWC-01 to us. We will file this form with the State of Rhode Island Department of Labor and Training.

By Phone:

Report claims by calling toll free: 1-866-270-3354.

This line is established for reporting new claims only and facilitates the initial claim reporting process. Please have your policy number on hand prior to calling. You will receive a completed Form DWC-01 and a confirmation letter, followed by a claim acknowledgment letter including the name of the Claim Representative assigned to your case. We will file Form DWC-01 with the State of Rhode Island Department of Labor and Training. Even if the claim is for first-aid only injury claims, submit the Form DWC-01 to us. We will file this form with the State of Rhode Island Department of Labor and Training.

After the initial claim report: *Please direct ongoing claim and service inquiries to your Claim Representative at our toll free telephone number:* 1-800-876-2765

By Fax:

For **all** claims, complete and fax the Employer's First Report of Alleged Occupational Injury, Disease or Fatality (Form DWC-01) to us at **1-781-270-5599.** Form DWC-01 should be filed as soon as possible after knowledge of an employee's job-related injury, disease or fatality but no later than 72 hours thereafter. We will file Form DWC-01 with the State of Rhode Island Department of Labor and Training. Even if the claim is for first-aid only injury claims, submit the Form DWC-01 to us. We will file this form with the State of Rhode Island Department of Labor and Training.

By Mail:

Mail the completed Form DWC-01 to A.I.M. Mutual Insurance Companies, Attn: Claim Department, 54 Third Avenue, P.O. Box 4070, Burlington, MA 01803-0970

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

PO Box 20190, Cranston, RI 02920-0942

Phone (401) 462-8100 TDD (401) 462-8006 FAX (401) 462-8105

DWC No. _____

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	

EMPLOYER'S FIRST REPORT OF ALLEGED OCCUPATIONAL INJURY, DISEASE OR FATALITY (DWC-01)

By law, the employer must complete a First Report of Injury for an employee for any work-related injury, if that injury requires any medical treatment or if the employee loses full wages for at least three (3) days. The employer must also report any work-related death.

General Instructions:

- Please clearly print or type information into all of the areas of the First Report – FORMS MAY BE REJECTED IF INCOMPLETE.
- Completed by: Employer.
- Time Frame: Within 10 days of knowledge of the injury OR within 48 hours of death. If you do not send in the First Report on time **or** if it is incomplete, you may be subject to a **$250 fine**.
- Distribution: Send to A.I.M. Mutual Insurance Companies.
- Attachments: None. DO NOT ATTACH MEDICAL REPORTS.

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check if sending in an amended form.

1. ***Employer Location:***
   - *FEIN:* Employer's Federal Employer Identification Number.
   - *Name:* Employer's actual name where the employee was employed at the time of the injury.
   - *Address (including city, state, zip):* Address of the employer's actual location.
   - *Phone/Ext:* Phone number and extension (if necessary) of the employer's facility.
   - *Type of Business:* General classification of what the business does on a daily basis. (Ex. Restaurant; Jewelry Manufacturing; etc.)
   - *RI Unemployment Ins. No.:* This number (ERN – Employer Record Number) is assigned to employers by the Rhode Island Division of Taxation and is used by employers when paying their RI Unemployment Insurance and Temporary Disability Insurance taxes. The Division of Worker's Compensation will use this number for employer identification purposes only.
   - *NAICS:* North American Industry Classification System, established by the US Census Bureau to provide common industry classifications based on the type of business. Visit www.census.gov and click on NAICS to locate the industry code. IF THIS CODE CANNOT BE OBTAINED, BE SURE TO HAVE COMPLETED 'Type of business' on the form.
2. ***Employer Named on WC Insurance Policy:*** If this information is identical to the information in Block 1, check the 'Same' box, complete the WC Policy information, and move onto Block 3. If different, proceed below.
   - *FEIN:* Federal Employer Identification Number of the employer listed on the WC Insurance Policy.
   - *Name:* Insured named on the policy or the financially responsible self-insured employer, as certified by DLT.
   - *Address (including city, state, zip):* Mailing address of the employer named on the WC Insurance Policy.
   - *Phone/Ext:* Phone number and extension (if necessary) of the named employer's facility.
   - *WC Policy Number:* Number assigned to the WC contract or policy for that employer.
3. ***Insurance company named on WC Policy:***
   - *FEIN:* WC Insurance company's Federal Employer Identification Number.
   - *Name:* Name of the worker's compensation insurer OR 'Self-Insured' if the company has been certified as self-insured by DLT.
   - *Address (including city, state, zip):* Mailing address of the WC insurance carrier named on the WC Insurance Policy.
   - *Phone/Ext:* Phone number and extension (if necessary) of the named WC insurance carrier.
4. ***Claim Administrator:*** If this information is identical to the information in Block 3, check the 'Same' box, and move onto Block 5. If different, proceed below.
   - *FEIN:* Federal Employer Identification Number of the company administering the claim.
   - *Name:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
   - *Address (including city, state, zip):* Mailing address of the claim administrator.
   - *Phone/Ext:* Phone number and extension (if necessary) of the claim administrator.
5. ***Employee:***
   - *SSN:* Employee's Social Security Number.
   - *Male/Female:* Check one.
   - *Name:* Employee's full name as shown on payroll.
   - *Address (including city, state, zip):* Employee's current mailing address.
   - *Phone:* Employee's current home telephone number.
   - *Date of Birth:* Date the employee was born.
   - *Occupation:* Primary occupation of the employee at the time of the accident.
   - *Date Hired:* Date the employee began his or her employment with the employer.
   - *State of Hire:* State in which the employee was actually hired.
   - *Preferred Language of Employee:* Primary language spoken or understood by the employee.
6. ***Medical Information:***
   - *Treatment Facility:* Name of the facility where employee received treatment for injury or illness.
   - *Address (including city, state, zip):* Treatment facility address.
   - *Phone/Ext:* Phone number and extension (if necessary) of the treatment facility.
7. ***Witness Information:***
   - *Name:* Name of person or persons who witnessed injury.
   - *Phone:* Phone number (s) of witness(es)

