COMMONWEALTH OF KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS
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 _____ , _____.

Respectfully submitted,

_____

SIGNATURE

_____

(MAILING ADDRESS)

_____

(CITY/STATE/POSTAL CODE)

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, 500 Mero Street, 3rd Floor, 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:

_____
(Special Fund)

_____
(Mailing Address)

_____
(City/State/Postal code)