CONNECTICUT INTERLOCAL RISK MANAGEMENT AGENCY

P.O. Box 9558
New Haven, CT 06535-0558
Telephone (203) 946-3700
Fax (203) 773-8134

WORKERS' COMPENSATION CLAIMS STATUS

Claimant's Name _____ File Number _____
Address: _____
_____

Claimant Status

– *Please check all boxes that apply and provide information where requested* –

☐ I am receiving salary continuation in the amount of $_____ per_____ from _____.
☐ I am receiving Workers' Compensation benefits in the amount of $_____ per_____ from _____.
☐ I am not working for any other employer, nor am I self-employed.
☐ I am receiving disability insurance (short term/long term) from _____ in the amount of $_____.
☐ I am working:
Return to work date: _____.
Name, address of employer(s) _____
_____
Name, telephone number of supervisor: _____
_____

Gross weekly income: $_____

☐ I am self-employed.
Gross weekly income: $_____
Name, address of business: _____
_____
Type of Business: _____
Tax Identification Number: _____

– *Please return this form within 30 days of receipt.*
If you have any questions, please call the assigned adjuster –

_____ _____
Signature Date