PLEASE READ

When returning this questionnaire, please enclose copies of the following:

1. Copies of any and all correspondence you have received from the Alaska Workers' Compensation Board and/or the insurance company handling your claim in ascending order.

2. A copy of your occupational injury or illness report form and a copy of any Controversion Notices.

3. Copies of all medical reports pertaining to your work injury/s and preferably sorted by provider and ascending date order.

4. Copies of any medical evaluations performed at the request of the adjuster for the insurance company or the workers' compensation board.

5. Copies of any and all information related to your workers' compensation claim that will better assist us in evaluating your claim such as witness statements, wage information, etc.

PLEASE DO NOT SEND US THE ORIGINALS OF ANY OF YOUR DOCUMENTS. WE REQUEST THAT YOU PROVIDE US WITH COPIES OF THE RECORDS YOU ARE SENDING US. IF YOU WISH, YOU CAN PROVIDE US WITH A CD OF YOUR RECORDS OR A FLASH DRIVE. WE CANNOT BE RESPONSIBLE FOR YOUR ORIGINAL DOCUMENTS.

The requested information is necessary for us to properly review and evaluate your claim. Without the proper information, we **CANNOT** review your claim and will have to request additional information from you. Please be sure that you carefully read the letter we provided with this questionnaire.

Please mail to:

Kalamarides & Lambert
750 W 2nd Avenue, Suite 200
Anchorage, Alaska 99501

_____

WORKERS' COMPENSATION QUESTIONNAIRE

PLEASE READ OUR INFORMATION LETTER THAT WAS MAILED TO YOU IN THIS PACKAGE BEFORE COMPLETING THE QUESTIONNAIRE. IF THIS QUESTIONNAIRE IS NOT COMPLETED IN ITS ENTIRETY, IT MAY BE RETURNED TO YOU FOR ADDITIONAL INFORMATION AND THIS WILL HOLD UP THE PROCESS OF OUR REVIEWING YOUR CLAIM.

Date:_____

Name:_____

Address:_____

_____

_____

E-mail address: _____

Phone Number/s: _____

Date of Birth: _____

Social Security Number: _____

Date of Injury: _____

Employer Name: _____

Date Hired:_____

Alaska Workers' Compensation Board (AWCB) Case No.:_____

Job Title: _____

Place of Injury (town/city/village): _____

Insurance Company or Adjusting Agency name and address:

_____

_____

_____

Type of injury sustained (name all body parts):

_____

_____

Please state briefly how the work injury occurred:

_____

_____

Do you have any other cases or lawsuits arising out of this incident?

Yes:_____ No:____ If yes, who represents you: _____

Have you settled the case or lawsuit? Yes: _____ No:_____

If yes, what were the terms of the settlement? _____

_____

_____

_____

Did the work injury occur aboard a boat, vessel or fish processor? Yes: _____ No:_____

If you have sustained any injuries to the same body part/s prior to the date of your work injury, what was the nature of the injury and what treatment was received? _____

_____

_____

_____

_____

_____

If you have sustained prior injuries to the same area of your body, please state briefly where, when, and how these prior injury/s occurred:

_____

_____

_____

_____

_____

_____

Please list your treating physician(s) names and addresses:

_____

_____

_____

_____

_____

What treatment have you received for your current work related injuries? **(Be specific.)**

_____

_____

_____

_____

_____

What dates have you been off work because of your work related injuries? **(Be specific.)**

_____

_____

_____

_____

_____

Have you filed a **"EE's Report of Occupational Injury or Illness**" form with your employer?

Yes: _____ No:_____ If yes, what date was it filed? _____

Was your "**Report of Occupational Injury and Illness**" form filed with your employer within thirty (30) days of the date upon which you first became aware that you sustained a work-related injury? Yes:_____ No: _____

Have you filed a request with the Alaska Workers' Compensation Board for reemployment (retraining) benefits evaluation?:

Yes: _____ No:_____ If yes, what date was the request filed? _____

Have you filed a "**Claim for Workers' Compensation**" form requesting benefits with the Alaska Workers' Compensation Board? (this is a form available at the Board in which you would request specific benefits)

Yes: _____ No:_____ If yes, what date was it filed ?: _____

If you ever received biweekly workers' compensation benefits, the what is your weekly **Temporary Total Disability (TTD)** compensation rate? $_____.

Have you filed bankruptcy?

Yes:____ No:____

Has the insurance company or adjusting agency for your employer filed a **Controversion Notice** (denial notice) in your claim?

Yes: _____ No:_____ If so, what is the date of the **Controversion Notice/s**?_____

If your claim was controverted, what reason did the insurance or adjusting company give for their denial of benefits in your claim?

_____

_____

_____

_____

If your claim has not been controverted (denied), please list any present disputes you have with the insurance or adjusting company:

_____

_____

_____

Do you have any judgments or liens against your workers' compensation benefits or claim from any source such as Child Support Enforcement Division, the I.R.S., or any judgments from any civil or criminal action?

Yes: _____ No:_____

If yes, what judgement of lien do you have and who has asserted the lien against you?

_____

_____

Do you currently owe any child support payments?

Yes: _____ No:_____

If yes, how much do you owe and are there any back amounts owed:

_____

_____

Besides the workers' compensation carrier or adjusting company have you applied for or received payment for any medical benefits for your claim such as private insurance, Medicaid, or Medicare?

Yes: _____ No: _____

If yes, please list below the name of the company or entity and provide their name, address, phone number, policy or group number, and the claim number:

_____

_____

_____

Have you applied for or received any other form of disability benefits or other weekly, biweekly or monthly payments since your date of injury such as Public Assistance, long or short term disability, unemployment, Social Security retirement or Social Security disability?

Yes: _____ No: _____

If you have received other payments, please list below the name of the entity that is paying or has paid you benefits, the amount of the benefit received, the first date received and state whether or not the benefit is continuing to be received.

_____

_____

_____

Do you have any third party claims or any other claims arising from this work related injury?

Yes: _____ No.:_____

Do you have an attorney representing you in any third party claim or any other claim arising from this work related injury? If so, what is the name, address, and phone number of your attorney:

_____

_____

_____