

FORM RQ-01

REQUEST FOR VERIFICATION OF BENEFICIARY | PAYMENT RECIPIENT (ASG CLAIMS ONLY)

Instructions: For an official letter or notice to verify a person as workmen’s compensation beneficiary or a payment recipient for temporary wage benefits, the applicant must complete and submit this request form to the Commission’s Office. A verification letter will be facilitated for issuance within 5-days from the filing date. A service fee may be charged.

1. Name of Person Filing this Request: (First, Middle, Last)	2. Name of Employee, Beneficiary, or Payment Recipient:	3. Date this Request is Made:
4. Indicate the type of benefit the beneficiary is currently receiving payments for: <input type="checkbox"/> Death benefits <input type="checkbox"/> Permanent Total Disability <input type="checkbox"/> Permanent Partial Disability <input type="checkbox"/> Temporary Total Disability (TTD) <input type="checkbox"/> Temporary Partial Disability (TPD)	5. How is the benefit payment is disbursed? <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Other (specify):	6. Specify the total payment received (\$): \$ _____
7. Provide name of the intended person or entity requiring the verification letter:	8. Provide the specific Title of the person or Office Division:	
8. Indicate purpose for the Verification Letter or Notice: <input type="checkbox"/> Personal Financial Loan <input type="checkbox"/> Social Security / Retirement Benefits <input type="checkbox"/> Government Assistance Program (e.g., Food Stamp, WIC, etc.). <input type="checkbox"/> Medical Insurance or Other Insurance Purposes <input type="checkbox"/> Employment Purposes <input type="checkbox"/> Other Purposes (specify below):	9. Employee or Beneficiary Contact Information: Mailing Address: _____ _____ _____ Telephone: _____ E-mail Address): _____	
8. Authorization: <i>I hereby verify before the Commission as the employee or beneficiary, or person authorized on behalf of the beneficiary or employee, filing this request form for the intended purpose as stated herein. I duly acknowledge that all the information provided as required within this form are both true and not fraudulent and being answered to the best of my knowledge. I will also furnish and provide any relevant documentation requested by the Commission’s Office to properly facilitate my request.</i> _____ Authorized Signature _____ Date	FILED *** AUTHORIZED OWCC PERSONNEL ONLY **** 	