☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

State of Rhode Island

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 State of Rhode Island - URI

Claim Administrator Beacon Mutual

Address 1 Beacon Center

City, State, Zip Warwick RI 02886

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 If Yes, Spouse Name: ____________________

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

Please put an appropriate number in each box -- 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 (Add all of the above)	

(**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?	
1.			☐ Yes	☐ No
2.			☐ Yes	☐ No
3.			☐ Yes	☐ No
4.			☐ Yes	☐ No
5.			☐ Yes	☐ No
6.			☐ Yes	☐ No
7.			☐ Yes	☐ No
8.			☐ Yes	☐ No
9.			☐ Yes	☐ No
10.			☐ 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*