

Termination of Wage Loss Award

(formerly: Agreed Statement of Fact)

Virginia Workers' Compensation Commission

1000 DMV Drive Richmond VA 23220

SEE INSTRUCTIONS ON THE REVERSE SIDE OF THIS FORM

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 (see Employer's First Report)	Address
Phone number	Federal Tax Identification Number
Employee	
Name of employee	Address
Phone number	Social Security Number

Terms of Agreement					
<p>Payments of compensation under the outstanding award for the accident occurring on _____ are terminated for the reason indicated below.</p> <p>1. <input type="checkbox"/> The employee returned to work on _____ at a wage equal to or greater than the pre-injury average weekly wage of \$ _____</p> <p>2. <input type="checkbox"/> The employee was able to return to his/her pre-injury work on _____</p> <p>3. <input type="checkbox"/> The employee returned to work on _____ at a lower-than-pre-injury wage in the amount of \$ _____ (A Supplemental Agreement to Pay Benefits must be attached and the outstanding award will be terminated and an award for temporary partial benefits will be entered.)</p> <p>TOTAL AMOUNT OF COMPENSATION PAID THROUGH ABOVE DATES _____</p> <p>TOTAL COST OF LIVING ADJUSTMENT PAID THROUGH ABOVE DATES _____</p> <p>This agreement is subject to the Commission's approval. Signing this form is NOT a requirement for payment of compensation, and does not terminate the right to future compensation. See "Employee" section on the reverse of this form.</p>					
<table border="1"> <tr> <td colspan="2">(This space for Commission use only)</td> </tr> <tr> <td>Approved by:</td> <td>Date:</td> </tr> </table>		(This space for Commission use only)		Approved by:	Date:
(This space for Commission use only)					
Approved by:	Date:				

(This space reserved for use by the insurer or employer)					
Payment type	Compensation rate	Beginning date	Ending date	Total weeks paid	Amount paid
_____	\$ _____	_____	_____	_____	\$ _____
_____	\$ _____	_____	_____	_____	\$ _____
_____	\$ _____	_____	_____	_____	\$ _____
_____	\$ _____	_____	_____	_____	\$ _____

Signature of Employee, guardian, or committee	Date	Print Name	Phone ()
Insurer or authorized representative (signature of processor)	Date	Print Name	Phone ()
Name of Insurer	Third Party Administrator and Address (if applicable)		

INSTRUCTIONS

Termination of Wage Loss Award (formerly Agreed Statement of Fact) VWC Form No. 46

Insurer or authorized representative

1. Fill out this form to report compensation payments or Cost-of-Living supplements that have ended. Submit the form to the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond VA 23220.
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 NCCI. Self-insured employers are assigned a similar five-digit number by the Virginia Workers' Compensation Commission.
4. Check the appropriate reason for the termination of the award, and list separately at the bottom of the form the compensation paid for each period and type of payment.* Do not report anything that has been previously reported. If additional space is needed, use a separate sheet of paper with the same column headings.
5. 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 alternate versions of the form you develop yourself require prior approval by the Commission. Write to "Forms" at the listed Virginia Workers' Compensation Commission address.

Employee

The signing of this document is not a requirement for payment. Should you have any further disability, your claim can be reopened with the following limitations:

1. If the claim is for wage loss benefits, your claim must be reopened within 24 months from the last date for which compensation was paid under an Award.
2. If the claim is for permanent disability, it must be made within 36 months from the last date for which compensation was paid under an Award.

If such additional compensation is awarded at a hearing, the new period of compensation will not begin earlier than 90 days before you file an application for the hearing.

*The valid payment types are:

TT	Temporary Total
TP	Temporary Partial
PP	Permanent Partial (specific disability)
PT	Permanent Total
LS	Lump Sum
CL	Cost-of-Living
FT	Compensation paid in a fatal claim
FE	Funeral expense