KENTUCKY DEPARTMENT OF WORKERS’ CLAIMS
Application for Resolution of a Claim – Occupational Disease
Claim No. ______________________

__________________________________________ vs. ______________________________

Plaintiff

Social Security Number/ Green Card

Birth Date Gender

Plaintiff Mailing Address

City/State/Postal Code

Insurance Carrier

Outside United States

Country

Plaintiff’s Phone Number

Occupation

Additional Defendants

__________________________________________ Additional Defendant

Mailing Address

City/State/Postal Code

Reason for Joinder:

__________________________________________ Additional Defendant

Mailing Address

City/State/Postal Code

Reason for Joinder:
1. Date and location of last exposure:

<table>
<thead>
<tr>
<th>Date of Last Exposure</th>
<th>Location of Exposure (City/State/Postal Code)</th>
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☐ Plaintiff states that he/she became affected by reason of a disease arising out of and in the course of his/her employment.

2. Identify the occupational disease claimed:

Nature of disease: __________________________________________

3. When and by what means did the plaintiff give notice of occupational disease to the employer?

4. Name and address of physician providing medical report:

5. Place of last exposure?
   City __________________________ County __________________________ State __________________________

6. Nature of the work in which the plaintiff was engaged at the time of exposure:

7. Will an interpreter be needed for the formal hearing? (Yes / No) __________
   If yes, in which language? __________________________________________

8. Dependents
   Did the occupational disease result in death of claimant? (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>
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   If not a Kentucky claim, please provide the state in which you were awarded benefits: __________________________
10. If applying for retraining benefits, identify the training or education program in which the plaintiff is enrolled or plans to enroll:
   Name: ________________________________
   Street Address: ____________________________
   City: ___________________ State: ____________ Postal Code: ____________ Phone Number: ____________

12a. Is plaintiff currently engaged in the severance or processing of coal? (Yes / No) ________________

12b. Is plaintiff currently working in the industry in which the last exposure occurred? (Yes / No) ________________

13. Was there concurrent employment at the time of injury? (Yes / No) ________________
   Concurrent Employer Name: ________________________________
   Concurrent Employer City: ________________________________
   Concurrent Employer State: ____________________________ Postal Code: ____________

14. Has the plaintiff returned to work? (Yes / No) ________________

15. Name and address of current employer and description of job currently being performed:
   Current Employer Name: ________________________________
   Current Employer City: ________________________________
   Current Employer State: ____________________________ Postal Code: ____________
   Description of Job Performed: ________________________________

16. 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

__________________________________________  __________________________________________
Submitter Phone Number  Submitter Email Address

__________________________________________
Plaintiff Signature
Instructions for Completion of – Application for Resolution of a Claim – Occupational Disease

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 supporting the occupational disease.
   e. Proof of Wages, including W-2’s, paycheck stubs, etc.
   f. Social Security earnings record release form.

2. All information must be typewritten

3. Pro Se Submitters - 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.

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.