Arkansas Workers' Compensation Commission

Arkansas Forms and Procedures

Arkansas Workers' Compensation Commission
Contact Information

Please use the following email addresses when submitting forms and documentation. If you have a question about a form, call or email the person below who handles that particular form.

Form C - and responses to Form C filings	Casey Iskra **AND** Janna Craig	casey.iskra@arkansas.gov janna.craig@arkansas.gov	501-682-2774 501-682-2497
Form D	Robin Mickel	AWCC.FormD@arkansas.gov	501-682-5262
Form L	Johnny Gregory	AWCC.FormL@arkansas.gov	501-682-2694
Form M	Alexius French	AWCC.FormM@arkansas.gov	501-682-2641
Form S	Submit with Form 4 or Form 2		
Form O	Randy Clay	AWCC.FormO@arkansas.gov	501-682-2210
Form W	Linda Lewis	linda.lewis2@arkansas.gov	501-682-2668
Form V	Robin Mickel	AWCC.FormV@arkansas.gov	501-682-5262
Form 1	Casey Iskra **AND** Janna Craig	casey.iskra@arkansas.gov janna.craig@arkansas.gov	501-682-2774 501-682-2497
Form 2	Linda Lewis **AND** Janna Craig	linda.lewis2@arkansas.gov janna.craig@arkansas.gov	501-682-2668 501-682-2497
Form 2 Extensions	Janna Craig	janna.craig@arkansas.gov	501-682-2497
Form 3/ Medical Reports	Submit with Form 4 or Form 2		
Form 4	Alexius French **AND** Janna Craig **AND** Daniel Galarza	alexius.french@arkansas.gov janna.craig@arkansas.gov daniel.galarza@arkansas.gov	501-682-2641 501-682-2497 501-682-2776
Change of Physician	Susan Isaac	AWCC.COP@arkansas.gov	501-682-2043
Report Cards	Janna Craig	janna.craig@arkansas.gov	501-682-2497

Include the **name of the claimant** and **which form(s) you are submitting** in the subject line of your email. When submitting more than one form on the same claim on the same day, send all of the forms **in one email** addressed to all of the persons who handle those particular forms.

General Statements about filing Forms with the Arkansas Workers' Compensation Commission:

These training materials are subject to change as needed. They are current as of 05/28/2024.

1. Do not file a Form 1 unless one or more of the following applies:
   A. It is a lost time claim, meaning the claimant has already missed more than seven days (weekends count)
   B. You have received a Permanent Impairment Rating for that injury
   C. A claim has been opened by a Form C
   D. It is a controverted claim

2. If you submit an accepted medical only claim on a Form 1 (which you generally should not do), tell us why you are doing so. The only acceptable reasons are that it is part of a legal proceeding or in response to a Form C filing. It is not acceptable to file one because you think the claim will turn into a lost time claim.

3. Do not submit your forms as secure emails requiring a password.

4. Put the AWCC file # on all submissions, including the Form S, Form W, and the first page of medical (not on a fax cover sheet).

5. Average Weekly Wages are based on WEEKLY earnings. Wage records are required to report WEEKLY wages, and you are required to show the calculation to determine the AWW.

6. You may submit employer-provided wage records as long as those records are no more than five pages and provide WEEKLY earnings.

7. The Average Weekly Wage is based on earnings during full-time workweeks in the employment.

8. If you do not have weekly wages from the employer by the time you file the Form 2, indicate that AWW and TTD are estimated (put "est") next to whatever dollar amount you put on the form.

9. If you are going to submit more than one form, such as a Form 1 and Form 2, on the same claim at the same time, submit them together in one email, addressed to all of the persons who handle those particular forms.

10. Do not submit a Form 2 to request an extension to file a Form 2. Send an email to request an extension to file a Form 2.

11. We prefer email over fax, and fax over U.S. mail.

12. Medicals (Rule 099.27) submitted to the Commission should only include the diagnosis, documents taking the claimant off work, documents limiting the claimant's work, documents returning the claimant to work, documents releasing the claimant at MMI, or documents providing a Permanent Impairment Rating (do not include x-rays, operative reports, fax cover sheets, copies of e-mails, medical bills or prescriptions, etc.).

13. Each claim should have no more than one Form S, and the Form S and any required medicals should be submitted along with the closing Form 4.

14. Form S is not a required form for all claims. It is only required if:
    A. The claimant is released to restricted duty at any time during the life of the claim
    B. The claimant has non-consecutive days of disability (the claimant is off work, returns to work for even one day, and is off again, or has a TPD day). List the dates for which benefits were paid.
    C. The claimant receives both TTD and TPD benefits. List the dates paid for each type of benefit.
    D. There is some oddity about the claim that we will not be able to determine from the filing of the normal forms and medicals.

15. Never mark a form as being more than one type of filing. Only check one box at the top of a Form 2 and Form 4.

16. Most Form 4 filings are not a Report of Payment Suspension.

17. Do not submit a form twice. Do not email your form and also fax it, just to be sure it gets here.

18. If a file is opened with the Commission by a Form C, or even by the accidental filing of a Form 1, you are required to file a Form 1, a Form 2 and a Form 4.

19. A Form 4 requires a Grand Total, even if it is $0.

20. Salary Continuation claims are to be reported to the Commission if the claimant misses more than seven days (weekends count).

21. If you have a form rejected two times, you should call us to ask what you need to do to correct the filing.

22. When you call about any form filing, have:
    A. The AWCC file number
    B. The rejected form
    C. The Notice of Rejection, which states the reason(s) for the rejection

AWCC

FORM C

LETTER

Claim Office Contact Person
Claim Office Company
Address
City, State, Zip

Date: (Date)
AWCC File No: (File #) (Claimant v. Employer)
Date of Injury: (Date)

To The Claimant: This notice is for your information only, and it is not necessary for you to take any additional action. However, if you have any questions, contact your attorney, or if you do not have an attorney, feel free to call the Arkansas Workers' Compensation Legal Advisor Division at 501-682-3930, from within Pulaski County, or 1-800-250-2511 or 1-800-354-2711 if outside Pulaski County.

Carrier: An AR-C claim, or an Additional Benefits Letter, for workers' compensation benefits has been filed on behalf of the above named claimant. Please respond in the applicable manner as outlined below. Failure to properly respond may result in a hearing or administrative action, and possibly a fine. If needed, copies of the required forms may be downloaded from our website www.awcc.state.ar.us.

Please respond to this Form C filing, or request for Additional Benefits, using one of the options below:

1. **If you have not already both filed a Form 1 and a Form 2:**
   File both a Form 1 and a Form 2.
2. **If you have already filed a Form 1 and not filed a Form 2:**
   File only a Form 2.
3. **If you have already filed a Form 1 and a Form 2:**
   If your position has changed: Form and Amended Form 2.
   If your position has not changed: Re-state, in a letter, on letterhead, or in an e-mail, that your previous position has not changed.

While a copy of the Form C or letter requesting Additional Benefits is not part of this notice, it will be e-mailed to you, if you have an e-mail address on file with the commission. If not, it will be sent by regular mail.

Sincerely,

Janna Craig
Director, Operations/Compliance

cc: (claimant)
(claimant's attorney if there is one)

A-110 E-mail Notice/Spreadsheet

Effective January 11, 2007, the Commission began providing the A-110 notice via e-mail. The e-mail notice contains the same information as the original A-110 notice, however it also includes additional information pertaining to claims filed with the Commission. The e-mail notice includes an attached spreadsheet which contains the claim information. The following is a listing of the data elements and the order in which they appear.

Column	Field Name	Column	Field Name
A	AWCC #	X	Reporting Clm Off Zip
B	Date Posted	Y	Reporting Clm Off Email Address
C	Form 1 Receive Date	Z	Employer Name
D	Form C Receive Date	AA	Emp – FEIN
E	Carrier Name	AB	Emp – Addr1
F	Carrier Policy Number	AC	Emp – Addr2
G	Carrier Claim Number	AD	Emp – City
H	Designated Clm Off Name	AE	Emp – St
I	Designated Clm Off Contact - Last	AF	Emp – Zip
J	Designated Clm Off Contact – First	AG	Clmt – Last
K	Designated Clm Off Mailing Address 1	AH	Clmt – First
L	Designated Clm Off Mailing Address 2	AI	Clmt – MI
M	Designated Clm Off City	AJ	Clmt SSN
N	Designated Clm Off St	AK	Claimant Address 1
O	Designated Clm Off Zip	AL	Claimant Address 2
P	Designated Clm Off Email Address	AM	Claimant City
Q	Reporting Clm Off Name	AN	Claimant State
R	Reporting Clm Off Contact – Last	AO	ClaimantZip
S	Reporting Clm Off Contact – First	AP	Date of Injury
T	Reporting Clm Off Mailing Address 1	AQ	Date Employer Notified
U	Reporting Clm Off Mailing Address 2	AR	Date of Disability
V	Reporting Clm Off City	AS	Form 1 Due Date
W	Reporting Clm Off State	AT	Form 1 Status

The e-mail will be titled "Arkansas WC Claims established on <insert date>". The recipient of this email notification will be the contact person listed with the Commission for the carrier/self-insured's designated claim office. The notice is computer-generated, and it is not possible to add someone to the distribution.

