State of Connecticut
Workers' Compensation Commission

Information Packet

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Workers' Compensation Commission (WCC) Offices

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Hartford, CT 06106-8011
(860) 493-1500
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Compensation Review Board (CRB)
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Hartford, CT 06106-8011
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Education and Safety & Health Services
21 Oak Street
Hartford, CT 06106-8011
1-800-223-WORK (9675)
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(860) 493-1500

Rehabilitation Services
21 Oak Street
Hartford, CT 06106-8011
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Statistical Division
21 Oak Street
Hartford, CT 06106-8011
(860) 493-1500

First District
Commissioner
999 Asylum Avenue
Hartford, CT 06105
(860) 566-4154

Second District
Commissioner
55 Main Street
Norwich, CT 06360
(860) 823-3900

Third District
Commissioner
700 State Street
New Haven, CT 06511
(203) 789-7512

Fourth District
Commissioner
350 Fairfield Avenue
Bridgeport, CT 06604
(203) 382-5600

Fifth District
Commissioner
55 West Main Street
Waterbury, CT 06702
(203) 596-4207

Sixth District
Commissioner
233 Main Street
New Britain, CT 06051
(860) 827-7180

Seventh District
Commissioner
111 High Ridge Road
Stamford, CT 06905
(203) 325-3881

Eighth District
Commissioner
90 Court Street
Middletown, CT 06457
(860) 344-7453

An Introduction to the Workers' Compensation Act

ALL EMPLOYEES, WHETHER PART-TIME OR FULL-TIME, ARE COVERED UNDER THE WORKERS' COMPENSATION ACT FROM THE FIRST DAY OF THEIR EMPLOYMENT

What is Workers' Compensation?

The basic purpose of the Workers' Compensation Act is to provide wage replacement benefits and medical treatment for employees who have been injured or become ill due to a work-related injury or illness. It is the EXCLUSIVE REMEDY, which means that the employee may NOT sue their employer for any other benefits.

Workers' Compensation is a NO-FAULT system of insurance with the benefits paid by the employer's workers' compensation insurance coverage.

The Workers' Compensation Commission

This is the administrative agency created by the Workers' Compensation Act to administer the law. The Workers' Compensation Commission performs Administrative Hearings, with commissioners in eight (8) districts hearing disputed workers' compensation claims. (To contact any of our offices, please see page 1.)

Workers' Compensation Benefits

- MEDICAL TREATMENT [Sec. 31-294d]

  The most immediate concern in cases of occupational injury or illness is the health and physical well-being of the employee. While the employer is responsible for designating a medical facility for the initial treatment of an injury/illness, it is always the employee who chooses the "attending physician." (If the employer has a **Medical Care Plan** which has been approved by the Chairman's Office, then the employee's choice is limited to the doctors in that plan.)

- TEMPORARY TOTAL DISABILITY [Sec. 31-307]

  This is the wage replacement benefit for which an employee may be eligible, if they are totally disabled from a work-related injury or illness. The benefit rate is 75% of the AFTER-TAX-AND-SOCIAL-SECURITY average weekly wage, based upon the wages earned by the injured worker (hereafter referred to as "claimant") prior to the injury (up to 52 weeks).

- TEMPORARY PARTIAL DISABILITY [Sec. 31-308(a)]

  When an employee is able to perform some type of work, but not the same kind of work or the same number of hours they worked at the time of the injury, he or she may receive this benefit. It is 75% of the AFTER-TAX-AND-SOCIAL-SECURITY difference between the amount they are currently earning, and the amount they would have been earning if they hadn't been injured.

- PERMANENT PARTIAL DISABILITY [Sec. 31-308(b)]

  These benefits are paid to the claimant who has suffered a **permanent**, **partial** loss of use of a body part(s), due to their work-related injury. The exact amount is based upon the specific body part which was injured, the attending physician's determination of the percentage of that body part which has been disabled, and the employee's basic compensation rate.

- RELAPSE OR RECURRENCE [Sec. 31-307b]

  When an employee suffers a relapse or recurrence of the original injury or illness, he or she may be entitled to receive benefits for the period of relapse. This compensation would be the employee's basic compensation rate at the time of the original injury/illness (plus cost-of-living allowances) or their new rate based on their salary at the time of the recurrence, whichever is higher.

- DISCRETIONARY BENEFITS [Sec. 31-308a]

  A Workers' Compensation Commissioner "may" grant these additional benefits to an employee after he/she has been paid all of their Permanent Partial Disability. The employee must request an informal hearing at which the commissioner *may* or *may not* grant these benefits, depending upon the specific circumstances of the case.

- JOB RETRAINING [Sec. 31-283a]

  The Workers' Compensation Act also provides for vocational rehabilitation for those employees who are injured or become ill as a result of their work, and cannot return to the type of work which caused the injury or illness. These employees may be eligible for some kind of job re-training from the Workers' Compensation Commission's Rehabilitation Services.

The Flow of a "Typical" Workers' Compensation Case

This is a simplified chart representing the basic steps through a "typical" undisputed workers' compensation case, including the main events in the life of a claim and the corresponding actions taken by the injured/ill employee, the employer/insurer, and the employee's attending physician.

[NOTE: Any given workers' compensation case *may* or *may not* include any or all of the following steps (e.g., an employee may completely bypass Temporary Total Disability benefits and begin receiving Temporary Partial Disability benefits, if his or her injury only *partially* incapacitates him or her from work). Also, if an employee's employer operates an approved Preferred Provider Organization, or PPO, then the appropriate statutes and regulations are in effect.]

1 — Employee Has Work-Related Injury or Illness

Employee:

- Immediately reports injury/illness to employer
- Accepts initial medical treatment from employer-designated physician
- Files 30C Claim Form (Notice of Claim for Compensation)

Employer / Insurer:

- Provides employee with initial medical treatment
- Files "First Report of Injury" Form (Accident Report)

Attending Physician:

- Renders initial medical treatment
- Submits initial medical report to employer/insurer and to injured/ill employee at same time

2 — Continued Medical Treatment and Total Incapacity from Work

Employee:

- Chooses attending physician, after initial medical treatment
- Accepts appropriate medical treatment from attending physician
- Furnishes employer/insurer with record of physician/treatment visits for mileage reimbursement

Employer / Insurer:

- Provides wage statement to insurer, who initiates payment of Temporary Total Disability (TT) benefits upon confirmation of total incapacity from work
- Insurer provides Cost-of-Living Adjustment(s) and/or Dependency Allowance(s), if applicable
- Pays medical bills

Attending Physician:

- Renders appropriate medical treatment
- Confirms Temporary Total Disability
- Provides medical reports as needed to employer/insurer and to injured/ill employee at same time
- Sends medical bills to employer/insurer

3 — Continuing Period of Total Incapacity while under Treatment by Attending Physician

Employee:

- Continues to accept medical treatment from attending physician
- Signs Voluntary Agreement for TT benefits
- Calls employer/insurer and/or Workers' Compensation Commission with any questions

Employer / Insurer:

- Continues paying weekly TT benefits
- Issues Voluntary Agreement for TT benefits
- Continues paying medical bills

Attending Physician:

- Renders appropriate medical treatment
- Provides periodic medical reports on injured/ill employe's medical status to employer/insurer and to injured/ill employee at same time
- Sends medical bills to employer/insurer

4 — Medical Status Improves & Employee Becomes Capable of "Light Duty" or "Restricted" Work

Employee:

- Requests light duty/restricted work from employer
- If unavailable from employer, performs a job search and contacts insurer to request Temporary Partial Disability (TP) benefits
- If attending physician indicates that restrictions are permanent, may apply to WCC's Rehabilitation Services for help with job retraining and/or placement

Employer/Insurer:

- Sends a Form 36 (Discontinuation Notice) to Workers' Compensation Commission and to injured/ill employee for discontinuation of TT benefits
- Begins payment of TP benefits
- Continues paying medical bills

Attending Physician:

- Reports injured/ill employee's medical status and work restrictions to employer/insurer and to employee at same time
- Renders appropriate medical treatment
- Provides periodic medical reports, as earlier
- Sends medical bills to employer/insurer

5 — Injured/Ill Employee Reaches Maximum Medical Improvement (MMI)

Employee:

- Contacts insurer to reach agreement on Permanent Partial Disability (PPD) benefits for any permanent physical impairment
- Signs Voluntary Agreement for PPD benefits

Employer/Insurer:

- Begins payment of PPD benefits
- May request an Employer's/Respondent's Examination (formerly IME)
- Issues Voluntary Agreement for PPD benefits for any permanent physical impairment

Attending Physician:

- Issues disability evaluation for any permanent physical impairment on Form 42 or in the form of a medical report to the Workers' Compensation Commission, the injured/ill employee, and the employer/insurer, at the same time

6 — Employee Exhausts Period in which PPD Benefits are Paid (Specific Award)

Employee:

- May request an Informal Hearing with a Workers' Compensation Commissioner in a District Office to apply for additional discretionary wage differential "308a" benefits, just prior to the end of the period for which PPD benefits are paid

Employer/Insurer:

- Pays additional wage differential "308a" benefits, if directed by a Workers' Compensation Commissioner at an Informal Hearing
- Continues paying medical bills

Attending Physician:

- Renders further medical treatment, if necessary
- Sends medical bills to employer/insurer

7 — Injury or Surgery Causes Disfigurement and/or Scarring (except for inguinal hernia or spinal surgery)

Employee:

- Just prior to a year after the date of the injury or surgery which caused the disfigurement or scar, contacts the Workers' Compensation Commission District Office to request scar/disfigurement evaluation by a Workers' Compensation Commissioner (see page 9 for details on which disfigurements and scars are eligible for statutory benefits)

Employer/Insurer:

- Makes payment for scar or disfigurement award, if eligible under the Workers' Compensation Act and if directed by a Workers' Compensation Commissioner

Attending Physician:

- NONE

Medical Treatment for Employees with Work-Related Injuries or Illnesses

Initial Medical Treatment [Sec. 31-294d]

When an injury occurs, a claimant is entitled to receive all necessary and appropriate medical treatment. The employer is responsible for furnishing the **initial** medical treatment at an employer-designated office or facility. After this initial treatment, the employee may choose an attending physician.

If the claimant refuses the **initial** employer-provided medical care and fails to obtain treatment, they may risk their entitlement to Workers' Compensation benefits.

Choice of Physician [Sec. 31-294d]

A claimant may choose an attending physician AFTER the initial visit with an employer-designated medical practitioner.

If the employer **does not** participate in an approved medical care plan, the claimant may choose *any* medical practitioner who is licensed to practice in Connecticut, including practitioners of chiropractic, medicine, naturopathy, osteopathy, and podiatry.

A claimant whose employer **does** participate in an approved medical care plan **must** choose a physician from the list of doctors included in that plan. If the employee chooses a physician "outside" the plan, a Workers' Compensation Commissioner may suspend all rights to workers' compensation benefits.

In either case, it is the *injured worker* who has the right to choose.

Change of Physician [Sec. 31-294d]

A claimant may change their attending physician, if dissatisfied with the medical treatment being rendered. There are three ways in which a claimant may effect a change of physician:

(1) Get a referral from the present attending physician,

(2) Obtain approval to change physicians from the workers' compensation insurance carrier involved (or the employer, if it is self-insured),

OR

(3) Write to the Workers' Compensation Commissioner in the District Office having jurisdiction. Indicate the name, address, and medical specialty of the present physician, as well as the name, address, and medical specialty of the "new" physician, and the reason(s) for requesting a change. In this case, the commissioner could reply by mail or set up an informal hearing.

