

State of Rhode Island
EMPLOYEE'S CERTIFICATE OF DEPENDENCY STATUS

PLEASE CHECK IF CORRECTION OF PRIOR REPORT

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 _____
 Claim Administrator _____
 Address _____
 City, State, Zip _____
 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
 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. _____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. _____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. _____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. _____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. _____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. _____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. _____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. _____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. _____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. _____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> 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**