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 _____

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	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**