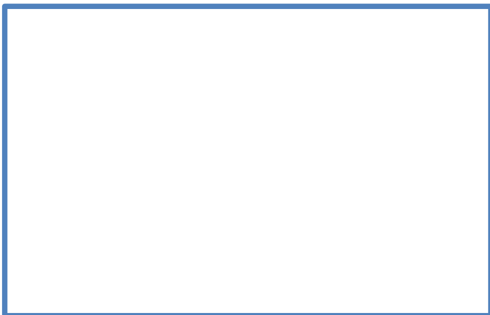
Mashantucket Pequot Tribal Nation
Workers' Compensation Commission
P.O. Box 3060
Mashantucket, CT 06338-3060
Phone (860)396-2424 Fax (860)396-2060
MPTNWCC@mptn-nsn.gov



Filing Status & Exemption Form

This form must be executed in every case of compensable disability for injuries occurring ON OR AFTER July 1, 1997 and must be completed in its entirety.

Injured Worker Information

Name: ____

Address: ____

____
City/Town State Zip Code

Date of Injury: ______________________ Claim #:______________________
Month Day Year

Filing Status and Exemptions

In order to determine your weekly benefit rate the following information is needed:

1.) Select your Federal tax filing status based upon your ACTUAL filing status as of the date of injury indicated above.

☐ **Single** ☐ **Head of Household**

☐ **Married filing jointly** ☐ **Married filing separately**

2.) Number of exemptions (including yourself) as of the date of injury listed at right = ____________

3.) Check all appropriate boxes:

☐ **Employee 65 yrs. of age or older** ☐ **Employee legally blind**

☐ **Spouse 65 yrs. of age or older** ☐ **Spouse legally blind**

4.) FICA withheld for the above-named employee? ☐ Yes ☐ No *(If NO, Insurer must manually calculate weekly benefits rate.)*

5.) List name (yourself first), date of birth and relationship to you for all exemptions included in question #2, above:

Name	Date of Birth	Relationship
____________	____________	Self
____________	____________	____________
____________	____________	____________
____________	____________	____________

Concurrent Employment

At the time of our injury were you employed by anyone in addition to MPGE or MPTN? ☐ Yes ☐ No

If **YES**, to be certain you receive all the benefits to which you are entitled please provide the following information for other employer on the date of injury indicated above:

Name of Employer	Address	Date of Hire
____________	____________	____________ (Month Day Year)

NOTE: Wage Information for each concurrent employer must be supplied by the claimant.

Signature of Injured Worker or Representative

WARNING: Any person who intentionally misrepresents or fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Employee's Signature ______________________ Date ______________________
Month Day Year

Revised 11/5/14