The spreadsheet will be sent the morning of the first business day following the processing of the Form 1 or Form C (Column B – Date Posted) to the Designated Claim Office Contact, and will contain all such claims processed in the one spreadsheet for that claim office (will include multiple carriers in the same spreadsheet). Reporting Claim Office Contacts will receive a similar spreadsheet listing all claims filed by that office.

All fields should be reviewed for accuracy. If errors are found, please submit a revised form making the correction. Key fields to note and review are:

Column D – Form C Receive Date – If this column contains a date, the claim originated via a Form C filing. One might not know of this claim; however, a claim should be established in the carrier claim system, and appropriate forms filed with the Commission.

AWCC

FORM 1

REQUIRED FORM 1 DATA

1. **EMPLOYER (NAME & ADDRESS INCL ZIP)** What we want is the business name and address that is on the policy. It can be a P.O. Box #.

2. **EMPLOYER FEIN** Double check this for accuracy.

3. **CARRIER/ADMINISTRATOR CLAIM #** What we want is your claim number. If you report your claim number on the Form 1, we will pick it up and include it in all of our correspondence with you. If you do not report your claim number on the Form 1, we will not pick it up, and everything you receive from us with have our claim number and the claimant's name.

4. **JURISDICTION** This is only required on EDI submissions of Form 1. For all claims submitted by means other than EDI, we will accept it and enter it as an AR claim.

5. **EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)** What we want is the physical Arkansas address (not a P.O. Box #), if it is different than what is reported in the top left of the form.

6. **CARRIER (NAME & ADDRESS)** Provide the Carrier Name and Address as it is registered with the Arkansas Workers' Compensation Commission.

7. **POLICY PERIOD** Self-insureds do not have a policy expiration date. Self-insurance must be marked in box 8 if the policy period is left blank. For claims covered by an insurance carrier, provide the policy period for the policy in effect on the date of injury/illness.
8. **SELF-INSURANCE** Mark this box only if the employer is self-insured.

9. **CLAIMS ADMINISTRATOR (NAME & ADDRESS)** If the carrier or self-insured is handling the claim, write "SAME" in this box. If a separate TPA is handling the claim, list the name and address of the TPA location registered with the Commission that is handling the claim.

10. **POLICY/SELF-INSURED NUMBER** Provide us with the policy number that existed on the date of injury/illness.

11. **EMPLOYEE NAME AND ADDRESS** Double check the spelling. Provide at a minimum the legal last and first name of the claimant.

12. **DATE OF BIRTH** An accurate date of birth is required. If the date of birth is obviously fabricated, the Form 1 will be rejected.

13. **SOCIAL SECURITY NUMBER** The full 9-digit Social Security Number is required on the Form 1. If the claimant does not have a social security number use the following format: 9, followed by the eight digit date of birth. (MMDDYYYY) For example, if the date of birth is 01/01/2001, report as 901012001. This format is to be used ONLY when the claimant does not have a social security number.

14. **DATE HIRED** This information is required only in Death cases. If the claimant dies after the Form 1 is filed, file an Amended Form 1 (clearly write "Amended" on the top of the Form, write the AWCC file number on the top of the form, and circle any data that is being added or changed), reporting the Date of Death and Date Hired.

15. **SEX** This means gender. Unknown cannot be accepted in this box.

16. **OCCUPATION/JOB TITLE** Enter the primary occupation of the claimant at the time of the accident/illness.

17. **EMPLOYMENT STATUS** The valid choices for Employment Status are:

Full-Time	On Strike	Volunteer	Seasonal
Part-Time	Disabled	Apprenticeship Full-Time	Piece Worker
Not Employed	Retired	Apprenticeship Part-Time	

18. **DATE OF INJURY/ILLNESS** This is a required field and is used on the subsequent forms filed for the claim. Please be sure the date is accurate. If you file subsequent forms for this claim with a different date of injury, they will likely be rejected.

19. **LAST WORK DATE** This date cannot be earlier than the date of injury. It is not necessary that this be a complete work day. If an employee is injured and has to leave work, that day is the last work date.

20. **DATE EMPLOYER NOTIFIED** This is not necessarily the date the adjuster was notified. This is the date a supervisor, HR, a company nurse, etc. was notified, or the date the carrier was notified, whichever is the EARLIER date. If this box is left blank, we will use the date of injury/illness.

21. **DATE DISABILITY BEGAN** Date the employee did not earn full wages, but NO EARLIER THAN the day after the date of injury/illness. If this box is left blank, we will use the day after the date of injury/illness.

22. **TYPE OF INJURY/ILLNESS** Following this instruction page is a complete list of injuries/illnesses and the code for each.

23. **PART OF BODY AFFECTED** Following this instruction page is a complete list of body parts and the code for each. Include the SIDE, such as LEFT ankle or RIGHT shoulder.

24. **HOW INJURY OF ILLNESS OCCURRED** What is needed is a short narrative of how the injury or illness occurred

25. **IF FATAL, DATE OF DEATH** This field is required for death claims, along with the Date of Hire (box 14). If the claim did not begin as a death claim but becomes one, you must file an Amended Form 1, reporting the Date of Death and Date of Hire. When filing an Amended Form 1, clearly write "Amended" at the top of the form and the AWCC file number at the top of the form, then circle any data being added or changed.

26. **PREPARER'S NAME AND TITLE** Provide the name of the adjuster handling the claim, not the name of the name of employer's staff person who may have filled out the Form 1.

27. **PHONE NUMBER** Provide the direct phone number of the adjuster handling the claim.

PLEASE NOTE THAT EDI CANNOT BE USED TO FILE A FORM 1 IF THE CLAIM WAS ESTABLISHED BY A FORM C FILING. IF THE CLAIM WAS ESTABLISHED BY A FORM C FILING, THE FORM 1 MUST BE FILED BY EMAIL, US MAIL OR FAX.

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)
1

CARRIER/ADMINISTRATOR CLAIM NUMBER
3

OSHA CASE NUMBER

REPORT PURPOSE CODE

JURISDICTION
4

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)
5

LOCATION #

PHONE #

INDUSTRY CODE

EMPLOYER FEIN
2

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)
6

POLICY PERIOD
7
TO

CHECK IF APPROPRIATE
8
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
9

CARRIER FEIN

POLICY/SELF-INSURED NUMBER
10

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)
11

DATE OF BIRTH
12

SOCIAL SECURITY NUMBER
13

DATE HIRED
14

STATE OF HIRE

ADDRESS (INCL ZIP)
11

SEX
15
M MALE
F FEMALE
U UNKNOWN

MARITAL STATUS
U UNMARRIED SINGLE/DIVORCED
M MARRIED
S SEPARATED
K UNKNOWN

OCCUPATION/JOB TITLE
16

EMPLOYMENT STATUS
17

PHONE

OF DEPENDENTS

ANSCI CLASS CODE

RATE PER ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER

DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO
DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY/ILLNESS
18

TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED ☐ AM ☐ PM

LAST WORK DATE
19

DATE EMPLOYER NOTIFIED
20

DATE DISABILITY BEGAN
21

CONTACT NAME/PHONE NUMBER

TYPE OF INJURY/ILLNESS
22

PART OF BODY AFFECTED
23

DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL
24

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH
25

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO
WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)

INITIAL TREATMENT
0 NO MEDICAL TREATMENT
1 MINOR: BY EMPLOYER
2 MINOR CLINIC/HOSP
3 EMERGENCY CARE
4 OVERNIGHT HOSPITALIZATION
5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE
26

PHONE NUMBER
27

FORM 1, TYPE OF INJURY/ILLNESS AND CODES (Box 22 on Form 1)

Code	Type of Injury/Illness
01	NO PHYSICAL INJURY
02	AMPUTATION
53	SYNCOPE (SWOONING, FAINTING)
54	ASPHYXIATION
55	VASCULAR LOSS
58	VISION LOSS
59	ALL OTHER
60	DUST DISEASE NOC
61	ASBESTOSIS
62	BLACK LUNG
63	BYSSINOSIS
64	SILICOSIS
65	RESPIRATORY DISORDERS (GASES,FUMES,ETC.)
66	POISONING - CHEMICAL
67	POISONING - METAL
68	DERMATITIS
69	MENTAL DISORDER
70	RADIATION
71	ALL OTHER OCCUPATIONAL DISEASE
72	LOSS OF HEARING
73	CONTAGIOUS DISEASE
74	CANCER
75	AIDS
76	VDT-RELATED DISEASE
77	MENTAL STRESS
78	CARPAL TUNNEL SYNDROME
79	HEPATITIS C

Code	Type of Injury/Illness
80	ALL OTHER CUMULATIVE INJURIES
90	MULTIPLE PHYSICAL INJURIES
91	MULTIPLE INJURIES
03	ANGINA PECTORIS (CHEST PAIN)
04	BURN
07	CONCUSSION
10	CONTUSION
13	CRUSHING
16	DISLOCATION
19	ELECTRIC SHOCK
22	ENUCLEATION (REMOVE TUMOR)
25	FOREIGN BODY
28	FRACTURE
30	FREEZING
31	HEARING LOSS (TRAUMATIC ONLY)
32	HEAT PROSTRATION
34	HERNIA
36	INFECTION
37	INFLAMMATION
40	LACERATION
41	MYOCARDIAL INFARCTION (HEART ATTACK)
42	POISONING GENERAL
43	PUNCTURE
46	RUPTURE
47	SEVERANCE
49	SPRAIN
52	STRAIN

FORM 1, BODY PART AFFECTED AND CODES (Box 23 on Form 1)

Code	Body Part
00	UNDEFINED
10	MULTIPLE HEAD INJURY
38	SHOULDER(S)
39	WRIST(S) & HAND(S)
40	MULTIPLE TRUNK INJURY
41	UPPER BACK AREA (THORACIC AREA)
42	LOW BACK AREA INC:LUMBAR & LUMBO-SACRAL
43	DISC (TRUNK AREA)
44	CHEST INC: RIBS,STERNUM,AND SOFT TISSUE
45	SACRUM AND COCCYX
46	PELVIS
47	SPINAL CORD
48	INTERNAL ORGANS
49	HEART
50	MULTIPLE LOWER EXTREMITIES INJURY
51	HIP
52	THIGH
53	KNEE
54	LOWER LEG
55	ANKLE
56	FOOT
57	TOE(S)
58	GREAT TOE
60	LUNGS
61	ABDOMEN (INCLUDING GROIN)
62	BUTTOCKS
63	LUMBAR AND/OR SACRAL VERTEBRA
64	ARTIFICIAL APPLIANCE
65	UNKNOWN - INSUFFICIENT INFORMATION

Code	Body Part
66	NO PHYSICAL INJURY
90	MULTIPLE BODY PARTS INJURY
91	MULT SYSTEMS AND MULT BODY SYSTEMS
99	UNSPEC
11	SKULL
12	BRAIN
13	EAR(S)
14	EYE(S)
15	NOSE
16	TEETH
17	MOUTH
18	OTHER FACIAL SOFT TISSUE
19	FACIAL BONES
20	MULTIPLE NECK INJURY
21	VERTEBRAE
22	DISC (NECK AREA)
23	SPINAL CORD
24	LARYNX
25	SOFT TISSUE
26	TRACHEA
30	MULTIPLE UPPER EXTREMITIES
31	UPPER ARM (INC: CLAVICLE AND SCAPULA)
32	ELBOW
33	LOWER ARM
34	WRIST
35	HAND
36	FINGER(S)
37	THUMB

AWCC

FORM 2

Form AR- 2	ARKANSAS WORKERS' COMPENSATION COMMISSION	2
Authority: Ark. Code Ann. §11-9-803, -810 Revised 1-1-2013	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

EMPLOYER'S INTENT TO ACCEPT OR CONTROVERT CLAIM

☐ **Initial Filing** **1** ☐ **Amended Filing**

2	3	4	5	
AWCC File No.	Carrier Claim No.	Employee Name (Last, First, MI)	Employee SS Number	
		6		
		Employer Name	Fed. Employer I.D. No.	
	Address	City	State	Zip Code
	7			
	Carrier or Self-Insured Name	Claims Office Name, Address, and Phone		

Is this a medical only claim? ☐ Yes ☐ No **8** **Is this a PPD-Only Claim?** ☐ Yes ☐ No

COMPENSATION (if not applicable, skip to next section)

Date of First Comp. Check	Dates Covered by First Check	Body Part Injured	First Day of Disability
Average Weekly Wage	.00 Wkly TTD Comp. Rate (rounded)	Was Disability Continuous During the First 8 Days? ☐ Yes ☐ No	Date Indemnity Triggered

STATEMENT OF POSITION

Date of injury or death: **9** City, State of Injury: **10** State your position. If controverting, state the grounds therefore:

11

DEATH CASE DATA **12**

List all Dependents below: *(If more space is needed, attach supplemental sheet)* If no Dependents, check here: ☐
Attach Death Certificate of Deceased Employee and Birth Certificates for Dependent Children

Name of dependent	Date of	Relationship to deceased	Weekly benefit amount

CERTIFICATION

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

13	14	Title:	16
Signature	Printed or Typewritten Name	Phone: **15**	Date

If insurer is represented by an attorney, that legal representative must sign below pursuant to Ark. Code Ann. § 11-9-717

Name and Address of Attorney	Signature

REQUIRED FORM 2 DATA

1. **INITIAL OR AMENDED FILING** Each form 2 must be marked to show whether it is an Initial or an Amended filing. The filing is an Initial filing until it is accepted. If changes need to be made after the Initial filing is accepted, then it will be an Amended filing. On Amended filings, circle the information that is being added or changed.

2. **AWCC FILE NUMBER** The AWCC file number is required on Form 2. The only exception is if you choose to submit your initial Form 1 and Form 2 filing together in the same email.

3. **CARRIER CLAIM NUMBER** Put your claim number here, and be sure that it matches what was reported on the Form 1. If the carrier claim number needs to be corrected, file an Amended Form 1.

4. **EMPLOYEE NAME** Make sure the employee name matches what was reported on the Form 1. If a correction needs to be made to the employee name, file an Amended Form 1.

5. **EMPLOYEE SOCIAL SECURITY NUMBER** Only the last 4 digits of the social security number are required on Form 2. Make sure this matches what was reported on the Form 1. If a correction needs to be made to the employee social security number, file an Amended Form 1.

6. **EMPLOYER NAME** Make sure the Employer Name matches what was reported on the Form 1. If the Employer Name needs to be corrected, file an Amended Form 1.

7. **CARRIER OR SELF-INSURED NAME** Make sure the Carrier or Self-Insured Name matches was was reported on the Form 1.

8. **IS THIS A MEDICAL ONLY CLAIM? IS THIS A PPD ONLY CLAIM?** Always answer both of these questions Yes or No.

   THE COMPENSATION SECTION MUST BE COMPLETED IF THE CLAIM IS ACCEPTED AND THE EMPLOYEE HAS MORE THAN 7 DAYS OF LOST TIME AND/OR PPD. FOLLOWING THIS INSTRUCTION PAGE ARE DIRECTIONS FOR COMPLETING THE COMPENSATION SECTION.

9. **DATE OF INJURY OR DEATH** Make sure this date matches what was reported on the Form 1.

10. **CITY, STATE OF INJURY** Double check this for accuracy. We collect this data for statistical purposes and for assigning the claim to an ALJ if a hearing is requested.

11. **STATEMENT OF POSITION** If you accept the claim, it is fine to simply write "accepted" in this section. But please note that you are required to state your reason if the claim is controverted, and simply writing "denied" is not sufficient.

12. **DEATH CASE DATA** Complete this section only if the claim is a death claim.

    If the deceased has no eligible dependents, there is a small box for you to check. If the deceased has no eligible dependents, you are required to pay $500.00 to the Death Permanent Total Disability Trust Fund.

    If the deceased does have eligible dependents, you are required to provide the name of the dependent, the date of birth, relationship to the deceased and the weekly benefit amount. You are also required to provide the death certificate and any other applicable documentation, such as the marriage license, birth certificate of a dependent child, etc.

    If you know the deceased has dependents, but you are unable to provide the required information, you may write in this space that you are gathering that information and will file an Amended Form 2 as soon as you have the information.

13. **SIGNATURE** A signature is required. We accept computer-generated signatures.

14. **PRINTED OR TYPEWRITTEN NAME** Print or type the name of the adjuster handling the claim.

15. **PHONE** Provide the direct phone number of the adjuster handling the claim, or the main office phone number and extension of the adjuster handling the claim.

16. **DATE** The date the form is submitted to the AWCC. The certification date on the Form 2 must always be the same day as the day the form is submitted to the AWCC.

REMEMBER TO INCLUDE THE AWCC FILE NUMBER ON FORM 2, UNLESS IT IS SUBMITTED IN THE SAME EMAIL AS YOUR INITIAL FORM 1 FILING. IF YOU FILE YOUR FIRST REPORT OF INJURY BY EDI, DO NOT FILE YOUR FORM 2 UNTIL YOU HAVE RECEIVED THE AWCC FILE NUMBER.

Form 2 Compensation Section

Date of First Comp. Check: If you issue payment for TTD, TPD, PPD or PTD, enter the date the check was issued in this box.
The date the First Comp. Check is due to be issued is the same as the date the Form 2 is due.
If you request and receive an extension to file your Form 2, you are also being granted an extension to make a timely first payment.

Dates Covered by First Check: Please enter two dates in this box. For example, if the claimant misses eight days and is entitled to TTD benefits for only one day, enter 06/17/20 – 06/17/20.

First Day of Disability:
For TTD and TPD claims:
The First Day of Disability will always be the first day on which there was disability, excluding the date of injury. If a claimant is hurt in the middle of the afternoon on Friday, March 3rd, leaves work and is off work for any number of days, the First Day of Disability is Saturday, March 4th, even though it is a weekend day.
For Permanent Partial Disability only claims:
The First Day of Disability is the date on which the claimant went to the Medical Provider to be assessed a permanent disability (date of the Doctor's appointment).

Date Indemnity Triggered:
For TTD and PPD claims:
The Date Indemnity Triggered varies:
a. If the claimant misses 8 consecutive days, (counting weekends), the Date Indemnity Triggered is the same date as the First Day of Disability.
b. If the claimant misses 8 days intermittently, the Date Indemnity Triggered is the 8th day the claimant misses, counting weekends.

For Permanent Partial Disability only claims:
The Date Indemnity Triggered is the date on which the impairment rating was received by the Carrier or TPA or Self-Insured, whichever is earlier.

Was Disability Continuous During the First 8 Days? This question is asking whether disability was continuous for the first 8 days, following the first date of disability.
If the disability was intermittent, the answer to this question is No. In this case, you will need to file a Form S listing the dates of disability.
If the claim is a PPD Only claim, the answer to this question is No.

Average Weekly Wage:
a. The Average Weekly Wage is based on WEEKLY wages, including both regular and overtime earnings each week.

b. If you are not paying the maximum benefit rate, you are required to provide a Form W or equivalent wage information.
c. On the Form W or wage information, write your calculations to show how you calculated the Average Weekly Wage, and make sure this amount is the same as the Average Weekly Wage reported on the Form 2.
d. You may provide employer pay records in lieu of a Form W if those records are no more than 5 pages and provide all of the information broken down by week for the 52-week period prior to the date of injury.
e. If you are paying the maximum benefit rate, please do not submit wages.
f. We will accept estimated wages on the Form 2, but if you are not paying the maximum benefit rate, you must file wages no later than when you file the Form 4.

Weekly TTD Comp. Rate (rounded):

Round the weekly TTD Comp. Rate to the nearest whole dollar.
The Weekly TTD Comp. Rate is 66 2/3% of the Average Weekly Wage, up to a maximum Amount which varies according to the year of the injury, not the year the claim was filed.

Salary Continuation:

If the employer is continuing full salary for the claimant, in the COMPENSATION section, write "SALARY CONTINUED" for "Date of First Comp. Check". Also write "SALARY CONTINUED" for "Dates Covered by First Check".
If at any time the employer elects to discontinue paying the claimant's full salary, file an Amended Form 2. For the "Date of First Comp. Check", indicate the date when **you** first began paying benefits. For the "Dates Covered by First Check", list the dates covered by the first check **you** issued. For the "Date Indemnity Triggered", list the day after salary continuation ended. It is also helpful for you to indicate in the STATEMENT OF POSITION a statement that salary continuation ended on a specific date and that you began paying benefits on a specific date.

DATE OF DISABILITY

On the Form 2, you are asked to provide First Day of Disability and Date Indemnity Triggered. These dates are different for different types of claims.

FOR TTD and TPD claims:

a. The **First Day of Disability** will always be the first day on which there was disability, excluding the date of injury. If a claimant is hurt in the middle of the day on Friday, March 3rd, leaves work, and is off work for any number of days, the First Day of Disability is Saturday, March 4th, even if it is a weekend day.

b. The **Date Indemnity Triggered** varies:
    1. If the claimant misses 8 consecutive days, it does not have to be the first 8 days following the date of injury, only 8 consecutive days once he or she begins missing days, counting weekends, the Date Indemnity Triggered is the same date as the First Day of Disability; and,
    2. If the claimant does not miss 8 consecutive days, missing intermittent days the Date Indemnity Triggered is the 8th day the claimant misses, counting weekends.

Answering the question "Was disability continuous during the first eight days?" will determine from which of these two dates timeliness will be graded. If you answer "Yes", we will use the First Day of Disability, which will be the same date as Date Indemnity Triggered, on the Form 2. If you answer the question "No", we will use Date Indemnity Triggered, which will be the 8th day of disability. You will have to provide medical documentation that the claimant was released to return to full duty, or limited duty and was paid regular wages, during the first eight days following the first date of disability.

For Permanent Partial Disability only claims, the **First Day of Disability** is the date on which the claimant went to the Medical Provider to be assessed a permanent disability (date of the Doctor's appointment). The **Date Indemnity Triggered** is the date on which the impairment rating was received by the Carrier or TPA or Self-Insured, whichever is earlier.

EXTENSION REQUESTS

1. Extensions may be granted for the filing of the Form 2.

2. Extensions are not granted for filing the Form 1, Form 4, Form M, etc.

3. Do not request an extension on a form, such as a Form 2 or a Form S.

4. Extension Requests must be in writing. They may be sent by e-mail, fax or US mail. Send your request to Janna Craig.

5. Extensions will not be granted after the Form 2 due date has passed, even if it on a weekend or a state holiday.

6. If you do not receive a granted extension reply, do not assume you were granted an extension.

7. If you are granted an extension for filing your Form 2, you are also receiving an extension in making the first payment.

8. Your extension request should be in the following format:

   AWCC Claim #:

   Date of Injury:

   Date Employer Notified:

   Date Carrier or Self-Insured Notified:

   Reason for Needing Additional Time:

   What you have done to alleviate the need for Additional Time:

AWCC

FORM W

Form AR-W	ARKANSAS WORKERS' COMPENSATION COMMISSION	W
Authority: Ark. Code Ann. §11-9-518 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	

WAGE STATEMENT IMMEDIATELY PRECEDING INJURY DATE

Weeks	Straight Time Worked		Wages Paid For Straight Time	Overtime Hours Worked		Wages Paid for Overtime
	Days	Hours		Days	Hours	
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
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42						
43						
44						
45						
46						
47						
48						
49						
50						
51						
52						
Total						

AWCC No.

Carrier Claim No.

Employee Name:

Employee S.S.No.:

Employer Name:

Employer FEIN No.:

Carrier or Self-Insured Name:

Carrier NAIC No.:

INSTRUCTIONS FOR COMPLETING WAGE STATEMENT
(To be completed only if claimant receives less than maximum benefits)

In completing the Wage Statement, in week one give information for the week prior to the injury and follow with preceding weeks. Days and hours of straight time work should be given in all cases.

Explanation of time lost by employee: _____

AWCC Form W
(Wage Statement)

1. The **AWCC Advisory 88-1** requires respondents to file **Form W** (with the AWCC file number for the case, obtained from **AWCC Form A-110)** if the claimant receives less than the maximum compensation rate.

2. The average weekly wage of the injured worker shall "[I]n no case...be computed on less than a full-time workweek in the employment." **[Ark. Code Ann. § 11-9-518(a)(1)]**

Information on Form W is available from the Office Services Section. General Information is available from the Support Services Division. (1-800-622-4472 or 501-682-3930)

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."

Advisory 2000-1

History of Workers' Compensation: Maximums, Minimums, and D&PTD Thresholds

BEGINNING WITH	BASED ON STATEWIDE AVERAGE WEEKLY WAGE* OF	MAXIMUM PPD RATE IS	MAXIMUM TOTAL DISABILITY RATE IS	MINIMUM RATE IS	D&PTD Threshold (see **Advisory 2007-1**)
01-01-2024	**$1,031.09**	**$657.00**	**$876.00**	**$20.00**	**N.A.******
01-01-2023	$981.98	$626.00	$835.00	$20.00	N.A.****
01-01-2022	$929.97	$593.00	$790.00	$20.00	N.A.****
01-01-2021	$865.73	$552.00	$736.00	$20.00	N.A.****
01-01-2020	$836.46	$533.00	$711.00	$20.00	N.A.****
01-01-2019	$817.96	$521.00	$695.00	$20.00	$225,875
01-01-2018	$791.34	$505.00	$673.00	$20.00	$218,725
01-01-2017	$777.84	$496.00	$661.00	$20.00	$214,825
01-01-2016	$760.48	$485.00	$646.00	$20.00	$209,950
01-01-2015	$740.53	$472.00	$629.00	$20.00	$204,425
01-01-2014	$725.53	$463.00	$617.00	$20.00	$200,525
01-01-2013	$707.91	$452.00	$602.00	$20.00	$195,650
01-01-2012	$686.71	$438.00	$584.00	$20.00	$189,800
01-01-2011	$676.49	$431.00	$575.00	$20.00	$186,875
01-01-2010	$661.66	$422.00	$562.00	$20.00	$182,650
01-01-2009	$647.40	$413.00	$550.00	$20.00	$178,750
01-01-2008	$614.25	$392.00	$522.00	$20.00	$169,650
01-01-2007	$593.01	$378.00	$504.00	$20.00	$ 75,000
01-01-2006	$573.65	$366.00	$488.00	$20.00	$ 75,000
01-01-2005	$548.38	$350.00	$466.00	$20.00	$ 75,000
01-01-2004	$533.28	$340.00	$453.00	$20.00	$ 75,000
01-01-2003	$518.22	$330.00	$440.00	$20.00	$ 75,000
01-01-2002	$500.38	$319.00	$425.00	$20.00	$ 75,000
01-01-2001	$482.50	$308.00	$410.00	$20.00	$ 75,000
01-01-2000	$464.07	$296.00	$394.00	$20.00	$ 75,000
01-01-1999	$441.73	$281.00	$375.00	$20.00	$ 75,000
01-01-1998	$422.93	$269.00	$359.00	$20.00	$ 75,000
01-01-1997	$409.58	$261.00	$348.00	$20.00	$ 75,000
01-01-1996	$396.04	$253.00	$337.00	$20.00	$ 75,000
01-01-1995	$385.12	$203.00	$270.00	$20.00	$ 75,000
01-01-1994	$381.14	$200.00**	$267.00**	$20.00	$ 75,000
01-01-1993	$360.43	$189.23	$252.30	$20.00	$ 75,000
01-01-1992	$345.62	$181.45	$241.93	$20.00	$ 75,000
01-01-1991	$330.53	$173.53	$231.37	$20.00	$ 75,000
01-01-1990	$323.02	$169.59	$226.11	$20.00	$ 75,000
01-01-1989	$313.62	$156.81	$209.08	$20.00	$ 75,000
07-01-1987	N.A.	$154.00	$189.00	$20.00	$ 75,000
07-01-1986	N.A.	$154.00	$175.00	$20.00	$ 75,000
03-01-1982	N.A.	$154.00	$154.00	$15.00	$ 75,000
03-01-1981	N.A.	$140.00	$140.00	$15.00	$ 75,000
03-01-1980	N.A.	$126.00	$126.00	$15.00	$ 50,000
03-01-1979	N.A.	$112.00	$112.00	$15.00	$ 50,000
03-01-1978	N.A.	$ 87.50	$ 87.50	$15.00	$ 50,000
03-01-1977	N.A.	$ 84.00	$ 84.00	$15.00	$ 50,000
03-01-1976	N.A.	$ 77.00	$ 77.00	$15.00	$ 50,000
07-01-1974	N.A.	$ 66.50	$ 66.50	$15.00	$ 50,000
04-01-1973	N.A.	$ 63.00	$ 63.00	$15.00	$ 50,000***
12-05-1968	N.A.	$ 49.00	$ 49.00	$10.00	N.A.

Average Weekly Wage

1. **AWCC Advisory 88-1** requires respondents to file **Form W** (with the AWCC file number) if the claimant receives less than the maximum compensation rate. It also allows for the filing of other appropriate wage documentation. If such documentation is provided in lieu of a Form W, the provided documentation must be 5 pages or less, and it must include a weekly breakdown of the claimant's wages for the 52-week period prior to the injury.

2. The average weekly wage of the injured worker shall in no case be computed on less than a full-time workweek in the employment. See A.C.A. § 11-9-518(a)(1).

3. INSTRUCTIONS FOR COMPLETING WAGE STATEMENT (To be completed only if claimant receives less than maximum benefits): In week one, give information for the week prior to the injury and follow with preceding weeks. Days and hours of straight time work should be given in all cases.

4. When filling out the Form W, be sure to put the following information on the form before submitting it:

    - AWCC file number
    - Claimant's name
    - Claimant's social security number (or the last four digits of the SSN)
    - Days worked each week, regular and overtime
    - Hours worked each week, regular and overtime
    - Earnings each week, regular and overtime
    - Total regular earnings
    - Total overtime earnings
    - Mark any weeks you do not include in earning and weeks worked
    - Show AWW calculations (Total Earnings ÷ Weeks Worked = AWW) at the bottom right of the form

The AWW calculation must match what is reported on the Form 2. If it does not, you must file an Amended Form 2, correcting the AWW and TTD amounts.

While the employer may supply the wage records, it is the responsibility of the adjuster to properly calculate the Average Weekly Wage.

AWCC

FORM S

Form AR-S	ARKANSAS WORKERS' COMPENSATION COMMISSION	S
Authority: Ark. Code Ann. § 11-9-529 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	

SUPPLEMENTAL REPORT

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

Employer Name	FEIN No.	City	State	Zip Code
Carrier Or Self-Insured Name	NAIC No.	Claims Office Address		

1. Date of injury: _____

2. Date employee began losing time from work: _____

3. Has employee returned to work? ❑ Yes ❑ No If yes, give date _____

4. If employee has returned to work, is he/she earning the same wages as before the injury? ❑ Yes ❑ No

   If not, please explain:

5. Has employee died? ❑ Yes ❑ No If yes, give date of death: _____

ADDITIONAL INFORMATION

CERTIFICATION

I certify that the information above is accurate according to the employer's/carrier's records.

Signature	Printed or Typewritten Name	Title	Date

AWCC

FORM 4

Form AR-4	ARKANSAS WORKERS' COMPENSATION COMMISSION	4
Authority: Ark. Code Ann. §11-9-810 Revised: 1-1-2011	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

REPORT OF COMPENSATION PAID/SUSPENSION OF PAYMENTS

☐ **AMENDED REPORT**

☐ **Closing Report** ☐ **Death/PTD Maximum Liability**
☐ **Report of Payment Suspension** ☐ **Update Report** (additional payments only)

AWCC File No.	Carrier Claim No.	Employee Name (Last, First, MI)	Employee S.S. Number
Employer Name	City	State	Zip Code
Carrier or Self-Insured Name	Claims Office Location (mailing address)		

DISABILITY INFORMATION

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 _____			

COMPENSATION INFORMATION:

COMPENSATION PAYMENTS MADE:

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

SUSPENSION OF PAYMENTS OF COMPENSATION

Date of Suspension of Compensation: _____ Reason for Suspension:

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.

Signature	Printed or Typewritten Name	Title	Date

Form 4 Types of Filing

When you file a Form 4, you are required to include the type of filing you are making:

AMENDED, CLOSING REPORT, DEATH/PTD MAXIMUM LIABILITY, REPORT OF PAYMENT SUSPENSION, or an **UPDATE REPORT.**

Select only **ONE** of the above types. There will never to a reason for you to select more than one type of filing.

AMENDED REPORT – An amended report corrects previously reported data (other than payment data) that was submitted on an Accepted Form 4. You can only amend a Form 4 that has previously been filed and accepted. **Amended Reports may only be used to correct data down through the Disability Information section on a Form 4.**

CLOSING REPORT – A closing report is filed to report the closing of a workers' compensation claim, or a Joint Petitioned claim. You are required to file a closing report, reporting all of the payments made over the life of the claim, within thirty (30) days of the last payment of compensation, whether indemnity or medical.

Even if previously closed, you are required to file a new closing report, reporting all of the payments made over the life of the claim within thirty (30) days of an Administrative Law Judge's approval of a Joint Petition.

You may Joint Petition a claim and leave the medical open. You are still required to file a closing report, reporting all of the payments made over the life of the claim. Include a Form S telling us that the medical is left open per the Joint Petition, and annually file an Update Report.

DEATH/PTD MAXIMUM LIABILITY REPORT – This report is to be filed when you have reached your maximum liability on a death or a permanent total disability case, and the AWCC Special Funds Division has accepted liability for future benefits.

