State of New Jersey Department of Labor and Workforce Development DIVISION OF WORKERS' COMPENSATION WC-376i (r. 3/19/13)	**ORDER FOR TOTAL DISABILITY w/Second Injury Fund**	CASE NO'S.: VICINAGE:

PETITIONER

SOCIAL SECURITY NUMBER:	DOB:
NAME:	
GENDER: ☐ MALE ☐ FEMALE	MEDICARE ELIGIBLE: ☐ YES ☐ NO
ADDRESS (Including County):	

ATTORNEY FOR PETITIONER

☐ SSN ☐ FEDERAL EMPLOYER NUMBER ☐ NJ REG NUMBER
NAME:
ADDRESS:
TELEPHONE NUMBER (AREA CODE):
APPEARING:

vs

RESPONDENT

NAME:
ADDRESS (Including County):

INSURANCE CARRIER

NAME ☐ SELF-INSURED ☐ TPA
CLAIM NUMBER:

ATTORNEY FOR RESPONDENT

NAME:
ADDRESS:
TELEPHONE NUMBER (AREA CODE):
APPEARING:
APPEARING FOR SECOND INJURY FUND:

DATE OF ACCIDENT OR OCCUPATIONAL EXPOSURE: DESCRIBE (Briefly):
FUND PETITION FILE DATE:

Upon the proofs presented and the stipulations made, I find and determine the following facts:

LAST COMPENSABLE ACCIDENT OR EXPOSURE

WAGES:	RATE:	Date of last payment of Permanent Compensation by Respondent:

In accordance with the provisions of the New Jersey Workers' Compensation Law (N.J.S.A. 34:15-1 et seq.), I find as follows:

Petitioner is totally and permanently disabled as of _____

Permanent Disability payable by Respondent (Describe Percentages, Nature and extent of Disability, and Members involved):

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AWARD WITHOUT SOCIAL SECURITY OFFSETS

TEMPORARY: _____ Weeks at $ _____ = $ _____ less $ _____ paid = Balance due $ _____

PERMANENT: _____ Weeks at $ _____ = $ _____ less $ _____ paid = Balance due $ _____

☐ Voluntary Tender ☐ Reopener Credit

PAYMENTS DUE FROM RESPONDENT WITH SOCIAL SECURITY OFFSETS

Payments before offset begins	_____	weeks at $	_____	less $	_____	Paid = $	_____ +
Payments with offset (aux)	_____	weeks at $	_____	less $	_____	Paid = $	_____ +
Payments with offset (no aux)	_____	weeks at $	_____	less $	_____	Paid = $	_____ +
After offset completed	_____	weeks at $	_____	less $	_____	Paid = $	_____
TOTAL PAYMENTS						$	_____

The total and permanent disability is due to the combined effects of the petitioner's previous disabilities and the last compensable accident or occupational exposure and is clearly within the provisions of the above cited statute.

Accordingly, it is determined that the petitioner receive benefits from the Second Injury Fund as follows:

a. ☐ _____weeks, being the difference between 450 weeks and the _____ weeks of permanent disability compensation previously received.
☐ 450 weeks has expired.

b. Weekly rate prior to offset is _____. (If third party offset, please explain on page 6)

c. Weekly rate subsequent to offset is $_____ .

d. Payment to begin upon the expiration of payment of compensation from the last compensation award, but, in any event, not sooner than the date of filing of the petition for benefits from the Second Injury Fund. Commencement date for Fund benefits is _____.

e. On_____, which is the expiration of the 450 week period, benefits to continue in accordance with the provision of N.J.S.A. 34:15-12(b) as amended.

MEDICAL BILLS (Doctors and/or Institutions):

☐ Petitioner is in receipt of Social Security Disability Benefits and the initial date of entitlement was _____.

Petitioner's 80% ACE is_____ and petitioner's initial entitlement was $_____including $_____ for auxiliary beneficiaries. Therefore respondent and the Second Injury Fund are entitled to an offset resulting in a rate of $_____ until petitioner's last auxiliary graduates from high school or turns 18 years of age, whichever is later. Thereafter, until the petitioner reaches 62 years of age on _____ the offset rate shall be $_____.

Name of Auxiliary	Date of Birth

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The first_____ weeks of permanent disability are to be paid at the full rate of $_____ reflecting Petitioner's share of counsel fee and costs.

☐ An Application for Social Security Disability Benefits and / or Government Ordinary Disability Pension ☐ is pending ☐ is on appeal ☐ has not been filed. Should Petitioner be awarded Social Security Disability Benefits and / or Government Ordinary Disability Pension, Petitioner shall immediately notify the Respondent and the Second Injury Fund of this award. The Petitioner shall reimburse the Respondent and the Second Injury Fund for any workers' compensation benefits paid to Petitioner in excess of the offset rate during the period of time Petitioner has received Social Security Disability benefits or Government Ordinary Disability Pension.

