Form AR-D	ARKANSAS WORKERS' COMPENSATION COMMISSION 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	D
Authority: Ark. Code Ann. §11-9-502 & Rule 28 Revised: 1-1-2001		

DEATH and PERMANENT TOTAL DISABILITY ACCEPTANCE/UPDATE

❑ **Initial Report** ❑ **Amended Report**

AWCC File No.	Carrier Claim No.	Employee Name (Last, First, MI)	Employee SS Number

Employer Name	Employer FEIN No.	City	State	Zip Code

Carrier or Self-Insured Name	NAIC No.	Claims Office Location (City, State)

CASE INFORMATION

Date of Injury	Death Date (if applicable)	Healing Period Ended	Date Acceptance or Award of PTD

Total Payments for weekly benefits as of Dec. 31, (year) ________________(excluding TTD) $ ______________________________Exact date that payment by insurer will end because of maximum liability :__________________
If this case has been controverted, but not closed, check here: ❑
This case was closed on _________________________ (Attach Supporting Documentation).

CASE STATUS CHANGES (since last report)

1. ❑ Payment ceased on _____________ because of: ❑ death, ❑ remarriage, ❑ lump sum payment, ❑ joint petition settlements, ❑ change in disability status, ❑ subrogation (payment to resume on:_____________) or because ❑ insurer has reached maximum liability. Because payments ended, AWCC Form 4 was submitted or is attached.
2. ❑ Payment to some dependents changed because of one or more of the following: ❑ death or ❑ remarriage of spouse, ❑ increase in dependents, ❑ marriage or ❑ death of dependent child, ❑ dependent attained maximum age, or ❑ other. (Explain "other" on back.)
3. ❑ Widow/widower remarried on_______________________. The lump sum payment was $ ______________________________. Remaining dependent(s) benefits increased on ________________.
4. ❑ Payment to children continues because of ❑ single, full-time student status or ❑ incapacity. (Supporting documentation must be attached when transferring liability to the Trust Fund for payment.)
5. ❑ Employee on PTD died on _________________and (check only one): ❑ Insurer accepts death as stemming from disabling accident and has begun payments to dependents or ❑ Insurer has declined to accept death as accident- or illness-related in connection with employment.

CERTIFICATION

In compliance with AWCC requirements, the above is a true, accurate report.

Signature	Printed or Typewritten Name	Title	Date

Address	Telephone No.

CURRENT PAYMENTS

Claimant/dependents are receiving benefits based on an average weekly wage of $ ______________________ .
Explain any adjustments to the weekly benefits.

Total weekly benefits $ ______________________ .

	Name	Relationship	Age/Birthdate	Amt. Per Week
1.	______________________ ______________________ ______________________ (Address)	____________	/ - -	$ ________
2.	______________________ ______________________ ______________________ (Address - if different)	____________	/ - -	$ ________
3.	______________________ ______________________ ______________________ (Address - if different)	____________	/ - -	$ ________
4.	______________________ ______________________ ______________________ (Address - if different)	____________	/ - -	$ ________
5.	______________________ ______________________ ______________________ (Address - if different)	____________	/ - -	$ ________

Check here ❑ if other names and addresses are listed by attachment to this AWCC Form D.

NOTICE

Once notification is received from the Death and Permanent Total Disability Trust Fund of **Certification of Acceptance** of the targeted date of last payment discharging the employer/carrier's obligation pursuant to Ark. Code Ann. §11-9-502(b), no additional Form D is required, unless there is a change in the status of a permanently totally disabled worker or the eligible dependents of a deceased worker. In the event of a change, an amended Form D must be filed within 15 calendar days of such change. In no event shall the employer or carrier cease bi-weekly payments for death or permanent total disability prior to filing a Form D and the approval of the date of termination of benefits by the Death and Permanent Total Disability Trust Fund.

AWCC Form D (Death or Permanent - Total Disability Case)

AWCC Form D is due in January to report on the previous calender year and filed each year until a Certification of Acceptance is issued by the AWCC to the respondent. Form D's importance and the need for its correct and timely filing cannot be overemphasized.

Contact the AWCC Special Funds Division for help with Form D. General Information is available from Support Services Division. (1-800-622-4472 or 501-682-3930)

Ark. Code Ann. §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."