

**COMMONWEALTH OF KENTUCKY  
DEPARTMENT OF WORKERS' CLAIMS**

**Workers' Compensation Claim No.** \_\_\_\_\_

\_\_\_\_\_  
PLAINTIFF/EMPLOYEE

**VS.**

**MOTION TO REOPEN**

\_\_\_\_\_  
DEFENDANT/EMPLOYER

The undersigned moves to reopen this claim based on the following grounds (**check all that apply**):

- Change of Disability shown by objective medical evidence
- Fraud
- Mistake
- Newly Discovered evidence
- Conforming the award to employee's work status for injuries after 12-12-96
- Reducing a permanent total disability award when employee returns to work

(To reopen for a medical dispute, please file a Form 112 Medical Dispute for re-opening a claim.)

Explanation:

Have you previously filed a motion to reopen?     Yes     No

Date of previous motion to reopen: \_\_\_\_\_

**NOTE:** Pursuant to KRS 342.125(3) no party may file a motion to reopen within one (1) year of any previous motion to reopen by the same party.

This motion is supported by the following attached documents:

- Affidavit(s) of employee / other witnesses
- Medical report
- A current medical release Form 106, signed and witnessed
- A copy of the Opinion and Award, Settlement, Agreed Order, or Agreed Resolution sought to be reopened
- Utilization review

The undersigned, being duly sworn, states the foregoing statements in this motion and in Form 106 are true and accurate to the best of my knowledge and belief.

This the \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_ .

Respectfully submitted,

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**Signature**

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**Mailing Address**

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**City/State/Postal Code**

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**Submitter Phone Number**

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**Submitter Email Address**

**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 material fact commits a fraudulent insurance act, which is a crime.**

CERTIFICATE OF SERVICE

I certify that the original was mailed to the Department of Workers' Claims, 657 Chamberlin Avenue, Frankfort, Kentucky 40601 or filed and served electronically through the Department of Workers' Claims Litigation Management System to the Department of Workers' Claims and copies of this motion and attachments were served on the names and addresses of the parties below:

Attorney for Employer or Insurance Carrier  
if applicable:

\_\_\_\_\_

**(Name)**

\_\_\_\_\_

**(Mailing Address)**

\_\_\_\_\_

**(City/State/Postal Code)**

Employer or Insurance Carrier:

\_\_\_\_\_

**(Name)**

\_\_\_\_\_

**(Mailing Address)**

\_\_\_\_\_

**(City/State/Postal Code)**

Other Parties, if applicable:

\_\_\_\_\_

**(Name)**

\_\_\_\_\_

**(Mailing Address)**

\_\_\_\_\_

**(City/State/Postal Code)**

Special Fund, if applicable:

\_\_\_\_\_

**(Name)**

\_\_\_\_\_

**(Mailing Address)**

\_\_\_\_\_

**(City/State/Postal Code)**