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		
_____		
Email Address		
_____		
Plaintiff's Phone Number		
_____		
Occupation		

Additional Parties

_____	_____
Additional Party	Additional Party
_____	_____
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. Highest grade completed in school? _____

17. G.E.D. Awarded? ☐ Yes ☐ No

18. Professional or Vocational Degrees, Certificates, or Licenses:

19. Are you alleging a violation of a safety rule/regulation pursuant to KRS 342.165? (Yes / No) _____

If yes, submit form SVC with the Application for Resolution of Claim.

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

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