

KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS
Application for Resolution of Occupational Disease Claim
Claim No. _____

Plaintiff

vs.

Defendant/Employer

Social Security Number

Street Address

Birth Date

City/State/Zip Code

Street Address

Insurance Carrier

City/State/Zip Code

Street Address

County

City/State/Zip Code

Phone Number

Other Defendant

Filed:

Street Address

City/State/Zip Code

Reason for Joinder:

Other Defendant

Street Address

City/State/Zip Code

Reason for Joinder:

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/or 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

Name	Social Security Number	Relationship

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