

Agreement to Pay Benefits
 (formerly: Memorandum of Agreement)
 Virginia Workers' Compensation Commission
 1000 DMV Drive Richmond VA 23220
SEE INSTRUCTIONS ON REVERSE SIDE

The boxes to the right are for the use of the Insurer	Reserved	VWC file number
	Insurer code	Insurer location
	Insurer claim number	

Employer	
Name of employer (trading as or doing business as, if applicable)	Address
Phone number	Federal Tax Identification Number
Is this worker covered by a PEO policy <input type="checkbox"/> YES <input type="checkbox"/> No	

Employee	
Name of employee	Phone number
Address	Date of birth
	Social security number

Time and Place of Accident		
City where injury or illness occurred	Cause of injury or illness	
Nature of injury or illness, including parts of body affected		
Date of injury or illness	List first seven days of incapacity	Pre-injury Average Weekly Wage

Terms of Agreement	
<p>We certify that the facts relating to this accident are correct as presented on this form, and agree that the employee shall receive the compensation or benefits indicated below until terminated in accordance with the provisions of the Workers' Compensation Act.</p>	
<div style="border: 1px solid black; padding: 5px; width: fit-content;">Temporary Total</div>	\$_____ shall be paid per week beginning ___/___/___ based on a pre-injury average weekly wage of \$_____
<div style="border: 1px solid black; padding: 5px; width: fit-content;">Temporary Partial</div>	\$_____ shall be paid per week beginning ___/___/___, the date on which claimant returned to work at a weekly wage of \$_____ compared to a pre-injury average weekly wage of \$_____
<div style="border: 1px solid black; padding: 5px; width: fit-content;">Permanent Partial</div>	\$_____ shall be paid per week for _____ weeks beginning ___/___/___, based on a ___% loss (or loss of use) of the _____, and a pre-injury average weekly wage of \$_____. This compensation shall be payable _____
<div style="border: 1px solid black; padding: 5px; width: fit-content;">Medical only</div>	<input type="checkbox"/> (Check here.) The parties agree to an award for payment of medical bills related to the compensable injury.

Signatures			
Employer	Print Name	Phone ()	Date / /
Employee, guardian, or committee	Print Name	Phone ()	Date / /
Insurer or authorized representative (signature of processor)	Print Name	Phone ()	Date / /
Name and address of Insurer	This space reserved for Commission use Fee Approved by: _____ Date _____		
Name and address of employee's attorney (if represented)			

This report is required by the Virginia Workers' Compensation Act

INSTRUCTIONS

Agreement to Pay Benefits (formerly Memorandum of Agreement) VWC Form No. 4

1. Fill out this form whenever a claim has been accepted as compensable. This Agreement to Pay Benefits provides the basis for the initial award of compensation, and contains sufficient information to establish the essential elements of a compensable claim. Submit the form to the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond VA 23220. For subsequent periods of compensation, a Supplemental Agreement to Pay Benefits (VWC Form 4A) must be filed.
2. The signatures of the employee and a representative of the employer or insurer (including the insurer's name) are required. If these signatures are missing, this form will be returned.
3. The information at the top right of the form should be provided by the insurer. Please note that the insurer code refers to the five-digit number assigned by NCCL. Self-insured employers are assigned a similar five-digit number by the Virginia Workers' Compensation Commission.
4. When filling out this form, please be sure to provide a brief description of how the accident or illness occurred in the "Cause of Accident" box, and to indicate all parts of the body affected in the "Nature of Injury" box.
5. Note that compensation is paid beginning with the eighth (8th) day of disability. If the disability lasts more than 21 days, then compensation is owed retroactively for the first seven (7) days of disability.
6. Additional copies of this form are available without cost by writing to the Commission. Please note that color coding of the forms greatly increases the Commission's efficiency in processing claims, and that any alternative versions of the form you develop yourself require prior approval by the Commission. Write to "Forms" at the listed Virginia Workers' Compensation Commission address.