Employee's Certificate of Dependency Status

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

☐ Check if this is a corrected report

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 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, 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 (2/13)

Instructions: EMPLOYEE'S CERTIFICATE OF DEPENDENCY STATUS (DWC-04)

General Instructions:

Completed by: The employee and claim administrator complete different sections of the form.

Purpose: This information is necessary to determine the employee's correct compensation rate. Payments may be delayed if the employee does not complete and send this form to the claim administrator promptly.

Distribution: The claim administrator completes the form through section 2. 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.

Form Instructions:

Check if this is a corrected report. Please check the box if this copy corrects a form already sent.

Claim Administrator File Number. Enter the file identification number used by the insurer or third party administrator, whichever party is handling this claim.

1. Employee Information. The claim administrator should complete section 1.
   - Enter the last four digits of the employee's social security number if available.
   - Indicate if the employee is male or female. Leave blank if unknown.
   - Complete the employee's address, including city, state, and zip code.
   - Provide the employee's phone number if available.
   - Enter the employee's date of birth if available.

2. Claim Information. The claim administrator should complete section 2.
   - Enter the company name of the injured worker's employer.
   - Enter the company name of the insurer or third party administrator, whichever party is handling this claim.
   - Complete the mailing address for the claim administrator.
   - Enter the injury date.
   - Enter the incapacity date, which is the first full day that the employee was unable to work. Include days the employee was not scheduled to work.

3. Marital Status. The employee should complete section 3.
   - Check a box to show if you are single or married for tax withholding purposes.
   - 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.
   - Enter your spouse's name.

4. Number of Federal Exemptions. The employee should complete section 4.
   - Enter the maximum number of exemptions you are allowed to claim for Federal income tax. This includes you, your spouse, your dependent children, and any other exemptions.
   - Please contact your claim administrator if you are allowed to claim any other exemptions for Federal income tax besides yourself, your spouse, and dependent children.

5. Dependents. The employee should complete section 5.
   - List each dependent on a separate line.
   - Include the dependent's first and last name, date of birth, and relationship to you.
   - Check YES or NO to show if the dependent is a full time student.

The employee must sign and date the form and return 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.