COMPLETE THIS AFFIDAVIT AND RETURN TO:
Department of Labor and Industries
Division of Insurance Services
PO Box 44291
Olympia WA 98504-4291

AFFIDAVIT for TIME-LOSS COMPENSATION

Claim Number
Name (Please Print)

Due to my work-related injury/illness, I didn't work and I wasn't able to work from _____ to _____.

Check one box on each line to complete the statements below:

☐ I **have**	☐ **have not**	been self-employed during this period.
☐ I **have**	☐ **have not**	performed any work, paid or unpaid, including but not limited to COPES or CHORE Services, or volunteer work, due to a work-related injury/illness.
☐ I **have**	☐ **have not**	applied for or received unemployment benefits during this period.
☐ I **have**	☐ **have not**	received Social Security benefits during this period.
☐ I **have**	☐ **have not**	applied for or received benefits from DSHS during this period.
☐ I **have**	☐ **have not**	been convicted of a crime and under sentence at any time during this period.

By signing below, I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct and further that:

I understand that if I make a false statement about my activities or physical condition, I will be required to refund my benefits, and I may face civil or criminal penalties.

I understand I must immediately contact my claim manager if I perform any work (paid or unpaid) , if my doctor releases me for work, if I am incarcerated and under sentence, if the custody of my children changes, and if I apply for or receive Social Security benefits or DSHS benefits.

_____ _____

Signature Date

MAILING Address			RESIDENCE Address:		
City	State	ZIP	City	State	ZIP
Residence is the same as MAILING address: Yes ☐ No ☐					