8. Injury Information:

- *Injury Date:* Date that the accident happened.
- *Time injury occurred:* Time that the injury happened.
- *Time employee began work:* Time that the employee began work on the day the injury happened.
- *First full day lost from work:* First full day that the employee lost from work (include weekends and holidays). This is referred to as the Incapacity Date throughout the claim OR check *NONE LOST* if the employee lost no time due to the injury.
- *Date returned to work (if appropriate):* If employee has returned to work, complete this question.
- *Date employer notified of injury:* Date that the injury was reported to a representative of the employer.
- *If fatal, REPORT WITHIN 48 HOURS – Date of Death:* Conditional, if employee died.
- *What was person doing when injured:* A brief description of how the accident happened.
- *List injured body parts and nature of injury:* Detailed description of what part or parts were injured and what type of injury it is.
- *Place where injury/illness occurred:* Check box if the injury happened at the address of the employer listed in Block 1 OR enter the complete address (including city and state) where injury actually took place.
- *Was this injury previously an incident-only with no medical treatment and no time lost?:* Check *No* if that is the appropriate answer. Checking *Yes* refers to injuries which were originally not reportable to the State—meaning that the employee lost no time or received no medical treatment for their injury (incident only). If the injury later becomes reportable because the employee now has **either** lost full wages for at least three (3) days **or** received any medical treatment due to the work-related injury, then check Yes.
- *If Yes, date employer first notified of medical treatment or time lost:* If *Yes* was checked, enter appropriate date.
- *Category(ies) of injury or illness:* Check the appropriate item(s).

- *Print Name of Report Preparer/Date Prepared/Phone & Extension:* Clearly enter the name of the person who filled out the form, the date that the form was prepared, and the complete phone number of the preparer.
- *Print Name of Employer Contact Person OR Same as above /Phone & Extension:* Check box if the information is identical or clearly enter the name and complete phone number of the employer's contact person.

State of Rhode Island
FULL-TIME WAGE STATEMENT (Hired for 20 hours or more per week)

☐ 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. _____

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

CLAIM INFORMATION:

Employer _____
Insurance Co. _____
Claim Administrator _____
Injury date _____
Incapacity date _____
Hire date _____

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	

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:

For instructions visit our web site: www.dlt.ri.gov/wc

FULL-TIME/PART-TIME WAGE STATEMENTS
(DWC-03F/DWC-03P)

General Instructions:

- Full-time: Hired for 20 hours or more per week. (13 weeks of wages)
- Part-time: Hired for less than 20 hours per week. (26 weeks of wages)
- Completed by: Employer.
- Time Frame: No set time frame. However, the wage statement should be completed as soon as the employee has been out of work for four consecutive days due to his or her work-related injury.
- Distribution: Original from employer to claim administrator. Claim administrator must attach to appropriate documentation when filing with DLT.
- Attachments: None.

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check if sending in an amended form.

1. Employee Information:

- *SSN:* Employee's Social Security Number.
- *Name:* Employee's full name.
- *Hired for:* Number of hours that the employee was hired to work per week. Check box if hours are not regularly scheduled but approximated.
- *Are these supplemental wages? Yes/No:* Check No if the wages are from the employer where the employee was injured. Check Yes if the employee has more than one employer and the wage statement is from the employer where the injury did not occur.
- *If Yes, supplemental employer name:* Name of the supplemental employer.
- *Maximum no. of exemptions/Single or Married:* Total exemptions the employee is able to claim; **not** necessarily what is on the employee's W-4 form. Check appropriate marital status.

2. Claim Information:

- *Employer:* Employer's actual name where the employee was employed at the time of the injury.
- *Insurance Co.:* Name of the worker's compensation insurer OR 'Self-Insured' if the company has been certified as self-insured by DLT.
- *Claim Administrator:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
- *Injury Date:* Date that the accident happened.
- *Incapacity Date:* First full day that the employee lost from work (include weekends and holidays).
- *Hire Date:* Date the employee began his or her employment with the employer.

