Award Agreement

(Agreement to Pay Benefits)

Virginia Workers' Compensation Commission
1000 DMV Drive Richmond Virginia 23220
1-877-664-2566

SEE INSTRUCTIONS ON REVERSE SIDE

www.vwc.state.va.us

Jurisdiction Claim #: _____

Claim Administrator #: _____

Injured Worker's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: ( ) -

Employer's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer's Phone: _____

Body Parts/Injuries Accepted: _____

Date of Injury: _____ **Pre-Injury Average Weekly Wage:** _____

Payment of Compensation Check one: ☐ Initial period ☐ Additional period ☐ Corrected period
(Check all that apply)

☐ A. **Temporary Total** at the compensation rate of $_____ per week. This period of disability began on _____ (m/d/yyyy).

☐ B **Temporary Partial:** Please select option 1 or 2 below and complete.

☐ 1 - Will be paid at the compensation rate of $_____ per week. This period of disability began on _____ (m/d/yyyy)

☐ 2 - Was paid an averaged weekly compensation rate of $_____ per week from _____ through _____ and will continue to be paid at a compensation rate of $_____ per week beginning on _____ (m/d/yyyy)

☐ C. **Permanent Partial** at the compensation rate of $_____ per week. This period of disability began on _____ (m/d/yyyy) for _____%
☐ loss of use, ☐ loss, or ☐ disfigurement of the _____. **Note: Medical report(s) or amputation chart must be attached.**

Do the parties agree to have this award paid in a lump sum with the 4% discount deducted? ☐Yes ☐No

☐ D. **Permanent Total** the compensation rate of $_____ per week. This period of disability began on _____ (m/d/yyyy) .

☐ E. **Medical Only**. The parties agree to an award for payment of medical benefits that are reasonable, necessary, authorized and causally related to the compensable injury.

THIS AGREEMENT IS SUBJECT TO ADJUSTMENT AND APPROVAL BY THE COMMISSION PURSUANT TO THE VIRGINIA WORKERS' COMPENSATION ACT

Signatures REQUIRED

By signing below, we certify that the facts relating to this accident are correct as presented on this form and agree that the Injured Worker shall receive compensation or benefits indicated until suspended in accordance with the provisions of the Virginia Workers' Compensation Act.

Signature of Injured Worker	Print Name	Date (m/d/yyyy)
Signature on behalf of the Employer/Insurer	Print Name	Date (m/d/yyyy)
Print Name and Address of Claim Administrator		Phone Number
Print Name and Address of Injured Worker's Attorney		Phone Number

Award Agreement
VWC Form #4

Filing Instructions

1. This form is to be completed whenever a claim has been accepted as compensable and the Injured Worker is entitled to an award. This Award Agreement provides the basis for the award of compensation and contains sufficient information to establish the essential elements of a compensable claim. Submit the completed form to the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, VA 23220. For subsequent periods of compensation benefits, this form should be used or a Varying Temporary Partial Award Agreement (VWC Form No. 4G) must be filed.

2. Definitions of Benefit Types:

   Temporary total (TT) disability – Injured Worker is totally disabled from work and is entitled to receive compensation for a period of total wage loss based upon 66 2/3% (.66667) of the pre-injury average weekly wage.*
   Temporary partial (TP) disability – Injured Worker is partially disabled from work but is entitled to receive compensation for a period of partial wage loss based upon 66 2/3% of the difference between the pre-injury average weekly wage and the post (current) average weekly wage. Forms received without specific dollar amounts or those that reflect the word "various" will be rejected. *

Calculation of Temporary Partial Rate:		Average weekly wage before injury	$
	–	Current weekly wage	$
All Amounts are Based on Weekly Figures	=	Difference in wages before injury and now	$
	x	.66667	$
		Temporary Partial Compensation Rate	**$**

   Permanent partial (PP) disability – Injured Worker is entitled to receive compensation based upon the loss of use or the loss of a ratable body part, based upon 66 2/3% (.66667) of the pre-injury average weekly wage for a specified number of weeks, pursuant to Va. Code §65.2-503. Please attach a copy of the medical report or the amputation chart that supports the permanency rating to the agreement form. If Permanent Partial is for disfigurement, the Commission must set the rating based on submitted photographs.*
   Permanent Total – Injured Worker is permanently and totally disabled from work and is entitled to receive compensation for the remainder of his/her life based upon 66 2/3% (.66667) of the pre-injury average weekly wage.*
   Medical Only – The parties agree that the Injured Worker sustained a compensable injury for which the employer and insurer will accept responsibility only for the medical expenses incurred as a result of a work related injury or occupational disease.

   * Compensation rate is subject to yearly maximum and minimum allowances.
   ** All wage information and compensation rate(s) reflected on the form(s) should be based on weekly figures.

3. For questions or assistance with completing this form, please contact Customer Assistance using the Commission's toll-free number 877-664-2566.