

**COMMONWEALTH OF KENTUCKY**  
**DEPARTMENT OF WORKERS CLAIMS**  
**CLAIM NO. \_\_\_\_\_**  
**BEFORE \_\_\_\_\_**

\_\_\_\_\_  
**(EMPLOYEE)**

PLAINTIFF

VS.

**MOTION TO REOPEN**  
**BY EMPLOYEE**

\_\_\_\_\_  
**(EMPLOYER)**

DEFENDANT(S)

\_\_\_\_\_  
**(INSURANCE CARRIER)**

\_\_\_\_\_  
**(OTHER DEFENDANTS, IF APPLICABLE)**

\_\_\_\_\_  
**(SPECIAL FUND, IF APPLICABLE)**

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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
- Medical dispute
- Conforming the award to employees work status for injuries after 12-12-96.
- Reducing a permanent total disability award when employee returns to work.

Explanation:

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The undersigned further states that the following information is correct (**check appropriate response**):

1.  No previous motion to reopen has been filed.

Previous motion to reopen filed

Month Day Year

On medical disputes:

2.  Utilization review was done on \_\_\_\_\_. A copy of the decision is attached.  
(DATE)

Utilization review is not required because

This motion is supported by the following attached documents:

1. Affidavit(s) of \_\_\_\_\_  
(EMPLOYEE, OTHER WITNESS NAMES)

2. Medical report of \_\_\_\_\_  
(DOCTOR'S NAME)

3. A current medical release Form 106 signed and witnessed.

4. A copy of the Opinion and Award, Settlement, Agreed Order, or Agreed Resolution sought to be reopened.

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\_\_\_\_.

\_\_\_\_\_  
**(EMPLOYEE'S SIGNATURE)**

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_.

\_\_\_\_\_  
**NOTARY PUBLIC**

My Commission expires: \_\_\_\_\_ County: \_\_\_\_\_

Respectfully submitted,

\_\_\_\_\_  
**(EMPLOYEE'S SIGNATURE)**

\_\_\_\_\_  
**(STREET ADDRESS)**

\_\_\_\_\_  
**(CITY/STATE/ZIP 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, Prevention Park, 657 Chamberlin Avenue, Frankfort, Kentucky 40601 and copies of this motion and attachments were mailed to the names and addresses of the parties given below:

Attorney for Employer or Insurance Carrier \_\_\_\_\_  
if applicable: **(Name)**

\_\_\_\_\_  
**(Street Address)**

\_\_\_\_\_  
**(City/State/Zip)**

Employer or Insurance Carrier: \_\_\_\_\_  
**(Name)**

\_\_\_\_\_  
**(Street Address)**

\_\_\_\_\_  
**(City/State/Zip)**

Other Parties, if applicable: \_\_\_\_\_  
**(Name)**

\_\_\_\_\_  
**(Street Address)**

\_\_\_\_\_  
**(City/State/Zip)**

Special Fund, if applicable: \_\_\_\_\_  
**(Special Fund)**

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**(Street Address)**

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**(City/State/Zip)**

This \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

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**(Employee's Signature)**