

Application Attachments and Initial Defense Pleadings

Department Of Workers' Claims

To file documents in claims to which you are already associated, log into LMS, select the claim you wish to file a document on from your My Claims or LMS Group Claims screen. You will be taken to the claim detail screen. From there, click the File document button.

Claim #: 202000003



 File Document

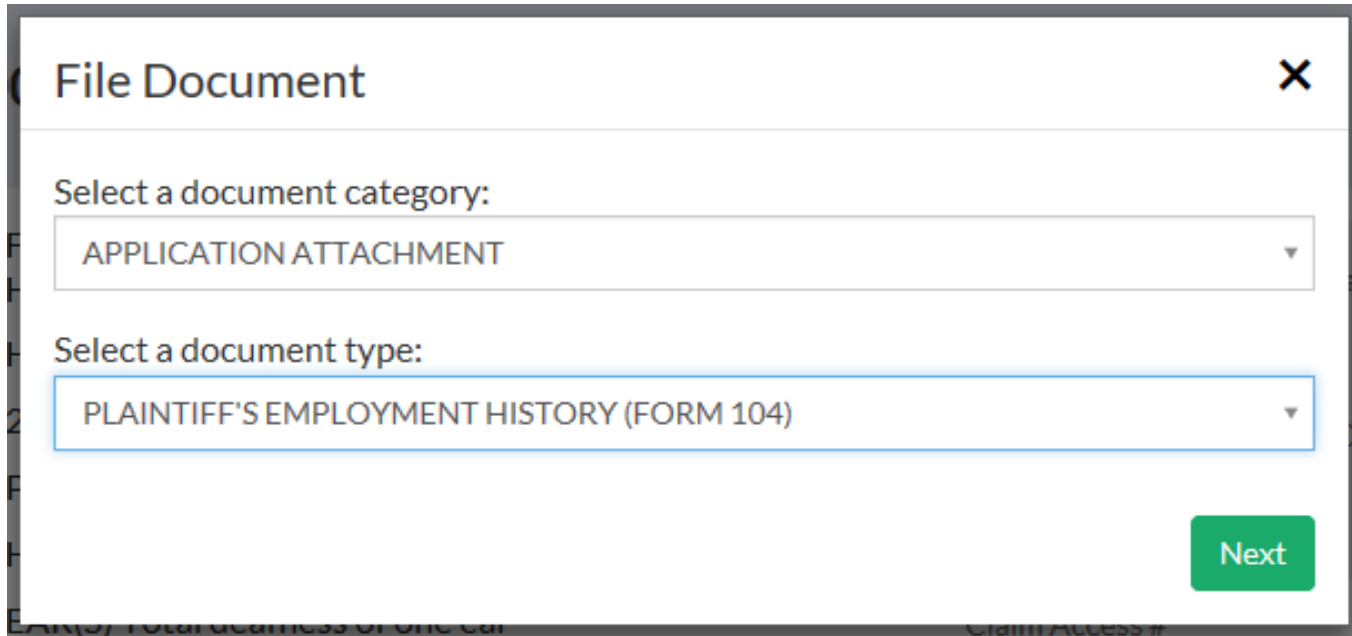
Style	FUNKMASTER FLEX VS KALAMAZOO TIGER HOUSING
Judge	HON ROBERT L. SWISHER
Date of Injury	2/1/2016
Disposition	PENDING
Nature	HEARING LOSS OR IMPAIRMENT (TRAUMATIC ONLY)
Body Part	EAR(S) Total deafness of one ear

Insurance Carrier Information

Maintenance Type Code	N/A
Maintenance Type Code Date	N/A
Claim Administrator #	N/A

Claim Access # [show access #](#)

To file a Form 104, select Application Attachment from the available document categories, then select Plaintiff's Employment History (Form 104) as the document type.



The image shows a 'File Document' dialog box with a close button (X) in the top right corner. It contains two dropdown menus. The first dropdown is labeled 'Select a document category:' and has 'APPLICATION ATTACHMENT' selected. The second dropdown is labeled 'Select a document type:' and has 'PLAINTIFF'S EMPLOYMENT HISTORY (FORM 104)' selected. A green 'Next' button is located at the bottom right of the dialog box.

File Document ×

Select a document category:

APPLICATION ATTACHMENT ▼

Select a document type:

PLAINTIFF'S EMPLOYMENT HISTORY (FORM 104) ▼

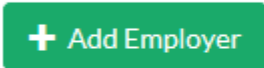

Next

Form 104 is a web form. The plaintiff's individual employment information can be entered by clicking the add employer button.

