Filed:

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS

Application for Resolution of a Claim – Occupational Disease

Claim No. ______________________

vs.

Plaintiff	Defendant/Employer (Business Name)
Social Security Number/ Green Card	Defendant/ Employer Mailing Address
Birth Date Gender	City/State/Postal Code
Plaintiff Mailing Address	Insurance Carrier
City/State/Postal Code	Insurance Carrier Mailing Address
☐ Outside United States	City/State/Postal Code
Country	
Plaintiff's Phone Number	
Occupation	

Additional Defendants

Additional Defendant	Additional Defendant
Mailing Address	Mailing Address
City/State/Postal Code	City/State/Postal Code
Reason for Joinder:	Reason for Joinder:

I. Nature of Occupational Disease

1. Date and location of last exposure:

______________________ ____

Date of Last Exposure Location of Exposure (City/State/Postal Code)

☐ 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:

Claim Number	Date of Injury	Nature of Injury/Disease	Awards/Benefits

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.