WID or SSN
DATE(S) OF CLAIMED INJURY

Minnesota Department of Labor and Industry
Workers' Compensation Division
PO Box 64221, St. Paul, MN 55164-0221
(651) 284-5032 or 1-800-342-5354
Fax: 651-284-5731

PRINT IN INK or TYPE
ENTER DATES in MM/DD/YYYY FORMAT

EC04

DO NOT USE THIS SPACE

Reset

EMPLOYEE
VS.
EMPLOYER(S)
AND
INSURER (S)
AND

Employee's Claim Petition

NOTE: File Petition and Affidavit of Service with the Division

☐ **Amended Claim Petition**
(to amend a party/date of injury to the claim)

☐ **Amendment to the Claim Petition**
(to amend issues(s) relating to this claim)

Private or confidential data you supply on this form, and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.

TO THE WORKERS' COMPENSATION DIVISION, DEPARTMENT OF LABOR AND INDUSTRY

The Employee above named, for his/her petition, alleges the following as facts:

1. That his/her address is _____
2. That the address of the employer is _____
3. That on the date or dates indicated above he/she sustained a personal injury or occupational disease.
4. That on said date he/she was in the employ of the above employer.
5. That his/her weekly wage at the time of said alleged injury or disease was _____
6. That said injury or disease arose out of and in the course of said employment.
7. That the nature of said injury or disease was as follows: _____
8. That said employer had knowledge or due notice of the occurrence of the injury, disease and/or death alleged in paragraph 3.
9. That on said date the employer was insured against compensation liability by the insurer or insurers indicated above.
10. That said employer and insurer are liable for the following:

DISABILITY BENEFITS

a. Temporary Total from _____ to _____
b. Temporary Partial from _____ to _____
c. Permanent Total from _____ to _____
d. Permanent Partial _____ % _____
(Applicable PPD rule citation)

MEDICAL BENEFITS

Doctor / Hospital / Other **Amount**

e. _____ $ _____
f. _____ $ _____
g. _____ $ _____

REHABILITATION BENEFITS

h. Describe _____

OTHER

i. Describe _____

11.

NAME and ADDRESS of any third party who has paid disability or medical benefits or income maintenance related to this claim	AMOUNT	CLAIM NUMBER or POLICY NUMBER

12. That employee's date of birth is _____

WHEREFORE, Employee petitions for an award against said Employer and Insurer for such benefits as provided for by the Workers' Compensation Law of Minnesota.

EMPLOYEE SIGNATURE			ATTORNEY FOR EMPLOYEE SIGNATURE	
ADDRESS			ADDRESS	
CITY	STATE	ZIP CODE	CITY STATE	ZIP CODE
TELEPHONE			ATTORNEY REGISTRATION #	TELEPHONE

TRIAL DATA:

Request is made for a settlement conference. ☐ Yes ☐ No Estimated hours to present evidence: _____

Requested place of: Pretrial _____ Trial _____

Number of Witnesses: _____ (Attach names and addresses) An Affidavit of Significant Financial Hardship is attached. ☐ Yes ☐ No

If an interpreter is requested for a hearing or conference, specify the language/dialect: _____

If a reasonable accommodation of disability is requested for a hearing or conference, describe: _____

STATE OF MINNESOTA }
} ss.
COUNTY OF _____ }

AFFIDAVIT OF SERVICE

I, _____, being first duly sworn, state that on _____, I served a true and correct copy of this document, enclosed in a properly addressed envelope, by depositing the same, with postage prepaid, in the United States mail at _____, Minnesota, addressed as follows:

NAMES AND ADDRESSES

Subscribed and sworn to before me
this _____ day of _____
Notary Public _____
My Commission expires _____