[NOTE: If the claimant is covered by an approved employer medical care plan, the "new" physician MUST also be a participating practitioner in the plan.]

If a claimant does not have an attending physician's referral to another medical practitioner, or permission to change physicians from the insurer, self-insured employer, or Commissioner, they will most likely be liable to pay for any "unauthorized" medical bills which may arise.

Out-of-State Physicians [Sec. 31-294d]

A claimant MUST receive all necessary medical care for the injury or illness from medical practitioners licensed to practice in Connecticut. If, for any number of reasons, the employee requires treatment with a doctor **outside** of the state, the employer/insurer *could* grant permission or the claimant would have to request permission from a Workers' Compensation Commissioner who *may* or *may not* authorize out-of-state treatment.

If the claimant *resides* in another state, a Workers' Compensation Commissioner may authorize medical care by a physician in that state.

Employer's/Respondent's Examination (Formerly IME) [Sec. 31-294f]

At any time while claiming or receiving workers' compensation benefits, an employee may be directed by a Workers' Compensation Commissioner, or requested by the employer or its workers' compensation insurance carrier, to submit to an *Employer/Respondent's Examination* (formerly known as IME), paid for by the employer/respondent. The purpose of the exam is to determine the nature and extent of the injury. The claimant may have their own attending physician present (at their own expense), but this is not a common practice. The claimant must submit to examination *upon reasonable request*, and refusal to do so may suspend any right to receive compensation. *(A request may be considered unreasonable, if it involves lengthy or difficult travel. The claimant should request an Informal Hearing before a Commisioner to make this determination.)*

The examining physician must furnish the employer's/respondent's medical report within 30 days of its completion, at the same time and in the same manner, to both the employer (or its insurer) and to the claimant (or their attorney, if represented).

The Commissioner's Exam [Sec. 31-294f]

Sometimes there is a significant difference in opinion between the attending physician and the employer's/ respondent's physician, and the parties are unable to reach an agreement. In these cases the Workers' Compensation Commisioner has the authority to send the claimant for a "Commissioner's Examination". The examiner is chosen on the basis that he/she is free of any bias or interest, not aligned with either of the parties, and therefore able to impart an independent medical opinion. The claimant must agree to be seen by this doctor or risk the chance of losing their workers' compensation benefits.

Medical Bills [Sec. 31-279-9]

All medical bills for a compensable injury or illness should be paid by the workers' compensation provider (workers' compensation insurance carrier or self-insured employer). All medical bills for compensable claims must be sent directly to the workers' compensation provider, **NEVER** to the claimant. It is also against Connecticut Regulations for any medical practitioner to ask a claimant for payment for medical treatment, or to refuse a claimant necessary medical care because the practitioner has not yet been paid by the workers' compensation provider for previously-rendered services.

Unauthorized Medical Care [Sec. 31-294d]

Medical care provided by a practioner *other* than the attending physician or a specialist to whom the claimant has been referred, is the claimant's responsibility as these treatments and their charges are considered unauthorized.

Travel Expenses for Medical Services [Sec. 31-312]

The employer must furnish, or pay for, transportation for an injured employee to go to and from medical examination, treatment, or testing. If medically necessary, this includes transportation by ambulance or taxi. If the claimant uses a private vehicle to travel to and from medical services, they must be reimbursed for expenses at the federal mileage reimbursement rate, as determined by the U.S. General Services Administration (GSA). In practice, most employees keep a record of their travel with each visit's date, location, and mileage, and send a copy of this record to the workers' compensation insurer or self-insured employer periodically or at the end of treatment. The insurer or employer should send the claimant a check for the expenses within a reasonable period of time. (See the *Forms* section beginning on page 24 for a mileage form you may use for this purpose.)

Lost Time Reimbursement for Medical Treatment [Sec. 31-312]

The claimant who needs medical attention should obtain such medical care during normal work hours, if this is possible, and should be paid by the employer at their normal rate of earnings (if the employee is not receiving or eligible to receive workers' compensation wage replacement benefits). An employer CANNOT require the claimant to receive medical treatment outside of their regular work hours, if such treatment is available during regular work hours. If necessary care is not available during normal work hours, the claimant should receive care when it is available and should be reimbursed at the rate of their average hourly earnings by the employer, as if it were time lost from work. The employer may then seek reimbursement from their workers' compensation insurer.

Prescription Reimbursement [Sec. 31-294d]

Prescriptions given by an attending physician as part of medical treatment for a work-related injury or illness are fully covered.

All expenses for prescriptions must be paid directly by the carrier or self-insured employer, and claimants should **not** have to pay for them or seek reimbursement. This relates to all employers whether they participate in a managed care plan or not.

Right to Medical Reports [Sec. 31-294f]

The claimant is entitled to a copy of every medical report by any medical practitioner providing care for the injury or illness, in the same manner and at the same time as reports provided to the employer or its workers' compensation insurance carrier, at no additional charge. If the claimant retains legal counsel, the reports must be furnished to the attorney instead of the claimant.

Wage Replacement Benefits for Employees Disabled from Work-Related Injuries and Illnesses

Full Pay for Day of Injury [Sec. 31-295]

The employee should receive his/her full day's wages for the day the injury occurred, whether or not he/she was able to return to work after the accident.

Waiting Period [Sec. 31-295]

No compensation benefits for Temporary Total Disability or Temporary Partial Disability (below) are paid until an injured or ill employee is incapacitated from work for MORE than three calendar days. Benefits begin on the fourth day of incapacity from work and if the employee remains incapacitated for seven or more calendar days, the three-day waiting period is eliminated and benefits are paid from the beginning of the employee's incapacity. In counting days of incapacity from work, all calendar days are counted, even if the employee was not scheduled to work during any or all of them. (The day of the injury itself does NOT count as a day of incapacity from work.)

Temporary Total Disability (TT) Benefits [Sec. 31-307]

Weekly TT benefits while totally disabled from ANY type of work are equal to 75% of the employee's after-tax average weekly wage (after federal and state taxes and FICA deductions) for the 52-week period prior to the injury or illness, subject to the legislated maximum and minimum amounts.

Temporary Partial Disability (TP) Benefits during a Job Search [Sec. 31-308(a)]

If the employee is released for "light duty" or "restricted" work and the employer does not have such work, he/she is entitled to Temporary Partial Disability (TP) benefits while performing a job search for suitable employment. TP benefits are paid at the basic weekly TT compensation rate, subject to the legislated maximum and minimum amounts.

Temporary Partial Disability (TP) Benefits in a Lower-Paying Job [Sec. 31-308(a)]

If, as a result of the injury, the employee returns to a lower-paying job (described as either "light duty" or "restricted"), he/she is entitled to Temporary Partial Disability (TP) wage differential benefits. These TP benefits are equal to 75% of the **after-tax** difference between the wages they are currently earning, and the wages currently being paid in their former job, subject to the legislated maximum and minimum amounts.

Permanent Partial Disability (PPD) Benefits [Sec. 31-308(b)]

If the employee's attending physician determines that Maximum Medical Improvement (MMI) has been reached and that the employee has sustained a **permanent**, but only **partial** loss, or loss of use of, a body part, that physician should issue a percentage disability rating, usually on a Form 42 or in the form of a medical report. Such a disability rating marks the end of other workers' compensation benefits (TT and/or TP) and makes the employee eligible to receive weekly PPD benefits for a **specific** number of weeks.

The weekly PPD benefit rate is determined by the specific body part that was injured and the basic compensation that the employee was receiving at the time of their original injury. This also is subject to the legislated maximum and minimum amounts. Payment of this benefit does not close out the claimant's case. (See pages 14-15 of this Packet for more information.)

Cost-of-Living Adjustment (COLA) to Dependent Survivor Benefits [Sec. 31-307a]

Dependents of employees who died as a result of their work-related injury or illness are entitled to an annual Cost-of-Living Adjustment every October 1st beginning with the October 1st after their death. The amount of the increase is based upon the date of the injury pursuant to section 31-309 of the Workers' Compensation Act.

Cost-of-Living Adjustment (COLA) [Sec. 31-307a]

Effective July 1, 1993, only claimants who are judged to be **Permanently Totally** disabled or claimants who have been Temporarily Totally disabled for **five (5) years or more** are entitled to receive Cost-of-Living Adjustments, in accordance with the provisions set out in section 31-309 of the Workers' Compensation Act.

Benefits for a Recurrence or Relapse from Recovery [Sec. 31-307b]

If the employee returns to work from an injury, but then has a recurrence or relapse from recovery, he/she will again be eligible to receive workers' compensation wage replacement benefits. This weekly compensation rate is based on the original TT benefit rate (plus cost-of-living adjustments) OR the TT rate based on the employee's earnings at the time of the recurrence or relapse, *whichever is higher*.

Disfigurement and Scarring Benefits [Sec. 31-308(c)]

A Commissioner may award benefits for any permanent, significant disfigurement or scar due to a work-related injury (1) on the face, head, or neck, or (2) on any other area of the body that handicaps the claimant in obtaining or continuing to work. These awards cannot be requested any earlier than one (1) year after nor any later than two (2) years after the injury or surgery causing the disfigurement or scar. Scarring is not allowed for spinal surgery of the neck.

The weekly Disfigurement and Scarring benefit rate is equal to the employee's weekly TT benefit rate, subject to the legislated maximum and minimum amounts, and may be paid for a period of up to 208 weeks.

Discretionary Wage Differential "308a" Benefits [Sec. 31-308a]

A Workers' Compensation Commissioner "may" grant additional benefits to an employee after he/she has been paid all of their Permanent Partial Disability, if the injury results in their inability to find employment, or the new employment pays less than the original job. The employee must request a hearing in the appropriate Workers' Compensation district in order to request these benefits.

"308a"/Discretionary benefits are equal to 75% of the employee's **after-tax** loss in earnings, subject to the legislated maximum and minimum amounts. This is the NET difference between the amount the employee is currently earning and the amount they would have been earning, if they hadn't been injured. The employee "may" be granted this benefit for a specific number of weeks, which may be less than but cannot exceed the number of weeks he/she received their Permanent Partial payments.

Dependent Survivor ("Fatality") Benefits [Sec. 31-306]

When an employee's death is caused by a work-related injury or illness, a surviving spouse or other eligible dependent may be entitled to burial expenses of $4,000 and weekly wage replacement benefits equal to 75% of the deceased employee's after-tax average weekly wage (after federal and state taxes and FICA deductions), subject to the legislated maximum and minimum amounts. (Also see the Dependent Survivors' COLA information above.)

There are other benefits provided by the Workers' Compensation Act and other State laws for which you may also be eligible. For a description of some of these, see *Medical Treatment for Employees with Work-Related Injuries or Illnesses* (page 5) and *Other Benefits Provided by the Workers' Compensation Act* (page 16).

The 30C Form: Notice of Claim for Compensation

When an employee is injured or becomes ill as a result of their employment, the Workers' Compensation Act (Sec. 31-294c) requires that he/she notify their employer of their intention to file a workers' compensation claim. The law allows the employee 1 year from the date of injury or 3 years from the 1st manifestation of a symptom of an occupational disease in which to do this. Although the employer files a *First Report of Injury* to notify the insurer, it is the **Form 30C**, which is filed by the injured worker and served upon the employer, which satisfies this statutory requirement. (You can find copies of these forms in the *Forms* section beginning on page 24 of this Packet.)

