

Filed:

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS

Application for Resolution of a Claim – Occupational Disease

Claim No. _____

Plaintiff

vs.

Defendant/Employer (Business Name)

Social Security Number/ Green Card

Defendant/ Employer Mailing Address

Birth Date Gender

City/State/Postal Code

Plaintiff Mailing Address

Insurance Carrier

City/State/Postal Code

Insurance Carrier Mailing Address

Outside United States

City/State/Postal Code

Country

Email Address

Plaintiff's Phone Number

Occupation

Additional Parties

Additional Party

Additional Party

Mailing Address

Mailing Address

City/State/Postal Code

City/State/Postal Code

Reason for Joinder:

Reason for Joinder:

I. Nature of Occupational Disease

1. Date and location of last exposure:

_____ Date of Last Exposure

_____ Location of Exposure (City/State/Postal Code)

Plaintiff states that he/she became affected by reason of a disease arising out of and in the course of his/her employment.

2. Identify the occupational disease claimed:

Nature of disease: _____

3. When and by what means did the plaintiff give notice of occupational disease to the employer?

4. Name and address of physician providing medical report:

5. Place of last exposure?

City _____ County _____ State _____

6. Nature of the work in which the plaintiff was engaged at the time of exposure:

7. Will an interpreter be needed for the formal hearing? (Yes / No) _____

If yes, in which language? _____

8. Dependents

Did the occupational disease result in death of claimant? (Yes / No) _____

If deceased, dependent information is required for a deceased worker. If work injury resulted in the death of claimant, attach/provide/upload Form F in addition to the application for Resolution of Claim.

9. Have you previously filed for or received workers' compensation benefits in Kentucky? (Yes / No) _____

If yes, please provide the following information:

Claim Number	Date of Injury	Nature of Injury/Disease	Awards/Benefits

If not a Kentucky claim, please provide the state in which you were awarded benefits: _____

10. If applying for retraining benefits, identify the training or education program in which the plaintiff is enrolled or plans to enroll:
 Name: _____
 Street Address: _____
 City: _____ State: _____ Postal Code: _____ Phone Number: _____
- 12a. Is plaintiff currently engaged in the severance or processing of coal? (Yes / No) _____
- 12b. Is plaintiff currently working in the industry in which the last exposure occurred? (Yes / No) _____
13. Was there concurrent employment at the time of injury? (Yes / No) _____
 Concurrent Employer Name _____
 Concurrent Employer City _____
 Concurrent Employer State _____ Postal Code _____
14. Has the plaintiff returned to work? (Yes / No) _____
15. Name and address of current employer and description of job currently being performed:
 Current Employer Name _____
 Current Employer City _____
 Current Employer State _____ Postal Code _____
 Description of Job Performed: _____
16. Highest grade completed in school? _____
17. G.E.D. Awarded? Yes No
18. Professional or Vocational Degrees, Certificates, or Licenses: _____
19. Are you alleging a violation of a safety rule/regulation pursuant to KRS 342.165? (Yes / No) _____
 If yes, submit form SVC with the Application for Resolution of Claim.

NOTICE

Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

By entering your name below, you are confirming the accuracy of this form to the best of your knowledge.

 This form prepared and submitted by

 Relationship to injured worker

 Submitter Phone Number

 Submitter Email Address

 Plaintiff Signature