3. Employed Less Than 2 Weeks: Use this section **only** if the employee was employed for less than two full weeks.

- *List agreed upon hourly wage:* Hourly rate of pay agreed to between employer and employee.
- *Number of hrs. per week for full-time (part-time) employees:* Enter number of hours full-time (part-time) employees are generally scheduled for the employer.
- *Multiply #1 by #2:* Multiply the hourly rate by the number of scheduled hours for the average weekly wage (AWW).
- *OR Give average weekly for same or similar employment:* If no hourly rate was agreed upon, put the AWW for the same or similar job.

4. Employed More Than 2 Weeks: Follow the instructions.

- *LIST 13 (26)* ***CONSECUTIVE*** *WEEKS:*
  - *Week Ending Date:* Ending date of the weekly earnings period.
  - *No. of standard hours worked:* Number of hours worked for the week listed.
  - *Gross Wages (No Overtime):* Gross wage for the week listed. Include Sunday and Holiday pay. Do not include overtime.
  - *Total number usable weeks:* Total the number of weeks listed that have wages entered.
  - *Total Earnings:* Total of wages entered.
- *BONUS AND OVERTIME CALCULATION:*
  - *Number of weeks employed(up to 52):* Number of weeks the employee had been employed prior incapacity date. If more than 52, enter 52.
  - *Total BONUS amount paid in past 52 weeks:* Total of all bonus monies paid to employee in 52 weeks prior to incapacity date.
  - *Divide Block 2 by Block 1 for average bonus:* Divide total bonus monies by number of weeks employed (up to 52).
  - *Total OVERTIME amount paid in past 52 weeks:* Total of all overtime monies paid to employee in 52 weeks prior to incapacity date.
  - *Divide Block 4 by Block 1 for average overtime:* Divide total overtime monies by number of weeks employed (up to 52).
- *CALCULATION OF AVERAGE WEEKLY WAGE(AWW):*
  - *1. Total earnings from 13 (26) weeks:* Enter the total earnings from the left side of the wage statement.
  - *2. Total number usable weeks:* Enter the total the number of usable weeks from the left side of the wage statement.
  - *3. Divide total earnings by number of usable weeks:* Enter calculation.
  - *4. Average bonus:* Enter the calculation from Block 3 above.
  - *5. Add 3 and 4 for AWW excluding Overtime:* Enter calculation.
  - *6. Average overtime:* Enter calculation from Block 5 above.
  - *7. Add 5 and 6 for Total Average Weekly Wage:* Enter calculation.
- *Print Preparer Name/Date:* Clearly enter the name of the person who filled out the form and the date that the form was prepared.
- *Print Adjuster Name/Date:* Clearly enter the name of the adjuster who checked the calculations on the form and the date signed.
- More wage calculation tips.

WAGE CALCULATION TIPS

When a wage statement arrives at DLT, Division of Workers' Compensation from the claim administrator, each one is calculated separately to ensure accuracy. If incorrect, a letter is sent to the claim administrator who must contact the employer to get the corrections; the corrections go back to the claim administrator and again are sent to DLT. To avoid this lengthy process and promote prompt payment to the injured worker, please review these tips.

- Be ready to prepare a wage statement as soon as the employee has been out of work for 4 calendar days. A delay in completing the wage statement can lead to problems with a claim.
- Know which wage statement to use and have it available. Do not wait for the claim administrator to send you the wage statement. Use the…
  - Full-time for a person hired for 20 hours or more per week.
  - Part-time for a person hired for less than 20 hours per week.
  - Seasonal for a person hired to work for 16 weeks or less.
- The same rules for completion apply to the full-time and the part-time wage statements. The seasonal wage statement is different.
- Complete all areas of the wage statement – you may not realize the many uses for a single number or date.
- Be sure to include the number of hours per week the employee was hired to work.
- Injury date and Incapacity date are very important. Incapacity date is the first full calendar day that the employee was out of work due to their injury.
- Hire date must be provided – it is used for several reasons.
- Use the correct section depending on whether the employee worked less or more than 2 weeks.
- USE CONSECUTIVE WEEKS ALWAYS – whether the employee earned money or not.
- COMPLETE ALL COLUMNS. Skipping weeks and incomplete columns are two troublesome errors.
- Weeks go backwards from the incapacity date – not the injury date.
  - EX: Injury date: 5/10/2003; Incapacity date: 8/13/2003. Wages would go from 8/13/2003 back 13 or 26 weeks (depending on the statement used).
- In this same example, you would not use the week of incapacity unless it was a full week worked.
  - EX: If the employee was hired for 40 hours and worked 40 hours during the week of the incapacity, that week could be used on the wage statement. If the employee worked less than the 40 hours, you would not list the week, but would start with the week previous (no matter how many hours worked that week).
  - The same rule applies for the week of hire if it appears on the wage statement, only use it if a full week was worked.
- No overtime or bonus monies or hours should be listed in the 13 (26) weeks. They are calculated separately on the right side of the form.
- Since overtime is generally paid after 40 hours, if an employee worked more than 40 hours without earning any overtime, use the total hours and put *NO OT* next to the hours. This will let others know that, although more than 40 hours are listed, no overtime is included.
- Common examples of what <u>will be</u> included in the 13 (26) weeks:
  - Commissions
  - Holiday Pay - except during an unpaid plant shutdown week
  - Shift Differential
  - Sick Pay or put "UNPAID"
  - Sunday Pay
  - Vacation Pay or put "UNPAID"
- Sick and vacation pay are included, but if the employee did not receive payment for any of those weeks which might appear, put the word "UNPAID" in the Gross Wages column instead of a zero. This will let others know that it was, in fact, unpaid. Otherwise, one might think that the preparer did not know that those monies are used.
- When determining *Total number of usable weeks*, add up only the weeks where wages are listed. Zero weeks are not used in the mathematical computation when getting the average weekly wage (AWW).
- Although only 13 or 26 weeks of wages are used, you must go back 52 weeks from the incapacity date to collect bonus and overtime monies.
- In *Block 1*of the Bonus and Overtime Calculation, remember to only use the number of weeks employed up to 52. If the employee worked for less than 52, list the actual number – if greater than 52, list 52.
- Following the step-by step instructions on the remainder on the wage statement should result in an accurate computation of the AWW.
- Many unique circumstances may develop when completing a wage statement, contact your WC claim administrator or call a DLT Claims Analyst at (401) 462-8120 for help.
- All wage statements are available in an Excel format, which will do the final calculations for you!

State of Rhode Island
PART-TIME WAGE STATEMENT (Hired for less than 20 hours per week)

☐ 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. _____

EMPLOYEE INFORMATION:

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

CLAIM INFORMATION:

Employer _____
Insurance Co. _____
Claim Administrator _____
Injury date _____
Incapacity date _____
Hire date _____

EMPLOYED LESS THAN 2 WEEKS:

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

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 26 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			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
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 26 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-03P (01/03)

For instructions visit our web site: www.dlt.ri.gov/wc

State of Rhode Island
SEASONAL WAGE STATEMENT (Hired for 16 weeks or less)

☐ 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 INFORMATION:

SSN _____

Name _____

Maximum no. of exemptions_____ ☐ Single ☐ Married

Wages for how many employers are listed below? _____

2. CLAIM INFORMATION:

Employer _____

Insurance Co. _____

Claim Administrator _____

Injury date _____

Incapacity date _____

Hire date _____

List 52 CONSECUTIVE weeks of gross wages for *any* employment held by this person within the 52 week period.

Week Number	Week Ending Date	Gross Wages	Week Number	Week Ending Date	Gross Wages
1			27		
2			28		
3			29		
4			30		
5			31		
6			32		
7			33		
8			34		
9			35		
10			36		
11			37		
12			38		
13			39		
14			40		
15			41		
16			42		
17			43		
18			44		
19			45		
20			46		
21			47		
22			48		
23			49		
24			50		
25			51		
26			52		
		Total earnings:			Total earnings:

1. Combine total earnings listed _____
2. Divide total earnings by 52 ÷ 52
3. Average Weekly Wage $ _____

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

SEASONAL WAGE STATEMENT
(DWC-03S)

General Instructions:

- Seasonal: Hired for 16 weeks or less (52 weeks of wages) NOTE: Only used when the employee is injured on his or her seasonal job.
- Completed by: Employers/Insurer.
- Time Frame: No set time frame. However, the wage statement should be completed as soon as the employee has been out of work for four consecutive days due to his or her work-related injury.
- Distribution: Original from employer to claim administrator. Claim administrator must attach to appropriate documentation when filing with DLT.
- Attachments: None.

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check if sending in an amended form.

1. Employee Information:

- *SSN:* Employee's Social Security Number.
- *Name:* Employee's full name.
- *Maximum no. of exemptions/Single or Married:* Total exemptions the employee is able to claim; **not** necessarily what is on the employee's W-4 form. Check appropriate marital status.
- *Wages for how many employer are listed below?:* Enter total number of separate employers wages are listed for on statement.

2. Claim Information:

- *Employer:* Employer's actual name where the employee was employed at the time of the injury.
- *Insurance Co.:* Name of the worker's compensation insurer OR 'Self-Insured' if the company has been certified as self-insured by DLT.
- *Claim Administrator:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
- *Injury Date:* Date that the accident happened.
- *Incapacity Date:* First full day that the employee lost from work (include weekends and holidays).
- *Hire Date:* Date the employee began his or her employment with the employer.

- *List 52 CONSECUTIVE weeks of gross wages for any employment held by this person within the 52 period:*
  - *Week Ending Date:* Ending date of the weekly earnings period.
  - *Gross Wages:* Gross wage for the week listed. Include all earnings (Sunday, Holiday, Overtime, etc).
  - *Total Earnings:* Total of wages entered for each column.

  - *1. Combine total earnings listed:* Enter the total earnings from both columns.
  - *2. Divide total earnings by 52:* Do the math.
  - *3. Average Weekly Wage:* Enter calculation.

