Reset Form

Indiana Worker's Compensation Board
Application for Second Injury Fund Benefits

State Form 51247 (2-03)

Instructions: This form must be submitted in duplicate to: Indiana Workers Compensation Board 402 W. Washington, RM W196, Indianapolis, IN 46204-2753

PRIVACY NOTICE
***This agency is requesting disclosure of your Social Security number in accordance with IC 22-3-4-13. This disclosure is not mandatory and you will not be penalized for refusing.**

Accident Number

CLAIMANT INFORMATION

Social Security Number *	Date of Birth	Last Name	First	Middle

Address	City

State	Zip	Phone ( )

INJURY INFORMATION

Date of Injury	Disputed Cause #	Date of Award	Type of Injury/Illness	Part of Body

Briefly describe the injury in your own words

☐ Check here if you have received any second injury fund payments for this accident.

CLAIMANT'S AFFIDAVIT

As the injured party requesting benefits of the second injury fund administered by the Indiana Worker's Compensation fund, I do hereby solemnly swear and affirm that the information given in this application is a true and accurate representation of the information regarding my work-related injury, as witnessed on this _____day of _____, two thousand and _____.

Notary Seal	Notary Signature	Applicant Signature
	Notary Printed Name	Applicant Printed Name
	Notary Commission Expiration Date	Date Prepared

APPLICATION CHECKLIST

In order to proceed in processing this application, The Board must receive from you the following items (Please Check):

☐ This completed application is signed and notarized

☐ Form submitted in duplicate

☐ A current copy of the applicant's medical report.