_____
Signature

INSTRUCTIONS

1. Failure to properly and fully fill out the claim petition, with appropriate documentation, in accordance with workers' compensation rules of practice, shall not be considered proper filing under Minn. Stat. § 176.291 and 176.305. The Workers' Compensation Division may refuse to accept a claim petition that lacks any of the following: employee's name, date of injury, WID or social security number, or name of employer/insurer.
2. The claim must be presented in terms of the Minnesota Workers' Compensation Act.
3. If you have more defendants or more injuries than can be listed on the claim petition, it may be modified accordingly.
4. A doctor's report supporting the claim MUST be filed with the claim petition.
5. If additional space is required to list all medical benefits claimed, or to list the names, addresses, etc., of third parties making payment of medical expenses or disability benefits, or there are other issues you wish to include on the petition, attached a separate sheet containing such information to each copy of the petition.
6. If no third party has made payment of any disability, rehabilitation or medical benefits, enter the word "NONE" in the space provided for the name and address in #11.
7. If the employee has fewer than three days of lost time from work, attach a copy of the First Report of Injury, unless one has already been filed with the Department of Labor and Industry.
8. The petitioner must serve a copy of the petition on EACH adverse party (employer(s), insurer(s), the Special Compensation Fund, if applicable, and any third party named in #11) by first class mail or personally.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354/Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

443 Lafayette Road N.
St. Paul, Minnesota 55155
www.dli.mn.gov

MINNESOTA DEPARTMENT OF LABOR & INDUSTRY

(651) 284-5005
1-800-DIAL-DLI
TDD: (651) 297-4198

Instructions for Completing a Claim Petition Form

Use a Claim Petition if you want a hearing with a compensation judge to resolve a dispute where the insurer has denied primary liability for a claim or where the workers' compensation insurer has accepted liability for the claim but is denying wage loss, permanency, and any medical or rehabilitation benefits.

Since the issues typically claimed on the Claim Petition may be complex, you may want to retain the services of an attorney to file the Claim Petition and represent you in the hearing. You will be able to find a workers' compensation attorney by checking the Yellow Pages of your local phone directory or contacting the bar association in your county, which usually have referral services to direct you to an appropriate attorney.

#1-9 and 12 on the front of the form. Complete identifying information about employee, employer and the workers' compensation claim itself.

10a-i. List the workers' compensation benefits being claimed on the Claim Petition:

10a-d. List the wage loss and/or permanent partial disability benefits to which you feel that you are entitled to. Temporary total disability benefits are wage loss benefits you receive when you are off work completely due to the work injury. Temporary partial disability benefits are wage loss benefits you receive when you return to work at a lower wage, due to your injury. Permanent total disability benefits are wage loss benefits you get when you are permanently unable to return to work. Permanent partial disability benefits are monetary benefits you receive to compensate you for a permanent disability (when your doctor gives you a "rating"). Don't worry about the monetary amounts being claimed; just try to list the dates you feel the benefits should have been paid. Attach supporting information, such as an off-work slip from your doctor or a Health Care Provider Report listing the percentage of disability to the whole body, in support of your claim.

10e-g. List any medical bills that are unpaid. Attach copies of the bills and supporting medical documentation. Attach additional sheets if necessary to list all the medical providers involved.

10h. Fill out this section if you are requesting the services of a Qualified Rehabilitation Consultant (QRC) to help you return to work.

11. If your medical treatment has been paid for by a health insurer or you have received short- or long-term disability benefits or unemployment compensation, list them here.

On the back of the form, put in your name, address and telephone number, complete with area code. If you are represented by an attorney, the attorney also gives his or her name, address, telephone number and registration number.

Trial Data section. Fill out this section to the best of your ability. Most hearings take 1/2 day. Specify where the hearing should be held - hearings are usually held in St. Paul, Duluth and Detroit Lakes. A settlement conference would be appropriate if you are interested in settling your claim through a process of negotiation. Witnesses, while not required, usually include the injured worker, co-workers who may have witnessed the workers' compensation injury, QRC or vocational experts.

Affidavit of Significant Hardship. You may complete a form indicating that you have a significant financial hardship and are requesting an expedited hearing.

Affidavit of Service section. Fill out the names and addresses of all the parties to the claim including employer(s), insurer(s), health care providers, any third party that has paid benefits under #11, etc. Fill out and sign the rest of this section in the presence of a Notary Public, who will stamp the form and attest to the true and correct nature of the copy sent through the U.S. mail.

Make a copy of the Claim Petition and each attachment for each of the parties indicated on the back of the form and mail it to each party. Keep a copy for yourself. Mail the original to the Department of Labor and Industry at the address listed on the top of the front of the form.

Additional instructions appear on the bottom of the back page.

If you have questions about how to complete the form, you may call the Alternative Dispute Resolution Unit at: (651) 284-5032 in the Minneapolis/St. Paul metropolitan area, or toll free at 1-800 342-5354 statewide.