Application for Resolution of a Claim - Injury

**KENTUCKY DEPARTMENT OF WORKERS’ CLAIMS**
Application for Resolution of a Claim - Injury
Claim No. ____________________

<table>
<thead>
<tr>
<th>Plaintiff</th>
<th>vs.</th>
<th>Defendant/Employer (business name)</th>
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<tbody>
<tr>
<td>Social Security Number/Green Card</td>
<td>Mailing Address</td>
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</tr>
<tr>
<td>Birth Date</td>
<td>Gender</td>
<td>City/State/Postal Code</td>
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<tr>
<td>Mailing Address</td>
<td>Insurance Carrier</td>
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<tr>
<td>City/State/Postal Code</td>
<td>Mailing Address</td>
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<td>City/State/Postal Code</td>
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<tr>
<td>Outside United States</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country</td>
<td>Additional Defendant Name</td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td>Mailing Address</td>
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<td>City/State/Postal Code</td>
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<tr>
<td></td>
<td>Reason for Joinder:</td>
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<td></td>
<td>Additional Other Defendant</td>
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<td>Mailing Address</td>
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<td>City/State/Postal Code</td>
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<td>Reason for Joinder:</td>
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I. Nature of Injury

1. Date and location of accident/injury:

Date of Injury __________________________ Location of Injury (City/State/Postal Code)

☐ Plaintiff states that he/she was injured within the scope and course of employment with defendant employer on the above date and at the above location.

2. Describe how the accident/injury occurred:

Cause of Injury: __________________________

3. Body part injured: __________________________

4. When and by what means did the plaintiff give notice of injury to the employer?

________________________________________________________________________

5. Describe medical treatment, if any:

6. Name and address (city/state/postal code) of physician whose report will be provided:

7. Will an interpreter be needed for the formal hearing? (Yes/No) ______

If yes, in which language? __________________________

8. Dependents

Injured worker is deceased? (Yes/No) ______

If deceased, dependent information is required for a deceased worker. If work injury resulted in the death of claimant, attach/provide/upload Form F in addition to the Application for Resolution of Claim.

9. Have you previously filed for or received workers’ compensation benefits in Kentucky? (Yes/No) ______

If yes, please provide the following information:

<table>
<thead>
<tr>
<th>Claim Number</th>
<th>Date of Injury</th>
<th>Nature of Injury/Disease</th>
<th>Awards/Benefits</th>
</tr>
</thead>
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</table>

If not a Kentucky claim, please provide the state in which you were awarded benefits: __________________________
10. Was there concurrent employment at the time of injury? (Yes / No) _________

11. Name and address of concurrent employer:

   Concurrent Employer Name _________________________________
   Concurrent Employer City _________________________________
   Concurrent Employer State ________________ Postal Code __________________

12. Has the plaintiff worked since the injury? (Yes / No) _________

13. Name and address of current employer and description of job currently being performed:

   Current Employer Name _________________________________
   Current Employer City _________________________________
   Current Employer State ________________ Postal Code __________________

14. Are you alleging a violation of a safety rule/regulation pursuant to KRS 342.165? (Yes / No) _________

   If yes, submit form SVC within 15 days after filing the Application for Resolution of Claim.

   **Attestations:**

   [ ] I understand that 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 to be separately filed, are true.

   By entering your name below, you are confirming the accuracy of this form to the best of your knowledge.

   This form prepared and submitted by ________________________________ Relationship to injured worker: ________________________________

   Plaintiff Signature ________________________________
**Instructions for Completion of – Application for Resolution of a Claim - Injury**

1. All sections of this form must be completed, and the following shall be filed within 15 days:
   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**, Mayo-Underwood Building, 500 Mero Street, 3rd Floor, 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.

**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.