

KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS
Application for Resolution of Coal Workers' Pneumoconiosis 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 Occupational Disease

1. Plaintiff states that on the day of, 20.....,
(day) (month) (year)
he/she became affected by coal workers' pneumoconiosis arising out of and in the course of his/or
her employment.

16. Has plaintiff been exposed to the disease while working for more than one employer?
 ___ yes ___ no
14. Weekly wage currently earned: _____ Attach copy of any proof of current wages.

IV. Medical Data

15. List name and address of "B" reader whose report is attached to this Form. File original x-ray read by this "B" reader with this form.

Name of "B" Reader	Address

16. Are you alleging a pulmonary impairment as the result of coal dust exposure?
 ___ yes ___ no
 If yes, attach results of pulmonary function studies and tracings.

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 of Attorney for Plaintiff

Name of Attorney (Print or Type)

Street Address

City/State/Zip Code

Telephone Number

**Instructions for
Completion of Forms 101, 102, 102-CWP 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 To Be Announced Ave., 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 & Form 102-CWP - 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 of "B" reader supporting the disease. (Applies to 102-CWP only)
 - e. Original x-ray read by "B" reader (Applies to 102-CWP only)
 - f. Pulmonary function studies and tracings if a pulmonary impairment is alleged
 - g. Proof of Wages, including W-2's, paycheck stubs, etc.
 - h. 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 To Be Announced Ave., Frankfort, Kentucky, 40601.
5. If you have questions, call 1-800-554-8601.

Note: Please list the correct name and address of the employer and insurance carrier to avoid delay in processing the claim.

Revised July, 2002