SOUTH DAKOTA DEPARTMENT OF LABOR AND REGULATION **DIVISION OF LABOR AND MANAGEMENT**
Tel: 605.773.3681 dlr.sd.gov

CALCULATION OF COMPENSATION

Claim Administrator Information:

Claim Administrator Federal ID No _____ **Carrier Code** _____ **Claim #** _____

Name (DBA) _____

Address _____ **City** _____ **State** _____ **Zip** _____

Telephone Number _____ **Form Completed By** _____

Employer Information:

Employer Federal ID No _____ **Employer Name (DBA)** _____

Employee/Injury Information:

Employee/Claimant SSN _____ **Date of Injury** _____

Body Part(s) Injured _____ _____ _____ _____

Employee/Claimant Name _____ _____ _____
(Last) (First) (MI)

Compensation Information:

Date Disability Began _____ **Gross Average Weekly Wage:** _____

Please attach a statement of all wages the claimant is known to have been receiving from this or any other employment at the time immediately preceding the injury. If no wage statement is available please explain how the average weekly wage was calculated.

Compensation will be paid at the rate of _____ **per week, to be paid (please indicate one of the following)**

◯ **Weekly** ◯ **Bi-Weekly** ◯ **Monthly** ◯ **Other (please specify)** _____

beginning _____ **until terminated in accordance with the provisions of the Workers' Compensation Laws of the State of South Dakota.**

This document does not constitute an agreement, stipulation, or release. This document does not affect the employee's right to seek benefits, including a change in the rate of compensation, nor does it restrict the employer/insurer's right to deny any claim. This form is meant to lead to an understanding between the parties regarding the rate of compensation.

No party is required to sign this form in order to make payments or receive payment of benefits.

Claimant/Employee Signature _____ **Date** _____

Employer Signature _____ **Date** _____

Claim Administrator Signature _____ **Date** _____

Completed and signed form should be mailed to the insurance company