Form CMB-APP-1
Application for Continuation of Benefits
Revised August 2018

KENTUCKY LABOR CABINET

Department of Workers' Claims

500 Mero Street, 3rd Floor
Frankfort, KY 40601

APPLICATION FOR CONTINUATION OF MEDICAL BENEFITS

WORKERS' COMPENSATION CLAIM NUMBER: ____________

NAME: ____

SSN: ____

ADDRESS: ____

DATE OF BIRTH: ____

DATE OF INJURY/LAST EXPOSURE: ____

NATURE OF INJURY/OCCUPATIONAL DISEASE: _______________________________________

EMPLOYER: ____

I apply for a continuation of medical benefits for my work injury or occupational disease.

I need a continuation of medical benefits because:

____

____

____

CLAIMANT: ________________________________

DATE: ____________________________________