Application for Resolution of a Claim – Injury
February 2020 Edition

Filed:

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS

Application for Resolution of a Claim - Injury

Claim No. _____

_____	vs.	_____
Plaintiff		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		
_____		
Plaintiff's Phone Number		
_____		
Email Address		
_____		
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 Injury

1. Date and location of accident/injury:

Date of Injury _____ Location of Injury (City/State/Postal Code) _____

☐ Plaintiff states that he/she was injured within the scope and course of employment with defendant employer on the above date at the above location.

2. Describe how the accident/injury occurred:

Cause of Injury: _____

3. Body part injured: _____

4. When and by what means did the plaintiff give notice of injury to the employer?

5. Describe medical treatment, if any:

6. Name and address (city/state/postal code) of physician whose report will be provided:

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

If yes, in which language? _____

8. Dependents

Injured worker is deceased? (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. Was there concurrent employment at the time of injury? (Yes / No) _____

11. Name and address of concurrent employer:

    Concurrent Employer Name _____

    Concurrent Employer City _____

    Concurrent Employer State _____ Postal Code _____

12. Has the plaintiff worked since the injury? (Yes / No) _____

13. 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:

14. Highest grade completed in school? _____

15. G.E.D. Awarded? ☐ Yes ☐ No

16. Professional or Vocational Degrees, Certificates, or Licenses:

17. 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