DO NOT WRITE IN THIS SPACE

EMPLOYEE'S CLAIM
WORKERS' COMPENSATION COMMISSION

6 NORTH LIBERTY STREET
BALTIMORE, MARYLAND 21201-3785
BALTIMORE PHONE (410) 767-0900
TOLL FREE PHONE 1-800-492-0479 IN MARYLAND
BALTIMORE TTY FOR DEAF 383-7555

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Claim No.

Insurance Co. and Code No.

Commission has received	Yes	No
Employer's Report		
Doctor's Report		

Ins. Co.

Ins Co. Claim No.

1. First Name | Middle Name | Last Name | 2. Phone No.

DO NOT WRITE IN SPACE BELOW

3. Mailing Address | City | County | State | Zip Code

1 INS. CO.

4. Social Security Number | 5. Sex | 6. Date of Birth | 7. Single ☐ Married ☐ | 8. What was your regular work?

2 ATTY

9. Gross wages or earnings (including Tips, Bonus, Overtime, Allowances) at time of accident Per week | 10. Were you paid full wages for the day of the accident? Yes ☐ No ☐ | 11. What was your work when injured?

3 INS. CO. 2

12. Full and correct business name of your employer

Complete address

City | State | Zip Code

Employer phone no.

13. Nature of Employer's business (type Business, work done, kind of trade, etc.)

4 ATTY

14. Location where accident occurred

5 EMPLOYER

15. Name of Foreman | Have you given him/her notice of injury? Yes ☐ No ☐

6 EMP.ATTY

16. Give date of first day you could not work because of injury or disease even if it was a day you normally do not work.

7 CLMT. ATTY

17. Date of Accident: month day year 19 at am ☐ pm ☐

18. If occupational disease, give date of disablement.

8 CAUSE

19. Describe how accidental injury occurred OR describe how occupational disease occurred

9 BODY LOC.

10 CLASS CODE

11 N.OF I

12 INDUSTRY

13 M.I.

NOTE: Failure to disclose information or giving false information, including information regarding any work related activity or return to work either before or after an award of benefits, may subject you to fines, imprisonment, or both, and disqualify you from receiving benefits. COMPLETE ALL BLOCKS OR CLAIM PROCESSING MAY BE DELAYED. MAKE COPY OF COMPLETED FORM AND SEND THE COPY TO EMPLOYER. THIS WILL HELP INSURER TO EXPEDITE CLAIM.

20. What member of your body was injured?

21. Has injury resulted in amputation Yes ☐ No ☐ If yes, describe loss

14 ILL. EMP.

22. Did you request your employer to provide medical care? Yes ☐ No ☐ Has he done so? Yes ☐ No ☐

23. Have you returned to work? If "Yes", on what date did you return? Yes ☐ No ☐

15 O.D.

24. Name and Address of Attending Physician:

25. If an Attorney is representing you in this case give his name, address and phone no.

16 MEDICAL

26. Were you in a hospital? If "Yes", give name and address of hospital: Yes ☐ No ☐

17 HEALTH

27. Is this the only Workers' Compensation claim you have filed for this Accident or Occupational Disease? If "No, give claim no. Yes ☐ No ☐

18

28. If Health Insurance used, give name of Insurance Co.

19

I hereby make claim for compensation for an injury resulting in my disability, due to an accident (or disease) arising out of and in the course of my employment, and in support of it make the foregoing statement of facts. I hereby certify that the information I have given is accurate and that I have read the information on this form:

20

READ REVERSE BEFORE SIGNING — KEEP DUPLICATE COPY FOR YOUR RECORDS

21

DATE:_____ 19 _____ SIGNATURE:_____
EMPLOYEE FULL NAME

22

DO NOT WRITE IN THIS SPACE

23

ATTENTION: FOR EMPLOYER AND INSURER INFORMATION ONLY

24

Consideration Date: Unless the Compensability of this claim is contested by the filing of issues with the Commission on or before an appropriate award will be passed.

25

Correct Name of Employer according to Commission records (if different from Item 12):

WCC Form C1 (Rev 2/94)

APPENDIX E

IMPORTANT: It is the responsibility of the employee to provide this commission with any changes in address. Always include claim number on any correspondence.

