State of New Jersey
Department of Labor and Workforce Development
Division of Workers' Compensation
PO Box 381
Trenton, New Jersey 08625-0381
WC-365 8/26/2015

EMPLOYEE CLAIM PETITION

☐ **NEW FILING** ☐ **AMENDED FILING**

Case No.: _____

Vicinage: _____

please enter above only if filing an Amended Claim

PETITIONER

SOCIAL SECURITY NUMBER: ☐ SSN Not Available

NAME:

ADDRESS:

DATE OF BIRTH: | SEX:

☐ **A guardian or other representative is filing on behalf of the petitioner. See Supplemental Page for details.**

ATTORNEY FOR PETITIONER

TAX IDENTIFICATION NUMBER:

NAME:

ADDRESS:

TELEPHONE NUMBER: | FAX NUMBER:

VS

EMPLOYER

NAME:

IF EMPLOYER IS KNOWN BY DIFFERENT NAME, PLEASE INDICATE HERE:

ADDRESS:

INDICATE THE STATUS OF THE EMPLOYER:

☐INSURED ☐UNINSURED ☐SELF-INSURED (PRIVATE) ☐SELF-INSURED (GOVT. AGENCY)

☐ **If uninsured, individual corporate officers, or others, are also named as respondent(s). See Supplemental Page for details.**

INSURANCE CARRIER or SELF-INSURED ENTITY

NAME:

ADDRESS:

CARRIER CLAIM NUMBER:

PERIOD OF COVERAGE: FROM: TO:

☐ **See Supplemental Page for additional carriers**

TO THE DIVISION OF WORKERS' COMPENSATION - INJURY AND EMPLOYMENT DETAILS:

Date of Accident or Last Exposure:	Occupational Disease: ☐ YES ☐ NO	If Occupational Disease Give Periods of Exposure:
Where Injury Occurred (incl. town and county):		How Injury Occurred:

DESCRIBE EXTENT AND CHARACTER OF INJURY: If there has been amputation or disability to any member or impairment of any physical function, explain fully:

Date Stopped Work:	Date Returned to Work:	Date Injury Reported:	Injury Reported To Whom:	Occupation and Type of Work:

Gross Wages $	Wage Period:	Rate of Temp. Compensation: $	Weeks of Temp. Disability paid:	Temporary Disability Paid: $	Permanent Disability Paid: $

Employer Furnished Medical Aid: ☐ YES ☐ NO

☐ **Demand is hereby made for answers to standard occupational disease interrogatories. [N.J.A.C. 12:235-3.8(f)]**

☐ **Demand is hereby made for all records of medical treatment, examinations and diagnostic studies. [N.J.A.C. 12:235-3.8 (c)]**

Are you Medicare eligible or a Medicare beneficiary? ☐ **YES** ☐ **NO**

Were you eligible for Medicaid benefits at the time of the work injury? ☐ **YES** ☐ **NO**

Did you become eligible for Medicaid benefits after the work injury? ☐ **YES** ☐ **NO**

What other facts are there that you believe important:

Summary of Changes (*Complete only if filing an Amended pleading*):

Petitioner therefore requests that the Division of Workers' Compensation determine the amount of compensation due Petitioner from said Respondent, pursuant to R.S. 34:15-7 et seq., and that Petitioner may be awarded Petitioner's costs in this proceeding, and such other or further relief as may be proper.

_____
Petitioner

STATE OF NEW JERSEY
COUNTY OF _____

Subscribed and sworn or affirmed
to before me this _____ day of _____ , 20_____

_____

Please be advised that information collected from the filing of this claim petition may be used by the Division of Workers' Compensation for record keeping, record access/distribution, and case scheduling purposes. Petitions filed with the Division are public documents and may be inspected and copied except where prohibited by Section 34:15-128 of the Workers' Compensation Statute.

The Privacy Act, 5 U.S.C. §552a, the Social Security Act, 42 U.S.C. § 405, and N.J.S.A. 34:15-1 et seq. authorize the Division of Workers' Compensation to request that the Petitioner supply the Division with his or her Social Security Number for record keeping purposes and cross-matches with the Social Security Administration, Workforce New Jersey, Temporary Disability Insurance and any other proper public purpose.

State of New Jersey Department of Labor and Workforce Development Division of Workers' Compensation PO Box 381 Trenton, New Jersey 08625-0381 WC-365.1 5/7/2015	**EMPLOYEE CLAIM PETITION SUPPLEMENTAL PAGE**	Case No.: _____ Vicinage: _____

GUARDIAN OR REPRESENTATIVE

NAME:

ADDRESS:

RELATIONSHIP TO PETITIONER:

ADDITIONAL CARRIERS

NAME:

ADDRESS:

CARRIER CLAIM NUMBER:

PERIOD OF COVERAGE:

FROM: TO:

NAME:

ADDRESS:

CARRIER CLAIM NUMBER:

PERIOD OF COVERAGE:

FROM: TO:

NAME:

ADDRESS:

CARRIER CLAIM NUMBER:

PERIOD OF COVERAGE:

FROM: TO:

NAME:

ADDRESS:

CARRIER CLAIM NUMBER:

PERIOD OF COVERAGE:

FROM: TO:

INDIVIDUAL CORPORATE OFFICERS/PARTNERS/LLC MEMBERS

NAME:

ADDRESS:

NAME:

ADDRESS:

NAME:

ADDRESS:

NAME:

ADDRESS: