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

☐ NEW FILING ☐ AMENDED FILING

Case No.: _____

Vicinage: _____

please enter above only if filing an Amended Claim

PETITIONER

SOCIAL SECURITY NUMBER: ☐ SSN Not Available

NAME:

ADDRESS:

DATE OF BIRTH: | SEX:

☐ 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:

VS

EMPLOYER

NAME:

IF EMPLOYER IS KNOWN BY DIFFERENT NAME, PLEASE INDICATE HERE:

ADDRESS:

INDICATE THE STATUS OF THE EMPLOYER:

☐ INSURED ☐ UNINSURED ☐ SELF-INSURED (PRIVATE) ☐ SELF-INSURED (GOVT AGENCY)

☐ 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:

☐ See Supplemental Page for additional carriers

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

Date of Accident or Last Exposure:	Occupational Disease: ☐ YES ☐ 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: ☐ YES ☐ 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

What other facts are there that you believe important:

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.