

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 Employer _____
Claim is for Occupational Disease 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, 2011 to June 30, 2012 - \$747.00, 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, 2016 to June 30, 2017 - \$817.00.** 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.



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