- *Print Preparer Name/Date:* Clearly enter the name of the person who filled out the form and the date that the form was prepared.
- *Print Adjuster Name/Date:* Clearly enter the name of the adjuster who checked the calculations on the form and the date signed.

AUTHORIZATION FOR THE RELEASE OF INFORMATION
AUTORIZACIÓN PARA LA LIBERACIÓN DE INFORMACIÓN

Claim Number / Número de Reclamo _____ **Date of Injury / Fecha de la Lesión** _____
Employee / Empleado _____ **Date of Birth / Fecha de Nacimiento** _____

I hereby authorize the divisions of A.I.M. Mutual Insurance Companies, their representative or bearer, to review, inspect, copy, and/ or photograph any and all of the following documents:

Por este medio autorizo las divisiónes de A.I.M. Mutual Insurance Companies, su representante o portador, a revisar, inspeccionar, copiar, y/o fotografiar cualquier y todo de los siguientes documentos:

1. Any and all medical records, including but not limited to office and hospital records, laboratory results, diagnostic reports and films, psychiatric records, medical correspondences, doctor's and nurse's notes, and medical histories relevant to my workers' compensation claim. I also hereby give permission to A.I.M. Mutual Insurance Companies representatives to contact the attending physicians involved in the treatment of all related conditions.

   Cualquier y todo expediente médico, incluyendo pero no limitado, a los expedientes de la oficina y hospitales, resultados de laboratorios y filminas, expedientes psiquiátricos, correspondencia médica, notas de los doctores y enfermeros(as), e historiales médicos relevantes a mi reclamo de compensación de trabajadores. También, por este medio le doy permiso a los representantes de A.I.M. Mutual Insurance Companies para comunicarse con el médico tratante envuelto en el tratamiento de todas las condiciones relacionadas.

2. All employment and human resource information including but not limited to: hiring and employment records, payroll and income statements, documentation related to this or any other relevant injury and any other information pertinent to providing benefits and services necessary for the completion of this claim.

   Toda información del empleo y de recursos humanos, incluyendo pero no limitado a: expedientes de contratación y empleo, declaraciones de nómina e ingresos, documentación relacionada a esta o cualquier otra lesión relevante, y cualquier otra información pertinente que provea los beneficios y servicios necesarios para completar este reclamo.

The released information is required for the following reasons:
La información liberada es requerida por las siguientes razones:

1. To provide for adequate preparation, investigation, evaluation, review, and discovery of a claim for workers' compensation benefits. Specifically, to determine the causation and the nature and extent of any possible pre-existing, concurrent or aggravating medical conditions with potential medical, legal, or factual implications in the this work-related injury or injuries.

   Para proporcionar una preparación, investigación, evaluación, revisión, y descubrimiento adecuado del reclamo de beneficios de compensación de trabajadores. Específicamente, para determinar la causa y la naturaleza y extensión de cualquier posible condición médica pre-existente, concurrente o agravante con potencial médico, legal, o implicaciones fácticas en esta lesión o lesiones relacionadas al trabajo.

2. To provide the treating physician, consultant or evaluator with medical information necessary to provide you with the best possible medical care and medical advice.

   Para proporcionar al médico tratante, consultor, o evaluador con la información médica necesaria para proporcionarle el mejor cuidado médico posible y consejería médica.

(CONTINUED ON PAGE 2)
(CONTINÚA EN LA PÁGINA 2)

AUTHORIZATION FOR THE RELEASE OF INFORMATION (PAGE 2)
AUTORIZACIÓN PARA LA LIBERACIÓN DE INFORMACIÓN (PÁGINA 2)

Claim Number / Número de Reclamo _____ **Date of Injury / Fecha de la Lesión** _____
Employee / Empleado _____ **Date of Birth / Fecha de Nacimiento** _____

3. To facilitate recovery of all benefits paid toward your workers' compensation claim from any third party responsible for this injury.

   Para facilitar la recuperación de todos los beneficios pagados por su reclamo de compensación de trabajadores de cualquier tercer parte responsable de esta lesión.

4. To ensure that you are accurately compensated for any amount of lost wages, time or resources while undergoing evaluation, treatment and recovery for this injury.

   Para asegurar que usted se encuentra compensado correctamente por cualquier cantidad de salarios, tiempo, o recursos perdidos mientras se somete a la evaluación, tratamiento, y recuperación de esta lesión.

5. To obtain any information necessary to appropriately determine further actions as a result of the injury or condition and to prevent further issues for you and other employees.

   Para obtener cualquier información necesaria para determinar apropiadamente acciones adicionales como resultado de la lesión o condición, y para prevenir problemas adicionales para usted y otros empleados.

This consent and authorization is effective immediately, and is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate on conclusion of the claim without express revocation.

Este consentimiento y autorización es efectivo inmediatamente, y está sujeto a la revocación del abajo firmante en cualquier momento excepto a la extensión en que se hayan tomado acciones en dependencia con esto de aquí en adelante, y si no es revocado anteriormente, terminará con la conclusión del reclamo si no se presenta una revocación expresa.

