

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

Case No.: _____

Vicinity: _____

please enter above only if filing an Amended Claim

NEW FILING

AMENDED FILING

PETITIONER	SOCIAL SECURITY NUMBER: <input type="checkbox"/> SSN Not Available	
	NAME:	
	ADDRESS:	
	DATE OF BIRTH:	SEX:
	<input type="checkbox"/> 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:

EMPLOYER	VS	
	NAME:	
	IF EMPLOYER IS KNOWN BY DIFFERENT NAME, PLEASE INDICATE HERE:	
	ADDRESS:	
	INDICATE THE STATUS OF THE EMPLOYER: <input type="checkbox"/> INSURED <input type="checkbox"/> UNINSURED <input type="checkbox"/> SELF-INSURED (PRIVATE) <input type="checkbox"/> SELF-INSURED (GOVT. AGENCY) <input type="checkbox"/> 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:
	<input type="checkbox"/> See Supplemental Page for additional carriers	

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

Date of Accident or Last Exposure:		Occupational Disease: <input type="checkbox"/> YES <input type="checkbox"/> 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: <input type="checkbox"/> YES <input type="checkbox"/> 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

<p>What other facts are there that you believe important:</p>

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.

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Department of Labor and Workforce Development
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PO Box 381
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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:

