DIVISION OF WORKERS' COMPENSATION

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
P.O. Box 58
Jefferson City, MO 65102-0058

INJURY NUMBER

CLAIM FOR COMPENSATION

+ ☐☐ - ☐☐☐☐☐☐

NOTE: This form should be used to file a Claim for Compensation for accident or injury including occupational diseases and occupational diseases due to toxic exposure that occur on or after January 1, 2014.

This form should be completed in its entirety and must be typed or hand printed in **black ink**.

SUBMIT AN ORIGINAL AND THREE COPIES.

☐ ORIGINAL CLAIM ☐ AMENDED CLAIM ☐ SECOND INJURY FUND ONLY

Please read instructions before completing this form.

BOX NUMBER(S) AMENDED

EMPLOYEE INFORMATION

1. INJURED EMPLOYEE'S NAME LAST FIRST INITIAL OR MIDDLE NAME			1A. MAILING ADDRESS (ALSO INCLUDE STREET ADDRESS)	
1B. CITY	1C. STATE	1D. ZIP CODE	2. SOCIAL SECURITY NO. (Last 4 digits) XXX-XX-	3. DATE OF BIRTH
4. DATE OF ACCIDENT OR OCCUPATIONAL DISEASE	5. AVERAGE WEEKLY WAGE	6. TIME OF ACCIDENT A.M. P.M.	7. PLACE OF ACCIDENT *(City, County, State, Zip)*	

8. Check the appropriate box if you are filing a Claim due to an Occupational Disease due to Toxic Exposure:

- ☐ asbestosis
- ☐ berylliosis
- ☐ coal worker's pneumoconiosis
- ☐ bronchiolitis obliterans
- ☐ silicosis
- ☐ silicotuberculosis
- ☐ manganism
- ☐ acute myelogenous leukemia
- ☐ myelodysplastic syndrome.

☐ Check this box ONLY if you are filing a Claim due to an Occupational Disease due to **toxic exposure resulting in a diagnosis of mesothelioma.**

9. PART(S) OF BODY INJURED

10. DESCRIBE WHAT THE EMPLOYEE WAS DOING AND HOW THE INJURY OCCURRED.

EMPLOYER INFORMATION – If additional employers need to be listed or if you need more space, attach additional sheets.

11. EMPLOYER(S) AGAINST WHOM THIS CLAIM IS FILED. THIS IS THE EMPLOYER IN WHOSE EMPLOYMENT THE INJURY OR OCCUPATIONAL DISEASE OR OCCUPATIONAL DISEASE DUE TO TOXIC EXPOSURE OCCURRED.

EMPLOYER A:	MAILING ADDRESS	
CITY	STATE	ZIP CODE
EMPLOYER B:	MAILING ADDRESS	
CITY	STATE	ZIP CODE
EMPLOYER C:	MAILING ADDRESS	
CITY	STATE	ZIP CODE

DIVISION USE ONLY

Date Stamp

BE SURE TO COMPLETE NEXT PAGE.

INJURY NUMBER

		-						

12. ☐ PLEASE CHECK THIS BOX IF YOU ARE FILING A CLAIM AGAINST THE SECOND INJURY FUND FOR PERMANENT TOTAL DISABILITY BENEFITS

13. DID INJURY RESULT IN DEATH? ☐ YES ☐ NO 12A. DATE OF DEATH ____/____/_____

IF DEATH OCCURRED, **EMPLOYEE'S DEPENDENTS (SPOUSE, MINOR CHILDREN, OR OTHER PERSONS DEPENDENT ON EMPLOYEE).**
IF YOU NEED TO LIST DEPENDENTS IN ADDITION TO THESE LISTED BELOW, PLEASE ATTACH A SEPARATE SHEET.

14. NAME	DATE OF BIRTH	RELATIONSHIP	
MAILING ADDRESS	CITY	STATE	ZIP CODE
14A. NAME	DATE OF BIRTH	RELATIONSHIP	
MAILING ADDRESS	CITY	STATE	ZIP CODE
14B. NAME	DATE OF BIRTH	RELATIONSHIP	
MAILING ADDRESS	CITY	STATE	ZIP CODE

CLAIM IS HEREBY MADE FOR ALL COMPENSATION AS PROVIDED UNDER THE MISSOURI WORKERS' COMPENSATION LAW, RELATING TO INJURY OR OCCUPATIONAL DISEASE OR OCCUPATIONAL DISEASE DUE TO TOXIC EXPOSURE (OR DEATH) OF THE EMPLOYEE ARISING OUT OF AND IN THE COURSE OF THE EMPLOYMENT.

15. INJURED EMPLOYEE OR CLAIMANT'S SIGNATURE	16. EMPLOYEE/CLAIMANT TELEPHONE NO.	17. DATE
18. ATTORNEY SIGNATURE	18A. ATTORNEY NAME *(type or print)*	18B. BAR NUMBER
19. ATTORNEY PHONE NUMBER	19A. ATTORNEY FAX NUMBER	19B. ATTORNEY E-MAIL ADDRESS
20. ATTORNEY MAILING ADDRESS	20A. CITY	20B. STATE / 20C. ZIP CODE

21. ADDITIONAL STATEMENTS – Please use this Box to add any further information that will assist you in filing your Claim.

Do not submit Confidential Documents at the time of filing the Claim for Compensation.

Missouri Division of Workers' Compensation is an equal opportunity employer/program.
Auxiliary aids and services are available upon request to individuals with disabilities.