

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

SELECT ONE FILING TYPE:

- | | |
|--|---|
| <input type="checkbox"/> Closing Report
<input type="checkbox"/> Report of Payment Suspension | <input type="checkbox"/> Death/PTD Maximum Liability
<input type="checkbox"/> 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:		(9) Defense Attorney Fees _____
(1) TTD Weeks _____ Days _____ \$ _____	(2) TPD Weeks _____ Days _____	*(10) Other (Compensation Related) _____
(3) PPD Weeks _____ Days _____	(4) _____ Weeks PTD _____	(11) Hospital Expenses _____
(5) _____ Weeks for Death _____	(6) Lump Sum payment _____	(12) Medical Expenses _____
(7) Joint Petition settlement _____	(8) Claimant Attorney Fees _____	(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

AWCC Form 4
(Report of Payment)

A Final Report is due within 30 days of the last compensation payment. [Ark. Code Ann. § 11-9-810(b)(1)]

Every **Form 4** must provide the AWCC file number.

Form 4 is for all end-of-payment reports, i.e.:

1. The suspension of benefits; reason for suspension must be given.
2. The closing of a medical-only case that was accidentally opened by the respondent on **Form 1** or by a claimant on **Form C**.
3. The Final Report of a compensable case, detailing all payments. **Forms 1, 2, and 3** (or narrative medical report) are required for these cases.
4. Maximum liability being reached in cases involving death or permanent total disability (both the Compensation Section and the Suspension of Payments Section are to be completed). The box for Death/PTD Maximum Liability must be marked.
5. **Other* in (10) of the Compensation Information Section includes benefits not listed elsewhere, such as interest and penalties.
**Other* in (16) would include court reporter fees and mileage reimbursement.

Information on Form 4 may be supplied by the Support Services Division. For a specific case, refer to the Office Services Division, which processes Form 4 and closes the case. (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.”