# DAS
# Concurrent Employment Third Party Liability Form

***Per WC-211 Rev. 2/05***

## *EMPLOYEE TO COMPLETE*

| | |
|---|---|
| Employee Name (last) (First) (MI) | Social Security Number |
| Address (No. and Street) | Telephone Number |
| City or Town | Date of Injury |
| Employing State Agency | Date of Birth |
| Address of Employing Agency (No. and Street) Zip | Date First Employed by State |

## *EMPLOYEE INSTRUCTIONS*

The information requested on concurrent employment below is necessary to determine your Workers' compensation benefit rate:

1. You must complete this form for every Workers' Compensation claim you file.
2. You must keep the information contained in this form current while you are receiving Workers' Compensation benefits.
3. You must return this form to your personnel office within three days.

Note: If your claim is for Temporary Total or Temporary Partial disability benefits, you must advise your employer of any other earnings while receiving these benefits. Failure to do so may result in civil and/or criminal liability.

## *CONCURRENT EMPLOYMENT* CHECK IF ANY OF THE FOLLOWING APPLY: ☐ NONE

☐ Employed by Another State Agency ☐ Employed Outside State Government

| | | |
|---|---|---|
| Name of Other Employer | Supervisor's Name | Telephone Number of Employer |
| Address of Employer (No. and Street) | City or Town | State Zip |

## *THIRD PARTY LIABILITY INFORMATION*

1. Was the cause of your accident/injury the result of the actions of a party other than you or your employer?

Yes ☐ No ☐

If you checked yes, please describe the facts.

Name the Third Party _____

Address _____

Insurance Carrier of Third Party _____

2. Were there any witnesses?

Yes ☐ No ☐

Name of witnesses _____

3. Have you initiated a claim against this responsible Third party?

Yes ☐ No ☐ Date _____

I DECLARE THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND I AM AWARE THAT PROVIDING FALSE INFORMATION MAY RESULT IN CIVIL, OR CRIMINAL LIABILITY.

Signature _____ Date _____