A copy or fax is as valid as the original.
Una copia o fax es tan válida como el original.

-

_____

_____

_____

(Names, addresses, and phone numbers of providers) (Nombres, direcciones, y números de teléfonos de los proveedores)

I have read this authorization and fully understand its entire contents. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received. I understand that I have a right to receive a copy of this authorization upon my request.

He leído esta autorización y entendido completamente su contenido en su totalidad. He hecho preguntas sobre todo lo que no estaba claro para mí y estoy satisfecho con las contestaciones que he recibido. Yo entiendo que tengo derecho a recibir una copia de esta autorización una vez lo solicite.

Signed / Firma _____ **Date / Fecha** _____

State of Rhode Island
Workers' Compensation Claim Reporting Procedures

It is important the instructions in these procedures be followed exactly as outlined. Prompt filing of the correct forms with all the necessary information helps speed necessary claim investigations and the proper payments of benefits when due. **LATE FILINGS OR LATE PAYMENTS MAY ALSO RESULT IN PENALTIES IMPOSED ON YOUR COMPANY AND/OR A.I.M. MUTUAL INSURANCE COMPANIES AS YOUR INSURER.**

Keep in mind:

- **If it's a serious accident, call us immediately: 1-866-270-3354**
- **We will file the Employer First Report of Alleged Occupational Injury, Disease or Fatality (Form DWC-01) with the State of Rhode Island Department of Labor and Training.**

If you need additional forms, they may be requested from A.I.M. Mutual Insurance Companies at 1-800-876-2765, Claim Services Department or downloaded from www.aimmutual.com or the State of Rhode Island Department of Labor and Training website: https://dlt.ri.gov/forms/

Applicable Forms include

For any job-related claim:

1. Form DWC-01 Employer's First Report of Alleged Occupational Injury, Disease or Fatality

Additional Forms for any lost-time claim:

1. Form DWC-03F Full-time Wage Statement
2. Form DWC-03P Part-time Wage Statement
3. Form DWC-03S Seasonal Wage Statement
4. A.I.M. Mutual Employee's Authorization for the Release of Information

Reporting First Aid Injuries and/or Loss of Time Claims

Complete Employer's First Report of Alleged Occupational Injury, Disease or Fatality (Form DWC-01)

You need to complete the Employer's First Report of Alleged Occupational Injury, Disease or Fatality (DWC-01) as soon as possible after knowledge of an employee's job-related injury or disease, but no later than 72 hours thereafter. **The timing of the filing of Form DWC-01 is very important.** Please file this report with us within 72 hours of the injury or disease, or immediately upon your receiving notice. We will file Form DWC-01 with the State of Rhode Island Department of Labor and Training. If you phone in or report a new claim over the Internet, a completed Form DWC-01 will be sent to you. Report a claim at www.aimmutual.com.

If a first-aid claim only claim becomes a lost time claim, notify A.I.M. Mutual immediately. You will then be required to complete a Wage Statement (Form DWC-03F) which we will then file with the State of Rhode Island Department of Labor and Training.

Mail or Fax to:

A.I.M. Mutual Insurance Cos.
Attn: Claim Department
54 Third Avenue
P.O. Box 4070
Burlington, MA 01803-0970

Fax: 781-270-5599

For lost time claims, be sure to give the injured employee a completed copy of Form DWC-01.

Employers' Responsibility for Reporting an Injury
State of Rhode Island Department of Labor and Training

1. You must report any injury that results in medical care or an absence of work within 72 hours of notice or having knowledge of the injury to A.I.M. Mutual Insurance Companies. Filing a First Report does not make you liable for the injury.

2. First-aid only injury claims also must be reported using Form DWC-01. Complete and submit Form DWC-01 to A.I.M. Mutual Insurance Companies and we will report the claim to the State of Rhode Island Department of Labor and Training on your behalf.

3. A.I.M. Mutual will assign an adjuster to investigate your claim and either accept or deny it within 14 days of your having notice or knowledge of the injury. Send any information that you have regarding the injury or incident directly to your A.I.M. Mutual adjuster to assist him or her in the investigation.

4. Once you have been notified that the injured worker has a work capacity, keep A.I.M. Mutual aware of any available work that you have for the injured employee. **Be sure to notify A.I.M. Mutual as soon as the injured employee returns to work.**

Employee's Certificate of Dependency Status

☐ Check if this is a corrected report

State of Rhode Island
Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100

Claim Administrator File Number:

1. Employee information:		2. Claim information:	
SSN:	XXX - XX -	Employer name	
Name		Claim Administrator	
Address		Address	
City, St, Zip		City, St, Zip	
Phone		Injury Date	
Date of Birth		Incapacity Date	

Employee: complete this form and return it to the Claim Administrator.
This information is needed to calculate your compensation rate.

3. Marital Status At the time of the injury the employee was ☐ Single ☐ Married

☐ Spouse works ☐ Spouse does not work Spouse's name

4. Number of Exemptions ☐

Enter the maximum number of personal exemptions you are allowed to claim for workers' compensation purposes. Include yourself, your spouse, your dependents, and any other exemptions.