As soon as the employer receives this notice of claim, they should forward it to the insurer in order to allow them time to make a determination as to the compensability of the claim. The employer/insurer then has 28 days in which to commence payment for lost time (if any), or deny the claim. If they do neither within that period of time, they lose their right to contest the claim, thereby accepting responsibility. If payments are begun within the 28 days, the employer/insurer then has up to ONE YEAR in which to contest the claim, should circumstances warrant.

Voluntary Agreement [Sec. 31-296]

If the injury/illness disables the claimant for more than 3 days and the insurance company does not deny the claim, they **must** issue a Voluntary Agreement (VA), which is a statement of acceptance of responsibility for the claim. The VA must be signed by all parties and approved by a Workers' Compensation Commissioner.

The law **requires** the insurance company to issue this Voluntary Agreement. If you do not receive a VA within a month from the date of your disability, you should call the insurance company and request that they issue one to you. It is your right and their responsibility under the law.

The official State of Connecticut Workers' Compensation Voluntary Agreement form is green. (We have included a COPY of the Voluntary Agreement in the *Forms* section of this Packet beginning on page 24, so you will know what it looks like.)

To the Claimant: Filing an Official Workers' Compensation Claim (30C Form)

If you are injured on the job or are diagnosed as having a work-related disease, you should file a written notice of claim for workers' compensation as soon as possible. The 30C is the official form which the Workers' Compensation Commission provides for this purpose. (There is a 30C form which you may use, as well as line-by-line directions for completing it, in the *Forms* section on page 24 of this Packet.)

A **Form 30C** should be filed promptly after a work-related injury takes place. There is a statute of limitation for filing workers' compensation claims: within ONE YEAR of the date of an injury or within THREE YEARS of the first manifestation of a symptom of an occupational disease. Neither the First Report of Injury nor the employer's accident report satisfies this statutory requirement.

The **30C Form** must be sent by registered or certified mail to **both** your employer and the Workers' Compensation Commission District Office which has jurisdiction over the city or town in which you were injured or became ill; NOT the town in which you live. You must ask for a return receipt from the Post Office as proof of the date that it was received. You may also deliver it in person. If you do, you must have your employer sign and date the form as proof of their receipt.

(See pages 21-23 of this Packet for a complete list of Connecticut cities and towns and the District Offices which have jurisdiction over them for workers' compensation claims.)

You should file a 30C Claim Form because:

1. It is the **best** way to insure that you have met the statute of limitations for filing a workers' compensation claim.
2. A simple "accident report" filed with your employer is NOT an official claim for workers' compensation benefits.
3. Your claim will be more likely to receive prompt attention from your employer or insurance carrier.
4. Once your employer receives an official claim, it has only 28 calendar days in which to either deny your claim or to begin making workers' compensation benefit payments "without prejudice." If an official denial is not issued within 28 calendar days or if benefit payments are not initiated within 28 calendar days, your employer MUST accept the compensability of your claim.

If you are injured on the job, follow the proper procedures to protect your rights!

First Report your injury immediately to your employer, who **must** then provide you with proper medical attention. Do not delay in reporting workplace injuries. Many claimants are initially denied benefits because they did not report their injuries immediately.

Second File a proper written notice of claim—a 30C Form—as soon as possible!
This is YOUR RESPONSIBILITY! A 30C Form has been included in this packet for your convenience.

Third Ask your employer for the name of their workers' compensation insurance company.

Follow the directions and, if you need assistance, call our toll-free number in Connecticut at 1-800-223-WORK (9675) or call 860-493-1500 and ask to speak to an Education Coordinator.

The Form 36: Notice of Intention to Reduce or Discontinue Payments

When a physician indicates that the claimant is capable of *some* type of work it means that the claimant is no longer **totally** disabled. In order to discontinue *temporary total benefits* the employers/insurers are required to file a Form 36, which must be signed by a Connecticut-licensed physician or attached to the physician's report. This form must be sent by certified mail to the claimant and the Workers' Compensation Commissioner in the proper District Office. The Commissioner will automatically approve the Form 36 **within 15 days of receipt**, unless contested by the claimant. If the notice of discontinuation is properly contested, the employer/insurer must continue to pay workers' compensation benefits until an Informal Hearing is held on the matter.

TO THE CLAIMANT: If you receive a Form 36 and have reason to contest it…see the information on "Informal Hearings" in this Packet (beginning on page 12)**.**

[**NOTE: A Form 36 does NOT necessarily mean that ALL workers' compensation benefits are being discontinued**! For example, a claimant no longer eligible for Temporary Total Disability (TT) benefits may be entitled to further benefits for Temporary Partial Disability (TP) or Permanent Partial Disability (PPD).]

“Light Duty” Work Guidelines and Job Search

If you are released for “light duty” or “restricted” work, the Workers’ Compensation Commission suggests that you follow the procedures outlined below:

1. Apply to your employer for the type of light or restricted work your attending physician says you can do. If no such work is offered, register with the Connecticut Job Service and initiate a job search for *any* type of suitable work in your geographical area, even if it is not your ordinary type of work.

2. Inform the insurance carrier of your change in status and make arrangements to send a list of your employment contacts on a weekly basis to the adjuster that is handling your case. (You can find a form you may use for this purpose in the *Forms* section beginning on page 24 of this Packet.)

3. Confirm that the adjuster will be sending you a weekly check for **temporary partial benefits** for every week that your list of job searches is received. Your TP benefit rate will be equal to your original weekly benefit rate subject to the maximum and minimum benefit amounts.

4. If you find work that pays you less than what you would usually earn in your regular work, notify the adjuster. You should receive *wage differential benefits* from the insurer, until your attending physician either says that you can return to your regular work or you have reached your maximum level of medical improvement. You will need to send copies of your pay stubs to the adjuster in order to receive this payment, which is 75% of the difference between what you are currently earning and what you would have been earning in your original job.

Once your attending physician indicates that you have reached Maximum Medical Improvement (MMI) and issues a Permanent Partial Disability (PPD) evaluation or rating, the employer/insurer MUST issue you a Voluntary Agreement. (See pages 14-15 for information on the Voluntary Agreement and PPD). At this time, job searches are no longer necessary.

If you return to work, you may now collect your weekly pay **and** receive your PPD benefits. If you do not have a job at this time and the Unemployment Office deems you eligible, you may collect your PPD benefits while you are **also** collecting unemployment benefits. To determine whether you are eligible for these benefits, contact the nearest Department of Labor Unemployment Office (usually listed in the blue pages of your phone book).

Hearings and Appeals

Most employees with work-related injuries or illnesses will have undisputed cases in which their medical treatment, wage replacement benefits, and other benefits proceed smoothly and expeditiously. These employees will not need a workers’ compensation hearing, because there will be no dispute to settle; all parties agree on the compensability of the accident or illness and on the medical treatment and benefits due the employee as a result. However, for those cases in which there is some level of difference of opinion, disagreement, or misunderstanding, the Workers’ Compensation Act provides for several levels of hearings in which to resolve disputes.

Of all disputed cases, over 95% are settled in Informal Hearings. In a very small number of cases, usually involving very complex issues or matters of law, disputes are taken to Formal Hearings for resolution. Decisions rendered at Formal Hearings may be appealled to the Compensation Review Board (CRB). [Cases may also be appealed past the CRB to the Appellate Court and to the State Supreme Court, but this is very rare indeed.] Sec. 31-290a cases, involving Discharge and Discrimination, do not get appealed to the CRB, but directly to the Appellate Court.

Hearings may also be held for reasons other than disputes. For instance, a claimant must request an Informal Hearing before a Workers’ Compensation Commissioner to request discretionary “308a” wage differential benefits or to have a scar or disfigurement evaluation.

Informal Hearings

An Informal Hearing is an informal conference held at a Workers' Compensation Commission District Office and presided over by a Workers' Compensation Commissioner. The purpose of the conference, which usually lasts about 15 minutes, is to resolve disputes in workers' compensation cases, or to make appropriate awards of benefits such as "308a" or scar and disfigurement benefits. A Commissioner presiding over an Informal Hearing will not "represent" either party in a case, but will serve as an impartial fact finder and mediator between the two parties.

Either party—claimant or respondent—may request an Informal Hearing by contacting the District Office having jurisdiction. However, an effort must be made to resolve the dispute ***prior*** to requesting the hearing.

Both the claimant and the employer or its workers' compensation insurance carrier attend the Informal Hearing. (An Informal Hearing will not be postponed if one party fails to attend, unless both parties have agreed ahead of time to such a postponement.) A claimant may come alone to an Informal Hearing or may come with an interpreter (if needed) and may also be represented by an attorney, union official, or other workers' compensation representative. Employers and insurers often have an insurance adjuster and/or attorney as their representative(s).

As a claimant, you have the right to attend hearings involving your case, including when represented by counsel.

The Informal Hearing is informal in nature, simply including a discussion of the issues and evidence, and most often a recommendation by a Commissioner as to how to resolve the dispute. There are no stenographic records of such hearings.

The party requesting the hearing should clearly explain to the Commissioner any issues that are in dispute. Evidence (such as medical reports, test results, evaluations, or any documents supporting the request) should have been attached to the Hearing Request so that the Commissioner will have them in the file.

After reviewing evidence presented and discussing the issues, the Commissioner will usually make a recommendation to resolve the dispute. If both parties agree, the recommendation(s) will be binding upon the parties as an award made by the Commissioner.

When a resolution cannot be determined and agreed upon in one Informal Hearing, another one is usually scheduled for more discussion, presentation of evidence, or for whatever other reason(s) the Commissioner deems necessary. In cases where the parties cannot reach agreement after one or more Informal Hearing(s), it may be necessary to request a Formal Hearing.

Pre-Formal Hearings

If a Commissioner determines that a dispute cannot be resolved informally, or one of the parties requests a Formal Hearing, a Pre-Formal Hearing may be held prior to the scheduling of the Formal Hearing. Where possible, a party who has not been represented by an attorney during the Informal Hearings may wish to consider retaining counsel, as discussed in the section on Formal Hearings (below).

The purpose of the Pre-Formal Hearing is to help the settlement of claims and to prepare a case for trial at a Formal Hearing by clarifying the issues in dispute. At the Pre-Formal Hearing, the parties should cover the issues to be decided at the Formal Hearing, the evidence that they expect to submit, the particular testimony to be addressed, and the names of persons being deposed. Once the hearing is concluded, the parties should know what the Commissioner expects of them for the Formal Hearing. They should not expect the Commissioner to consider issues or evidence, including testimony, that goes beyond the matters addressed at the Pre-Formal Hearing.

At the Pre-Formal Hearing, the parties should also agree to a timetable for preparing their respective cases. This timetable will be given to the Commissioner, who may either schedule a second Pre-Formal Hearing to confirm that the parties have followed the schedule, or proceed to schedule the Formal Hearing. The goal of a Pre-Formal Hearing is to streamline the overall process.

Formal Hearings

Unlike Informal Hearings, a "Formal Hearing" is a formal legal proceeding presided over by a Workers' Compensation Commissioner which may last up to several hours and may involve more than one session.

The purpose of Formal Hearings, like that of the Informal Hearings, is to resolve differences and disagreements. It is the second level of hearing available to adverse parties in a workers' compensation case, although perhaps only about 3% or 4% of disputed cases ever reach this level. (NOTE: A Formal Hearing is scheduled ONLY when disputes are not resolved by a Commissioner at one or more Informal Hearings; they are NOT scheduled without previous attempts to reach agreement at the Informal Hearing level.)

Like the Informal Hearing, either party—claimant or respondent—may request a Formal Hearing, if earlier Informal Hearings have failed to produce an agreement between the adverse parties. Both the claimant and the respondent attend the hearing. Although a claimant may represent himself or herself (called "pro se") at a Formal Hearing and they are not legally required to retain an attorney, it is almost always recommended that the claimant be represented at this level by legal counsel.

In Formal Hearings, which resemble court trials, evidence is submitted as exhibits, witnesses may be produced and provide testimony under oath, and a stenographic record of the proceedings is taken. Unlike regular court trials, however, a Commissioner is not as restricted by statutory rules of evidence or procedure. It is the Commissioner's duty in a Formal Hearing to make inquiry (through oral testimony, deposition testimony, or through written or printed records) in a manner designed to ascertain each of the parties' substantial rights and carry out the provisions of the Workers' Compensation Act, as well as its intent.

Following a Formal Hearing the presiding Commissioner reviews the evidence presented, as well as any briefs filed with the Commissioner after the actual hearing, and renders a written decision called a "Finding and Award" or a "Finding and Dismissal" in which he or she issues any findings of fact and conclusions regarding the disputed issue(s) in the case. It must be delivered to both parties within 120 days after the conclusion of the hearing. This written decision is binding on all parties, unless appealed by either party to the Workers' Compensation Commission's Compensation Review Board (CRB).

Appeals

A small number of disputed workers' compensation cases are appealed to the Workers' Compensation Commission's Compensation Review Board (CRB), which is a panel of two (2) Workers' Compensation Commissioners and the Workers' Compensation Commission Chairman that regularly meets to review such appeals of decisions from lower level workers' compensation hearings. The CRB may affirm, modify or reverse the decision of the Commissioner, subject to appeal to the Appellate Court.

After a Commissioner has rendered a Formal Hearing decision, either party to the claim has twenty (20) days in which to appeal the Commissioner's decision to the CRB, which does NOT try the case again, but hears the appeal on the record of the earlier hearing. The CRB will not change a Commissioner's decision from the earlier hearing, if that decision was based on the evidence presented. New evidence or testimony will be allowed ONLY if the CRB determines that such evidence or testimony is material and there were good reasons for failure to present it at the Formal Hearing.

Benefits for Permanent Partial Disability resulting from a Work-Related Injury or Illness

Many employees with work-related injuries or illnesses end up with a "Permanent Partial Disability" (PPD), meaning that they have lost some body part, or some use of a body part or function, and are usually eligible for PPD benefits. When the attending physician determines that the injured employee has reached "maximum medical improvement" (MMI), he/she should issue an opinion about whether a permanent partial disability resulted from the injury or illness by assigning the disability rating to the specific body part involved.

Section 31-308 provides a list (see page 15) of body parts with the total number of weeks of compensation provided by law for each. For example, the master arm is scheduled for 208 weeks, so a "20% loss of use of the master arm" equals 20% of 208 weeks which equals 41.6 weeks of benefits. An employee eligible for a $200 per week benefit rate would receive 41.6 weekly payments of $200 for a total PPD benefit payment of $8,320.

The PPD weekly benefit rate is determined by the employee's basic compensation rate *at the time of the original injury or illness*. As in everything else, it is subject to the legislated maximum and minimum amounts.

After completing the disability evaluation, Form 42 (see the *Forms* section beginning on page 24), the attending physician giving the PPD rating should forward it to the employee, the employer/insurer, and the WCC District Office. PPD benefits should then begin within 30 days of the MMI date, or interest penalties may be applied.

If the employer/insurer accepts the evaluation, a **Voluntary Agreement** (see the *Forms* section beginning on page 21) should be issued promptly for a Commissioner's approval. **This does not close out the case.** The claim remains open and the employer/insurer is still liable for future medical expenses and other compensation benefits. No workers' compensation case may be closed without mutual agreement on the part of the claimant and the employer/insurer.

If there are two different opinions as to the degree of disability, the employee and the employer/insurer can either attempt to work out a compromise or request an **Informal Hearing** on the matter, where a Commissioner will review all medical information presented and may suggest a resolution to the dispute. (See *Hearings and Appeals* on page 12.)

In most cases, claimants will receive undisputed PPD benefits without the need for legal representation.

Maximum PPD Benefit Schedule [31-308]

(for injuries/illnesses ON OR AFTER July 1, 1993)

Arm *(master)*	208 Weeks
Arm *(other)*	194
Back	374
Brain	520
Carotid Artery	520
Cervical Spine	117
Coccyx *(actual removal)*	35
Eye	157
Finger *(first)* **	36
Finger *(second)* **	29
Finger *(third)* **	21
Finger *(fourth)* **	17
Foot	125
Gall Bladder	13
Hand *(master)*	168
Hand *(other)*	155
Hearing *(both ears)*	104
Hearing *(one ear)*	35
Heart	520
Jaw *(mastication)*	35
Kidney	117
Leg	155
Liver	347
Loss of Bladder	233
Loss of Drainage Duct of Eye *(if corrected or uncorrected by prosthesis)*	17 each
Lung	117
Mammary	35
Nose *(sense and respiratory function)*	35
Ovary	35
Pancreas	416
Pelvis	% of Back
Penis	35-104
Rib Cage (bilateral)	69
Sense of Smell	17
Sense of Taste	17
Speech	163
Spleen	13
Stomach	260
Testis	35
Thumb *(master Hand)* *	63
Thumb *(other Hand)* *	54
Toe *(great)* ***	28
Toe *(any other)* ***	9
Uterus	35-104
Vagina	35-104

Notes

* The loss or loss of use of one phalanx of a thumb shall be construed as 75% of the loss of the thumb.

** The loss or loss of use of one phalanx of a finger shall be construed as 50% of the loss of the finger.
The loss of or loss of use of two phalanges of a finger shall be construed as 90% of the loss of the finger.

*** The loss or loss of use of one phalanx of a great toe shall be construed as 66-2/3% of the loss of the great toe.
The loss of the greater part of any phalanx shall be construed as the loss of a phalanx and shall be compensated accordingly.

Other Benefits Provided by the Workers' Compensation Act

Vocational Rehabilitation [Sec. 31-283a]

If you cannot return to your usual work because of a significant permanent physical impairment, you may be entitled to vocational rehabilitation. If you are eligible, your rehabilitation program will be paid for by the Workers' Compensation Commission's Rehabilitation Services. (For more information, see page 18.)

Continued Health Insurance Coverage [Sec. 31-284b]

Sec. 31-284b says that the injured workers's employer must continue paying for their insurance(s) while the employee is receiving workers' compensation benefits. In 1992 the U.S. Supreme Court determined that **this law was unconstitutional** as it relates to employees in the private sector. This is because private sector employees come under the protection of the Federal Government's *Employee's Retirement Income Security Act*, also known as ERISA. Therefore, the state of Connecticut could not enact legislation affecting these kinds of employee issues.

- Since state and municipal employees do NOT come under the ERISA Act, 31-284b still applies and their employers must continue paying for their employees' insurance(s) while they are receiving, or eligible to receive, workers' compensation benefits.

Protection Against Discharge or Discrimination [Sec. 31-290a]

Section 31-290a of the Workers' Compensation Act prohibits employers from discharging, or in any way discriminating against, any employee *just* because the employee has filed a claim for workers' compensation benefits or otherwise exercised his or her rights under the Act.

Any employee who claims to have been so discharged or so discriminated against may either (1) bring a civil action in the superior court for the judicial district where the employer has its principal office or (2) file a complaint with the Workers' Compensation Commission (WCC) Chairman alleging violation of section 31-290a. Upon receiving such a complaint, the WCC Chairman shall select a Workers' Compensation Commissioner to hear the complaint in the WCC District Office having jurisdiction over the location of the employer's principal office.

If a Commissioner finds that the employee was wrongfully discharged or discriminated against, he or she may award job reinstatement, payment of back wages, and any other employee benefits which the employee lost, as well as reasonable attorney's fees.

To file a Discrimination Complaint under Section 31-290a, the employee should send their complaint to: John A. Mastropietro, Chairman, Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106. The complaint must include: (1) the employee's name and address, (2) the name and address of the employer, (3) the date of the injury or illness, and (4) the date and nature of the alleged discharge or discrimination.

The WCC Chairman will see that a hearing is scheduled before a Commissioner in the appropriate workers' compensation district office.

Workers' Compensation Fraud [Sec. 31-290c]

Workers' compensation fraud is either a class C felony, if the amount of benefits claimed or received is less than $2,000, or a class B felony, if the amount of benefits claimed or received exceeds $2,000.

Workers' Compensation Fraud Unit [Sec. 31-290d]

The State of Connecticut's Fraud Unit operates out of the Chief State's Attorney's Office, Division of Criminal Justice, and investigates complaints of all parties alleged to be engaging in any form of workers' compensation fraud. The Unit makes arrests and prosecutes those it believes to be engaging in workers' compensation fraud. For more information, or to report alleged cases of workers' compensation fraud, call the Workers' Compensation Fraud Unit at (860) 258-5800.

Benefits under Group Medical Policy [Sec. 31-299a]

If an employee's claim is denied and that employee has other insurance that pays for their medical care or lost time (i.e., health or disability insurance), they should submit their claims for payment to *those* insurance companies, while their workers' compensation claim is pending. The workers' compensation insurer should issue a **Form 43** (see the *Forms* section beginning on page 21), if they are denying the claim. This should then be submitted along with any medical bills, or claims for wage replacement, to the employee's health insurer or short-term/long-term disability insurer, if they have one. Since the Form 43 attests to the fact that the workers' compensation insurer has denied the claim, the "other" insurance companies must honor their contractual obligations pending the outcome of the workers' compensation claim. If the workers' compensation claim is eventually approved, then the "other" insurances will have to contact the workers' compensation insurer about getting their money back.

Artificial Aids Covered [Sec. 31-311]

Employers are liable for payment of damages to artificial legs, feet, arms, or hands sustained by their employees in the course of employment (consisting of the cost of the artificial aid's repair or replacement). Repair or replacement of eyeglasses, contact lenses, hearing aids, and artificial teeth is also covered, when damage to such aids is accompanied by bodily injury about the face or head.

Right of Transfer to Suitable Work [Sec. 31-313]

If the injured worker cannot return to their usual job because of their injury, the employer should transfer that employee to full-time suitable work, if it is available, provided this does not conflict with the terms of a labor contract.

All workers' compensation benefits are non-taxable *(except for benefits obtained under Section 7-433c, Heart & Hypertension Benefits for Police and Firefighters)*.

For more information on taxability of benefits, contact the Internal Revenue Service (for federal guidelines) or the State Department of Revenue Services (for state guidelines).

Return to Work through the Workers' Compensation Commission's Rehabilitation Services

The Basic Idea of Rehabilitation Services

Most workers in the state of Connecticut are protected by workers' compensation insurance. In addition to provisions covering the loss of earnings and medical care, the Workers' Compensation Act provides for Vocational Rehabilitation. This service is designed to help you begin to overcome any permanent and substantial loss of earning power you may have suffered as a result of a compensable injury or occupational disease.

The main goal of Rehabilitation Services is to help the injured worker get back to work in a position that is physically appropriate. Prompt and well-planned vocational rehabilitation may help prevent future injuries. Early referral may help the injured worker return to the job market sooner than otherwise might be possible.

