

ARKANSAS WORKERS' COMPENSATION COMMISSION

**324 Spring Street
P.O. Box 950
Little Rock, AR 72203-0950**

TO: Interested Parties

**FROM: Carl Bayne
Operations/Compliance**

DATE: November 20, 2012

SUBJECT: Form 4 Required Data

Following this notice you will find a Form 4 clearly marked showing what data is required and providing an informative and easy-to-understand explanation of each.

Please note that failure to provide any of the data marked on the accompanying Form 4 will cause your submission to be rejected.

Form AR-4**ARKANSAS WORKERS' COMPENSATION COMMISSION**

324 Spring Street, Little Rock, AR 72201
 Mail: P.O. Box 950, Little Rock, AR 72203-0950
 501-682-3930 / 1-800-622-4472

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Authority Ark. Code
 Ann. §11-9-810
 Revised 1-1-2011

REPORT OF COMPENSATION PAID/SUSPENSION OF PAYMENTS

<input type="checkbox"/> AMENDED REPORT			
<input type="checkbox"/> Closing Report	1	<input type="checkbox"/> Death/PTD Maximum Liability	
<input type="checkbox"/> Report of Payment Suspension		<input type="checkbox"/> Update Report (additional payments only)	
2	3	4	5
AWCC File No.	Carrier Claim No.	Employee Name (Last, First, MI)	Employee S.S. Number
6	7		8
Employer Name	City		State
10		11	
Carrier or Self-Insured Name		Claims Office Location (mailing address)	

DISABILITY INFORMATION:

12	13	14	15
Date of Injury	Last Day Employee Worked	Date Employee Able to RTW	Return-to-Work Date
Total days worked between injury and date able to RTW _____			16

COMPENSTAION INFORMATION:

COMPENSATION PAYMENTS MADE:	17		
(1) TTD Weeks _____ Days _____		(9) Defense Attorney Fees	_____
(2) TPD Weeks _____ Days _____		* (10) Other (Compensation Related)	_____
(3) PPD Weeks _____ Days _____		(11) Hospital Expenses	_____
(4) _____ Weeks PTD		(12) Medical Expenses	_____
(5) _____ Weeks for Death		(13) Drugs, Medicine	_____
(6) Lump Sum payment		(14) Funeral Expenses	_____
(7) Joint Petition settlement		(15) Rehabilitation	_____
(8) Claimant Attorney Fees		* (16) Other (Expense Related)	_____
		(1-16) GRAND TOTAL	_____

SUSPENSION OF PAYMENTS OF COMPENSATION

Date of Suspension of Compensation: _____	Reason for Suspension: _____	18
Compensation paid through _____ (date).		

CERTIFICATION

I certify that the foregoing is a complete and accurate report according to the records of the insurer pertaining to payments of compensation and suspensions of payment information. I further certify that a copy of this report or equivalent information has been provided to the employee or beneficiaries.

19	20	21
Signature	Printed or Typewritten Name	Title
		Date

REQUIRED FORM 4 DATA

1. TYPE OF FILING:

Amended Report: An amended report corrects previously reported data or provides previously forgotten data that was submitted on an accepted Form 4. If the previously filed Form 4 was rejected because you left something off or your numbers didn't add up, when you fix the problem, your submission is not amended. You can only amend a Form 4 that we have previously accepted.

Closing Report: Your closing report is due within 30-days of the last compensation payment being made, a Joint Petition being signed by and Administrative Law Judge, or a final Judicial order.

Death/PTD Maximum Liability: This Form 4 is to be filed when you've reached your maximum liability and AWCC Special Funds has accepted liability for future benefits.

Report of Payment Suspension: A suspension of payments is when there is a sudden interruption in OWED compensation. If the claimant has reached MMI, if you have reached your maximum liability, compensation is no longer OWED, and you are not suspending compensation. It has come to an end and should not be reported as a suspension of payments, as nothing else is OWED.

However, if you begin getting your compensation checks back because the claimant has moved and left no forwarding address, if the claimant happens to become a guest of the Department of Corrections, or if the claimant stops going to his/her medical/therapy appointments, compensation payments are merely interrupted and will begin again whenever the problem(s) causing the interruption is corrected. These payments are being suspended.

Too, a suspension of payments is only reported when compensation is suspended to the claimant, not to the claimant's dependents.

Update Report (additional payments only): Anytime an additional payment is made after a closing report has been filed, you are required to file an update report. On the update report, list only the additional payment having been made, not the new total. For example, if after you file a closing report a wayward attorney's bill comes in, after you've made the payment, file a Update Report and show only the recently amount you've paid the attorney.

2. AWCC FILE NUMBER: If an AWCC File Number exists, you are required to place it legibly in this box. So, if this claim was opened by a Form C, if it was opened by the previous filing of a Form 1, if this is an Amended filing, etc., provide the AWCC Claim Number.

However, if this claim is being opened by a Form 1 which is being sent along with this Form 4, we understand that you don't have a current file number and we will, in this instance only, accept your Form 4 filing and enter the claim number for you.

Please note, though, that if you file a Form 4 without an AWCC file number and the Form 4 is not accompanied by a Form 1, you are likely to get a very nicely written "No Report" letter, telling you that while the Form 4 isn't being rejected (because it doesn't have a file number we can key a rejection to), we are returning it to you for completion. It will, also, be returned to the name and claims office address which is your company's point-of-contact with AWCC.

3. CARRIER CLAIM NUMBER: Make sure this claim number matches what was reported on the Form 1. If it does not match what was reported on the Form 1, correct the Form 4 data or file an Amended Form 1 correcting the Carrier Claim Number submitted on the Form 1, whichever is necessary.

4. EMPLOYEE NAME: Make sure this employee name matches what was reported on the Form 1. If it does not match what was reported on the Form 1, correct the Form 4 data or file an Amended Form 1 correcting the Employee Name submitted on the Form 1, whichever is necessary.

5. EMPLOYEE SOCIAL SECURITY NUMBER: Make sure this Social Security Number matches what was reported on the Form 1. If it does not match what was reported on the Form 1, correct the Form 4 data or file an Amended Form 1 correcting the Social Security Number submitted on the Form 1, whichever is necessary.

If you provide to us the AWCC File Number, Employee Name and the Date of injury or death, OR if filing this Form 4 with a Form 1 to open the claim, you provide the Carrier Claim Number, Employee Name and Date of injury or death, we will accept your Form 4 filing with only the last four numbers of the Social Security Number.

6. EMPLOYER NAME: Make sure this employer name matches what was reported on the Form 1. If it does not match what was reported on the Form 1, correct the Form 4 data or file an Amended Form 1 correcting the Employer Name submitted on the Form 1, whichever is necessary.

7. CITY: Make sure that your Form 4 submission names the city in which the employer for the claimant reported to work is located. If the claimant worked for Carl's Fabulous Burgers, of Hoboken, New Jersey, 00325, but reported to work each day at the Carl's Fabulous Burgers in Little Rock, Arkansas, 72211, report Little Rock as the city.

8. STATE: Make sure that your Form 4 submission names the state in which the employer for the claimant reported to work is located. If the claimant worked for Carl's Fabulous Burgers, of Hoboken, New Jersey, 00325, but reported to work each day at the Carl's Fabulous Burgers in Little Rock, Arkansas, 72211, report Arkansas as the state.

9. ZIP CODE: Make sure that your Form 4 submission provides the zip code in which the employer for the claimant reported to work is located. If the claimant worked for Carl's Fabulous Burgers, of Hoboken, New Jersey, 00325, but reported to work each day at the Carl's Fabulous Burgers in Little Rock, Arkansas, 72211, report 72211 as the zip code.

10. CARRIER OR SELF-INSURED NAME: Make sure this carrier or self-insured name matches what was reported on the Form 1. If it does not match what was reported on the Form 1, correct the Form 4 data or file an Amended Form 1 correcting the Carrier or Self-Insured Name submitted on the Form 1, whichever is necessary.

11. CLAIMS OFFICE LOCATION (mailing address): Make sure this claims office location matches what was reported on the Form 1. If it does not match what was reported on the Form 1, correct the Form 4 data or file an Amended Form 1 correcting the Claims Office Location submitted on the Form 1, whichever is necessary.

12. DATE OF INJURY: Make sure this date of injury matches what was reported on the Form 1. If it does not match what was reported on the Form 1, correct the Form 4 data or file an Amended Form 1 correcting the Date of Injury submitted on the Form 1, whichever is necessary.

13. LAST DAY EMPLOYEE WORKED: This is the last date the employee worked for any amount of time. If the claimant came to work and after only 20-minutes decided (s)he wasn't ready to return to work, that date is the last day the employee worked. This date does not have to be a full work day!

14. DATE EMPLOYEE ABLE TO RTW: This is the date the medical provider releases the claimant to return to work, even if that release is limited in the type of work or number of hours for which the claimant is available.

If, as often happens, the claimant refuses to return to the medical provider to obtain a release, you need not put a date in this box, but you must file an accompanying Form S and tell us the circumstances, which might be something as simple as “claimant refused to return to Doctor for final medical release”.

Please note that if the above referenced Form S does not come in with this Form 4, you will likely be getting the Form 4 back as there is no Able to RTW date and no explanation.

15. RETURN-TO-WORK DATE: This is the actual date the claimant returns to work. If this date is different than the Date Employee Able to RTW, file an accompanying Form S and explain the difference between the Able To RTW and the actual Return-To-Work date.

16. TOTAL DAYS WORKED BETWEEN INJURY AND DATE ABLE TO RTW: This number, if a number is reported here, represents the total number of days the claimant worked, regardless of the amount of time or job duties performed. If the claimant clocks in for 15-minutes, that’s a day of work for this purpose.

17. COMPENSATION PAYMENTS MADE:

1 – 5: The amount of time these lines add up to must equal the amount of time between Last Day Employee Worked (box 13) and Return-to-Work Date minus the Total days worked between injury and date able to RTW.

If lines 1 – 5 add up to 52 weeks of compensation being paid and there are 53 weeks between Last Day Employee Worked and Return-to-Work Date, we will reject the Form 4 as it doesn’t equal.

In a situation such as this, it may be that the claimant worked several days during those 53 weeks, and these days weren’t reported on the Total days worked between injury and date able to RTW. Once those days are included on the Form 4, we will have 52 weeks of compensation paid and 7 days of work, which will then equal 53 total weeks, everything will balance and everyone will happily go about their business caring for the working men and women of Arkansas.

6. Lump Sum payment: This is where you report a lump sum payment made outside of a Joint Petition. If you indicate here that a Lump Sum payment was made, we will want to see one of several things, a Judicial Order, a filed and accepted Form L, or that you paid the entire compensation amount without taking any discount. All lump sum payments reported on this line require one of these three criteria.

7. Joint Petition settlement: The Joint Petition settlement amount includes those amounts paid to or on behalf of the claimant. As an example, if a JP says that the claimant’s attorney is to be paid \$2,000.00, \$1,000.00 from the respondents and \$1,000.00 from the claimant, only the \$1,000.00 paid on behalf of the claimant is included in the JP amount.

Note that many times payments agreed to in a JP are not reported here, as they are not made on behalf of the claimant. An example is when a payment for medical expenses is agreed to. As this is now an accepted claim for workers’ compensation benefits, these medical expenses aren’t being paid on behalf of the claimant, but being paid as the responsibility of the carrier, and therefore reported on line 12, Medical Expenses.

Remember, only those monies paid to or on behalf of the claimant are reported here.

8. Claimant Attorney Fees: This includes fees paid to the claimant's attorney which are not paid by or on behalf of the claimant. If a JP says that \$1,000.00 will be paid to the claimant attorney as the respondent's portion of the attorney's fees, that \$1,000.00 is reported here, as it is not paid to or on behalf of the claimant.

Similarly, if a JP says that \$1,000.00 will be paid to the claimant attorney on behalf of the claimant, that amount is reported not on this line, but on the Joint Petition settlement line (line 7) as it is being paid on behalf of the claimant.

9. Defense Attorney Fees: Report the total defense attorney fees paid at the time the Form 4 is due. If any additional defense attorney fees are paid after filing the Form 4, file an Amended Form 4 reporting the entire amount of the defense attorney fees, not just the additional payments, and mark clearly that this total is being amended (we suggest you put a big circle around whatever you're amending).

If a claim goes to a Hearing or a Joint Petition, or if the file indicates that there is/was a respondent's attorney, we're looking to make sure that these expenses are reported.

10. Other (Compensation Related): This includes benefit related expenses, such as interest, penalties, or Medicare Set Aside.

11. Hospital Expenses: self-explanatory

12. Medical Expenses: anything that isn't Hospital or Drugs, Medicine

13. Drugs, Medicine: self-explanatory

14. Funeral Expenses: self-explanatory

15. Rehabilitation: VOCATIONAL rehab services

16. Other (Expense Related): This includes expenses that aren't related to benefits and don't have a line of their own on which to be reported. Examples of these expenses include court reporter fees or mileage reimbursement.

1 – 16: GRAND TOTAL: Double-check your math. The items entered in lines 1 through 16 must add up to the grand total amount listed here. When we enter everything into our computer system and perform our audit, if the grand total we get in our system and the grand total you have listed here are not the same, we will reject the Form 4 and let you find the error.

Too, some dollar amount must be written on this line. If the grand total of all the compensation and expenses associated with this claim is \$0.00, then write \$0.00.

18. SUSPENSION OF PAYMENTS OF COMPENSATION: A suspension of payments is when there is a sudden interruption in OWED compensation. If the claimant has reached MMI, if you have reached your maximum liability, compensation is no longer OWED, and you are not suspending compensation. It has come to an end and should not be reported as a suspension of payments, as nothing else is OWED.

However, if you begin getting your compensation checks back because the claimant has moved and left no forwarding address, if the claimant happens to become a guest of the Department of Corrections, or if the claimant stops going to his/her medical/therapy appointments, compensation payments are merely interrupted and will begin again whenever the problem(s) causing the interruption is corrected. These payments are being suspended.

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19. SIGNATURE: I will accept a computer generated signature if you are unable to physically sign the Form 4.

20. PRINTED OR TYPEWRITTEN NAME: This should match the name of the adjuster listed on the previous Form 2 filing.

21. DATE: Please provide the date the Form 4 is completed by the adjuster handling the claim.