DISCLOSURE PURSUANT TO EXECUTIVE ORDER 01.01.1983.18

1. The personal information requested on this form in intended to be used in processing your claim for benefits under worker's compensation laws.
2. Failure to provide the information requested may result in delay of your claim for benefits.
3. You have a right to inspect, amend and correct the information provided on this form pursuant to Sections 1-5 of Article 76A of the Maryland Annotated Code.
4. This form will be made part of your claim file and is generally available for public inspection.
5. The information contained on this form is routinely shared with State, Federal or local government agencies.

QUESTIONS AND ANSWERS ABOUT MARYLAND WORKERS' COMPENSATION LAW

WHAT IS WORKERS' COMPENSATION ?
Workers' Compensation is an insurance program in which your employer provides you with medical treatment and partial income replacement benefits and for any permanent disability you may have sustained.

WHO PAYS?
If your claim is found to be compensable, YOUR WEEKLY BENEFITS AND ALL MEDICAL BILLS WILL BE PAID BY YOUR EMPLOYER OR THE INSURANCE COMPANY, WHICH REPRESENTS YOUR EMPLOYER. DO NOT SEND BILLS TO THE WORKERS' COMPENSATION COMMISSION.

HOW LONG DO I HAVE TO WORK TO BE COVERED UNDER WORKERS' COMPENSATION?
You are covered from the first day you are on the job.

HOW DO I KNOW IF THE COMPANY I WORK FOR IS COVERED BY WORKERS' COMPENSATION ?
In the upper right hand corner of the copy of your claim form will be the name of the insurance company covering your employer.

WHEN SHOULD I REPORT THE ACCIDENT?
You should report any accident to your employer immediately. A delay in reporting may affect your claim.

HOW DO I FILE A CLAIM?
If your employer does not have a claim form, the Workers' Compensation Commission will provide you with one and all the necessary information you may need. All forms are provided free of charge.

WHAT DO I DO ABOUT A DOCTOR?
If your employer does not provide a doctor, you may choose your own.

WHO PAYS FOR THE DOCTOR?
Your company will pay for your doctor's visit if the injury was caused by an accident on the job.

WHAT MEDICAL TREATMENT WILL WORKERS' COMPENSATION INSURANCE PAY FOR ?
All doctor bills, hospital bills, physical therapy, prescriptions and necessary expenses are covered by this insurance.

WHEN AM I ENTITLED TO BENEFITS?
You are entitled to benefits if you miss more than three (3) days from work. If you miss more than 14 days, you will be paid for the first three days, provided your employer did not pay you for any of these days. A claim number is assigned by the Commission and a consideration date is placed on the bottom of the form. The consideration date means we allow your employer or his insurer until that date to raise any objections they may have to your claim.

HOW MUCH WILL MY WEEKLY BENEFITS BE?
You should receive two-thirds of your average weekly wage, but not more than the State's average weekly wage for the year that the accident occurred.

HOW LONG WILL I RECEIVE WEEKLY BENEFITS?
You will receive benefits so long as you are unable to work because of the injury.

WHAT IF MY INJURY PREVENTS ME FROM RETURNING TO MY JOB?
If you are not capable of returning to your job or some other job for which you are qualified, you may be eligible for vocational rehabilitation. Call the Worker's Compensation Commission.

WHAT KIND OF BENEFITS WILL I RECEIVE IF I HAVE PERMANENT DISABILITY?
You will receive weekly benefits based on the type and extent of your permanent disability.

WHAT HAPPENS AFTER I FILE A CLAIM?
If you do not receive any benefits, you may request a hearing before the Workers' Compensation Commission. Your case will be decided by a Commissioner who listens to both sides of the case and determines what benefits if any, you should receive. The Commissioner's decision will be based on the law and facts involved.

DO I HAVE TO HAVE A LAWYER?
You may have an attorney of your choice to represent you, or you may represent yourself. The Commissioner can not be your attorney.

WHO PAYS THE ATTORNEY?
Do not pay money to anyone to assist you with your claim. If you hire a lawyer, the Commission will fix his fee. If an award is made to you, the fee will be deducted from your award and paid separately by the employer or insurance company to the attorney.

WHAT IF I WANT TO HIRE A LAWYER BUT DON'T KNOW ONE?
If you are a resident of Maryland, you may call the Lawyer Referral Service by dialing 539-3112 in Baltimore. You may also check your phone directory for the number of a local lawyer referral service.

THE ABOVE INFORMATION IS INTENDED TO BE ONLY A GENERAL GUIDE ON MARYLAND WORKERS' COMPENSATION.

APPENDIX E