UC-11Q (R. 12/07/00)

Connecticut Department of Labor
Working with you for a better future.

SPECIAL BASE PERIOD: WORKERS' COMPENSATION QUESTIONNAIRE SICK LEAVE/DISABILITY LEAVE QUESTIONNAIRE

IMPORTANTE
TENGA ESTO TRADUCIDO INMEDIATAMENTE

Case No :
Name : SS# :

In your application for unemployment benefits, you indicated that you are/were receiving Workers' Compensation, sick or disability pay. You may be eligible for a Special Base Period because you have been out of work due to a work related injury or disability. Please answer the questions and submit this document by mail or fax with the cover sheet enclosed, within ten (10) days of the mailing date on the "Notice to Claimant of Hearing."

If you have filed for and received Workers' Compensation, please fill out sections A and C only. If you have filed for and received sick or disability pay, fill out sections B and C only.

A. WORKERS' COMPENSATION:

Date you were injured?	Date you started receiving Workers' Compensation payments?
Name and address of the insurance company handling your claim:	Name of the agent handling your claim:
	Agent's telephone number:
Your claim number:	Your disability rating, if known:

Please indicate below the type(s) of payment(s) received, weekly amount, and the dates the payment(s) covered.

TYPE	DOLLAR AMOUNT	DATES
☐ temporary total disability		
☐ temporary partial disability		
☐ permanent partial disability		
☐ permanent total disability		

When did your Workers' Compensation payments stop?

Please provide documentation that you received Workers' Compensation payments (award letter, pay stubs, notice to discontinue benefits, etc.).

B. SICK LEAVE / DISABILITY LEAVE

Did your employer approve your sick or disability leave? ☐ Yes ☐ No	Did your employer have a specific sick leave or disability leave policy? ☐ Yes ☐ No

If "Yes," in what manner did your employer demonstrate approval of sick/disability leave?

- ☐ Written approval (attach copy).
- ☐ Coverage under employer-paid disability insurance plan (provide dates covered).
- ☐ Claimant returned with sick pay (provide dates covered).
- ☐ Employer continued to extend employee benefits for a period of time beyond the initial day of absence. (Explain below)
- ☐ Unwritten/verbal approval only. (What did you understand the terms of that policy to be? Employer statement as to terms required.)

NOTE: Employer verification is required in each case. Please attach that verification, if available. If verbal authorization was given, please provide name, title and telephone number of the individual who gave you verbal authorization.

- Continue on the reverse side –

Case #:

C. EMPLOYMENT INFORMATION

On what date did you last work? _____

Explain why you were unable to work. If a work related injury occurred, provide the date the injury occurred and explain how you were injured. _____

Provide employer's name and address at the time of injury: _____

Have you returned to work since your injury/disability leave?

☐ Yes ☐ No If Yes, provide dates: _____

Provide employer's name(s) and address(es): _____

Please list below your employment history for the last three (3) years.

	Employer Name	Employer Address	Date Started	Last Day Worked
1				
2				
3				
4				
5				

Additional Comments: _____

CERTIFICATION

Print your name: _____ **SS #:** _____

Signature: _____ **Date:** _____ **Telephone #:** _____

I certify that this information is true and correct, knowing the law provides penalties for false statements or the withholding of facts.