5. Dependents

A dependent for workers' compensation includes children you support who are:

- Under age 18, or age 18 to 23 and a full time student
- Mentally or physically incapacitated from earning at any age

Dependent's Name	Date of Birth	Relationship	Full time student?	
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No

Employee's Signature Date

DWC-04 (4/19)

An Employee's Certificate of Dependency Status is required with a Memorandum of Agreement or a Nonprejudicial Agreement to verify marital status, maximum number of personal exemptions, and number of dependents for calculation of weekly benefits.

The claim administrator (the company handling the claim: the insurer, self-insured employer or third party administrator) completes sections 1 and 2 of the form. The employee completes the rest of the form, signs it, and returns the form to the claim administrator. The claim administrator sends the form to the DLT as part of a Nonprejudicial Agreement, Memorandum of Agreement, or as required by court order or decree.

Top of form:

- Correction Box: Check if this document is correcting a document previously filed.
- Claim Administrator File Number: Provide the claim number or file identification number for the company handling the claim: the insurer, self-insured employer or third party administrator.

1. Employee Information. The claim administrator completes section 1.
   - SSN: provide at least the last 4 digits of the employee's social security number or the employee ID number assigned by RIDLT. 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: complete the employee's street address, city, state, and zip code.
   - Phone: provide the employee's phone number if available.
   - Date of Birth: enter the employee's date of birth if available.

2. Claim Information. The claim administrator completes section 2.
   - Employer name: enter the company name of the injured worker's employer.
   - Claim Administrator: enter the company name of the party handling the claim.
   - Address: complete the mailing address for the claim administrator.
   - Injury date: enter the injury date.
   - Incapacity date: Enter the incapacity date, which is the first full day that the employee was unable to work.

3. Marital Status. The employee completes section 3.
   - Check the **single** box if you are unmarried, widowed or divorced. Check the **married** box if you are married or separated.
   - If you are single, leave the rest of section 3 blank.
   - Check "Spouse works" if your spouse is employed or "Spouse does not work" if not. A non-working spouse qualifies as a dependent for workers' compensation.
   - Enter your spouse's name.

4. Number of Exemptions. The employee completes section 4.
   - Enter the maximum number of personal exemptions you are allowed to claim for workers' compensation purposes. This includes you, your spouse, your dependent children, and any other exemptions.
   - A single employee with no dependents has a maximum number of personal exemptions of at least one (1). A married employee with three (3) dependent children has a maximum number of personal exemptions of at least five (5); the employee, spouse and three children. An employee may be entitled to additional exemptions.

- The maximum number of allowed personal exemptions used here might not be the same number of personal exemptions or withholding allowances the employee actually claims for federal withholding.
- The Department of Labor and Training relies upon exemption guidelines established prior to the Tax Cuts and Jobs Act of 2017. You may refer to IRS Publication 501 (2017) for further guidance.

5. Dependents. The employee completes section 5.
   - Dependents for workers' compensation include children you support who are under age 18, full time students to age 23, or mentally or physically incapacitated from earning at any age.
   - A child may qualify as a personal exemption even if they do not qualify as a dependent for workers' compensation purposes. Contact your claim administrator if you believe that you are allowed to claim any other personal exemptions beside yourself, your spouse, and children who qualify as dependents for workers' compensation.

The employee must sign and date the form and return the form to the claim administrator. The claim administrator sends the form to the Department of Labor and Training as part of a Nonprejudicial Agreement, Memorandum of Agreement, or as required by court order or decree.

Revised 04/2019

MyMatrixx Pharmacy Program for Injured Workers

As part of our workers' compensation medical management services, we ask injured workers to use a pharmacy program through MyMatrixx. MyMatrixx is a pharmacy benefit management company that is uniquely set up to provide prescription medications for work-related injuries.

Injured employees will be notified by mail about the pharmacy program and how it works shortly after their claim has been approved. They will also receive a prescription identification card; **the card is valid only for prescriptions related to the specific, approved work injury.** Injured employees will be asked to use a MyMatrixx affiliated pharmacy to fill their injury-related prescriptions.

MyMatrixx also offers a mail service program, which employees will find convenient for refilling maintenance (long-term) prescription medications. I'm sure you are familiar with the cost benefits of a mail order prescription program, and we ask that you encourage injured workers to take advantage of this service. Most prescriptions are filled within 48 hours of receipt and mailed directly to the injured employee's home. Injured employees can sign up for the mail service program through MyMatrixx by phone or by mail.

Additional benefits of the program include 24-hour access to a registered pharmacist via a toll-free number and an extensive network of pharmacies to choose from. MyMatrixx offers significant savings of up to 35% over fee schedules and usual and customary charges, and the program will expedite claim processing and payment. Injured employees will incur no out-of-pocket expenses.

Injured workers will receive a condensed list of chain pharmacies in the network on their prescription card information sheet. Most major pharmacies such as CVS, Walgreens and Rite Aid are affiliated with MyMatrixx For a full listing injured workers can go to www.MyMatrixx.com or call MyMatrixx at 1-800-945-5951. While injured employees may use a non-affiliated pharmacy, we strongly recommend they use a pharmacy within the MyMatrixx network and the mail order service to realize the program benefits.

