



Injured Worker Information		
Injured worker name	Date of injury	Claim number
Injured worker email address	Injured worker phone number	

Instructions

- If you are submitting copies of payroll check stubs or other proof of earnings provided to you by your current employer, do not complete this form. If you are not submitting copies of payroll check stubs or other proof of earnings, complete this form as indicated below for submission of earnings for the payment of living maintenance wage loss compensation.
- If BWC is processing your claim, fax the completed form to 1-866-336-8352, or send it to the BWC customer service office where the claim is assigned.
- If a self-insuring employer is processing your claim, send this form directly to your employer.

To be completed by the injured worker

I am requesting living maintenance wage loss benefits from (provide specific dates) _____ to _____ and submitting evidence in support of my request.

With your permission, BWC may assist you in obtaining clarification of the reported earnings below; if necessary (check one of the options below).

- BWC may contact the employer listed below to obtain clarification of the reported earnings information.
- BWC may not contact the employer listed below to obtain clarification of the reported earnings information.

I have answered the foregoing questions truthfully and completely. I am aware that any person, who knowingly makes a false statement, misrepresents or conceals facts or any other act of fraud to obtain compensation as provided by BWC or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment or both.

Injured worker signature	Date
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The information below is provided by the employer injured worker.

Provide earnings information based on the pay period begin and end dates, not payment/check dates. Include all gross earnings for the period prior to any deductions such as for taxes, garnishment, insurance, or employee contributions to retirement programs.

Employer name	BWC policy number	FEIN	Employer phone number
Address	City	State	Nine digit ZIP code

Pay period beginning date	Pay period ending date	Gross earnings	Number of days worked	Number of hours worked



Does the earnings information on the previous page include bonuses, commissions, allowance or other payments in addition to regular earnings? Yes No

If yes, please provide specific details about the payment in the comment box below, including the period over which the payment was earned.

You may also provide other information you wish to have considered in the calculation of living maintenance wage loss compensation in the space below.

Comments:

I certify the information provided is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by the BWC or who knowingly accepts payment to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment or both.

Signature of the person completing this report	Title	Date
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