

Supplemental Agreement to Pay Benefits
 (formerly: Supplemental 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 (see Employer's First Report) | Address |
| Phone number | Federal Tax Identification Number |

| | | |
|---------------------------|-------------------------------------|---|
| Employee | | |
| Name of employee | Phone number | Cause of injury/ illness |
| Address | Date of birth | Nature of injury/ illness (incl. body parts) |
| | Social security number | City or county where injury/illness occurred: |
| Date of injury or illness | List first seven days of incapacity | |

| | |
|---|--|
| Temporary Total | |
| \$ _____ shall be paid per week during total incapacity, beginning ____ / ____ / ____ | |

| | |
|--|--|
| Temporary Partial | |
| \$ _____ shall be paid per week during partial incapacity beginning ____ / ____ / ____, based on a current weekly wage of \$ _____, compared to a pre-injury average weekly wage of \$ _____ | |

| | |
|--|--|
| Permanent Partial | |
| \$ _____ shall be paid per week for a period of _____ weeks beginning ____ / ____ / ____, based on _____% loss (or loss of use) of the _____, payable _____ <small>(body part) (payment interval)</small> | |

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

INSTRUCTIONS

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

1. Fill out this form whenever additional periods of compensation occur for an accident or illness for which an initial Agreement to Pay Benefits has already been submitted. 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 NCCL. Self-insured employers are assigned a similar five-digit number by the Virginia Workers' Compensation Commission.
4. When completing this form, please be sure to provide a brief description of how the injury or illness occurred in the "Cause of injury/illness" box, and to indicate all parts of the body affected in the "Nature of injury/illness" box.
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 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.