REPORT OF PAYMENT SUSPENSION – This report is to be filed ONLY when you are suspending benefits temporarily, and you expect to resume payment of benefits in the

future. Otherwise, you are not required to file a Form 4 Report of Payment Suspension. If, for example, you are suspending benefits because the claimant returned to work, do not file a Form 4 Report of Payment Suspension. Most claims do not require the filing of a Form 4 Report of Payment Suspension at any time.

UPDATE REPORT (additional payments only) - Any time an additional payment is made after a claim has been closed, by the filing and acceptance of a Closing Report Form 4, you file an Update Report. Report only the new expenditures and provide the Grand Total of only the amounts you report on the Update Report. The exception is when a file is Joint Petitioned. Then you will file a Closing Report AR-4, regardless of whether the file has previously been closed with an accepted Closing Report AR-4.

Form 4 General Information

AWCC File Number: Unless you are filing your Form 4 at the same time and in the same email as your initial Forms 1 and 2, the AWCC file number is required on Form 4.

Employee Name: Last name must match the Form 1 and Form 2.

Employee S.S. Number: If you have the AWCC file number entered on the Form 4, you only need to provide the last four digits of the S.S.N. If you are submitting the Form 4 along with the Form 1 and Form 2 and you do not yet have an AWCC File Number, you are required to provide the full S.S.N.

Employer Name, City, State, Zip Code: This needs to match what is reported on the Form 1.

Carrier or Self-Insured Name: NOT the TPA name.

Claims Office Location (mailing address): The TPA name and mailing address, or the Carrier's Claims Office handling the claim name and mailing address.

Form 4 Disability Information

Date of Injury: The Date of Injury reported on the Form 1, Form 2 and Form 4 must match.

- The Date of Injury must be before the Last Day Worked.
- The Date of Injury must be before the Date Employee Able to RTW.
- The Date of Injury must be before the Return to Work Date.

Last Day Employee Worked: The Last Day Employee Worked must be the same as the Last Work Day on the Form 1.

- The Last Day Employee Worked is the day before the First Day of Disability on the Form 2.
- The Last Day Employee Worked must be a date before the Date Employee Able to RTW.
- The Last Day Employee Worked must be a date before the Date Employee RTW.

Date Employee Able to RTW: This is the date (or the last date if there are multiple periods of disability) the employee is medically released to return to work with or without restriction. The Date Employee Able to RTW may be as soon as the day after the Last Day Employee Worked.

Return to Work Date: This is the date (or the last date if there are multiple periods of disability) that the employee actually returns to work, regardless of his/her medical release.

NOTE 1: You may have a situation in which the claimant does not return to the medical provider for a medical release to return to work, but he or she simply shows up at work saying he or she feels fine. In a situation such as this, enter the Able to RTW and Return to Work dates as the date the employee returned to work, and submit a Form S telling us that he/she returned without going to the doctor for a medical release.

NOTE 2: Any time an employee is released to return to work with restrictions, you are required to include a Form S when filing the Closing Report Form 4.

Form 4 Compensation Information

1. **TTD Weeks and Days:** TTD Weeks and Days is an AUDITED line. We require two things on every claim for which you pay TTD: medical documentation for days work is missed and date(s) the claimant may return to work; and weekly wages to calculate Average Weekly Wages and TTD benefits (unless you are paying the maximum benefit rate).

2. **TPD Weeks and Days:** Every day the claimant works without earning full pre-injury wages is a TPD day. The Carrier/Self-Insured/TPA is responsible for paying 66 2/3% of the difference between the weekly wages earned and the Average Weekly Wage.

3. **PPD Weeks and Days:** PPD Week and Days is an AUDITED line. We require two things on every claim for which you pay PPD: a Permanent Impairment Rating issued by a licensed medical provider or an Administrative Law Judge; and weekly wages to calculate the Average Weekly Wage and PPD benefit rate (unless you are paying the maximum benefit rate).

4. **Weeks PTD:** You are responsible for paying PTD benefits until the claimant passes away or returns to work, unless the Death and Permanent Total Disability Trust Fund has liability and begins making payments to the claimant. PTD benefits are generally due at the end of the claimant's healing period.

5. **Weeks for Death:** You are responsible for paying death benefits to any eligible dependent. The length of time you are responsible for paying death benefits may vary, based upon several factors (see A.C.A. § 11-9-527). If there are no eligible dependents, you are required to pay $500.00 to the Death and Permanent Total Disability Trust Fund.

6. **Lump Sum Payment:** This is NOT the line to report a Joint Petition amount. This line is used for reporting a discounted lump sum payment of PPD benefits, approved by a Legal Advisor after a Form L filing. This line is also used for reporting a lump sum for remarriage payment made to a surviving spouse on a death claim.

7. **Joint Petition settlement:** This is the amount awarded in a Joint Petition paid to the claimant, including any amount withheld and paid in child support on the claimant's behalf. In cases where more than one claim is Joint Petitioned at the same time, the amount that is properly posted on this line is to be split between the claims Joint Petitioned.

8. **Claimant Attorney Fees:** This is the amount of attorney's fees paid to the attorney for the claimant. At times these fees may be paid to more than one attorney who has represented the claimant. Please report the total amount of fees paid.

9. **Defense Attorney Fees:** This is the amount of attorney's fees paid to the attorney for the Respondent at the time the Form 4 is filed. If you pay additional defense attorney fees after the Closing Report AR-4 is filed and accepted, report the additional fees paid on an Update Report AR-4.

10. **Other (Compensation Related):** This includes compensation-related expenses, such as interest and penalties. This also includes Medicare Set Asides amounts paid.

11. **Hospital Expenses:** This should be self-explanatory.

12. **Medical Expenses:** This includes medical expenses other than Hospital Expenses or Drugs, Medicine.

13. **Drugs, Medicine:** This should be self-explanatory.

14. **Funeral Expenses:** For all compensable death claims, the benefit payor is responsible for up to $6,000.00 of funeral expenses.

15. **Rehabilitation:** This is Vocational Rehab Services.

16. **Other (Expense Related):** This includes expenses that are not related to benefits and do not have a natural line on which you would report them. Examples include court reporter fees and audit expenses.

1 – 16 Grand Total: Please double-check your math. The dollar amounts entered on Lines 1 through 16 must add up to the amount entered as the Grand Total. Also, a Grand Total is required on every Form 4, even if the Grand Total is zero.

Suspension of Payments of Compensation section: Complete this section ONLY IF you are temporarily suspending benefits and expect to resume payment of benefits at a later date.

Certification:

Signature – Every AR-4 must be signed. We accept computer-generated signatures.

Printed or Typewritten Name – Print or type your name.

Date – Enter the date that you are submitting the Form 4 to the Commission. If you are re-submitting the form after rejection, update the date to the current date.

Permanent Impairment Ratings

A permanent impairment rating may only be assigned by a licensed medical provider or an Administrative Law Judge.

If the treating medical provider refuses to assign a permanent impairment rating when one is warranted, you may refer the claimant to another medical provider or you may request an assignment to an Administrative Law Judge to schedule a hearing for the purpose of establishing an impairment rating.

A permanent impairment rating must be to the most specific scheduled body part. For example, if the claimant suffers an injury to the ankle, the rating cannot be assigned to the leg above the knee or to the body as a whole.

Permanent impairment ratings are paid as a percentage of the body as a whole (450 weeks), unless the rating is to one of the scheduled injuries listed below:

Scheduled Permanent Injuries (A.C.A. § 11-9-521)

Body part affected	Weeks payable	Body part affected	Weeks payable
Body as a whole	450	Phalange of first finger	21.5
Arm amputated at or above the elbow	244	Second finger (long)	37
Arm amputated below the elbow	183	Phalange of second finger	18.5
Hand	183	Third finger (ring)	24
Leg amputated at or above the knee	184	Phalange of third finger	12
Leg amputated below the knee	131	Fourth finger (little)	19
Foot	131	Phalange of fourth finger	9.5
Eye	105	Great toe	32
Hearing, both ears	158	Phalange of great toe	16
Hearing, one ear	42	Other toe	11
Thumb	73	Phalange of other toe	5.5
Phalange of thumb	36.5	One testicle	53
First finger (index)	43	Two testicles	158

Facial disfigurement (A.C.A. § 11-9-524) is paid in an amount not to exceed $3,500.00 and is paid at least 12 months after the date of injury.

Hips and shoulders are rated to the body as a whole.

100% loss or loss of use of a limb or digit is paid at the TTD rate, not the PPD rate.

(See A.C.A. § 11-9-501)

Loss of a Finger

Arkansas does not use the A.M.A. Guides to determine the percentage loss of a finger.

Instead, we have **Rule 099.12, Compensation for Amputation of Fingers.**

"Loss by amputation of one-half or less than one-half of the terminal phalange of a member shall be one-half of the loss of the phalange, or one-fourth of the digit. Loss of more than one-half of the terminal phalange of a member shall constitute loss of the phalange, or one-half of the finger. Loss of more than one phalange by amputation shall constitute loss of the digit, or all of the finger. More than one phalange means any bony loss in excess of the first phalange by reason of amputation but not the surgical rounding of the joint, or the smoothing of the articular surfaces, done for the convenience of the injured employee. Ordinarily, the base of the nail may be used as a gauge of half of the phalange. In disputed cases, more accurate measurements may be made by use of x-rays." (Effective March 1, 1982)

What this means is:

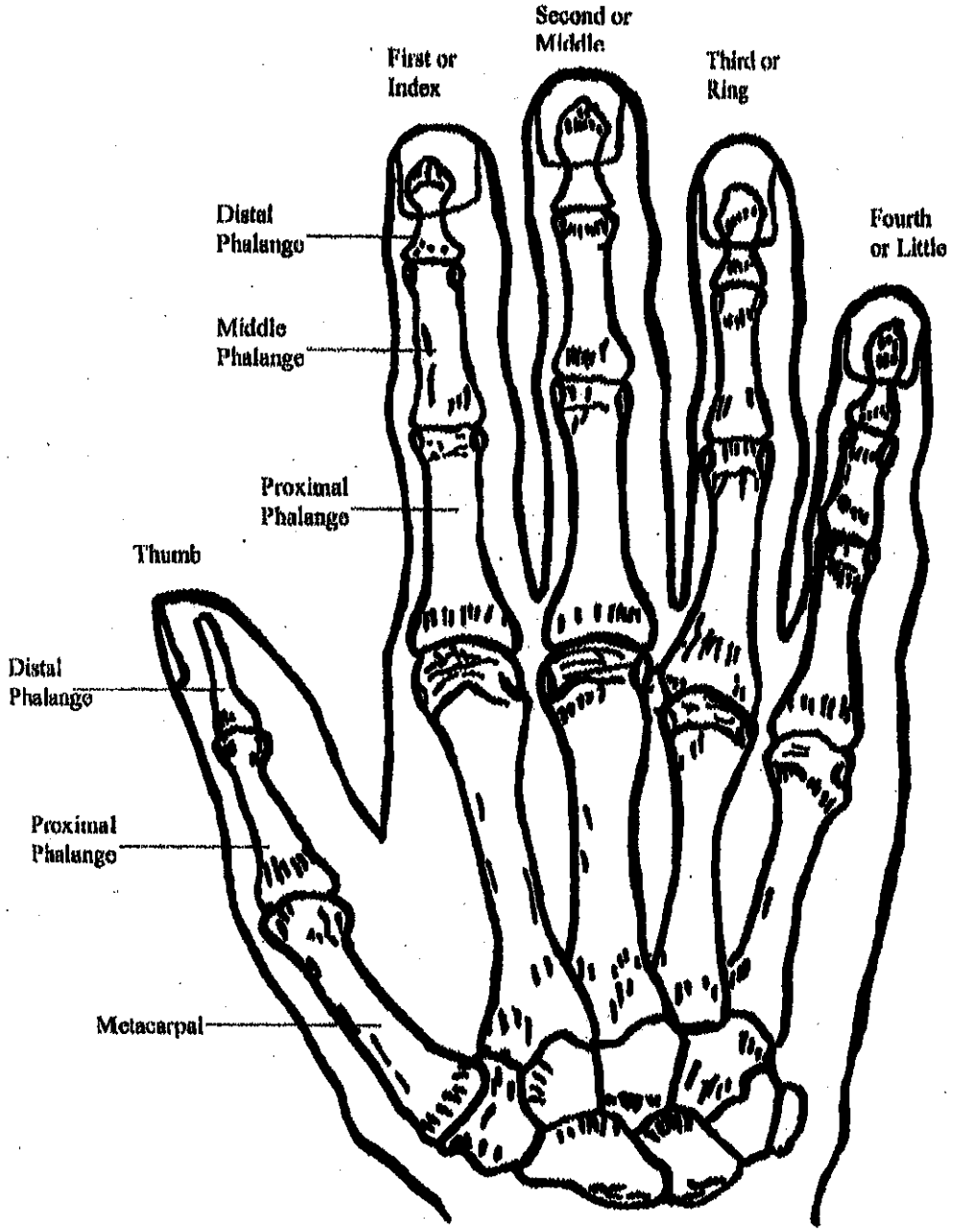
- Any loss of bone from the tip of the finger up to the nail bed (generally) is a 25% loss of that finger.
- Any loss of bone between the nail bed and first joint (DIP Joint) is a 50% loss of that finger.
- Any loss of bone beyond the first joint is a 100% loss of that finger and is paid at the TTD rate.

If the medical provider rates the amputation of a finger using the A.M.A. guides it can be rejected if it does not meet or exceed the rating that is warranted under Rule 099.12.

This is why we prefer the Hand Dismemberment Chart.

Also, A.C.A. § 11-9-521(d) provides that compensation for amputation or loss of use of two (2) or more digits or one (1) or more phalanges of two (2) or more digits of a hand or foot may be proportioned to the total loss of use of the hand or the foot occasioned thereby but shall not exceed the compensation for total loss of a hand or a foot.

