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)