

**KENTUCKY**  
**DEPARTMENT OF WORKERS CLAIMS**  
**Application for Resolution of Injury Claim**  
**Claim No. \_\_\_\_\_**

.....  
**Plaintiff**  
.....  
..... **Social**  
**Security Number**  
.....  
..... **Birth**  
**Date**  
.....  
.....  
**Street Address**  
.....  
.....  
**City/State/Zip Code**  
.....  
.....  
**County**

vs.

.....  
**Defendant/Employer**  
.....  
.....  
**Street Address**  
.....  
.....  
**City/State/Zip Code**  
.....  
.....  
**Insurance Carrier**  
.....  
.....  
**Street Address**  
.....  
.....  
**City/State/Zip Code**

..... **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

	Name	Date of Birth	Social Security Number	Relationship

12. Have you previously filed for or received workers' compensation benefits? \_\_\_\_yes \_\_\_\_no  
 If yes, give Dept. of Workers' Claims file number(s), dates and nature of injury or disease: \_\_\_\_\_  
 \_\_\_\_\_

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:\_\_\_\_\_

**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**

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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 the Office 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 the Office 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**