

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
