**COMMONWEALTH OF KENTUCKY**
**DEPARTMENT OF WORKERS' CLAIMS**
**CLAIM NO. _____**
**BEFORE _____**

_____ PLAINTIFF
**(EMPLOYEE)**

VS. **MOTION TO REOPEN KRS 342.732 BENEFITS**

_____ DEFENDANT(S)
**(EMPLOYER)**

_____
**(INSURANCE CARRIER)**

_____
**(OTHER DEFENDANTS)**

**********

The undersigned moves to reopen this coal workers pneumoconiosis claim. The order or award being reopened was :

___ An Order or Award for retraining incentive benefits.

___ An Order or Award for other benefits under KRS 342.732.

___ Dismissed due to a finding of no coal workers pneumoconiosis on x-ray or failure to meet medical eligibility standards.

This Order or Award was issued _____/_____/_____.

The undersigned states that the grounds for reopening are stated below:

___ Progression of occupational disease resulting from coal workers pneumoconiosis .

___ Development or progression of respiratory impairment due to occupational pneumoconiosis.

___ Review of university x-ray in compliance with reconsideration procedures of KRS 342.732, effective 7-15-02. Last exposure prior to 12-12-96.

___ Review of dismissal or award under KRS 342.732 as effective 7-15-02. Last exposure between 12-12-96 and 7-14-02.

___ Medical fee dispute. Medical bills in question are attached.

___ Other:

_____
_____
_____.

The undersigned further states that the following information is correct:

1. The employee's last date of exposure to coal dust was _____.

2. The employee was awarded _____ and received _____ under the prior award or settlement for coal workers pneumoconiosis.

3. The employee /plaintiff states that the employee/plaintiff has _____ or has not _____ had two additional years of exposure to coal dust in the Commonwealth of Kentucky. This additional exposure was with _____ at _____.

4. __ No previous motion to reopen has been filed.

   __ Previous motion to reopen was filed _____/_____/_____.

5. On medical fee disputes:

   __ Utilization review was done on _____. A copy of the decision is attached.

   __ Utilization review is not required because

   _____.

The motion to reopen is supported by the following attached documents:
(**INCLUDE IF NEEDED)**

1. Affidavit(s) of _____.

2. Medical report of _____ showing progression of the disease by x-ray and/or pulmonary function studies (FVC, FEV1) showing development or progression of pulmonary impairment attributable to coal workers' pneumoconiosis.

3. A current medical release (Form 106) which has been signed and witnessed.

4. A copy of the Opinion and Award, Settlement, Agreed Order or Order of Dismissal sought to be reopened.

5. Updated work history (Form 104) and medical history (Form 105).

The undersigned, being duly sworn, states the foregoing statements in this motion and Forms 104, 105, & 106 are true and accurate to the best of my knowledge and belief.

_____
**(MOVANTS SIGNATURE)**

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

_____
**NOTARY PUBLIC**

My Commission expires: _____ County:_____

Respectfully submitted,

_____
**(MOVANTS SIGNATURE)**

_____
**(MOVANTS STREET ADDRESS)**

_____
**(MOVANTS CITY/STATE/ZIP CODE)**

**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 material fact commits a fraudulent insurance act, which is a crime.**

CERTIFICATE OF SERVICE

I certify that the original was mailed to the Commissioner at the Department of Workers' Claims, Prevention Park, 657 Chamberlin Avenue, Frankfort, Kentucky 40601 and copies of this motion and attachments were mailed to the names and addresses of the parties given below:

Attorney for Employer or Insurance Carrier if applicable:

_____
**(Attorney Name or Law Firm)**

_____
(**Attorney Address or Law Firm Street Address)**

_____
**(Attorney Address, City/State/Zip)**

Employer or Insurance Carrier: _____
**(Company Name or Employer Name)**

_____
**(Company or Employer Street Address)**

_____
**(Company or Employer City/State/Zip)**

Other Parties, if applicable:

_____
**(Name of Party)**

_____
**(Party Street Address)**

_____
**(Party City/State/Zip)**

This _____ day of _____, 20____.

_____

**(Movants Signature)**