October 2016 Edition

Filed:

**Application for Resolution of a Claim – Occupational Disease**

**KENTUCKY DEPARTMENT OF WORKERS' CLAIMS**
**Application for Resolution of a Claim**
**Claim No. _____**

_____ vs. _____
Plaintiff — Defendant/Employer (business name)

_____ _____
Social Security Number/Green Card — Mailing Address

_____ _____
Birth Date Gender — City/State/Postal Code

_____ _____
Mailing Address — Insurance Carrier

_____ _____
City/State/Postal Code — Mailing Address

☐ Outside United States _____
City/State/Postal Code

_____ _____
Country — Additional Defendant Name

_____ _____
Occupation — Mailing Address

_____
City/State/Postal Code

Reason for Joinder:

_____

_____
Additional Other Defendant

_____
Mailing Address

_____
City/State/Postal Code

Reason for Joinder:

_____

## II. Nature of Occupational Disease

1. Date and Place of last exposure

_____ _____

Date of Last Exposure Place 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:

_____

City State Postal Code

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, which language?_____

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

9 . Dependents

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

10. 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: _____

11. If applying for retraining incentive benefit, 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 _____

16. Are you alleging a violation of a safety rule/regulation pursuant to KRS 342.165? (Yes / No) _____

    If yes, submit form SVC within 15 days after filing the Application for Resolution of Claim.

**Attestations:**

☐ I understand that 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.

☐ Plaintiff herein being duly sworn, states that the statements in this application and in Form 104, 105, and 106 to be separately filed, are true.

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:

_____

Plaintiff's Signature

**Instructions for Completion of**
**Application of Resolution of a Claim –**
**Occupational Disease**

## Application for Resolution of a Claim - Occupational Disease

1. All sections of this form must be completed, and the following shall be filed within 15 days:
   a. Form 104 (Plaintiff's Employment History)
   b. Form 105 (Plaintiff's Chronological Medical History)
   c. Form 106 (Medical Waiver and Consent)
   d. Medical report supporting the occupational disease
   e. Proof of Wages, including W-2's, paycheck stubs, etc.
   f. Social Security earnings record release form.

2. This form may be filed in combination with an Application for Resolution of a Claim – Injury if both benefits are sought. Information provided should be current through the date application is signed by plaintiff.

3. All information must be typewritten.

4. File the original of this form and sufficient copies for all named defendants with the **Department of Workers' Claims**, Prevention Park, 657 Chamberlin Avenue, Frankfort, Kentucky, 40601.

5. If you have questions, call 1-800-554-8601.

**Note: Special attention should be given to stating the correct name and address of the employer and insurance carrier. Otherwise, claim processing may be delayed.**