Form 104 - Plaintiff's Employment History

List of Employment History

Employer Name	From	To	Remove
---------------	------	----	--------

By entering my full name below, I attest that this form is accurate and complete to the best of my knowledge. *

(by entering your name in the field above, you are providing your electronic signature)

Add New Employment History



Employer Name *

Address

City/Town *

State *



Postal Code *

Type of Industry *



Occupation *

Employed from * mm/dd/yyyy

to present, or

Employed to mm/dd/yyyy

Was an injury sustained while working for this employer? *


No Yes


Save

As each employer is entered, information is added to the list. This list can be edited and individual employers can be removed. When all additions have been made, add a signature. The Preview Document button allows you to print and save the document. When the document is complete, clicking the Finish button will submit your document to the DWC.


Form 104 - Plaintiff's Employment History

List of Employment History

Employer Name	From	To	Remove
Employer	2/3/2004	Present	 

 Add Employer

By entering my full name below, I attest that this form is accurate and complete to the best of my knowledge. *

Injured Worker| 

(by entering your name in the field above, you are providing your electronic signature)

Cancel

Preview Document

Finish

**KENTUCKY DEPARTMENT OF WORKERS' CLAIMS
PLAINTIFF'S EMPLOYMENT HISTORY**

Name FUNKMASTER FLEX		Social Security Number/Green Card 789456123			
Name and Address of Employer (Begin with most recent employer)	Type of Industry	Occupation	Period of Employment Begin date End date	Exposure to substances causing occupational disease (specify substance)	Was an injury sustained while working for this employer?
1. Employer 1 Job St. Louisville, Kentucky 40105	ADMIN. OF SOCIAL & MANPOWER PROGRAMS	Placement Officer	2/3/2004 - Present		No
2.					
3.					
4.					
5.					
6.					
7.					

I hereby certify that the above information is true and correct to the best of my knowledge and belief.

/s/ Injured Worker

Plaintiff's Signature

Date

To file a Form 105, select Application Attachment from the available document categories, then select Plaintiff's Chronological Medical History (Form 105) as the document type.

The image shows a software dialog box titled "File Document" with a close button (X) in the top right corner. Below the title bar, there are two dropdown menus. The first dropdown is labeled "Select a document category:" and has "APPLICATION ATTACHMENT" selected. The second dropdown is labeled "Select a document type:" and has "PLAINTIFF'S CHRONOLOGICAL MEDICAL HISTORY (FORM 105)" selected. At the bottom right of the dialog box, there is a green button labeled "Next".

Form 105 is also a web form where the Plaintiff's medical history can be entered by clicking the Add Physician/Hospital button.

Form 105 - Plaintiff's Chronological Medical History

List of Physician/Hospitals
(Begin with most recent treatment)

Physician/Hospital Name	From	To	Edit/Remove
-------------------------	------	----	-------------

[+ Add Physician/Hospital](#)

By entering my full name below, I attest that this form is accurate and complete to the best of my knowledge. *

(by entering your name in the field above, you are providing your electronic signature)

[Cancel](#) [Preview Document](#) [Finish](#)

Add New Physician/Hospital



Physician/Hospital Name *

Address

City/Town *

State *

Postal Code *

Treatment start date * mm/dd/yyyy

to present, or

Treatment end date mm/dd/yyyy

Nature of injury/disease *



Body Part *

Add

As each Physician or Hospital is entered, information is added to the list. This list can be edited and individual employers can be removed. When all additions have been made, add a signature. The Preview Document button allows you to print and save the document. When the document is complete, clicking the Finish button will submit your document to the DWC.

Form 105 - Plaintiff's Chronological Medical History

List of Physician/Hospitals
(Begin with most recent treatment)

Physician/Hospital Name	From	To	Edit/Remove
Dr. Doctor	3/1/2016	Present	 

 Add Physician/Hospital

By entering my full name below, I attest that this form is accurate and complete to the best of my knowledge. *

Injured Worker



(by entering your name in the field above, you are providing your electronic signature)

Cancel

Preview Document

Finish

KENTUCKY
DEPARTMENT OF WORKERS CLAIMS
PLAINTIFF'S CHRONOLOGICAL MEDICAL HISTORY

Include all injuries and major illnesses to the date of filing of the claim
(Begin with most recent treatment)

Name & Address of Physician or Hospital	Period Treatment Received	Nature of Injury or Disease and Part of body affected?	Still under a doctor's care?
1. Dr. Doctor 1 Medical Place Frankfort, Kentucky 40601	3/1/2016 - Present	ENUCLEATION (REMOVAL OF ORGAN OR TUMOR) - EAR(S)	Yes
2.			
3.			
4.			
5.			
6.			

I hereby certify that the above information is true and correct to the best of my knowledge and belief.

/s/ _____
Plaintiff's Signature

4/13/2016 _____
Date

To file a Form 106, select Application Attachment from the available document categories, then select Medical Waiver and Consent Form (Form 106) as the document type.

The image shows a 'File Document' dialog box with a close button (X) in the top right corner. It contains two dropdown menus. The first dropdown is labeled 'Select a document category:' and has 'APPLICATION ATTACHMENT' selected. The second dropdown is labeled 'Select a document type:' and has 'MEDICAL WAIVER AND CONSENT FORM (FORM 106)' selected. A green 'Next' button is located in the bottom right corner of the dialog box.

File Document

Select a document category:

APPLICATION ATTACHMENT

Select a document type:

MEDICAL WAIVER AND CONSENT FORM (FORM 106)

Next

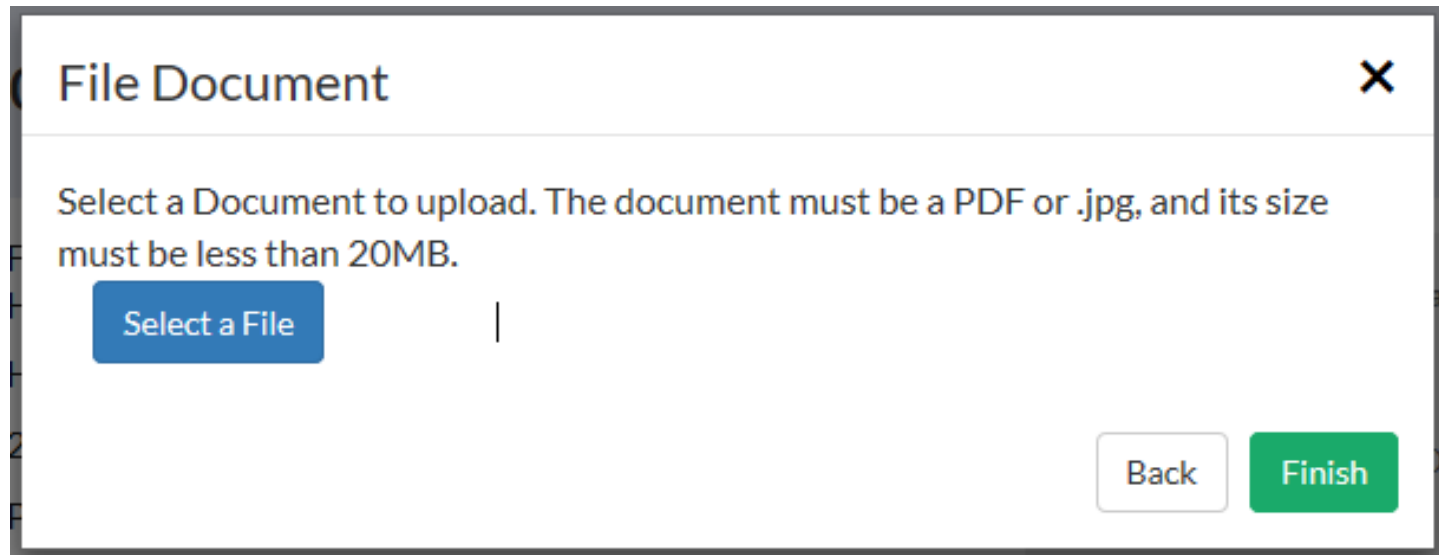
Form 106 is not a web form, it accepts PDF attachments. Click next to proceed.

File Document ✕

Proceed to upload your document on the next step.

[Back](#) [Next](#)

By clicking the Select a File button below, you will be prompted to select a file from your computer to attach to the Form 106. Please note that the file must be in PDF format and may not be more than 20 MB in size.



The image shows a dialog box titled "File Document" with a close button (X) in the top right corner. The main text inside the dialog reads: "Select a Document to upload. The document must be a PDF or .jpg, and its size must be less than 20MB." Below this text is a blue button labeled "Select a File". At the bottom right of the dialog are two buttons: a white "Back" button and a green "Finish" button.

Once the file has been attached, clicking the Finish button will submit your document to DWC.

File Document ✕

Select a Document to upload. The document must be a PDF or .jpg, and its size must be less than 20MB.

0bb576_10420326e31d4d9080c43c4619748a1f.pdf

To file an SVE, select Safety Violations from the available document categories, then select SVE Safety Violation Raised Against the Claimant as the document type. The following slides show the SVE web form.



