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

EMPLOYEE'S CERTIFICATE OF DEPENDENCY STATUS

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

DWC No. ____________________

Insurer File No. ____________________

1. EMPLOYEE INFORMATION:

SSN ____________________ ☐Male ☐Female
Name ____________________
Address ____________________
City, State, Zip ____________________
Phone ____________ Date of Birth ____________

2. CLAIM INFORMATION:

Employer: University of Rhode Island
Claim Administrator: State Employees' Workers' Compensation
Address: One Capitol Hill
City, State, Zip: Providence, RI 02908-5866
Date of Injury ____________ Date of Incapacity ____________

THE EMPLOYEE MUST COMPLETE ALL REQUIRED INFORMATION:

> Please return this form to your employer's workers' compensation *Claim Administrator*. If they do not receive this completed form promptly, it may result in a delay of your claim.

3. MARITAL STATUS & EXEMPTION INFORMATION: (Needed to calculate your weekly compensation payment)

Were you married at the time of your injury? ☐Yes ☐No Spouse Name: ____________________

If Yes, does your spouse work? ☐Yes ☐No If Yes, Spouse SSN**: ____________________

Please put an appropriate number on each line -- you are entitled to one exemption for yourself and one for your spouse.

Yourself 1
Spouse ________
Total Dependents Listed **Below** ________
Total Other ________
Total Number of Exemptions 1

(**Other**: You may be entitled to additional exemptions if you or your spouse are over 65 or blind. Please contact your employer's workers' compensation Claim Administrator for further information)

4. DEPENDENT INFORMATION List each dependent child below. A dependent child includes:

~ Children under the age of eighteen living with you or whom you were required to support at the time of the injury
~ Children you support who are over eighteen but who are mentally or physically incapacitated from earning
~ Children under the age of twenty-three who are full-time students at an accredited educational facility

Dependent's Name:	Dependent's Date of Birth:	Dependent's Social Security Number:**	If over 18 and under 23, Full-Time Student?	
			☐Yes	☐No
			☐Yes	☐No
			☐Yes	☐No
			☐Yes	☐No
			☐Yes	☐No
			☐Yes	☐No
			☐Yes	☐No
			☐Yes	☐No
			☐Yes	☐No
			☐Yes	☐No

Employee Signature: Date:

**** Completion of the Social Security Number for Spouse and Dependents is optional.**

Employee Note: **DO NOT return this form to the Department of Labor and Training - RETURN TO *Claim Administrator***

DWC-04 (01/03) *For instructions visit our web site: www.dlt.ri.gov/wc*