Form AR-D	ARKANSAS WORKERS' COMPENSATION COMMISSION	D
Authority: Ark. Code Ann. §11-9-502 & Rule 28 Revised: 1-1-2001	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

DEATH /PERMANENT AND TOTAL DISABILITY ACCEPTANCE/UPDATE

❑ **Initial Report 1** ❑ **Amended Report**

2	3	4	5
AWCC File No.	Carrier Claim No.	Employee Name (Last, First, MI)	Employee SS Number

6	7	8	9	10
Employer Name	Employer FEIN I.D. No.	City	State	Zip Code

11	12	13
Carrier or Self-Insured Name	NAIC No.	Claims Office Location (City, State)

CASE INFORMATION

14	15	16	17
Date of Injury	Death Date (if applicable)	Healing Period Ended	Date Acceptance or Award of PTD

Total Payments for weekly benefits as of Dec. 31, (year) **18** (excluding TTD) $ **19**
Exact date that payment by insurer will end because of maximum liability : **20**
If this case has been controverted, but not closed, check here: ❑
This case was closed on _____ (Attach Supporting Documentation).

CASE STATUS CHANGES (since last report) **33**

1. ❑ Payment ceased on _____ because of: ❑ death, ❑ remarriage, ❑ lump sum payment, ❑ Joint petition settlements, ❑ change in disability status, ❑ subrogation (payment to resume on:_____) or because ❑ insurer has reached maximum liability. Because payments ended, AWCC Form 4 was submitted or is attached.
2. ❑ Payment to some dependents changed because of one or more of the following: ❑ death or ❑ remarriage of spouse, ❑ increase in dependents, ❑ marriage or ❑ death of dependent child, ❑ dependent attained maximum age, or ❑ other. (Explain "other" on back.)
3. ❑ Widow/widower remarried on_____. The lump sum payment was $ _____. Remaining dependent(s) benefits increased on _____.
4. ❑ Payment to children continues because of ❑ single , full-time student status or ❑ incapacity. (Supporting documentation must be attached when transferring liability to the Trust Fund for payment.)
5. ❑ Employee on PTD died on _____and (check only one): ❑ Insurer accepts death as stemming from disabling accident and has begun payments to dependents or ❑ Insurer has declined to accept death as accident- or illness -related in connection with employment.

CERTIFICATION

In compliance with AWCC requirements, the above is a true, accurate report.

21	22	23	24
Signature	Printed or Typewritten Name	Title	Date

25	26
Address	Telephone No.

CURRENT PAYMENTS

Claimant/dependents are receiving benefits based on an average weekly wage of $ **27** .
Explain any adjustments to the weekly benefits.

Total weekly benefits $ **28** .

	Name	Relationship	Age/Birthdate	Amt. Per Week
1.	**29**	**30**	**31** / - -	$ **32**
	(Address)			
2.			/ - -	$
	(Address - if different)			
3.			/ - -	$
	(Address - if different)			
4.			/ - -	$
	(Address - if different)			
5.			/ - -	$
	(Address - if different)			

Check here ❑ if other names and addresses are listed by attachment to this AWCC Form D.

NOTICE

Once notification is received from the Death and Permanent Total Disability Trust Fund of **Certificate of Acceptance** of the targeted date of last payment discharging the employer/carrier's obligation pursuant to Ark. Code Ann. §11-9-502(b), no additional Form D is required, unless there is a change in the status of a permanently totally disabled worker or the eligible dependents of a deceased worker. In the event of a change, an amended Form D must be filed within 15 calendar days of such change. In no event shall the employer or carrier cease bi-weekly payments for death or permanent total disability prior to filing a Form D and the approval of the date of termination of benefits by the Death and Permanent Total Disability Trust Fund.

AWCC Form D (Death or Permanent - Total Disability Case)

AWCC Form D is due in January to report on the previous calender year and filed each year until a Certificate of Acceptance is issued by the AWCC to the respondent. Form D's importance and the need for its correct and timely filing cannot be overemphasized.

Contact the AWCC Special Funds Division for help with Form D. General Information is available from Support Services Division. (1-800-622-4472 or 501-682-3930)

REQUIRED FORM D DATA

1. Type of Report: Every Form D submission must be marked to indicate the its type filing, an Initial Report or an Amended Report. For the purposes of the Form D, the first filing you make is an Initial Report. Ever subsequent filing you submit on the same case is an Amended Report.

Ark. Code Ann. §11-9-106(a): Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission.

2. AWCC File No.: This AWCC File Number that you enter here must match exactly the file number assigned to this claim when it was initially opened, whether by a Form C or a Form 1, and must match the file number you submit on any Form 2 or Form 3 filings. All AWCC file numbers are formatted as one letter and six numbers, i.e. A123456.

3. Carrier Claim No.: The Carrier Claim Number is the number assigned by the Claims Administrator. This must match exactly the Carrier Claim Number you reported on the Form 1 and Form 2.

4. Employee Name: The employee names, at least last name and first name, are required. As these names are required on the Form 1, Form 2, Form 3 (if you submit one), medical records, wage records, etc. it shouldn't be a problem to find it for the Form D.

5. Employee Social Security Number: You do not have to submit the employee's nine digit Social Security Number. As long as the employee's name, the AWCC File Number, and the Carrier Claim Number match all of the previous filings, you may submit the last four of the Social. If, however, there is any discrepancy in these items I mentioned above, and you only submit the last four of the Social, it's possible that you will get the Form D sent back to you so that you can fix whatever discrepancy exists.

