WORKER'S ANNUAL REPORT OF INCOME

Return to: Carrier or Self-Insured Employer Address

Date Mailed: _____

ICA Claim No.: _____

Soc. Sec. No.: _____

SSN not required if correct ICA claim number is provided

Claimant's Name and Address

Carrier Claim No. _____

Employer: _____

Date of Injury: _____

To the Claimant: You are required to report annually on the anniversary date of your award of permanent compensation benefits ALL OF YOUR EARNINGS for the 12 months prior. This report must be fully and accurately completed and signed by you and promptly returned to the Carrier or Self-Insured Employer at the address shown above. A.R.S. § 23-1047

Failure to submit an annual report within 30 days of the date of this notice shall result in the suspension of benefits by the carrier or self-insured employer.

	MO.	DAY	YEAR		MO.	DAY	YEAR
Period				Through			

Name and Address of Employer *(Include Self Employment)*	Period Worked		Total Wages and other Earnings	Describe Work
	From	Through		
			$	
			$	
			$	
			$	
			$	

MY TOTAL GROSS EARNINGS FOR THE ABOVE PERIOD WERE: $ _____

Any person who knowingly makes a false statement or representation to obtain any compensation, benefit or payment is guilty of a class 6 felony and is subject to up to one and one-half years in prison, a fifty thousand dollar fine and forfeiture of benefits. By my signature below, I am applying for all benefits to which I may be entitled and I swear that the statements made on this application are true, correct and complete to the best of my knowledge.

Claimant's signature required _____ Date _____

Email address: _____

Current Residence _____

Phone:_____

Address to which mail should be sent::

Street _____

City _____ State _____ Zip Code _____

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

Form ICA 04—110-A (Rev 6/2015)