The screenshot shows a web form titled "File Document" with a close button (X) in the top right corner. The form contains two dropdown menus. The first dropdown is labeled "Select a document category:" and has "SAFETY VIOLATIONS" selected. The second dropdown is labeled "Select a document type:" and has "SVE SAFETY VIOLATION RAISED AGAINST THE CLAIMANT" selected. A green "Next" button is located at the bottom right of the form. At the bottom of the image, there is a footer with the text "APPEALED TO WORKERS= COMPENSATION" on the left and "Maintenance Type Code Da" on the right.

Form SVE - Safety Violation (Employer)

For the alleged safety violation to KRS 342.165, state the safety rule(s), regulation(s), or statute(s) the employee is alleged to have failed to follow or obey *

If it is to be alleged the employee intentionally failed to use a safety appliance furnished by the employer, state the safety appliance

State the facts as to how the alleged failure by the employee to use a safety appliance furnished by the employer or to obey a safety rule, regulation, statute or order caused, in any degree, the accident to occur *

The following attachments should be submitted, if applicable and available:

- Accident report
- OSHA, MSHA or other report of investigation
- Any safety manual, employee handbook or other document provided to the employee by the employer relative to the use of the subject safety appliance, rule, regulation, statute or order



Maximum of 5 attachments

By entering your name below, you are confirming under penalty of perjury the accuracy of this form *

Cancel

Finish

Form SVE - Safety Violation (Employer)

For the alleged safety violation to KRS 342.165, state the safety rule(s), regulation(s), or statute(s) the employee is alleged to have failed to follow or obey *

If it is to be alleged the employee intentionally failed to use a safety appliance furnished by the employer, state the safety appliance

State the facts as to how the alleged failure by the employee to use a safety appliance furnished by the employer or to obey a safety rule, regulation, statute or order caused, in any degree, the accident to occur *

The following attachments should be submitted, if applicable and available:

- Accident report
- OSHA, MSHA or other report of investigation
- Any safety manual, employee handbook or other document provided to the employee by the employer relative to the use of the subject safety appliance, rule, regulation, statute or order

Attachment	Remove
0bb576_10420326e31d4d9080c43c4619748a1f.pdf	

 Attach File

Maximum of 5 attachments

By entering your name below, you are confirming under penalty of perjury the accuracy of this form *

Cancel

Finish

To file a Medical Report, select Other Pleadings from the available document categories, then select Notice of Medical Report Filed as the document type.

The image shows a 'File Document' dialog box with a close button (X) in the top right corner. It contains two dropdown menus. The first dropdown is labeled 'Select a document category:' and has 'OTHER PLEADINGS' selected. The second dropdown is labeled 'Select a document type:' and has 'NOTICE OF MEDICAL REPORT FILED' selected. A green 'Next' button is located at the bottom right of the dialog box. At the very bottom of the dialog box, there is a faint label 'Client Access #'.

File Document X

Select a document category:

OTHER PLEADINGS

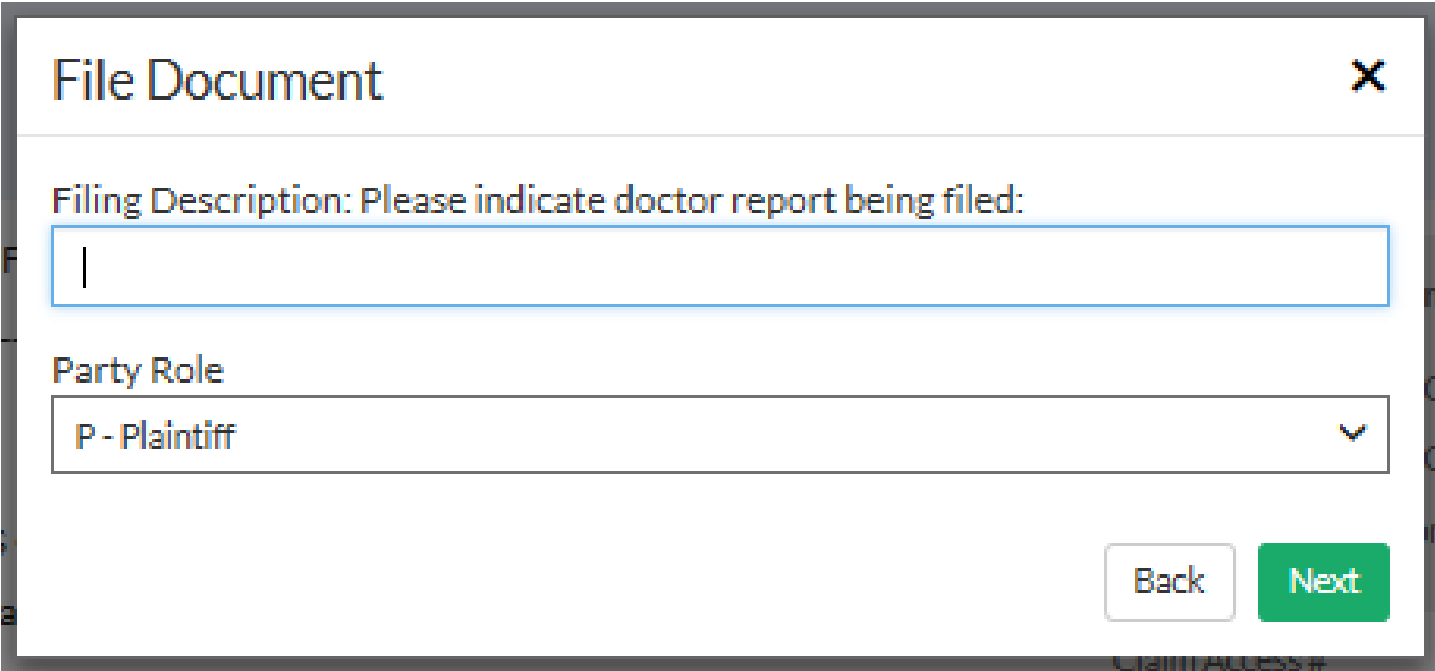
Select a document type:

