



**State of Connecticut  
Workers' Compensation Commission**  
Please TYPE or PRINT IN INK

Rev. 3-17-2006

**1A**

# Filing Status and Exemption

This form must be executed in every case of compensable disability for injuries occurring ON OR AFTER October 1, 1991, and must be completed in its entirety.

WCC File # \_\_\_\_\_

Date filed in District \_\_\_\_\_

(for WCC use only)

**EMPLOYEE**

Name \_\_\_\_\_ Soc. Sec.# (optional) \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**FILING STATUS AND EXEMPTIONS** — In order to determine your weekly benefit rate, as per Sec. 31-310 C.G.S., we need the following information:

1. Select your Federal tax filing status based upon your ACTUAL filing status as of the date of injury listed at right:  
 Single     Head of Household     Married filing jointly     Married filing separately

2. Number of exemptions (including yourself) as of the date of injury listed at right = \_\_\_\_\_

3. Check all appropriate boxes:  
 Employee 65 years of age or older     Employee legally blind     Spouse 65 years of age or older     Spouse legally blind

4. FICA withheld for the above-named employee? .....  YES .....  NO — *If NO, insurer must manually calculate weekly benefit rate.*

5. List name (yourself first), date of birth, and relationship to you for all exemptions included in question #2, above:

Name	Date of Birth	Relationship
_____	_____	<b>SELF</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**CONCURRENT EMPLOYMENT** — To be certain you receive all the benefits to which you are entitled, provide the following information if you were working for more than one employer on the date of injury indicated above:

Name of Employer	Address	Date of Hire
_____	_____	_____
_____	_____	_____
_____	_____	_____

NOTE: Wage information for each concurrent employer must be supplied by the claimant.

**SIGNATURE OF INJURED WORKER OR REPRESENTATIVE**

**WARNING:** Any person who intentionally misrepresents or fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_