Form 141 # INITIAL STATEMENT OF INSURANCE CARRIER OR SELF-INSURER WITH RESPECT TO PAYMENT OF BENEFITS

PLEASE PRINT OR TYPE

Original ☐ Amended ☐ Reason(s) for Amendment

Total Cumulative Lost Work Days Due to this Injury _____

Employee _____ Date Carrier Notified of Lost Time _____

Survivor _____ Employee Phone _____

Address _____ Social Security Number _____

_____ Please list part of body injured _____

Claim Number _____ Date of Injury _____

Claim is for a FATALITY ☐

(List Fatality Dependent(s) as an Addendum)

Claim is for Injury ☐

Claim is for Occupational Disease ☐

Employer _____

Address _____

City, State, ZIP _____

COMPUTATION OF BENEFIT RATE

Basic Rate of Pay (Specify whether per hr/day/week/month) _____ $_____

Basic Benefit Rate (2/3 of Gross Avg. Weekly Wage not to exceed Maximum) = $_____

$5.00 dependency allowance for spouse _____ and ____ dependent children $_____

Amount of weekly benefit (Basic + Dep. Allowance) = $_____

The Maximum =100% State Average Weekly Wage: Dependents' benefits of $5.00 for spouse and $5.00 for each dependent minor child under 18 (up to 4) is added to reach maximum, but at no time can the weekly benefits exceed the maximum, or be less than the minimum of $45.00 per week. The maximum up to July 1, 2012 to June 30, 2013 -- $762.00, July 1, 2013 to June 30, 2014 -- $782.00, July 1, 2014 to June 30, 2015 -- $790.00, July 1, 2015 to June 30, 2016 - $811.00, **July 1, 2017 to June 30, 2018 $855.00**. The first 3 days are not compensable unless 15 days or more are missed.

First check for _____ weeks _____ days from _____ to _____ in the amount of _____ was mailed on _____.

Insurance Carrier _____ **Phone** _____

Adjustor _____ **Adjustor's Signature** _____

(Type or Print)

Adjustor's Address _____

(Street / PO Box) (Phone Number) (City, State, Zip)

"Statement of Insurance Carrier or Self Insured with Respect to Payment of Benefits – Form 141" - This form is used for reporting the initial benefits paid to an injured employee. This form must be filed with or mailed to the Labor Commission on the same date the first payment of compensation is mailed to the employee. A copy of this form must accompany the first payment.

NOTICE TO EMPLOYEE Travel Reimbursement for Medical Care: You may be eligible for reimbursement for travel to and from medical care which has been authorized by the insurance carrier (per Rule R612-300-8). You will need to contact your insurance adjuster.

Official Form 141 **Revised 07/17**

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