Summary of Benefits Paid

State Form TBD (R1 /)

INDIANA WORKER'S COMPENSATION BOARD
402 West Washington Street, Room W196
Indianapolis, IN 46204
Telephone: (317) 233-3009
www.in.gov/wcb

Date of Injury (month, day, year)	Jurisdiction Claim Number

CLAIM INFORMATION

Name of Injured Worker	Name of Employer
Address (number and street, city, state, and ZIP code)	Address (number and street, city, state, and ZIP code)
Telephone Number	Name of Claim Administrator
E-mail Address	Administrator Claim Number

CLAIMS ADJUSTER INFORMATION

Name of Claims Adjuster	Telephone Number
Address (number and street, city, state, and ZIP code)	
E-mail Address	

ACCIDENT INFORMATION

Nature of Injury		
Date Returned to Work (if available)	Date of Maximum Medical Improvement (if available)	Average Weekly Wage
Last Check Date		TTD Rate

INDEMNITY BENEFITS

Disability Type: TTD,TPD,PTD	Total Paid	$/Wk Rate	# of Weeks	# of Days	Benefit Start Date	Benefit End Date

A new period of disability must be reported each time the TTD Rate changes; or Type of Disability changes.

If asterisk (*) is present in Benefit Start Date and Benefit End Date Header, it indicates non-consecutive periods of payment reported via use of State Form 54217 Notice of Suspension of Compensation and/or Benefits.

Data displayed on form is taken only from electronic filing of SROI SX. This EDI transaction populates both the 38911 and the Benefits Summary. Numbers are not verified by WCB.