NOTICE OF MEDICAL REPORT FILED

Next

Client Access #

Enter the name of the report into the first field of this window and choose the appropriate party role.



The image shows a software window titled "File Document" with a close button (X) in the top right corner. Below the title bar, there is a label "Filing Description: Please indicate doctor report being filed:" followed by a text input field containing a vertical cursor. Below the text field is a dropdown menu labeled "Party Role" with "P - Plaintiff" selected and a downward arrow. At the bottom right, there are two buttons: "Back" (white with a grey border) and "Next" (green).

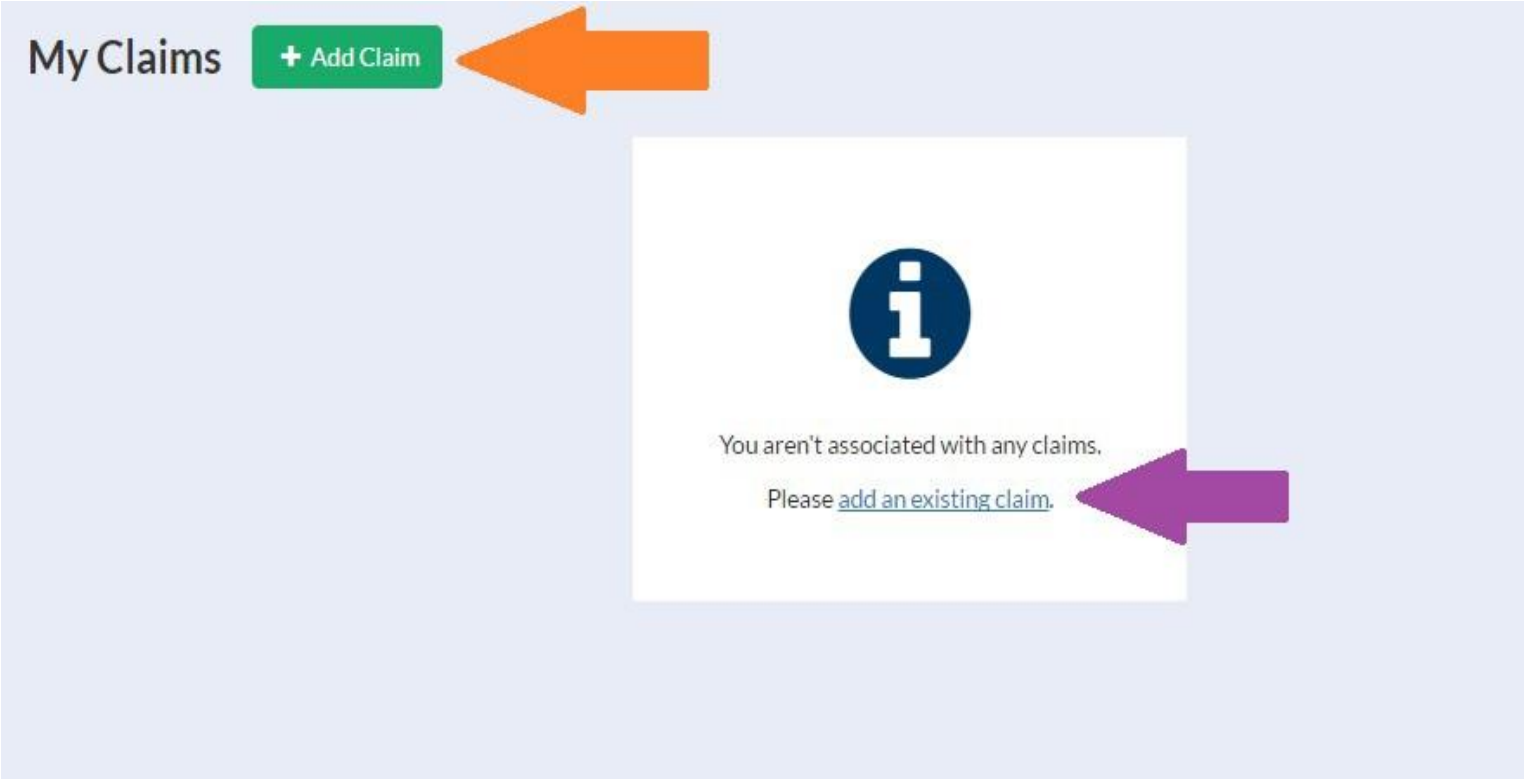
By clicking the Select a File button below, you will be prompted to select a file from your computer to attach to the Notice of Medical Report Filed. Please note that the file must be in PDF format and may not be more than 20 MB in size. Once the file has been attached, clicking the Finish button will submit your document to DWC.

