

COMPLETE THIS AFFIDAVIT AND
 RETURN TO:
 Department of Labor and Industries
 Division of Insurance Services
 PO Box 44291
 Olympia WA 98504-4291



AFFIDAVIT for TIME-LOSS COMPENSATION

Claim Number
Name (Please Print)

Due to my work-related injury/illness, I didn't work and I wasn't able to work from _____
 to _____.

Check one box on each line to complete the statements below:

- I have** **have not** been self-employed during this period.
- I have** **have not** performed any work, paid or unpaid, including but not
 limited to COPEs or CHORE Services, or volunteer work,
 due to a work-related injury/illness.
- I have** **have not** applied for or received unemployment benefits during this
 period.
- I have** **have not** received Social Security benefits during this period.
- I have** **have not** applied for or received benefits from DSHS during this
 period.
- I have** **have not** been convicted of a crime and under sentence at any time
 during this period.

By signing below, I certify under penalty of perjury under the laws of the State of Washington
 that the foregoing is true and correct and further that:

I understand that if I make a false statement about my activities or physical condition, I will be
 required to refund my benefits, and I may face civil or criminal penalties.

I understand I must immediately contact my claim manager if I perform any work (paid or
 unpaid) , if my doctor releases me for work, if I am incarcerated and under sentence, if the
 custody of my children changes, and if I apply for or receive Social Security benefits or DSHS
 benefits.

 Signature

 Date

MAILING Address			RESIDENCE Address:		
City	State	ZIP	City	State	ZIP
Residence is the same as MAILING address: Yes <input type="checkbox"/> No <input type="checkbox"/>					