FORM 126

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 126
Lafayette City Center, 2 Avenue de Lafayette, Boston, MA 02111-1750
Info. Line (800) 323-3249 Inside Mass. / (857) 321-7470 Outside Mass.
www.mass.gov/dia

DIA USE ONLY

EMPLOYEE'S EARNING REPORT

1. Employee's Name (Last, First, MI):	2. Social Security Number*:	3. Date of Injury (mm/dd/yy):
4. Employee's Mailing Address (No. & Street, City, State, Zip Code):		
5. Employee's Residential Address (if different from Mailing Address):		
6. Employee's Attorney (Last, First, MI) and Address (No. & Street, City, State, Zip Code):		
7. DIA Board Number (If Known):	8. Date of Birth (mm/dd/yy):	

As an employee entitled to receive weekly compensation, you have an affirmative duty to report to the insurer all earnings, including wages or salary from self-employment. If you fail to report any earnings whether paid cash or otherwise, you may be subject to civil or criminal penalties. If you fail to return this form within 30 days of this request, the insurer may suspend your weekly benefits under M.G.L. Chapter 152 § 11D (1). You cannot be required to file an earnings report more often than once every six months.
Please report your earnings below:

9. Week No.	Year: Week Ending Month	Day	Gross Amount Before Taxes	Week No.	Year: Week Ending Month	Day	Gross Amount Before Taxes
1				14			
2				15			
3				16			
4				17			
5				18			
6				19			
7				20			
8				21			
9				22			
10				23			
11				24			
12				25			
13				26			

10. Name/ Address of Employer or other Payer of Wages, Commissions, Etc. If more than one payer, please list additional names and addresses on back.

11. I have not received earnings for any period in which I was entitled to receive Workers' Compensation Benefits.
☐ **Mark box with an X if the above statement is TRUE under the pains and penalties of perjury.**

12. Employee's Signature:	**13. Date Signed (mm/dd/yyyy)**

THE EMPLOYEE MUST MAIL THIS COMPLETED FORM TO THE INSURER AT THE ADDRESS INDICATED BELOW:

14. Insurance Carrier's Name & Address (No. Street, City, State & Zip Code):

*Disclosure of Social Security Number is Voluntary. It will assist in the processing of your report.

Reproduce as needed.

Names and Addresses of additional employers: