

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

P. O. Box 20190

Cranston, RI 02920-0942

Phone (401) 462-8100 www.dlt.ri.gov/wc

DWC claim number

Claim Administrator
File Number

1. Employee information:		2. Claim Information:	
SSN: XXX-XX-	<input type="checkbox"/> Male <input type="checkbox"/> Female	Employer Name	
Name		Claim Administrator	
Address		Address	
City, ST Zip		City, ST Zip	
Phone	Date of Birth	Injury Date	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 Federal Exemptions Enter the maximum number of Federal Exemptions you are allowed to claim for Federal income tax. 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
- Age 18 to 23 and a full time student
- Mentally or physically incapacitated from earning

Dependent's Name	Date of Birth	Relationship	Full time student?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Employee's Signature		Date	
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