

Application for Permanent Total Disability Benefits

PLEASE REVIEW THE INSTRUCTIONS AND COMPLETE ALL FIELDS BELOW

Please be advised that any person desiring consideration must have:

- Been awarded the sum of 50% in prior permanent partial disability awards;
- Suffered a single occupational injury or disease which results in a finding by the carrier that a medical impairment of 50% exists; or have
- Sustained a 35% statutory disability.

All of the information contained in this application for benefits is necessary to properly adjudicate the request. Failure to complete all questions on this application may cause substantial delay and possible rejection for consideration, which may affect your rights to benefits in the future. Any incomplete application will not be accepted and will be returned for complete information.

After completion, please forward this application for benefits and any supporting evidence to your private carrier/
self-insured/TPA administrating your workers' compensation claim.

1. Personal Information			
Name:		Social Security Number:	
Address:		Date of birth:	
City, State and Zip:		Claim in which you are filing your PTD application:	
Phone (include area code):		County of Residence:	
2. Present Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Self-Employed <input type="checkbox"/> Off Due to Injury <input type="checkbox"/> Retired			
3. Are you receiving any of the following retirement benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No Check all that apply: <input type="checkbox"/> Social Security <input type="checkbox"/> Employer-Funded <input type="checkbox"/> Self-Funded Date Benefits Started:			
4. Are you receiving any of the following disability benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No Check all that apply: <input type="checkbox"/> Social Security <input type="checkbox"/> Employer-Funded <input type="checkbox"/> Self-Funded Date Benefits Started:			
5. Are you receiving any income from other sources not listed above? Describe benefit and onset. (Retirement, pension, etc.)			
Benefit:		Onset Date:	Did you contribute: <input type="checkbox"/> Yes <input type="checkbox"/> No
Benefit:		Onset Date:	Did you contribute: <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is there a pending civil action in any of your workers' compensation claims that has been brought by you or on your behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please attach a copy.			
7. Dependent Information: please list all dependent information below:			
Dependent Name	Social Security Number	Date of Birth	Relationship
8. Please list all workers' compensation claims and any impairment rating (%) that may have been awarded. Attach additional pages as necessary.			
Claim Number	PPD %	Date of Injury	Body Part(s)
9. List all disability claims you have filed with other state or federal agencies (include Social Security, veteran's and workers' compensation from other states). Attach additional pages as necessary. Please include a copy of the decision granting benefits.			

10. List any non-work-related conditions for which you have received treatment in the past 10 years. Include the name, address and telephone number of the treating physician, clinics or hospitals that treated you. Attach additional pages as necessary.

11. List all prescription medications you are taking and include the name of the prescribing physician.

Prescription Medication	Prescribing Physician	Prescription Medication	Prescribing Physician

12. Rehabilitation: List all vocational rehabilitation services you have received because of a work-related condition (job placement, retraining, etc)

Services Received	Service Provider	Dates of Service

13. Employment History: Please complete your employment history beginning with the most recent and continue in reverse order.

Begin Date	End Date	Employer's Name	Employer's Address

14. List job titles you have held and any specialized training you received to perform these jobs.

Job Title	Duties / Training Received	Date(s) of Training

15. Educational Background: Please list the names of all schools you have attended. This should include public, private, vocation or colleges and universities. Please include date of attendance and highest degree attained.

School Name	Location	Program	Dates Attended	Degree / Result

16. Did you receive a GED? Yes No If yes, date of completion:

17. Have you served in the military? Yes No If yes, dates of service: From: to

18. If yes, please list the specific military branch, the highest rank attained and any special duties or training received.

Branch	Highest Rank Attained	Training / Duties

I certify the statements and answers set forth in this document are true and correct to the best of my knowledge. I am aware the law, generally, Chapters 23 and 61 of the WV Code and specifically, §61-3-24f, provides for severe penalties if I knowingly certify a false report or statement and/or withhold a material fact regarding any information requested by the Insurance Commissioner, private carrier, self-insured employer, or TPA. I acknowledge the provisions of the aforementioned code and the severe penalties for knowingly and with fraudulent intent aiding or abetting anyone in securing or attempting to secure benefits to which he or she is not entitled.

Signature:

Date: