



State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 3-28-2012

VA

Voluntary Agreement This form is NOT a final settlement.

- Review and sign 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.

(for WCC use only)

EMPLOYER

Name
Address
City/Town State
Zip Code Tel.#

FICA withheld for the above-named employee? YES NO
Medicare YES NO

INJURY

Date of Injury (MM/DD/YY)
Date Incapacity Began (MM/DD/YY)
City/Town of Injury
State Zip Code
Cause of Injury
Describe Specific Body Part(s) Injured and Nature of Injury:

Occupational Disease Repetitive Trauma

Name of Authorized Physician

INSURER

Name Pol.#
Address
City/Town State
Zip Code Tel.#
Third Party Administrator

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)

# 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 concurrent employment = \$ \_\_\_\_\_ (B)**

Concurrent Employer 1 \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Tel.# \_\_\_\_\_

**Gross Wages earned during weeks with Concurrent Employer 1 = \$ \_\_\_\_\_**

Concurrent Employer 2 \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Tel.# \_\_\_\_\_

**Gross Wages earned during weeks with Concurrent Employer 2 = \$ \_\_\_\_\_**

**Add TOTAL Gross Wages earned from the Concurrent Employer(s) = \$ \_\_\_\_\_ (C)**

### 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)**