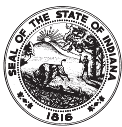

APPLICATION FOR ADJUSTMENT OF CLAIM

State Form 29109 (R5 / 6-05)

FOR STATE USE ONLY
Application number

INDIANA WORKER'S COMPENSATION BOARD
402 W. Washington St., Rm. W196
Indianapolis, IN 46204-2753

INSTRUCTIONS: *Please TYPE or PRINT.*
*File **ORIGINAL** and **4 COPIES**.*

* The request for your Social Security number is VOLUNTARY and you will not be penalized for refusing to supply it.

Name of plaintiff / employee		vs.	Name of defendant / employer
Address (*number and street*)			Address (*number and street*)
City, state, ZIP code			City, state, ZIP code
Telephone number ( )	Social Security number *		Telephone number ( )
Employer's Worker's Compensation insurance company (*if known*)			

The undersigned petitioner respectfully requests a hearing before a member of the Board for the following reasons. (*please check one*)

☐ Worker's Compensation Claim ☐ Occupational Disease Claim ☐ Change of Condition

ATTENTION: ONLY ONE INJURY DATE PER FORM

Date of injury / last exposure / death	Date employer notified of illness / injury / death	If not within 30 days explain

Actual location of incident (*number and street, city, state, ZIP code*)	County of incident

Average weekly earning of the employee at the time of illness / injury / death
$

Briefly describe how the accident / exposure occurred.

If an employee has died as a result of the injury / exposure, complete this section for all persons surviving as all and only dependents. (*attach extra information on depenedents if needed*)

NAME	AGE	RELATIONSHIP	WHOLLY OR PARTIALLY DEPENDENT	ADDRESS

Comments or additional information that you feel is pertinent to this claim.

Name of attorney	Attorney number
Address (*number and street, city, state, ZIP code*)	
Telephone number ( )	

Signature of petitioner

SIGN HERE

Date signed (*month, day, year*)