Form 101
Revised 6/05

KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS
Application for Resolution of Injury Claim
Claim No. _____

_____	**vs.**	_____
Plaintiff		**Defendant/Employer**
_____		_____
Social Security Number		**Street Address**
_____		_____
Birth Date		**City/State/Zip Code**
_____		_____
Street Address		**Insurance Carrier**
_____		_____
City/State/Zip Code		**Street Address**
_____		_____
County		**City/State/Zip Code**
_____		_____
Phone Number		**Other Defendant**
		_____
		Street Address
		_____
		City/State/Zip Code
		Reason for Joinder:
		_____
		_____
		_____
		Other Defendant
		_____
		Street Address
		_____
		City/State/Zip Code
		Reason for Joinder:
		_____
		_____

Filed:

I. Nature of Injury

1. Plaintiff states that on the _____ day of _____ 20____, he/she was injured within the scope and course of employment with defendant employer at _____
(City/County/State)

2. Describe how the injury occurred: _____
_____
_____

3. Body part injured:_____

4. State the date and means by which the plaintiff gave notice of injury to the employer:
_____
_____

5. Describe medical treatment, if any: _____
_____
_____

6. Name and address of physician whose report is attached: _____
_____

II. Personal Data

7. Name and address of last school attended: _____
_____

8. Highest grade completed in school: _____

9. GED awarded _____yes _____no

10. Professional or vocational degrees, certificates, or licenses: _____
_____

11. Dependents: Name Date of Birth Social Security Number Relationship

12. Have you previously filed for or received workers' compensation benefits? _____yes _____no

    If yes, give Department of Workers' Claims file number(s), dates and nature of injury or disease and any award of benefits received:
    _____
    _____
    _____

III. Employment Data

13. Is plaintiff currently working? _____yes _____no

14. Type of work performed at date of injury: _____
_____

15. Describe the physical requirements of job performed at date of injury: _____
_____
_____

16. Weekly wage at date of injury: _____. Attach copy of any proof of wages, such as paycheck stub, W-2, etc.

17. Weekly wage currently earned: _____. Attach copy of any proof of current wages.

18. Name and address of current employer and description of job currently being performed:
_____
_____
_____

19. Are you alleging a violation of a safety rule/regulation pursuant to KRS 342.165? _____yes _____no

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.

Plaintiff herein being duly sworn, states that the statements in this application and in Form 104, 105, and 106 are true. This the _____ day of _____ 20____.

_____
Plaintiff's Signature

Subscribed and sworn to before me this _____ day of _____ 20____.

_____
Notary Public

My Commission expires:_____ County: _____

Prepared and submitted by: _____
Signature/Representative for Plaintiff

_____
Title

_____
Street Address

_____
City/State/Zip

_____
Telephone Number

Instructions for
Completion of Forms 101, 102 and 103

Form 101 – Application for Resolution of Injury Claim

1. All sections of this form must be completed, and must be accompanied by the following:
   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 describing and supporting the injury which is the basis of the claim.
   e. Proof of Wages, including W-2's, paycheck stubs, etc.

2. All information must be typewritten.

3. 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.

Form 102 - Application for Resolution of Occupational Disease Claim, and Form 103 – Application for Resolution of Hearing Loss Claim

1. All sections of this form must be completed, and must be accompanied by the following:
   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. This form may be filed in combination with an Application for Resolution of Injury Claim (Form 101) if both benefits are sought. Information provided should be current through the date application is signed by plaintiff.

3. All information must be typewritten.

4. 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.

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.

Revised January 25, 2005