6. Employer Name: This must match what has been submitted on the Forms 1 and 2.

7. Employer FEIN I.D. No.: This must match what has been submitted on the Forms 1 and 2.

8. City: This must match what has been submitted on the Forms 1 and 2.

9. State: This must match what has been submitted on the Forms 1 and 2.

10. Zip Code: This must match what has been submitted on the Forms 1 and 2.

11. Carrier or Self-Insured Name: This must match what has been submitted on the Forms 1 and 2.

12. NAIC No.: This is the first time you're required to file the employer's NAIC number. But, it is a requirement for the Form D.

13. Claims Office Location: This must match what has been submitted on the Forms 1 and 2.

14. Date of Injury: This must match what has been submitted on the Forms 1 and 2.

15. Death Date (if applicable): If this is not a death case, but a PTD case, leave this box empty.
If this case has become a Death Case after you filed your Form 1 and Form 2, remember to file Amended Forms 1 and 2 indicating the date of death.

16. Healing Period Ended: Healing Period is to the Form D what MMI is to most every other Form used by AWCC. This box must be completed for PTD cases. If this is a Death Case, leave this box empty.

17. Date Acceptance or Award of PTD: Provide the date (day, month and year) upon which you accepted PTD liability, or the date PTD benefits were awarded.

18. Total Payments ... Dec. 31, (year): Enter in this space the year for which you are reporting, IF THIS IS YOUR ANNUAL REPORT (more about that later). As you are required to report each January (up until the year after you have received a Certificate of Acceptance from the Death and Permanent Total Disability Trust Fund), if you were filing this Form D in January of 2013, the report would be for 2012, and 2012 would be entered here.

19. (excluding TTD)$: Provide the total dollar amount of benefits you have paid which will apply towards your maximum liability. Remember that TTD payments DO NOT count toward your maximum liability!

20. date ...end because of maximum liability: THIS IS NOT A REQUIRED FIELD! We ask you to provide the date, I know it says "Exact", but we only ask that you get as close as you can in your estimate, that you will reach your maximum liability. If, for any reason, you are unable to, or uncomfortable in, making this estimate, it is permissible to leave this blank.

21. Signature: We are looking for the signature of the adjuster handling this particular claim. It should match the signature on the Form 2.

22. Printed or Typewritten Name: This should also match the name of the adjuster noted on the Form 2.

23. Title: I don't know that we're going to reject your Form D filing because you've left off the title of the person handling the claim, but as long as you're filling out the Form anyway, please put your title here.

24. Date: Enter the date the adjuster is completing the Form D.

25. Address: Enter the mailing address of the adjuster handling this claim.

26. Telephone No.: Enter the direct number, or the main number with the extension, to the adjuster handling this claim.

27. Average weekly wage: This should match the Average Weekly Wage reported on the Form 2.

28. Total weekly benefits $: Provide the total weekly benefits you are paying. For example, if this is a Death Case with multiple dependents, report the total amount you are paying per week for all of the dependents, combined.

29. Name and address: The Form D provides you with space to report five benefit recipients. Report in as many of the places as you need, the name and mailing address of the benefit recipient. If you have more than five benefit recipients, using the same format as used on page 2 of the Form D, attach a separate sheet of paper, or sheets of paper, until you've reported all of the beneficiary recipients.

30. Relationship: What is the relationship of this beneficiary recipient to the injured or deceased claimant? If you are paying PTD benefits to the claimant, the proper entry here is "Claimant" or "Self". If you are paying Death benefits, the relationship will usually be "Widow," "Widower," "Child," or whatever relationship exists in accordance with A.C.A. 11-9-527.

31. Age/Birthdate: Provide the age and birthdate of each benefit recipient. Note, though, that Attorneys receiving fees for legal service and individuals receiving only child support SHOULD NOT have the age and birthdate reported on the Form D.

32. Amount Per Week: Report the total amount paid to and on behalf of each individual recipient, to include Attorney fees and child support.

33. Case Status Changes (since last report): If you are reporting a change in the status of one or more of the benefit recipients, clearly mark the box next to the number that specifically applies to that circumstance and complete only the appropriate section.

If you have no change(s) in status, this section is to be left blank.

Status changes must be reported to AWCC on an Amended Form D within 15 days of your receipt of the status change information.

Examples of information which requires change in status reports are remarriage of a widow/widower, or death of a benefit recipient.

GENERAL COMMENTS:

You must file an Amended Form D each January, even if nothing has changed from your previous report, until you receive from the Death and Permanent Total Disability Trust Fund a **Certificate of Acceptance** discharging the employer/carrier's obligation pursuant to Ark. Code Ann. 11-9-502(b).

Once you have received this Certificate, no further reports are required, unless there is a change in the status of a permanently totally disabled worker or the eligible dependents of a deceased worker. In the event of a change, an amended Form D must be filed within 15 calendar days of such change.

In no event shall any employer or carrier cease making bi-weekly payments for death or permanent total disability prior to filing a Form D and receiving notice of approval of termination of benefits by the Death and Permanent Total Disability Trust Fund.

After completing both sides of the Form D, send it to the Special Funds Division of the Arkansas Workers' Compensation Commission. You may send it by U.S. mail, email, or fax.

Mailing Address: Arkansas Workers' Compensation Commission
Attn: Special Funds Division
P.O. Box 950
Little Rock, AR 72203-0950

Email Address: mbroderick@awcc.state.ar.us

Fax Number: 501-682-2504
Remember, if you fax the Form D, fax both the front and back sides of the form!

If you have questions or need assistance in completing a Form D, feel free to call the Special Funds Division at 501-682-2771, or 866-880-8444, if calling from outside of Pulaski County, Arkansas.