In the event there is a change in the number or status of the auxiliary beneficiaries while Petitioner is receiving Workers' Compensation benefits, Petitioner shall immediately notify the Respondent.

I further Order that Respondent furnish the Petitioner such medical attention, prosthesis, and medical supplies as the condition of the Petitioner may require. Should any emergency arise, necessitating immediate medical attention for the Petitioner, notice and request to Respondent shall not be necessary.

☐ Respondent authorizes_____ as treating physician.

The date of Petitioner's Permanent Total disability is_____.

On _____, which is the expiration of the 450 week period, benefits to continue in accordance with the provision of N.J.S.A. 34:15-12(b) as amended.

Pursuant to N.J.S.A. 34:15-12(b), petitioner will be referred to the Division of Vocational Rehabilitation Services for evaluation and services prior to the expiration of 450 weeks from the date of Total Permanent Disability.

PETITIONER DATA

Date of Last Employment:	Occupation:	Gross Weekly Wages:

PRE-EXISTING COMPENSABLE DISABILITIES

Date of Injury:	Claim Petition Number:
Employer Name:	
Permanent Disability Award:	
Description of Injury and Disability:	
Hearing Date:	

Date of Injury:	Claim Petition Number:
Employer Name:	
Permanent Disability Award:	
Description of Injury and Disability:	
Hearing Date:	

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Date of Injury:	Claim Petition Number:
Employer Name:	
Permanent Disability Award:	
Description of Injury and Disability:	
Hearing Date:	

Date of Injury:	Claim Petition Number:
Employer Name:	
Permanent Disability Award:	
Description of Injury and Disability:	
Hearing Date:	

Date of Injury:	Claim Petition Number:
Employer Name:	
Permanent Disability Award:	
Description of Injury and Disability:	
Hearing Date:	

Date of Injury:	Claim Petition Number:
Employer Name:	
Permanent Disability Award:	
Description of Injury and Disability:	
Hearing Date:	

(Provide like data on additional sheets as required)

State of New Jersey Department of Labor and Workforce Development DIVISION OF WORKERS' COMPENSATION WC-376i	**ORDER FOR TOTAL DISABILITY w/Second Injury Fund - Page 5**	CASE NO'S.: VICINAGE:

PRE-EXISTING NON-COMPENSABLE DISABILITIES

Date of Onset:	Origin (if known): ☐ Congenital ☐ Accident / Injury
Description:	

Date of Onset:	Origin (if known): ☐ Congenital ☐ Accident / Injury
Description:	

Date of Onset:	Origin (if known): ☐ Congenital ☐ Accident / Injury
Description:	

Date of Onset:	Origin (if known): ☐ Congenital ☐ Accident / Injury
Description:	

Date of Onset:	Origin (if known): ☐ Congenital ☐ Accident / Injury
Description:	

Date of Onset:	Origin (if known): ☐ Congenital ☐ Accident / Injury
Description:	

Date of Onset:	Origin (if known): ☐ Congenital ☐ Accident / Injury
Description:	

(Provide like data on additional sheets as required)

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PETITIONER DATA

Education (highest level completed):
Special Occupational Skills:

Rehabilitation Potential:

Third Party Actions:

If third party liability action is pending, provide the name and address of the attorney representing this petitioner if different than the workers' compensation attorney, the defense attorney(s), the case name and docket number.

(Respondent and Second Injury Fund reserve their rights under N.J.S.A. 34:15-40)

REMARKS:

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	REIMBURSE	TAX IDENTIFICATION NUMBER	TOTAL AMT. ALLOWED	PAYABLE BY PETITIONER	PAYABLE BY RESPONDENT
MEDICAL FEE ALLOWED: *(expert and/or testimonial)*					
ATTORNEY(S) FEE:					
STENOGRAPHIC SERVICE:					
MISCELLANEOUS FEES: *(fill in below)*					

☐ **ORDER FOR CHILD SUPPORT** ☐ **ADDENDUM ATTACHED**

DATE

JUDGE OF COMPENSATION

WE HEREBY CONSENT TO THE ENTRY AND FORM OF THIS ORDER AND ACKNOWLEDGE RECEIPT OF COPY:

Petitioner's Attorney

Respondent's Attorney

Petitioner (where applicable)

Deputy Attorney General

State of New Jersey Department of Labor and Workforce Development DIVISION OF WORKERS' COMPENSATION WC-168 r. 8/27/2015	**CASE EXHIBIT LISTING** **FOR: ☐ PETITIONER ☐ RESPONDENT**	CASE NO'S.: VICINAGE:

Judge: _

Petitioner: _____ **Respondent**: _____

Petitioner Attorney: _____ **Respondent Attorney**: _____

					Retained		
Hearing Date	***No.***	***ID***	***Ev.***	***Description***	***Court***	***Atty.***	***Reporter***
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