Who May Be Eligible?

You may be eligible, if your injury or occupational disease has resulted in permanent limitations which do not allow you to return to your regular job.

You must also have an accepted compensation claim or an approved stipulated agreement.

What Services are Provided?

Each person's program will be individualized, based on their needs. Services may include:

- Vocational Counseling
- Evaluation
- Aptitude/Interest Testing
- Training/Education
- Job Seeking Skills
- Placement Assistance

Am I Guaranteed A Job?

No one can guarantee you a job. You are, however, guaranteed that your Rehabilitation Coordinator will do everything possible to assist you in your efforts to return to work. This will include advice as to how to best apply for work and where openings in your field may be available.

When Should I Apply?

Apply to Rehabilitation Services as soon as your doctor sees a problem with you returning to your regular work.

Fact: You can refer yourself.

Fact: You don't have to wait until maximum medical improvement.

Fact: You do not need a high school diploma and you do not need to speak English.

Fact: THE SOONER YOU APPLY, THE GREATER YOUR CHANCES FOR SUCCESS!

How Do I Apply?

You can apply by calling the central Workers' Compensation Commission office at (860) 493-1500 and asking for Rehabilitation Services. We will send you a brochure and an application.

When your application is received, your case will be assigned to a Rehabilitation Coordinator and you will be scheduled for an interview. At that time we will begin the eligibility process and answer any questions you may have.

For a more detailed description of the program, please see the Client Handbook.

A Message to Employers

A company's most valuable asset is its work force. The sooner an injured employee can be returned to work, the lower the cost for the work-related injury. Rehabilitation Services can work with you, if a job modification or new skills are necessary to return your injured employee back to work. Rehabilitation Services has contracted with a Rehabilitation Engineer to provide a one-time work-site consultation for possible job modifications. New skills may be learned through classroom training or from on-the job training. THERE IS NO COST TO YOU FOR THESE SERVICES.

On-The-Job Training

Rehabilitation Services offers financial incentives for employers to take the time to train injured workers to return to the work force with new skills and abilities. Rehabilitation Coordinators are available to discuss your needs. The length of time for training varies based on the skill level of that position.

Is It Worth the Effort?

Only you can decide this. The best outcome of a work-related injury is a successful return to work as quickly as possible.

Rehabilitation Services and its staff of Counseling Coordinators are ready to help you help yourself.

Contact

Workers' Compensation Commission
Rehabilitation Services
21 Oak Street, 4th Floor
Hartford, CT 06106-8011

Telephone: (860) 493-1500

Education and Safety & Health Services

The Workers' Compensation Act, under Section 31-283g, requires that the Workers' Compensation Commission provide information and training in the area of workers' compensation procedures, standards and requirements. This education is available to all employees, employers, medical professionals and insurance personnel.

The following descriptions briefly outline our services and products, all of which are provided FREE of charge.

Automated WATS Telephone Info Line

Available toll-free in Connecticut—**24/7**—this phone service provides pre-recorded messages on a wide range of workers' compensation topics.

You may also use this toll-free number to speak to one of our Education Coordinators Monday thru Friday between the hours of 7:45 a.m. and 4:30 p.m. for basic information, or to discuss more complex issues in your workers' compensation case.

Web Site: http://wcc.state.ct.us

Also available **24 / 7**, the Commission's website on the Internet provides a wealth of workers' compensation materials including the addresses and driving directions for all of our Commission offices; updates on the workers' compensation system in Connecticut; over 250 workers' compensation and related statutes and regulations; over 1,800 Compensation Review Board (CRB) opinions from 1994 to the present; over 4,000 annotations to CRB opinions; downloadable documents and workers' compensation forms; and Chairman's memorandums.

Literature

The Commission's educational literature may be ordered by calling our toll-free WATS line or by sending in the order form at the end of this Packet.

Conferences and Speakers

The Workers' Compensation Commission has presented many educational conferences and seminars covering the basics of workers' compensation in Connecticut, as well as safety and health committees and medical care plans. Information on any future presentations will appear on our website (see above).

In addition, the Education Coordinators and Safety Program Officers are available to speak to groups of 25 or more on a wide variety of workers' compensation related topics. If you would like to request a speaker, please send a written request along with the specifics to:

John A. Mastropietro, Chairman
Workers' Compensation Commission
Capitol Place
21 Oak Street, 4th Floor
Hartford, CT 06106-8011

1-800-223-9675 (WORK) *Toll-Free in Connecticut only*
or
(860) 493-1500

Workers' Compensation City & Town Jurisdictions

Office of the Chairman
Chairman John A. Mastropietro
21 Oak Street
Hartford, CT 06106-8011

(860) 493-1500
wcc.chairmansoffice@po.state.ct.us

Compensation Review Board (CRB)
Chairman John A. Mastropietro
21 Oak Street
Hartford, CT 06106-8011

(860) 493-1500

Education and Safety & Health Services
21 Oak Street
Hartford, CT 06106-8011

1-800-223-WORK (9675) *toll-free in CT only*
(860) 493-1500

Rehabilitation Services
21 Oak Street
Hartford, CT 06106-8011

(860) 493-1500

Statistical Division
21 Oak Street
Hartford, CT 06106-8011

(860) 493-1500

First District — Commissioner, 999 Asylum Avenue, Hartford, CT 06105; (860) 566-4154

The Hartford District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Bloomfield
Blue Hills
Broad Brook
Crystal Lake
Dobsonville
East Granby
East Hartford
East Windsor
East Windsor Hill
Ellington
Enfield
Hartford
Hazardville
Melrose
North Somers
North Thompsonville
Poquonock
Rainbow
Rockville
Sadds Mill
Scantic
Scitico
Silver Lane
Somers
Somersville
South Windsor
Suffield
Talcotville
Thompsonville
Tolland
Vernon
Vernon Center
Warehouse Point
West Suffield
Wilson
Windsor
Windsor Locks
Windsorville

Second District — Commissioner, 55 Main Street, Norwich, CT 06360; (860) 823-3900

The Norwich District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Abington
Almyville
Amston
Andover
Ashford
Attawaugan
Atwoodville
Ballouville
Baltic
Bolton
Bolton Notch
Bozrah
Bozrah Street
Brooklyn
Burnetts Corner
Canterbury
Center Groton
Central Village
Chaplin
Chesterfield
Chestnut Hill
(Lebanon)
Clark Falls
Clarks Corner
Columbia
Coventry
Danielson
Dayville
Doaneville
Eagleville
East Brooklyn
Eastford
East Killingly
East Putnam
East Thompson
East Willington
East Woodstock
Ekonk
Elmville
Exeter
Fabyan
Fitchville
Franklin
Gales Ferry
Gilead
Gilman
Glasgo
Goshen Hill
Graniteville
Greenville
Griswold
Grosvenordale
Groton
Groton Heights
Groton Long Point
Gurleyville
Hallville
Hampton
Hanover
Harrisville
Hebron
Hopeville
Hop River
Hydeville
Jewett City
Jordan Village
Killingly
Killingly Center
Kenyonville
Laurel Glen
Lebanon
Ledyard
Ledyard Center
Liberty Hill
Lisbon
Long Society
Lords Point
Mansfield
Mansfield Center
Mansfield Depot
Mansfield Hollow
Mashantucket
Mashapaug
Mechanicsville
(Thompson)
Merrow
Mohegan
Montville
Moosup
Morningside Park
Mystic
Newent
New London
Noank
North Ashford
North Franklin
North Grosvenordale
North Stonington
North Windham
North Woodstock
Norwich
Norwichtown
Oakdale
Occum
Ocean Beach
Old Mystic
Oneco
Orcuttville
Pachaug
Packerville

Pawcatuck
Phoenixville
Plainfield
Pleasure Beach
Pomfret
Pomfret Center
Pomfret Landing
Poquetanuck
Poquonock Bridge
Preston
Putnam
Putnam Heights
Quaddick
Quaker Hill
Quinebaug
Rogers
Scotland
Sodom
South Chaplin
South Killingly
South Willington
South Windham
South Woodstock
Sprague
Spring Hill *(Mansfield)*
Stafford
Stafford Springs
Staffordville
Sterling
Sterling Hill
Stonington
Storrs
Taftville
Thompson
Uncasville
Union
Versailles
Village Hill *(Lebanon)*
Voluntown
Warrenville
Waterford
Wauregan
Wequetequock
Westford
Westminster
West Mystic
West Stafford
West Thompson
West Willington
West Woodstock
Willimantic
Willington
Wilsonville
Windham
Woodstock
Woodstock Valley
Yantic

Third District — Commissioner, 700 State Street, New Haven, CT 06511; (203) 789-7512

The New Haven District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Allingtown
Augerville
Bethany
Branford
Burr Hill
Clinton
Clintonville
Durham
East Haven
East River
Fair Haven
Foxon
Guilford
Hamden
Indian Neck
Killingworth
Madison
Momauguin
Montowese
Morningside
Mount Carmel
New Haven
North Branford
Northford
North Guilford
North Haven
North Madison
Orange
Pine Orchard *(Branford)*
Pond Meadow *(Killingworth)*
Quinnipiac
Rivercliff
Rockland
Sachem Head
Short Beach
Spring Glen
Stony Creek
West Haven
Westville
Whitneyville
Woodbridge

Fourth District — Commissioner, 350 Fairfield Avenue, Bridgeport, CT 06604; (203) 382-5600

The Bridgeport District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Ansonia
Berkshire
Botsford
Bridgeport
Derby
Devon
Dodgingtown
Easton
East Village
Fairfield
Greenfield Hill
Greens Farms
Hattertown
Hawleyville
Huntington
Huntingtontown
Long Hill District
Lordship
Milford
Monroe
Newtown
Nichols
Riverside *(Newtown)*
Sandy Hook
Saugatuck
Shelton
Southport
Stepney
Stevenson
Stratford
Trumbull
Upper Stepney
Westport
Woodmont

Fifth District — Commissioner, 55 West Main Street, Waterbury, CT 06702; (203) 596-4207

The Waterbury District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Amesville
Bantam
Beacon Falls
Bethlehem
Burrville
Campville *(Litchfield)*
Canaan
Canaan Valley
Cornwall
Cornwall Bridge
Cornwall Center
Cornwall Hollow
Drakeville
East Canaan
East Litchfield
East Morris
East Plymouth
Ellsworth
Falls Village
Flanders
Goshen
Greystone
Harwinton
Hotchkissville
Huntsville
Kent
Kent Furnace
Lakeside
Lakeville
Lime Rock
Litchfield
Lower City
Macedonia
Middlebury
Millville
Milton
Minortown
Morris
Naugatuck
Newfield *(Torrington)*
Norfolk
North Canaan
Northfield
North Kent
North Woodbury
Oakville
Oxford
Pequabuck
Plymouth
Pomperaug
Prospect
Quaker Farms
Salisbury
Seymour
Sharon
South Britain
Southbury
South Canaan
Southford
South Kent
Straitsville
Taconic
Terryville
Thomaston
Torringford
Torrington
Twin Lakes
Union City
Warren
Waterbury
Watertown
West Cornwall
West Goshen
West Torrington
White Oak
Woodbury
Wrightville

Sixth District — Commissioner, 233 Main Street, New Britain, CT 06051; (860) 827-7180

The New Britain District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Avon
Bakersville
Barkhamsted
Berlin
Bristol
Burlington
Canton
Canton Center
Colebrook
Collinsville
East Berlin
East Hartland
Edgewood
Elmwood
Farmington
Forestville
Granby
Hartland
Kensington
Marion
Mechanicsville
(Granby)
Milldale
Nepaug
New Britain
New Hartford
Newington
North Canton
North Colebrook
North Granby
Pine Meadow
Plainville
Plantsville
Pleasant Valley
Riverton
Robertsville
Simsbury
Southington
Tariffville
Unionville
Weatogue
West Avon
West Granby
West Hartford
West Hartland
West Simsbury
Wethersfield
Whigville
Winchester
Winchester Center
Winsted
Wolcott

Seventh District — Commissioner, 111 High Ridge Road, Stamford, CT 06905; (203) 325-3881

The Stamford District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Banksville
Belltown
Bethel
Boardmans Bridge
Branchville
Bridgewater
Brookfield
Brookfield Center
Byram
Cannondale
Church Hill
Cos Cob
Cranbury
Danbury
Darien
East Norwalk
Gaylordsville
Georgetown
Germantown
Glenbrook
Glenville
Greenwich
High Ridge
Long Ridge
(Stamford)
Lower Merryall
Lyons Plains
Marble Dale
Merryall
Mianus
Mill Plain
New Canaan
New Fairfield
New Milford
New Preston
Noroton
Noroton Heights
North Stamford
Northville
North Wilton
Norwalk
Old Greenwich
Park Lane
Redding
Redding Ridge
Ridgebury
(Ridgefield)
Ridgefield
Riverside
(Greenwich)
Romford
Round Hill
(Greenwich)
Rowayton
Roxbury
Roxbury Falls
Roxbury Station
Sherman
Silvermine
(Norwalk)
South Norwalk
South Wilton
Springdale
Stamford
Titicus
Topstone
Turn Of River
Upper Merryall
Washington
Washington Depot
West Norwalk
Weston
West Redding
Wilton
Winnipauk
Woodville

Eighth District — Commissioner, 90 Court Street, Middletown, CT 06457; (860) 344-7453

The Middletown District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Addison
Baileyville
Bashan
Black Hall
Black Point
Buckingham
Buckland
Centerbrook
Cheshire
Chester
Cobalt
Colchester
Cornfield Point
Crescent Beach
Cromwell
Deep River
East Glastonbury
East Haddam
East Hampton
East Lyme
Essex
Fenwick
Flanders Village
Gildersleeve
Glastonbury
Grove Beach
(Westbrook)
Haddam
Haddam Neck
Hadlyme
Hamburg
Higganum
Highland
Highland Park
Hopewell
Ivoryton
Knollwood Beach
Laysville
Leesville
Little Haddam
Lyme
Manchester
Manchester Green
Marlborough
Meriden
Middlefield
Middlefield Center
Middle Haddam
Middletown
Millington
Mixville
Moodus
Niantic
North Lyme
North Plains
North Westchester
Old Lyme
Old Saybrook
Pond Meadow
(Westbrook)
Ponset
Portland
Rockfall
Rocky Hill
Salem
Salem Four Corners
Saybrook Manor
Saybrook Point
Shailerville
Sound View
South Glastonbury
South Lyme
South Meriden
Tylerville
Wallingford
Westbrook
Westfield
Winthrop
Yalesville

State of Connecticut Workers' Compensation Forms

a. Forms You May Use IF YOU ARE INJURED

The following forms are provided for you to use IF YOU ARE INJURED.

If you need more copies of these forms, obtain them on our website [http://wcc.state.ct.us/download/forms.htm] or request them from our Education Services office or your local District Office.

- Instructions for Filing the 30C Form
- 30C Form: Notice of Claim for Compensation (Employee to Commissioner and to Employer)
- Hearing Request (HR)
- Record of Employment Contacts *(unofficial form)*
- Mileage Worksheet for Medical Treatment—Examination—Physical Therapy—Laboratory Test *(unofficial form)*
- Form WCR-1: Rehabilitation Request
- Education Services Order Form

Directions for Completing the 30C Claim Form

Please pay close attention to these directions. Remember to Type or Print Neatly In Ink (except for signatures).

In filling out the 30C Form, please note the following:

1. **In the "INJURED WORKER" box** at the upper left side of the form, **type or neatly print the name of the injured worker (If YOU are the injured worker, print YOUR name here.). Also fill in the injured worker's D.O.B.** (date of birth), **put a check in the box if the worker is a minor** (under the age of 18), **and fill in the injured worker's street address, town, state, zip code, and telephone number**.

2. **In the "EMPLOYER" box** at the lower left side of the form, **type or neatly print the name of the employer** ("Name of employer" means the name of the organization for which you work, NOT your boss or supervisor.) **and its street address, town, state, zip code, and telephone number**. **Next indicate** (YES or NO) **whether the injured worker's injury occurred at the employer's location just listed; *if the injury took place at a location other than that listed*, fill in the location, street address, town, state, zip code, and telephone number where the injury actually occurred**.

3. **In the "INJURY" box** at the upper right side of the form, **type or neatly print the date of the injured worker's injury and the town in which the injury occurred** (Note the city or town in which the injury actually occurred. This will not necessarily be the same location as the employer's business address!). **Next indicate the part(s) of the worker's body injured and how the injury occurred** (In the blank space describe your injury in simple terms. Indicate the part(s) of your body affected and the type(s) of injury. For example: "sprain to the right shoulder", "amputation of the left thumb", "fracture of the right ankle", "severe strain to lower back", etc.). **Lastly, indicate** (YES or NO) **whether the injury is an occupational disease or a repetitive trauma, and check the appropriate box, if you have more than one employer**.

4. **In the "SIGNATURE OF INJURED WORKER OR REPRESENTATIVE" box** at the lower right side of the form, **sign your name and fill in the date of your signature, if you are the injured worker. *If you are NOT the injured worker*, then sign your name, fill in the date of your signature, and then type or neatly print your name, the name** (if any) **of your firm, your street address, town, state, zip code, and your telephone number**.

5. **In the "WCC File #" box** at the upper right side of the form (just below the "30C" number in the upper right corner), **type or neatly print the WCC File Number, ONLY IF YOU KNOW IT**. In most instances, this number will be assigned to your claim by the Workers' Compensation Commission only after you send the 30C Form in, so **it is okay to leave this one area of the form blank, if you are not absolutely sure of the number**.

Once you have completed the 30C Form, follow these procedures:

6. **Make two (2) extra copies of your completed 30C Form** (this can be done at many quick-copy printers).

7. **Send the original 30C to your employer* by Certified or Registered mail, return receipt requested. The claim may also be delivered in person but if so, have the employer acknowledge in writing the receipt of the claim.**

   **** State employees**' work-related injuries and illnesses are reported on Form PER-WC 207, entitled "Report of Occupational Injury or Disease to an Employee". If a State employee elects to file a 30C Form, then he or she must send the 30C Form to the Commissioner of Administrative Services, 165 Capitol Avenue, Hartford, CT 06106, NOT to the particular office where employed. (The Form PER-WC 207 is ONLY an accident report and is NOT the official claim form for workers' compensation benefits — State employees, like any other employees, must file a 30C Form in order to file an official workers' compensation claim.)*

   **** Municipal employees**, like any other employees, must also file a 30C Form in order to file an official workers' compensation claim; if a municipal employee elects to file a 30C Form, then he or she must send the 30C Form to the town clerk of the municipality in which he or she is employed.*

8. **Send a copy of the 30C to the appropriate Workers' Compensation Commission District Office by Certified or Registered mail, return receipt requested, or deliver by personal presentation.** Addresses for all Workers' Compensation Commission District Offices may be found in this packet of material. **The "District Office"refers to the number given to the District Workers' Compensation Commission Office for the town in which you were injured**. Refer to the Connecticut map provided with the Form 30C for the number of the Compensation District for the town in which you were injured.

9. **Keep the remaining copy of the 30C for your own file.**

State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 7-1-2016

30C

WCC File #

Date filed in District

(for WCC use only)

Notice of Claim for Compensation

(Employee to Commissioner and to Employer)

This form prepared by the WCC is proper for ordinary use and is recommended, but any other notice complying with Section 31-294c shall be deemed sufficient.

Notice is hereby given that the injured worker, while in the employ of the employer, sustained injuries arising out of and in the course of his/her employment as follows, and makes claim for compensation benefits.

INJURED WORKER

Name _____
(first) *(middle)* *(last)*

D.O.B. *(required)* _____

Check, if a Minor ☐ *(under 18 yrs. of age)*

Address _____

Town _____ State _____

Zip Code _____ Tel.# _____

INJURY

Date of Injury _____

Town of Injury _____

Body Part(s) _____

Describe Injury and How It Happened:

☐ Check, if an Occupational Disease or a Repetitive Trauma

☐ Check, if you have MORE THAN ONE Employer

EMPLOYER

Employer _____

Address _____

Town _____ State _____

Zip Code _____ Tel.# _____

Was Injury ON Premises of Employer? ☐ YES ☐ NO

If NO, where? _____

Address _____

Town _____

Zip Code _____ Tel.# _____

SIGNATURE OF INJURED WORKER OR REPRESENTATIVE

Signature _____

Date _____

Print name & address below, if other than injured worker:

Name _____

Name of Firm _____

Address _____

Town _____ State _____

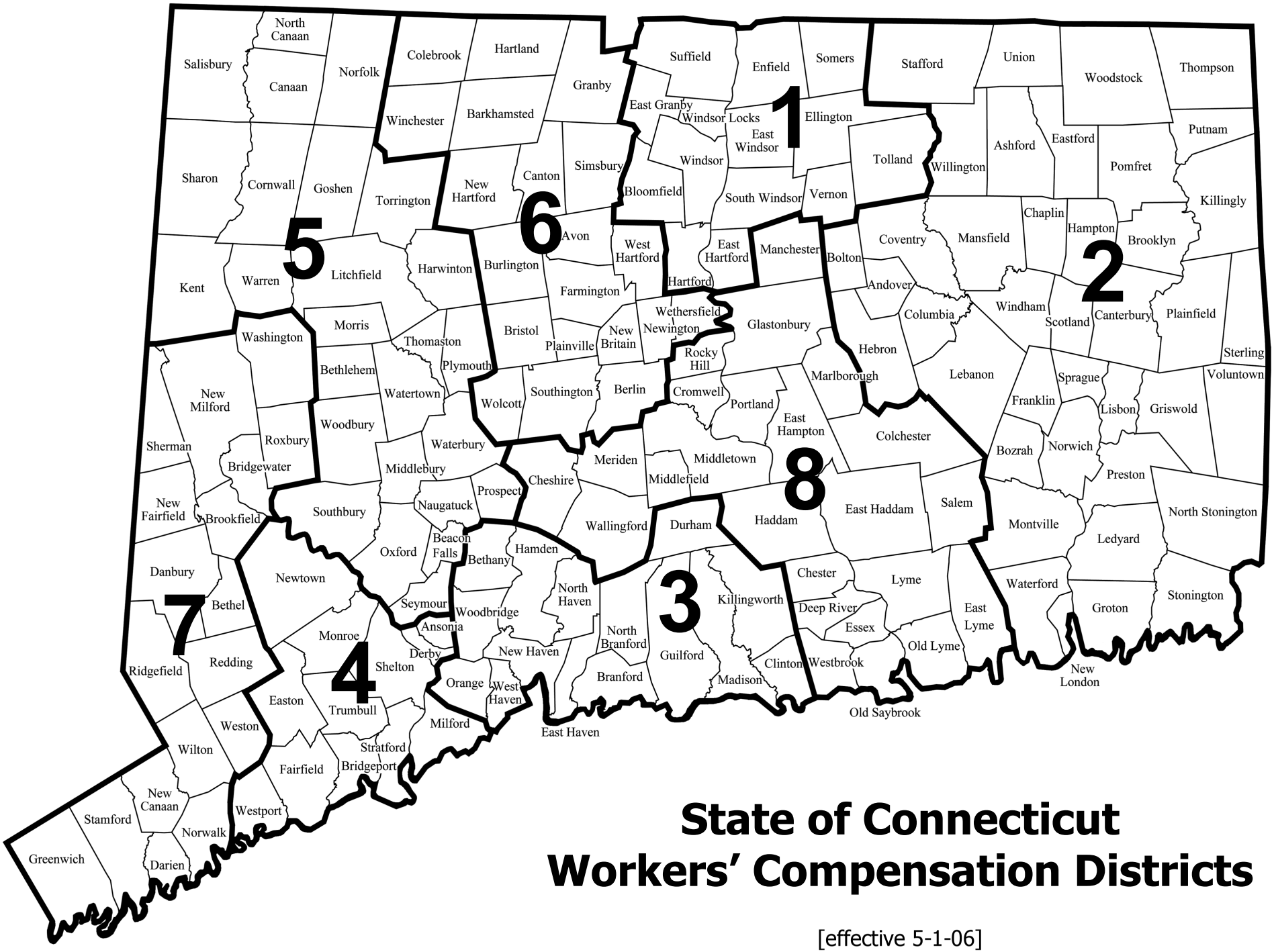
Zip Code _____ Tel.# _____

This notice must be served upon the Commissioner and *Employer by personal presentation or by registered or certified mail. For the protection of both parties, the employer should note the date when this notice was received and the claimant should keep a copy of this notice with the date it was served.

* *Persons employed by the State of Connecticut must also serve the employer by serving this notice upon the Commissioner of Administrative Services, 165 Capitol Avenue, Hartford, CT 06106.*

* *Persons employed by a municipality must also serve the employer by serving this notice upon the town clerk of the municipality in which he or she is employed.*

WARNING: If an employer does not file a notice contesting liability (e.g. Form 43) for this claim OR begin making workers' compensation benefit payments "without prejudice" within 28 calendar days from the date when this claim is received by personal delivery or by registered or certified mail, COMPENSABILITY SHALL BE PRESUMED and cannot thereafter be contested. If an employer chooses to begin making workers' compensation benefit payments "without prejudice" within 28 calendar days from the date of receipt of this claim and still wishes to contest this claim, it must do so by filing a notice contesting liability for this claim within one year from receipt of this claim. [See Sec. 31-294c(b).]



State of Connecticut
Workers' Compensation Districts

[effective 5-1-06]

State of Connecticut
Workers' Compensation Commission

Rev. 7-13-2009

HR

Please TYPE or PRINT IN INK
and SEND A COPY OF THIS REQUEST
TO ANY OTHER INTERESTED PARTY(IES)

Hearing Request

WCC File #

Date filed in District

(for WCC use only)

I hereby notify the Workers' Compensation Commission of my request for the following hearing:

☐ Informal ☐ Pre-Formal ☐ Formal ☐ Stip Approval

☐ Disfigurement / Scar — Surgery Date(s): _____

For injuries occurring ON OR AFTER July 1, 1993, disfigurement/scar benefits are available ONLY for disfigurements or scars on the face, head, neck, or any other area of the body that handicaps the employee from obtaining or continuing to work. [See Sec. 31-308(c)]

Reason(s) for the requested hearing **AND** supporting documents are required:

INJURED WORKER

Name _____

D.O.B. *(required)* _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

EMPLOYER

Name _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

INSURANCE

Policy Insurer Name _____

Policy No. _____ Eff. Date _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

Administrator Name _____

Contact Person _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

Attorney for Insurance Carrier _____

Name of Firm _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

INJURY

Date of Injury _____

City/Town of Injury _____

State _____ Zip Code _____

Body Part _____

ATTORNEY OR REPRESENTATIVE OF INJURED WORKER

Name _____

Name of Firm _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

ADDITIONAL INTERESTED PARTIES FOR NOTIFICATION — List:

REQUIRED

You MUST attach to this form a list of the names and addresses of each party you have contacted in your attempt to resolve this issue.

As the party requesting the hearing, **I CONFIRM THAT I HAVE CONTACTED ALL COUNSEL AND PRO SE PARTIES OF RECORD BY TELEPHONE OR WRITTEN COMMUNICATION AND HAVE BEEN UNABLE TO RESOLVE THE ABOVE ISSUES.**

I understand that it is improper to request a hearing without first trying to resolve the issues with the other party.

I am the ***(check ONE)*****:**

☐ injured worker or representative

☐ insurance company or representative

☐ additional interested party *(please specify)*:

_____

Signature _____ Date _____

Record of Employment Contacts

Employee Name _____ Telephone No. _____

Address _____

City _____ State _____ Zip_____

Employer _____

Insurance Carrier_____

Date of Injury _____

This is a record of the employers contacted by the above-named employee for the week of:

_____

(month / day / year — month / day / year)

Date of Contact	Employer Name and Address	Phone Number	Type of Job	Person Contacted	Result of Contact	Referral Source

You may copy this form for future use in your job search or you may submit sheets in your own handwriting.

A copy of your record of job search efforts should be forwarded to the workers' compensation insurance carrier or self-insured employer for its review. Be sure to include all the necessary information and make a copy for your own records. Don't forget to indicate your efforts to obtain employment through the Connecticut Job Service and/or other referral sources.

Mileage Worksheet for Medical Treatment — Examination — Physical Therapy — Laboratory Test

[Section 31-312 C.G.S.]

Rev. 3-17-2006

Employee Name _____ Date of Injury _____ Claim # _____

(Please TYPE or PRINT IN INK)

Employer Name _____

DATE: Month / Day / Year	FROM: City / Town , State	TO: City / Town , State	REASON FOR VISIT — NAME OF PHYSICIAN or Other Health Care Provider	ROUND-TRIP MILEAGE:
/ /				
/ /				
/ /				
/ /				
/ /				

DATE SUBMITTED _____

TOTAL MILEAGE = _____

Rehabilitation Request

State of Connecticut
Workers' Compensation Commission
Rehabilitation Services
21 Oak Street, 4th Floor
Hartford, CT 06106-8011

Please TYPE or PRINT IN INK

Rev. 7-13-2009

WCR-1

Date filed with Rehabilitation Services

(for WCC use only)

Name	Date of Birth *(required)*	Injured Body Part

Address *(Number and Street* *City or Town* *State* *Zip Code)*

Date of Injury	City or Town Where Injured	Employer at Time of Injury

I wish to receive services that will help me to return to work — *EMPLOYEE SIGNATURE REQUIRED*:

Telephone *(Area Code + Number)*

Date

FOR OFFICE USE ONLY

Rehabilitation District	Compensation District	WCC File #	Comments

Referral Source

Address

Date

State of Connecticut
Workers' Compensation Commission

Education Services Order Form

Name _____ Telephone: _____

Position _____ Email: _____

Organization _____

Address _____

City _____ State _____ Zip_____

Please mark the item(s) below that you would like to receive FREE of charge:

_____ Information Packet—overview of workers' compensation, includes a 30C claim form

❑ English ❑ Spanish

_____ Pocket Guide to Workers' Compensation

❑ English ❑ Polish ❑ Portuguese ❑ Spanish

_____ Bulletin—Workers' Compensation Act, related statutes, regulations and more

_____ A Guide to 1996 Workers' Compensation Reform Legislation

_____ A Guide to 1995 Workers' Compensation Reform Legislation

_____ Summary of 1993 Workers' Compensation Law Changes

_____ Subscriptions—Please add me to the following Chairman's Mailing List:

❑ Attorney ❑ Insurance ❑ Medical Practitioner ❑ Union

Mail this Order Form to:

Workers' Compensation Commission
Education Services
Capitol Place - 4th Floor
21 Oak Street
Hartford, CT 06106-8011

State of Connecticut Workers' Compensation Forms

b. SAMPLES of Other Forms used in the Workers' Compensation System – DO NOT USE

The following forms are not to be filled out. They are provided to you as SAMPLES of some forms you may be receiving as your case progresses.

- Employer's First Report of Occupational Injury or Illness (FRI)
- Form 1A: Filing Status and Exemption
- Voluntary Agreement (VA)
- Form 43: Notice to Compensation Commissioner and Employee of Intention to Contest Employee's Right to Compensation Benefits
- Form 36: Notice of Intention to Reduce or Discontinue Payments
- Form 42: Physician's Permanent Impairment Evaluation

State of Connecticut
Workers' Compensation Commission

Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011

Rev. 7-13-2009

FRI

Date filed in Chairman's Office

(for WCC use only)

Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT IN INK.

Employer *(Name, Address & Zip)* | Phone #

Carrier / Administrator Claim # | OSHA Log Case # | Report Purpose Code

Jurisdiction | Jurisdiction Claim #

Employer's Location Address *(if different)* | Phone #

SIC Code | FEIN

Carrier *(Name, Address & Zip)* | Phone #

Claims Administrator *(Name, Address & Zip)*

Policy / Self-Insured #

TO:

Employee: Last Name | First Name

State of Hire

D.O.B. *(required)*

Occupation / Job Title

Address *(incl. Zip)*

❑ Female

Rate of Pay $ _____ . _____ per

❑ Hour ❑ Day ❑ Week ❑ Bi-Weekly ❑ Other

NCCI Class Code

Town of Injury / Illness

Physician / Health Care Provider *(Name, Address & Zip)*

Time of Work ❑ a.m. ❑ p.m.

Did Injury / Illness occur on Employer's Premises? ❑ Yes ❑ No

Time of Occurrence ❑ cannot be determined ❑ a.m. ❑ p.m.

Type of Injury / Illness

Part of Body Affected

Date Employer Notified *(MM/DD/YY)*

Hospital *(Name, Address & Zip)*

Type of Injury / Illness Code

Date Disability Began *(MM/DD/YY)*

Part of Body Affected Code

Date Last Worked *(MM/DD/YY)*

Were Safeguards or Safety Equipment provided? ❑ Yes ❑ No

Date Return(ed) to Work *(MM/DD/YY)*

If provided, were they used? ❑ Yes ❑ No

Initial Treatment

❑ No Medical Treatment ❑ Emergency Care

❑ Minor — by Employer ❑ Hospitalized More Than 24 Hours

❑ Minor — by Clinic / Hospital ❑ Future Major Medical — Lost Time Anticipated

If Fatal, Date of Death *(MM/DD/YY)*

How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:

All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:

Date Administrator Notified *(MM/DD/YY)* | Date Prepared *(MM/DD/YY)*

Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:

Preparer's Name & Title | Phone #

Contact Name

Phone #

Cause of Injury Code

SAMPLE—DO NOT USE
This form is included for ILLUSTRATIVE PURPOSES ONLY

State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 7-13-2009

1A

WCC File #

Date filed in District

Filing Status and Exemption

This form must be executed in every case of compensable disability for injuries occurring ON OR AFTER October 1, 1991, and must be completed in its entirety.

EMPLOYEE

Name _____ Date of Birth *(required)* _____

Address _____

City/Town _____ State _____ Zip Code _____

FILING STATUS AND EXEMPTIONS — In order to determine your weekly benefit rate, as per Sec. 31-310 C.G.S.,we need the following informati

1. Select your Federal tax filing status based upon your **ACTUAL filing status as**
   (Must match your tax return, as if you were filing with the IRS on the date of your

   ❑ Single ❑ Head of Household ❑ M

2. Number of exemptions *(including yourself*

3. FICA withheld for the NO — ***If NO, insurer must manually calculate weekly benefit rate.***

4. C

   oyee legally blind ❑ Spouse 65 years of age or older ❑ Spouse legally blind

   elationship to you for all exemptions included in question #2, above:

Name	*Date of Birth*	*Relationship*
		SELF

CONCURRENT EMPLOYMENT — To be certain you receive all the benefits to which you are entitled, provide the following information *if you were working for more than one employer on the date of injury indicated above*:

Name of Employer	*Address*	*Date of Hire*

NOTE: Wage information for each concurrent employer must be supplied by the claimant.

SIGNATURE OF INJURED WORKER OR REPRESENTATIVE

I hereby attest that the above information is correct to the best of my knowledge.

Employee's Signature _____ Date _____

SAMPLE—DO NOT USE
This form is included for ILLUSTRATIVE PURPOSES ONLY

State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 5-7-2014

VA

Voluntary Agreement

This form is *NOT* a final settlement.

- **Review, sign, and submit ALL 4 COPIES. This does NOT close out your case.**
- **Your eligibility for Rehabilitation Services remains unaffected by this agreement.**
- **Certain individuals may be eligible to receive COLAs pursuant to C.G.S. § 31-307a.**

WCC File # _____

Insurer # _____

Date filed in District

EMPLOYEE

Name _____

D.O.B. *(required)* _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

CONCURRENT EMPLOYMENT

❑ **Check, if employee had MORE THAN ONE employer**

If concurrently employed, see reverse side for directions.

EMPLOYER

Name _____

Address _____

City/Town _____ State

Zip Code _____ Tel.#

FICA withheld for the above-named e

Medicare .....

INJURY

Date of Inj

Zip Code _____

Describe Specific Body Part(s) Injured and Nature of Injury:

❑ Occupational Disease ❑ Repetitive Trauma

Name of Authorized Physician _____

INS

State _____

Tel.# _____

Third Party Administrator _____

SAMPLE—DO NOT USE
This form is included for ILLUSTRATIVE PURPOSES ONLY

COMPUTATION OF AVERAGE WEEKLY WAGE

The number of weeks worked*_____ divided into the Gross Wages earned $ _____ equals the Average Weekly Wage $ _____

**52 weeks is the maximum number allowed*

IF THE BENEFIT IS FOR:

1 — **TOTAL** Incapacity, the Basic Compensation Rate is based upon the appropriate benefit rate table [C.G.S. § 31-307]. Employer to pay to employee $ _____ per week.

2 — **TEMPORARY PARTIAL** Incapacity, Light Duty Job Differential, and/or Job Search, benefit paid per benefit rate table to a maximum of $ _____ [C.G.S. § 31-308(a)].

3 — **PERMANENT PARTIAL** Disability, the Specific Award is paid at the Basic Compensation Rate [C.G.S. § 31-308(b)], according to the following:

(a) Employer to pay employee for _____ % loss, or loss of use, of body part(s)*_____ at $ _____ per week.

*INDICATE ❑ master OR ❑ non-master

Additional information *(if required)* _____

(b) Pursuant to C.G.S. § 31-308(b), the benefit computes to _____ weeks beginning on *(MM/DD/YY)* _____ , the date of Maximum Medical Improvement.

(c) A Licensed Physician's Report, as well as Form 1A ("Filing Status & Exemption"), MUST be attached or this form will NOT be processed.

AGREEMENT AND APPROVAL ***The Voluntary Agreement will NOT be processed without both signatures and the Form 1A, "Filing Status & Exemption".***

The undersigned parties acknowledge and accept all of the facts stated above, subject to C.G.S. § 31-315.

Employee Signature *(and parent/guardian, if minor)* Date *(MM/DD/YY)*

Authorized Signature of Respondent Date *(MM/DD/YY)*

Name of Person Completing Form *(please print)* Tel. # *(area code + number + extension)*

WORKERS' COMPENSATION COMMISSION APPROVAL
(for WCC use only)

See reverse side for Calculations and Information on Concurrent Employment.

WORKSHEET

Calculating Concurrent Employment / Second Injury Fund Responsibility

(C.G.S. § 31-310)

Employee Name: _____

If the injured employee was working for more than one employer on the date of the injury, the employer in whose employ he/she was injured is responsible for (1) all medical costs and either (2) the entire weekly compensation rate *(if wages earned from this employer entitle the injured employee to the maximum compensation rate)* or (3) a pro rata portion of the weekly compensation rate based on the calculations below.

Only wages earned during the "weeks of concurrent employment" listed below (A) can be used in the calculations.

Weeks of Concurrent Employment:

from _____ to _____ **Total number of weeks =** _____ (A)

(MM/DD/YY) *(MM/DD/YY)*

Responsible Employer _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

Gross Wages earned from this employer during weeks of c

Concurrent Employer 1 _____

Address _____

City/Town _____

Zip Code _____

rent Employer 1 = $ _____

State _____

Tel.# _____

Gross Wages earned during weeks with Concurrent Employer 2 = $ _____

Add TOTAL Gross Wages earned from the Concurrent Employer(s) = $ _____ (C)

SAMPLE—DO NOT USE
This form is included for ILLUSTRATIVE PURPOSES ONLY

TOTAL GROSS WAGES

Total number of weeks worked concurrently for all employers listed above (same as A) **=** _____ (D)

Total Gross Wages earned from all employers during period of concurrent employment is (B) plus (C) **= $** _____ (E)

CALCULATION AND RESPONSIBILITY FOR PAYMENT OF BENEFITS

Average Weekly Wage for all employers is (E) divided by (D) **= $** _____

(See the Benefit Rate Table that coincides with the date of injury.)

Total incapacity compensation rate for this AWW = $ _____ (F)

Average Weekly Wage for responsible employer is (B) divided by (D) **= $** _____

(See the Benefit Rate Table that coincides with the date of injury.)

Total incapacity compensation rate for this AWW = $ _____ (G)

Amount of compensation to be contributed by the Second Injury Fund (Form 44) is (F) minus (G) **= $** _____ (H)

State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 7-13-2009

43

WCC File #

Date filed in District

Notice to Compensation Commissioner and Employee of Intention to Contest Employee's Right to Compensation Benefits

SAMPLE—DO NOT USE
This form is included for ILLUSTRATIVE PURPOSES ONLY

EMPLOYEE

Name _____

D.O.B. *(required)* _____

Address _____

City/Town _____

Zip Code _____

ATTO

State _____

Code _____ Tel.# _____

EMPLOYER

Name _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

INSURER

Claim Number _____

Name _____

Address _____

City/Town _____ State _____

Zip Code _____

Contact Person _____

Tel.# _____

INJURY

Zip Code _____

ature of Injury _____

❑ Check, if an Occupational Disease or a Repetitive Trauma

REASON(S) FOR CONTEST — SIGNATURE

You are hereby notified that the employer/insurer will contest liability to pay compensation benefits to the employee named on this form for the following reason(s) — SPECIFIC EXPLANATION REQUIRED:

Signature _____

Date _____

Name *(type or print)* _____

Title _____

This notice must be served upon the Commissioner and Employee *(or representative, if applicable)* by personal presentation or by registered or certified mail. When medical care is the issue for contest, send a copy of this form to the medical provider also. For the protection of both parties, the claimant should note the date when this notice was received and the employer/insurer should keep a copy of this notice with the date it was served.

IMPORTANT

Rev. 7-13-2009

36

State of Connecticut Workers' Compensation Commission

Notice of Intention to Reduce or Discontinue Payments

Please TYPE or PRINT IN INK

WCC File #

Date filed in District

(for WC

You are hereby notified that the employer/insurer intends to REDUCE OR DISCONTINUE your compensation payments on

_____ **for the following reason(s):**
(date)

(Employer/insurer to explain and attach supporti

IF YOU OBJECT **to the reduction or discontinu** *ST A HEARING* **WITHIN 15 DAYS after your receipt of th** *ALLY BE APPROVED.*

TO REQUEST AN INFORMA **ict Office in which your case is pending:**

e box.)

❑ 1		900	❑ 5 — Waterbury	55 West Main Street	(203) 596-4207
		(203) 789-7512	❑ 6 — New Britain	233 Main Street	(860) 827-7180
	nue	(203) 382-5600	❑ 7 — Stamford	111 High Ridge Road	(203) 325-3881
			❑ 8 — Middletown	90 Court Street	(860) 344-7453

cal and other documentation to support your objection. For your protection, note the date when you received this notice.

SAMPLE—DO NOT USE
This form is included for ILLUSTRATIVE PURPOSES ONLY

E

Name _____

D.O.B. *(required)* _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

INJURY

Date of Injury _____

City/Town of Injury _____

State _____ Zip Code _____

Body Part _____

Nature of Injury _____

Cause of Injury _____

ATTORNEY OR REPRESENTATIVE OF EMPLOYEE

Name _____

Name of Firm _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

EMPLOYER

Name _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

INSURER

Claim Number _____

Voluntary Agreement Issued? ❑ YES ❑ NO

Name _____

Address _____

City/Town _____ State _____

Zip Code _____

Contact Person _____

Tel.# _____

Date Mailed _____

THIS NOTICE MUST BE SERVED UPON THE COMMISSIONER AND EMPLOYEE BY PERSONAL PRESENTATION OR BY REGISTERED OR CERTIFIED MAIL. IF THE CLAIMANT IS REPRESENTED BY AN ATTORNEY, A COPY SHOULD ALSO BE SENT TO THE CLAIMANT'S ATTORNEY.

State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 9-3-2010

42

WCC File # _____

Insurer # _____

Date filed in District

Physician's Permanent Impairment Evaluation

The Form 42 should be mailed to ALL parties (employee, insurer, attorneys).

SAMPLE—DO NOT USE
This form is included for ILLUSTRATIVE PURPOSES ONLY

EMPLOYEE

Name _____

D.O.B. *(required)* _____

Address _____

City/Town _____

Zip Code _____

EMPLOYER

Name _____

Zip Code _____

EY

42 for EACH body part!

ut Statutes do NOT recognize whole person ratings [Section 31-308(b)].

_____

..... ❑ LEFT ..... ❑ RIGHT

HAND, ARM, or THUMB is ..... ❑ MASTER ..... ❑ MINOR

EYE is ..... ❑ LEFT * ..... ❑ RIGHT *

* Indicate: ❑ complete and permanent loss of sight
❑ reduction of sight to one-tenth (1/10) or less of normal vision

Which standards were utilized in your evaluation (AMA Edition # or Other Source):

_____

Percentage of Permanent Loss (or Loss of Use) _____

Maximum Medical Improvement Exam Date _____

Does the patient have a work capacity? ..... ❑ YES ..... ❑ NO

If the patient DOES have a work capacity, please list any physical restriction(s):

_____

_____

_____

_____

CONNECTICUT-LICENSED PHYSICIAN — SIGNATURE

Name _____ Tel. # _____

Address _____

City/Town _____ State _____ Zip Code _____

Signature of Connecticut-Licensed Physician _____ Date _____

Print Name of Connecticut-Licensed Physician _____