NOTICE TO EMPLOYEES

State of Connecticut Workers' Compensation Commission

Revised 10-01-2021

The Workers' Compensation Act (Connecticut General Statutes Chapter 568) requires your employer,
DICKINSON COLLEGE 34 PUTNAM GRN
GREENWICH CT 06830

to provide benefits to you in case of injury or occupational disease in the course of employment.

Section 31-294b of the Workers' Compensation Act states "Any employee who has sustained an injury in the course of his employment shall immediately report the injury to his employer, or some person representing his employer. If the employee fails to report the injury immediately, the administrative law judge may reduce the award of compensation proportionately to any prejudice that he finds the employer has sustained by reason of the failure, provided the burden of proof with respect to such prejudice shall rest upon the employer."

An injury report by the employee is NOT an official written notice of claim for workers' compensation benefits; the Workers' Compensation Commission's Form 30C is necessary to satisfy this requirement.

NOTE: You must comply with P. A. 17-141 (see next box, below) when filing a compensation claim.

The INSURANCE COMPANY or SELF-INSURANCE ADMINISTRATOR is:

Name THE TRAVELERS INSURANCE COMPANIES

Address P.O. BOX 5008 Telephone (800) 238-6225

City/Town HARTFORD State CT Zip Code 06102-5008

Approved Medical Care Plan ☐ Yes ☐ No

The State of Connecticut Workers' Compensation Commission office for this workplace is located at:

Address 111 HIGH RIDGE ROAD Telephone (203) 325-3881

City/Town STAMFORD State CT Zip Code 06905

Public Act 17-141 allows an employer the option to designate and post – "in the workplace location where other labor law posters required by the Labor Department are prominently displayed" and on the Workers' Compensation Commission's website [wcc.state.ct.us] – a location where employees must file claims for compensation.

If your employer has listed a location below, you MUST file your compensation claim there.

When filing your claim, you are also required – by law – to send it by certified mail.

If blank below, ask your employer where to file your claim.

Employer Name _____

Address _____ Telephone _____

City/Town _____ State _____ Zip Code _____

THIS NOTICE MUST BE IN TYPE OF NOT LESS THAN TEN POINT BOLD-FACE AND POSTED IN A CONSPICUOUS PLACE IN EACH PLACE OF EMPLOYMENT. FAILURE TO POST THIS NOTICE WILL SUBJECT THE EMPLOYER TO STATUTORY PENALTY (Section 31-279 C.G.S.).

Date Posted: _____

Any questions as to your rights under the law or the obligations of the employer or insurance company should be addressed to the employer, the insurance company, or the Workers' Compensation Commission (1-800-223-9675).

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