**KENTUCKY**
**DEPARTMENT OF WORKERS’ CLAIMS**
Application for Resolution of Occupational Disease Claim
Claim No. ____________________________

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<th>Plaintiff</th>
<th>Defendant/Employer</th>
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<th>Social Security Number</th>
<th>Street Address</th>
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<th>Birth Date</th>
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<th>Street Address</th>
<th>Insurance Carrier</th>
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<th>Defendant/Employer</th>
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<th>Phone Number</th>
<th>Other Defendant</th>
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Filed:

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I. Nature of Occupational Disease

1. Plaintiff states that on the _______ day of ________ 20____, 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(s) claimed:_________________________________________________________________________________
3. State the date and means by which plaintiff gave notice of the injury to employer.

____________________________________________________________________________________________
____________________________________________________________________________________________

4. Place of last exposure ____________________________
    (city)   (county)    (state)

5. Nature of the work in which the plaintiff was engaged at the time of exposure_______________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

6. How did exposure to the disease occur? (Describe in detail) ____________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

II. Personal Data

7. Name and address of last school attended: ____________________________________________________________
____________________________________________________________________________________________

8. Highest grade completed in school: ____________________

9. GED awarded _____yes _____no

10. Professional or vocational degrees, certificates, or licenses: ______________________________________________
______________________________________________________________________________________________

11. Dependents: Name            Social Security Number              Relationship

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<th>Name</th>
<th>Social Security Number</th>
<th>Relationship</th>
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12. Has plaintiff previously filed for or received workers’ compensation benefits? _____yes _____no; If yes, give dates, nature of injury or disease and any award of benefits received: ____________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

13. If applying for retraining incentive benefits, identify the name, address and phone number of the training or education program in which the plaintiff is enrolled or plans to enroll. ______________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

14. Is plaintiff currently engaged in the severance or processing of coal? _____yes _____no

III. Employment Data

15. Type of work performed at date of occupational disease: _______________________________________________

16. Describe the physical requirements of plaintiff’s customary job: _________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

17. Weekly wage at date of occupational disease: _________________. Attach copy of any proof of wages, such as paycheck stub, W-2, etc.
18. Has plaintiff returned to work? _____yes  _____no; if yes, name and address of current employer and description of job currently being performed: ____________________________________________________________

Is plaintiff still working in environment where he/she is exposed to the hazards of the disease? _____yes  _____no

Number of years of exposure to hazards of occupational disease ____________________________________________

Has plaintiff been exposed to the disease while working for more than one employer? _____yes  _____no

19. Weekly wage currently earned:_____________ Attach copy of any proof of current wages.

20. Are you alleging a violation of a safety rule/regulation pursuant to KRS 342.165? _____yes  _____no

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.

Plaintiff herein being duly sworn, states that the statements in this application and in Form 104, 105, and 106 are true. This the ______ day of ___________________ 20____.

Plaintiff’s Signature

Subscribed and sworn to before me this _____ day of ____________ 20____.

Notary Public

My Commission expires:___________ County: ________________

Prepared and submitted by:____________________________________

Signature/Representative for Plaintiff

Title

Street Address

City/State/Zip

Telephone Number
Instructions for Completion of Forms 101, 102 and 103

Form 101 – Application for Resolution of Injury Claim

1. All sections of this form must be completed, and must be accompanied by the following:
   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 describing and supporting the injury which is the basis of the claim.
   e. Proof of Wages, including W-2’s, paycheck stubs, etc.

2. All information must be typewritten.

3. 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.

4. If you have no telephone number, please list a number at which you may be contacted.

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

Form 102 - Application for Resolution of Occupational Disease Claim, and
Form 103 – Application for Resolution of Hearing Loss Claim

1. All sections of this form must be completed, and must be accompanied by the following:
   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 Injury Claim (Form 101) 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.

Revised January 25, 2005