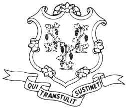

State of Connecticut
Workers' Compensation Commission
Please TYPE or PRINT IN INK

Rev. 6-14-2024

VA

Voluntary Agreement

This form is *NOT* a final settlement.

- **Review, sign, and submit ALL 4 COPIES. This does NOT close out your case.**
- **Your eligibility for Rehabilitation Services remains unaffected by this agreement.**
- **Certain individuals may be eligible to receive COLAs pursuant to C.G.S. § 31-307a.**

WCC File # ____________________
Insurer # ____________________

Date filed in District

(for WCC use only)

EMPLOYEE

Name ____________________
D.O.B. *(required)* ____________________
Address ____________________
City/Town ____________________ State ____________________
Zip Code ____________________ Tel.# ____________________

CONCURRENT EMPLOYMENT

❑ **Check, if employee had MORE THAN ONE employer**

If concurrently employed, see reverse side for directions.

EMPLOYER

Name ____________________
Address ____________________
City/Town ____________________ State ____________________
Zip Code ____________________ Tel.# ____________________
FICA withheld for the above-named employee? .... ❑ YES ❑ NO
Medicare .... ❑ YES ❑ NO

INSURER

Name ____________________ Pol.# ____________________
Address ____________________
City/Town ____________________ State ____________________
Zip Code ____________________ Tel.# ____________________

Third Party Administrator ____________________

INJURY

Date of Injury *(MM/DD/YY)* ____________________
Date Incapacity Began *(MM/DD/YY)* ____________________

City/Town of Injury ____________________
State ____________________ Zip Code ____________________

Cause of Injury ____________________
Describe Specific Body Part(s) Injured and Nature of Injury:

❑ Occupational Disease ❑ Repetitive Trauma

Name of Authorized Physician ____________________

COMPUTATION OF AVERAGE WEEKLY WAGE

❑ Check, if C.G.S. Sec. 5-142

The number of weeks worked*____________________ divided into the Gross Wages earned $____________________ equals the Average Weekly Wage $____________________
**52 weeks is the maximum number allowed*

IF THE BENEFIT IS FOR:

1 — **TOTAL** Incapacity, the Basic Compensation Rate is based upon the appropriate benefit rate table [C.G.S. § 31-307]. Employer to pay to employee $ ____________________ per week.

2 — **TEMPORARY PARTIAL** Incapacity, Light Duty Job Differential, and/or Job Search, benefit paid per benefit rate table to a maximum of $ ____________________ [C.G.S. § 31-308(a)].

3 — **PERMANENT PARTIAL** Disability, the Specific Award is paid at the Basic Compensation Rate [C.G.S. § 31-308(b)], according to the following:

(a) Employer to pay employee for ____________ % loss, or loss of use, of body part(s)*____________________ at $ ____________________ per week.
*INDICATE ❑ master OR ❑ non-master

Additional information *(if required)* ____________________

(b) Pursuant to C.G.S. § 31-308(b), the benefit computes to ____________ weeks beginning on *(MM/DD/YY)* ____________________ , the date of Maximum Medical Improvement.

(c) A Licensed Physician's Report, as well as Form 1A ("Filing Status & Exemption"), MUST be attached or this form will NOT be processed.

AGREEMENT AND APPROVAL

The Voluntary Agreement will NOT be processed without both signatures and the Form 1A, "Filing Status & Exemption".

The undersigned parties acknowledge and accept all of the facts stated above, subject to C.G.S. § 31-315.

____
Employee Signature *(and parent/guardian, if minor)* Date *(MM/DD/YY)*

____
Authorized Signature of Respondent Date *(MM/DD/YY)*

____
Name of Person Completing Form *(please print)* Tel. # *(area code + number + extension)*

WORKERS' COMPENSATION COMMISSION APPROVAL
(for WCC use only)

See reverse side for Calculations and Information on Concurrent Employment.

WORKSHEET

Calculating Concurrent Employment / Second Injury Fund Responsibility

(C.G.S. § 31-310)

Employee Name: ____________________

If the injured employee was working for more than one employer on the date of the injury, the employer in whose employ he/she was injured is responsible for (1) all medical costs and either (2) the entire weekly compensation rate *(if wages earned from this employer entitle the injured employee to the maximum compensation rate)* or (3) a pro rata portion of the weekly compensation rate based on the calculations below.

Only wages earned during the "weeks of concurrent employment" listed below (A) can be used in the calculations.

Weeks of Concurrent Employment:

from ____________________ to ____________________ **Total number of weeks =** ____________________ (A)

(MM/DD/YY) *(MM/DD/YY)*

Responsible Employer ____________________

Address ____________________

City/Town ____________________ State ____________________

Zip Code ____________________ Tel.# ____________________

Gross Wages earned from this employer during weeks of concurrent employment = $ ____________________ (B)

Concurrent Employer 1 ____________________

Address ____________________

City/Town ____________________ State ____________________

Zip Code ____________________ Tel.# ____________________

Gross Wages earned during weeks with Concurrent Employer 1 = $ ____________

Concurrent Employer 2 ____________________

Address ____________________

City/Town ____________________ State ____________________

Zip Code ____________________ Tel.# ____________________

Gross Wages earned during weeks with Concurrent Employer 2 = $ ____________

Add TOTAL Gross Wages earned from the Concurrent Employer(s) = $ ____________________ (C)

TOTAL GROSS WAGES

Total number of weeks worked concurrently for all employers listed above (same as A) **=** ____________________ (D)

Total Gross Wages earned from all employers during period of concurrent employment is (B) plus (C) **= $** ____________________ (E)

CALCULATION AND RESPONSIBILITY FOR PAYMENT OF BENEFITS

Average Weekly Wage for all employers is (E) divided by (D) **= $** ____________

(See the Benefit Rate Table that coincides with the date of injury.)

Total incapacity compensation rate for this AWW = $ ____________________ (F)

Average Weekly Wage for responsible employer is (B) divided by (D) **= $** ____________

(See the Benefit Rate Table that coincides with the date of injury.)

Total incapacity compensation rate for this AWW = $ ____________________ (G)

Amount of compensation to be contributed by the Second Injury Fund (Form 44) is (F) minus (G) **= $** ____________________ (H)