Notice of Claim Denial or Acceptance
Form 111-Injury and Hearing Loss
Adopted 1/1/97

Filed:

Do Not Write In This Space

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF WORKERS CLAIMS
Before Arbitrator_____
Claim Number_____

NOTICE OF CLAIM DENIAL OR ACCEPTANCE

_____ **Plaintiff/Employee**

vs.

_____ **Defendant/Employer**

Comes the defendant, _____, as insured by _____, and in response to the Application for Resolution of Claim, states as follows:

_____ 1. This claim is accepted as compensable in its entirety. A settlement agreement will be filed. (Note: if claim is accepted, do not complete paragraphs 2 – 7).

_____ 2. This claim is accepted as compensable, but there is a dispute concerning the amount of compensation owed to the plaintiff.

_____ 3. This claim is denied for the following reasons:

_____ (a) Plaintiff was not employed by defendant on the date of alleged injury.
Explain:

_____ (b) The alleged injury did not arise out of and in the course of employment.
Explain:

_____ (c) The plaintiff did not give due and timely notice to employer of the injury.
Explain:

_____ (d) The claim is barred by limitations.
Explain:

_____ Other reason for denial.
Explain:

4. The plaintiff's average weekly wage at the time of the alleged injury was $_____. Completed AWW-1 to support this calculation is attached, if amount is different from plaintiff's application for resolution.

5. The following witnesses may present testimony relevant to denial of this claim.
1.
2.
3.
4.

6. The following are admitted by the employer:

Yes	No	
___	___	Plaintiff's injury was covered under the Workers Compensation Act.
___	___	The injury occurred or became disabling on _____, 20____ Date

___ ___ Plaintiff gave due and timely notice of the injury.

___ ___ Plaintiff has returned to work for this employer and is earning $_____ per week.

___ ___ Temporary total disability income benefits were paid as the result of the injury.

___ ___ All known medical expenses have been paid as the result of this injury.

7. Describe in detail the physical requirements of plaintiff's job at the time of the alleged injury. If an official job description exists, a copy must be attached.

8. The following persons have gathered information for completion of this form.
For the employer: _____
Name Title

_____
Address: Street

_____
City State Zip Code

(_____)_____
Telephone Number

For the insurance carrier: _____
Name Title

_____
Address: Street

_____
City State Zip Code

(_____)_____
Telephone Number

Being duly sworn, the undersigned states that the statements in this form are true and correct to the best of my knowledge and belief. This the _____ day of _____, 20___.

_____
Signature **Title**

_____
Address

_____
Phone Number

Subscribed and sworn to before me this _____ day of _____, 20_____
My commission expires:_____
County:_____ _____
Notary Public

Prepared and submitted by:

_____
Representative/Title Address Phone Number