WC-3 (Rev. 3/92)

# WC-3 CARRIER'S CASE REPORT

| Case No. |
|---|
| FOR OFFICE USE ONLY<br>Date Received<br>Mo. / Day / Yr. |
| Carrier Case No. |
| Carrier I.D. |

CLAIMANT NAME AND ADDRESS

SOC. SEC. NO. _____

DATE OF INJURY/ILLNESS _____

EMPLOYER _____

CARRIER _____

ADJUSTER _____

ADDRESS _____

INDIVIDUAL TO CONTACT _____

TELEPHONE NO. _____

**CHECK ONE:**

1. ☐ DATE OF FIRST INCOME REPLACEMENT PAYMENT: MO. / DAY / YR.
2. ☐ REOPEN CASE
3. ☐ HEARING REQUESTED
4. ☐ NO LOST TIME/MEDICAL ONLY – PAYMENT DATE MO. / DAY / YR.
5. ☐ FINAL PAYMENT TO PREVIOUSLY ENDED CASE FOR _____
6. ☐ YEAR END REPORT FOR _____
7. ☐ FINAL REPORT (COPY TO EMPLOYEE) FOR _____

NOTE: WHEN 4, 5, 6 & 7 ARE CHECKED, PAYMENT BLOCK MUST BE FILLED IN.

RETURN TO WORK DATE: MO. / DAY / YR.

WEEKLY COMP. RATE _____

| BENEFIT PAYMENTS | Days | Payments Not Previously Reported | Prior Payments | Total Payments Made to Date |
|---|---|---|---|---|
| 1. Temporary Total * | | $ | $ | $ |
| 2. Temporary Partial * | | $ | $ | $ |
| 3. Permanent Total | | $ | $ | $ |
| 4. Permanent Partial | | $ | $ | $ |
| 5. Death | | $ | $ | $ |
| 6. Disfigurement | | $ | $ | $ |
| 7. Medical/Other Costs | | $ | $ | $ |
| 8. Services of Attendant | | $ | $ | $ |
| 9. Rehabilitation | | $ | $ | $ |

Carrier's Comments: _____

Medical Deductible:

*List Date(s) of Disability in Carrier's Comments Section.

I hereby certify the accuracy of all of the above statements.

NOTICE TO EMPLOYEE: With the final payment of compensation (as indicated hereon) on your industrial injury of ____/____/____ (month day year), identified as Case No. _____, the case shall be closed. This determination shall not constitute a bar to your reopening rights as provided by Section 386-89, HRS, nor to future medical benefits.

SIGNATURE _____

POSITION _____

DATE _____