Please call the MyMatrixx Patient Care Contact Center at 1-800-945-5951 with any questions you may have. The toll-free service is available 24 hours a day, seven days a week. As always, thank you for working with us to enhance our claim service.

A.I.M. MUTUAL INSURANCE COMPANIES

MyMatrixx
By EVERNORTH

A.I.M. Mutual
Insurance Companies since 1989

To the Injured Worker:

On your first visit, please give this form to any pharmacy listed on the back side to speed processing of your approved work-related injury prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the MyMatrixx Patient Care Contact Center at 800.945.5951.

Atencion Trabajador Lesionado:

En su primera visita, entregue este formulario a cualquier farmacia que se encuentre en el reverso del boleto para acelerar el procesamiento de sus recetas aprobadas para lesiones relacionadas con el trabajo (según las reglas establecidas por su empleador).

¿Tiene preguntas o necesita ayuda para localizar una farmacia participante? Llame al centro de contacto para pacientes de MyMatrixx al 800.945.5951.

Employee Information

_____
Full Name

_____
Street Address or PO Box

_____
City State ZIP

_____
Date of Birth

_____
Employer Name

To the Pharmacist:

MyMatrixx administers this occupational accident prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 14-day supply or a cost of $999. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary.

For assistance, please call MyMatrixx at 888.786.9640.

Processing Steps:

1. Enter RxBin 003858
2. Enter PCN WC
3. Enter Rx Group Number AIMWORKS
4. Enter 9-digit member ID (Patient SSN)
5. Enter Date of Injury

Temporary Prescription Card

ID#: _____
Your SSN is your temporary ID.

RxBIN#: 003858

PCN: WC

RxGroup #: AIMWORKS

Date of Injury: _____
MM/DD/YYYY

For Workers' Compensation Only

Visit www.MyMatrixx.com to locate a participating pharmacy near you!

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MyMatrixx
By EVERNORTH

Participating Pharmacy List

AHF PHARMACY
AHOLD CORPORATION
ALBERTSONS
ALIGNRX LLC
AMERITA INC
AURORA PHARMACY INC
BAKER'S
BIG Y FOODS INC
BI-LO HOLDINGS LLC
BROOKS/MAXI DRUG
BROOKSHIRE BROTHERS LTD
BROOKSHIRE GROCERY CO
CARDINAL HEALTH
CHEN NEIGHBORHOOD MEDICAL CENT
CITY MARKET
COBORN'S INC.
COSTCO WHOLESALE, INC
CVS CORP
DEDICATED US HOLDINGS LLC
DILLIONS
DISCOUNT DRUG MART
ECKERD
EPIC PHARMACY NETWORK
ESSENTIA HEALTH
EXPRESS RX
FAIRVIEW PHARMACY SVCS
FAMILY FARE, LLC
FOOD 4 LESS
FOOD LION PHARMACY
FOODS CO
FRED MEYER
FRY'S
FRUTH PHARMACY
GENOA HEALTHCARE LLC
GERBES
GIANT EAGLE PHARMACY
GUARDIAN PHARMACY LLC
HAC INC
HANNAFORD BROS. CO.
HARPS FOOD STORES INC
HARTIG DRUG
HEALTH MART ATLAS LLC
H-E-B LP
HENRY FORD HEALTH SYSTEM
HOMETOWN PHARMCY INC
HY-VEE FOOD STORES INC
INGLES MARKETS
INSTYMEDS CORP
JAY C FOOD STORE
KINGS SOOPERS
KROGER
KPH HEALTHCARE SERVICES
KS PHARM LLC
K-VA-T FOOD STORES INC
LEWIS DRUGS INC
LONGS DRUG STORE
MARC GLASSMAN INC
MARIANO'S
MEDICAP PHARMACY, INC.
MEDICINE SHOPPE
MEIJER PHARMACY
MERCY PHARMACY SERVICES
METRO MARKET
NCS HEALTHCARE
NEIGHBORCARE PHARMACY
OSBORN DRUGS INC
PATIENT FIRST
PAY-LESS SUPER MARKETS
PHARMEDQUEST PHARMACY
PHARMERICA, INC
PICK'N SAVE
PMR US HOLDINGS
PRESBYTERIAN MEDICAL
PRESCRIBEIT RX
PRICE CHOPPER PHARMACY
PUBLIX SUPER MARKETS, INC
QFC
RALEY'S
RALPHS
RECEPT PHARMACY LP
RITE AID CORPORATION
RULER
SAFEWAY, INC.
SAM'S CLUB
SMITH'S
SUPERVALU PHARMACIES, INC.
TARGET
THRIFTY WHITE STORES
TOPS MARKETS LLC
UNITED SUPERMARKETS INC
WALGREENS
WAL-MART
WEGMANS FOOD MARKETS,
WEIS MARKETS INC

Visit www.MyMatrixx.com to locate a participating pharmacy near you!

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