File Document ✕

Select a Document to upload. The document must be a PDF or .jpg, and its size must be less than 20MB.

0bb576_10420326e31d4d9080c43c4619748a1f.pdf

To file a Notice of Representation, either of the options below can be selected from the landing screen in LMS.



The add a claim button will bring up the add a claim window where a claim and access number can be entered.

Add a Claim ✕

To join as a party or representative to a claim you must be a named party and have an Access Number.

Claim Number *

Access Number *

You can also [file a new claim](#), submitting all documentation electronically.

If the party you need to associate with is not listed in the parties drop down, click the “None of These.”

Add a Claim ✕

Select your party *

If you are counsel for a party listed on this screen, select your party and click Continue to Form to file the Notice of Representation (NOR) form.

If you are associating to this claim as counsel for an existing party, you must file a notice of representation. Please select which party you represent, if any:

- VALCANO PROTECTION LLC
- KALAMAZOO TIGER HOUSING
- FUNKMASTER FLEX
- HANDY MANNY
- HANDY MANNY
- BOB THE BUILDER
- None of these

[Continue to Form](#)

The notice of representation form will populate with the information provided by the attorney at registration and ask for an electronic signature.

Form NOR

Step 1 of 3

Attorney Name and Address

Enter your name and address as parties should address filings.

First Name or Name of your Organization * ×

Last Name

Address *

Postal Code * City/Town * State

Electronic Signature *

(by entering your name in the field above, you are providing your electronic signature)

The list below is where the manner of service is chosen. Parties can be served by mail, email, LMS, in person or not served at all.

Form NOR

Step 2 of 3

Presented To

<input type="text"/>	▼	VALCANO PROTECTION LLC
<input type="text"/>	▼	KALAMAZOO TIGER HOUSING
<input type="text"/>	▼	FUNKMASTER FLEX
<input type="text"/>	▼	WINSTON CHURCHILL
<input type="text"/>	▼	BOB THE BUILDER
<input type="text"/>	▼	HANDY MANNY
<input type="text"/>	▼	HANDY MANNY
<input type="text"/>	▼	BOB THE BUILDER

[+ Add Recipient](#)

[Cancel](#) [Back](#) [Next](#)

On this screen, you can confirm the service chosen and if you choose, preview and save a copy of your notice. Clicking the finish button submits the form to DWC. The following slide shows an example of a system generated Notice of Representation.

