



**CONNECTICUT  
INTERLOCAL  
RISK  
MANAGEMENT  
AGENCY**

P.O. Box 9558  
New Haven, CT 06535-0558  
Telephone (203) 946-3700  
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**WORKERS' COMPENSATION CLAIMS STATUS**

Claimant's Name \_\_\_\_\_ File Number \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Claimant Status

*– Please check all boxes that apply and provide information where requested –*

- I am receiving salary continuation in the amount of \$\_\_\_\_\_ per\_\_\_\_\_ from \_\_\_\_\_.
- I am receiving Workers' Compensation benefits in the amount of \$\_\_\_\_\_ per\_\_\_\_\_ from \_\_\_\_\_.
- I am not working for any other employer, nor am I self-employed.
- I am receiving disability insurance (short term/long term) from \_\_\_\_\_ in the amount of \$\_\_\_\_\_.
- I am working:  
Return to work date: \_\_\_\_\_.  
Name, address of employer(s) \_\_\_\_\_  
\_\_\_\_\_  
Name, telephone number of supervisor: \_\_\_\_\_  
\_\_\_\_\_

Gross weekly income: \$\_\_\_\_\_

- I am self-employed.  
Gross weekly income: \$\_\_\_\_\_
- Name, address of business: \_\_\_\_\_  
\_\_\_\_\_
- Type of Business: \_\_\_\_\_
- Tax Identification Number: \_\_\_\_\_

*– Please return this form within 30 days of receipt.  
If you have any questions, please call the assigned adjuster –*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