Arkansas Workers' Compensation Commission
Hand Dismemberment Chart



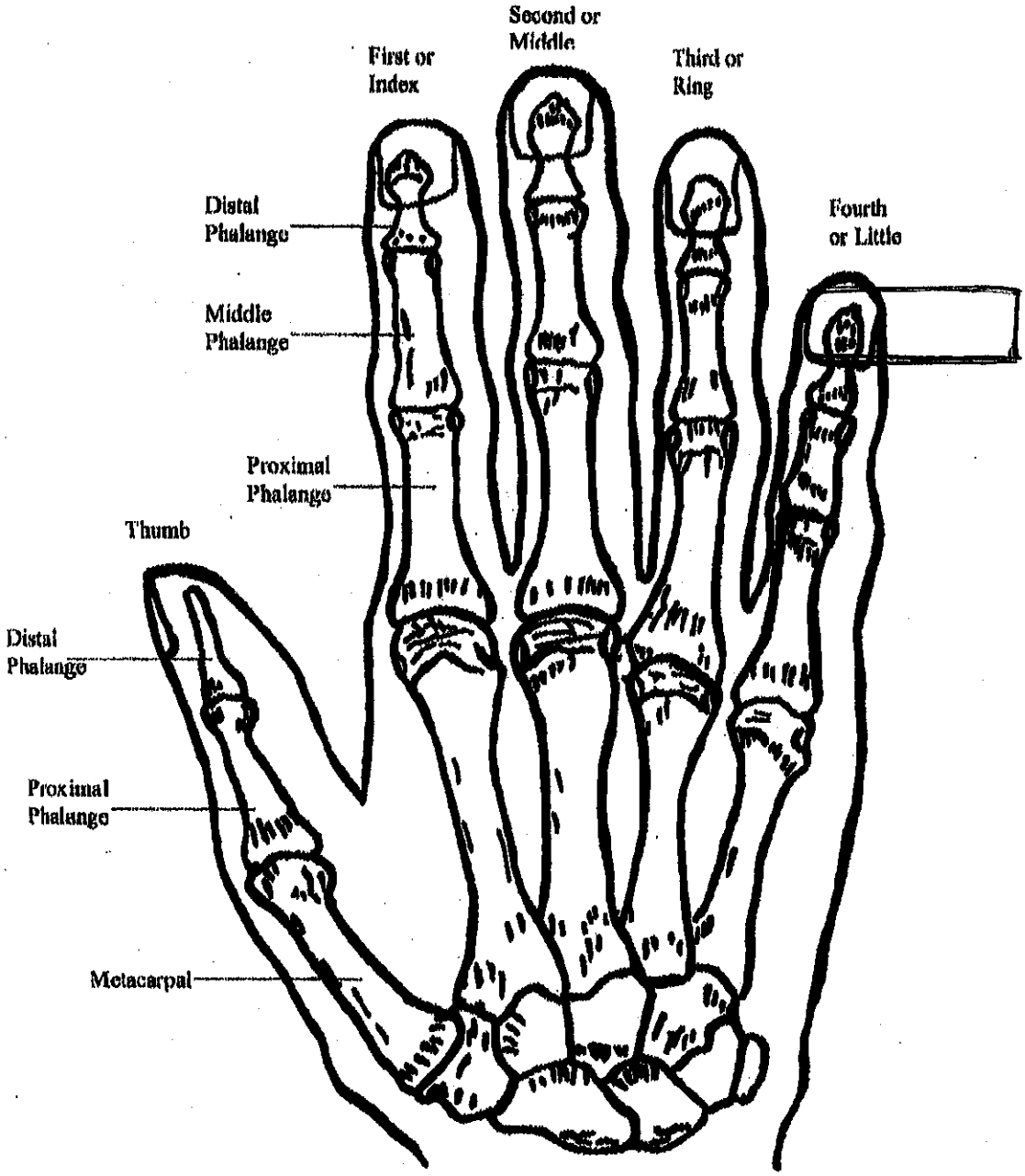
Injured Employee_____ AWCC Claim #_____

Right or Left Hand_____ Injury Date_____

Employer_____ Carrier Claim #_____

Marked by_____, M.D. Date_____

Arkansas Workers' Compensation Commission
Hand Dismemberment Chart



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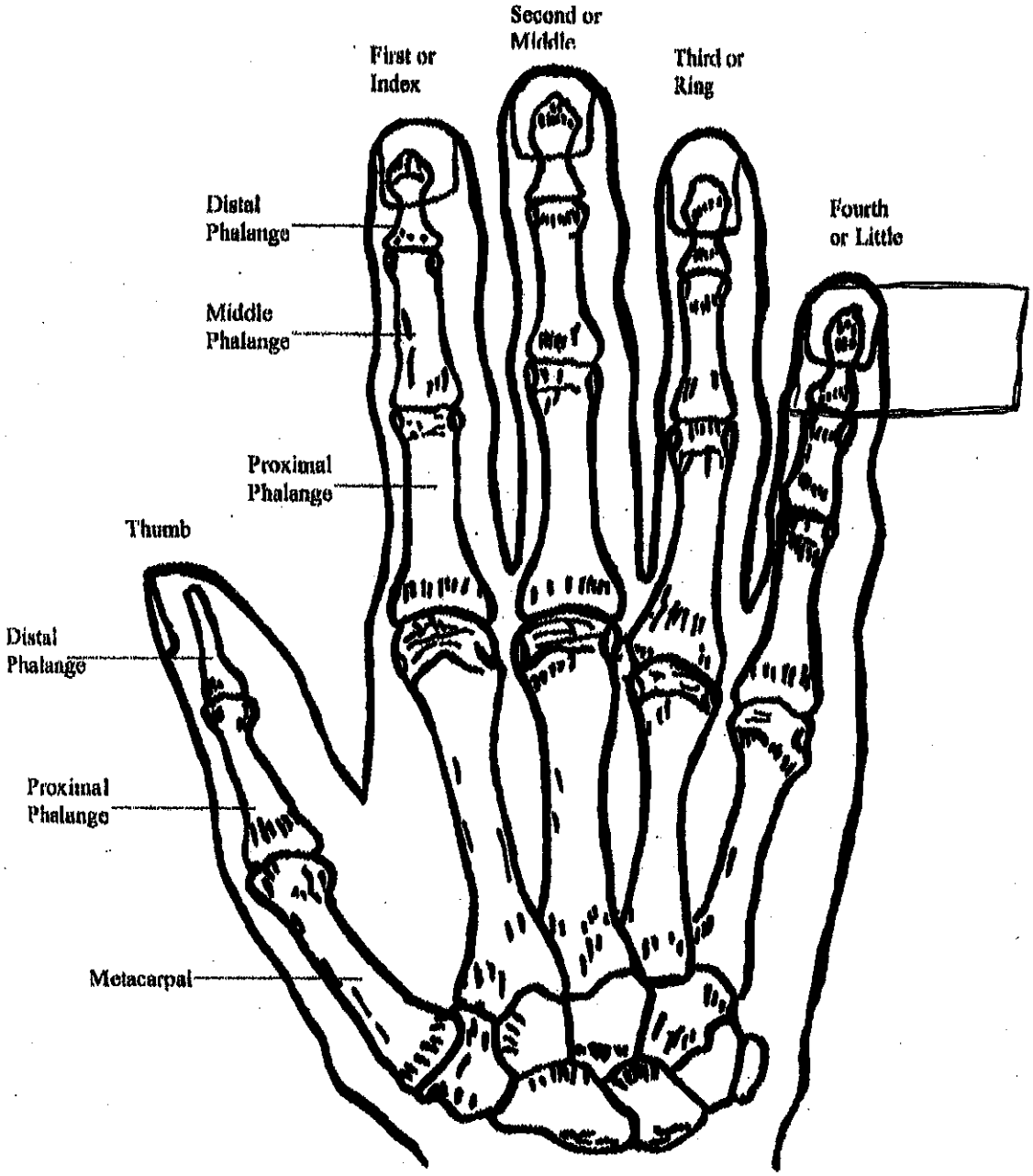
Arkansas Workers' Compensation Commission
Hand Dismemberment Chart



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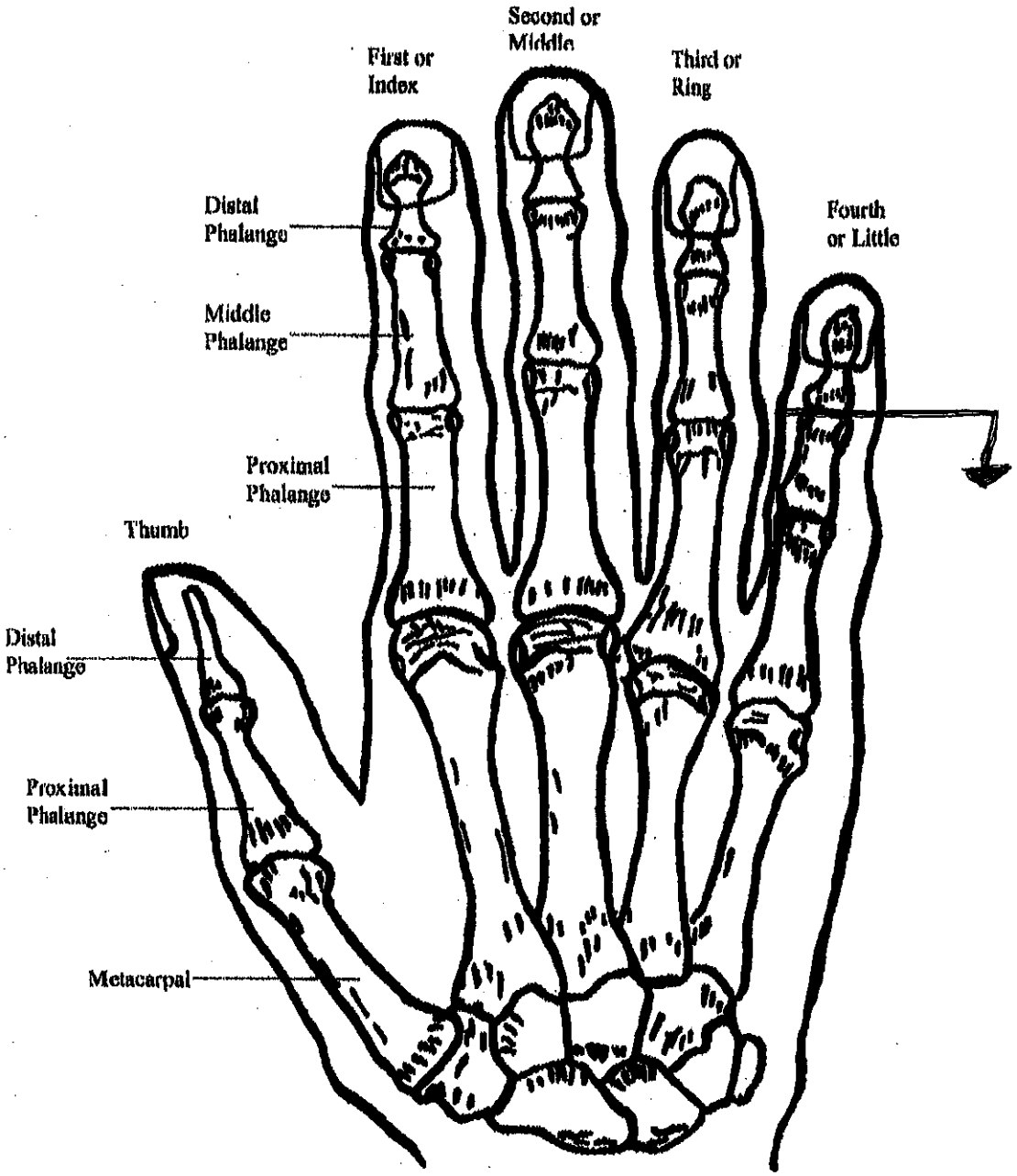
Hand Dismemberment Chart



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Marked by_____, M.D. Date_____