Form NOR

Step 3 of 3

Confirm Service

Served via LMS	▼	VALCANO PROTECTION LLC(Carrier)
Served by mail	▼	KALAMAZOO TIGER HOUSING(Defendant)
Served by email	▼	FUNKMASTER FLEX(Plaintiff)
Served by mail	▼	WINSTON CHURCHILL(Defendant Attorney)
Served by mail	▼	BOB THE BUILDER(Plaintiff Attorney)
Served	▼	HANDY MANNY(Medical Provider)
Served	▼	HANDY MANNY(Petitioner)
Served	▼	BOB THE BUILDER(Respondent)

Cancel Back Preview Document Finish

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS
CLAIM NO. 2020-00008

BEFORE:

GEORGE CLINTON

PLAINTIFF/EMPLOYEE

VS

NOTICE OF REPRESENTATION

BILL BILLINGSLEY

DEFENDANT/EMPLOYER(S)

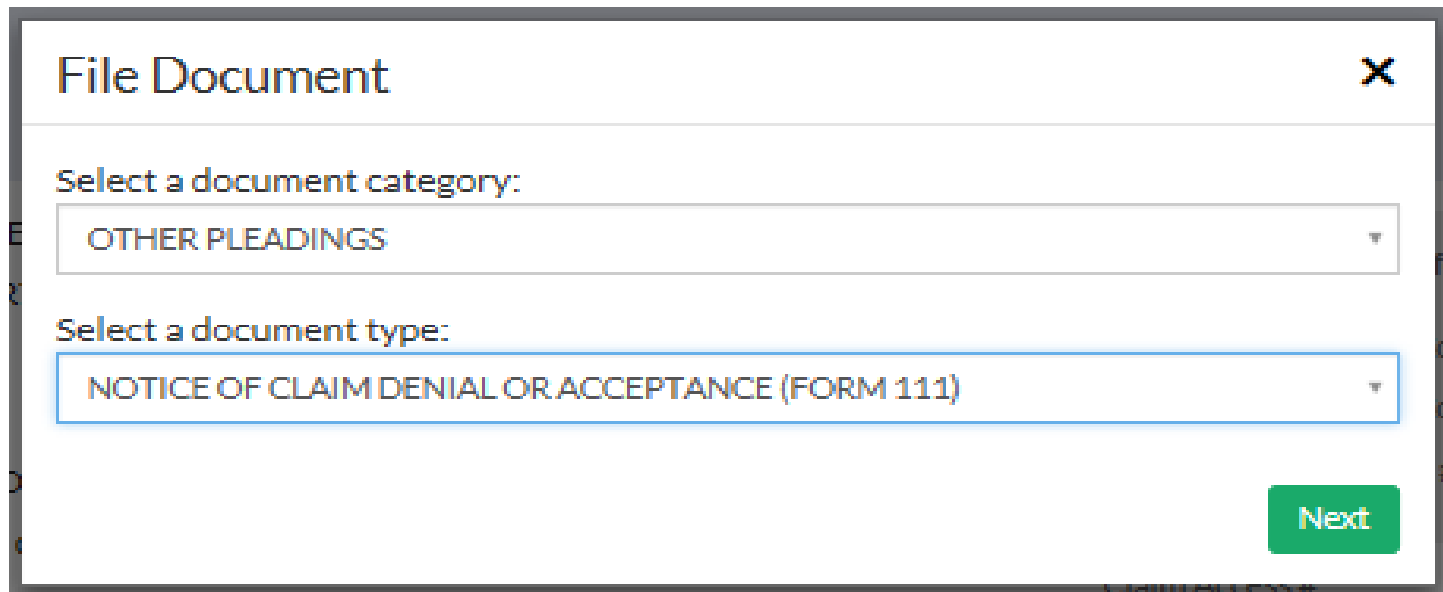
Comes *tes har* and gives notice of representation on behalf
of **BILL BILLINGSLEY** in the above referenced claim. All relevant
correspondence and pleadings should be served on counsel in the following
fashion:

tes har
14 oak

Frankfort, KY 40601

Respectfully submitted,
/s/ tes har

To file a Notice of Claim Denial or Acceptance (Form 111), select Other Pleadings from the available document categories, then select Notice of Claim Denial or Acceptance (Form 111) as the document type.



The screenshot shows a web form titled "File Document" with a close button (X) in the top right corner. The form contains two dropdown menus. The first dropdown is labeled "Select a document category:" and has "OTHER PLEADINGS" selected. The second dropdown is labeled "Select a document type:" and has "NOTICE OF CLAIM DENIAL OR ACCEPTANCE (FORM 111)" selected. A green "Next" button is located at the bottom right of the form. At the bottom of the form, there is a label "Claim/Access #".

File Document X

Select a document category:

OTHER PLEADINGS ▼

Select a document type:

NOTICE OF CLAIM DENIAL OR ACCEPTANCE (FORM 111) ▼

Next

Claim/Access #

Form 111 is a web form that accepts information from a user and generate a PDF document that can be filed with the DWC. Below is the first screen with the claim accepted option selected. The next slide shows available options when the claim denied option is selected.

