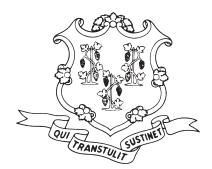
## NOTICE TO EMPLOYEES



**State of Connecticut Workers' Compensation Commission** 

Revised 10-01-2017

| The Workers' Compensation Act (Connecticut General State  | tutes Chapter 568  | 3) requires your employer,   |
|---|--|--|
| to provide benefits to you in case of injury or occupational  | l disease in the c   | ourse of employment.   |
| Section 31-294b of the Workers' Compensation Act states "in the course of his employment shall immediately report representing his employer. If the employee fails to report may reduce the award of compensation proportionately to has sustained by reason of the failure, provided the burd shall rest upon the employer."   | the injury to his of<br>the injury imme<br>o any prejudice t | employer, or some person diately, the commissioner hat he finds the employer |
| An injury report by the employee is NOT an official written notice of claim for workers' compensation benefits; the Workers' Compensation Commission's Form 30C is necessary to satisfy this requirement.   |  |  |
| NOTE: You must comply with P. A. 17-141 (see next box,  | below) when filin  | g a compensation claim.  |
| The INSURANCE COMPANY or SELF-INSURANCE ADMINISTRATOR is:  Name   |  |  |
| Address   |  |  |
| City/Town   | _ State  | Zip Code   |
| Approved Medical Care Plan  Yes  No   |  |  |
| The State of Connecticut Workers' Compensation Commis   |  | -  |
| Address   |  |  |
| City/Town   | _ State  |  |
| Public Act 17-141 allows an employer the option to designate and post – "in the workplace location where other labor law posters required by the Labor Department are prominently displayed" and on the Workers' Compensation Commission's website [wcc.state.ct.us] – a location where employees must file claims for compensation.  If your employer has listed a location below, you MUST file your compensation claim there.  When filing your claim, you are also required – by law – to send it by certified mail.  If blank below, ask your employer where to file your claim. |  |  |
| Employer Name   |  |  |
| Employer Name   |  |  |
| Address   |  |  |
|   | _ Telephone  |  |

THIS NOTICE MUST BE IN TYPE OF NOT LESS THAN TEN POINT BOLD-FACE AND POSTED IN A CONSPICUOUS PLACE IN EACH PLACE OF EMPLOYMENT. FAILURE TO POST THIS NOTICE WILL SUBJECT THE EMLOYER TO STATUTORY PENALTY (Section 31-279 C.G.S.).

Date Posted:

Any questions as to your rights under the law or the obligations of the employer or insurance company should be addressed to the employer, the insurance company, or the Workers' Compensation Commission (1-800-223-9675).