

**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: _____

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 \$20.00 for spouse and \$20.00 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, 2017 to June 30, 2018: \$855.00.

July 1, 2018 to June 30, 2019 is \$879.00. 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.



Official Form 141 Revised 08/18

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