Form 111 - Notice of Claim Denial or Acceptance

Step 1 of 4

Defendant filing this form *

D. Fendant

Insurance Carrier *

C. Arrier| X

This claim is accepted as compensable in its entirety

This claim is denied

Cancel Save & Exit Next

Form 111 - Notice of Claim Denial or Acceptance

Step 1 of 4

Defendant filing this form *

D. Fendant

Insurance Carrier *

C. Arrier

- This claim is accepted as compensable in its entirety
- This claim is denied

The claim is denied for the following reasons (select at least one or all that apply): *

- There is a dispute concerning the amount of compensation owed to the plaintiff
- Plaintiff was not employed by defendant on the date of alleged injury
- Plaintiff's last injurious exposure to the risks of the occupational disease alleged did not occur in the employment of this defendant
- The plaintiff did not give due and timely notice to employer of the alleged occupational disease
- The alleged injury did not arise out of and in the course of employment
- Plaintiff has not contracted the occupational disease alleged
- The plaintiff did not give due and timely notice to employer of the injury
- The claim is barred by limitations
- Other reason for denial

Cancel

Save & Exit

Next

Step 2 of Form 111 shows employer admission options.

Form 111 - Notice of Claim Denial or Acceptance

Step 2 of 4

The following are admitted by the employer (select all that apply):

- Plaintiff's alleged work event was covered under the Workers' Compensation Act.
- The work event occurred on
- Plaintiff reported the work event on
- Plaintiff returned to work.
Plaintiff continues to work for this employer.
 No Yes
- Temporary total disability income benefits were paid as the result of the injury.
- Medical expenses have been paid as the result of this injury.

Special answers and summaries are entered in Step 3.

Form 111 - Notice of Claim Denial or Acceptance

Step 3 of 4

Special Answer: The Defendant/Employer for its special answers asserts the following as a bar to recovery in whole or part in accordance with 803 KAR 25:010 Section 6 (2)(d)1. (Select all that apply):

- KRS 342.035(3), unreasonable failure to follow medical advice;
- KRS 342.165, safety violation, need to submit Form SVC within 15 days;
- KRS 342.316(7) or KRS 342.335, false statement on employment application;
- KRS 342.395, voluntary rejection of KRS Chapter 342;
- KRS 342.610(3), voluntary intoxication or self-infliction of injury;
- KRS 342.710(5), refusal to accept rehabilitation services; or
- Running of periods of limitations or repose under KRS 342.185, 342.270, 342.316, or other applicable statute;
- Injury resulted from "horseplay";
- Other

Provide a brief summary of the basis for each special answer listed:

An attestation of form accuracy and an electronic signature are required to complete Step 4. Here you may preview and save or print a copy of your form in PDF format. Selecting finish will submit your document to DWC. An example of a completed Form 111 is shown on the next slide.

Form 111 - Notice of Claim Denial or Acceptance

Step 4 of 4

By entering my full name below, I attest that this form is accurate and complete to the best of my knowledge.

Signature *

Title

 ×

(by entering your name in the field above, you are providing your electronic signature)

Cancel

Save & Exit

Back

Preview Document

Finish

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS

Notice of Claim Denial or Acceptance

Before ALJ: _____

Claim No. 202000003

FUNKMASTER FLEX

Plaintiff/Employee

vs.

KALAMAZOO TIGER HOUSING

Defendant/Employer

Comes the defendant, D. Fendant, as insured by C. Anner, and in response to the Application for Resolution of Claim, states as follows:

1. This claim is accepted as compensable in its entirety.
2. This claim is denied for the following reasons:
- (a) There is a dispute concerning the amount of compensation owed to the plaintiff.
 - (b) Plaintiff was not employed by defendant on the date of alleged injury.
 - (c) Plaintiff's last injurious exposure to the risks of the occupational disease alleged did not occur in the employment of this defendant.
 - (d) The plaintiff did not give due and timely notice to employer of the alleged occupational disease.
 - (e) The alleged injury did not arise out of and in the course of employment.
 - (f) Plaintiff has not contracted the occupational disease alleged.
 - (g) The plaintiff did not give due and timely notice to employer of the injury.
 - (h) The claim is barred by limitations.
 - (i) Other reason for denial.
3. The following are admitted by the employer:
- Plaintiff's alleged work event was covered under the Workers' Compensation Act.
 - The work event occurred on 4/5/2016
Date
 - Plaintiff reported the work event on 4/5/2016
Date

Thank you for joining us for this presentation.

Questions?

Contact Us: LaborKYWCLMS.TechnicalSupport@ky.gov