| State of New Jersey<br>Department of Labor & Workforce Development<br>DIVISION OF WORKERS' COMPENSATION<br>Office of Special Compensation Funds | **SECOND INJURY FUND VERIFIED PETITION**<br>SCF-161 (R 12-07) | **C.P. NO'S.:**<br><br>**VICINAGE:** |
|---|---|---|

**PETITIONER**

| | |
|---|---|
| SOCIAL SECURITY NUMBER: | ☐ SSN Unavailable |
| NAME: | |
| ADDRESS: | |

**ATTORNEY FOR PETITIONER**

| |
|---|
| FEDERAL EMPLOYER IDENTIFATION NUMBER: |
| NAME: |
| ADDRESS: |
| TELEPHONE NO: |

**VS**

**RESPONDENT**

| |
|---|
| NAME: |
| ADDRESS: |

**INSURANCE CARRIER**

| | |
|---|---|
| NAME : | Indicate if ☐ Self- Insured or ☐ Uninsured |
| ADDRESS: | |

**TO THE COMMISSIONER OF LABOR AND WORKFORCE DEVELOPMENT OF THE STATE OF NEW JERSEY:**

**Petitioner hereby alleges eligibility for benefits from the Second Injury Fund pursuant to N.J.S.A. 34:15-95 et seq., and respectfully states the following:**

| Date of Birth: | Age: | Sex: | Marital Status: | Number of Dependents:<br>(If one or more, see Page 3) |
|---|---|---|---|---|
| Educational Background: | | | Special Skills: | |

**Employment History: (List all former employers, dates of employment and job descriptions; use additional sheets as required.**

**Pre-Existing Medical Conditions: (List physical and/or psychiatric conditions which pre-existed your last compensable accident of exposure or dates of onset)**

**Description and Date of Last Compensable Accident or Occupational Disease Exposure:**

| Gross Weekly Wages for Last Compensable Injury: | Weekly Benefit Rate for Last Compensable Injury: |
|---|---|

**Brief Description of Treatment Received For Last Compensable Injury or Disease:**

**Current Medical Conditions: (List physical and/or psychiatric conditions which have been caused, aggravated or accelerated by the last compensable accident or exposure or dates of onset:**

**If you have initiated an action at law against a third party for all or any portion of the injury or disease you sustained as a result of your last compensable injury or disease, please provide the name and address of such third party, the status of your action, and, if concluded, the gross settlement amount of such action.**

| Provide below your current monthly income from the following sources: | | |
|---|---|---|
| **Social Security Retirement:** | **$** | **If receiving Social Security retirement benefits, provide the date of your entitlement:** |
| **Social Security Disability:** | **$** | **If receiving Social Security Disability benefits, provide the date of your entitlement:** |
| **Auxiliary Social Security:** | **$** | **If receiving Auxiliary Social Security, provide the date of your entitlement:** |
| **Black Lung Benefits:** | **$** | **If receiving Black Lung benefits, provide the date of your entitlement:** |
| **Retirement Pension Benefits:** | **$** | **If receiving Retirement Pension, provide the date you began receiving same:** |
| **Disability Retirement Benefits:** | **$** | **If receiving Disability Retirement Benefits, provide the date you began receiving same:** |
| **Veterans Administration Benefits:** | **$** | **If receiving Veterans Administration Benefits, provide the date you began receiving same:** |
| **Temporary Disability Benefits:** | **$** | **If receiving Temporary Disability Benefits, provide the dates of such benefits:** |
| **Unemployment Benefits:** | **$** | **If receiving Unemployment Benefits, provide the dates of such benefits:** |

**Are you currently eligible for benefits from Medicare? ☐ No ☐ Yes If Yes, have you applied for or received Medicare benefits?**

**Please provide the names and dates of birth of all dependents cited on Page 1.**

**Prior Compensation Awards: (Please list all claim petition numbers, dates of injury or last exposure, percentages of disability and body parts and attach any copies of Judgments in your possession:**

**Are you currently employed or engaged in a business activity?** ☐ **No** ☐ **Yes If Yes, please provide the following information:**

**Name, Address and Telephone of Employer:**

**Job Title and Nature of the duties performed:**

| **Number of hours worked per week:** | **Gross Weekly Wage or Earnings:** |
|---|---|

**I believe that I am totally and permanently disabled as the result of a combination of my pre-existing physical and/or psychiatric conditions and my last compensable injury or disease. Further, I believe that the exclusionary provisions of <u>N.J.S.A.</u> 34:15-95 do not apply to my case. Accordingly, I hereby petition for Second Injury Fund benefits under the provisions of <u>N.J.S.A.</u> 34:15-95, *et seq*. Therefore I hereby, on my oath, affirm that I have read the foregoing and am familiar with the contents thereof and that the matters set forth are true to the best of my knowledge and belief.**

_______________________________________ *(Petitioner Signature)*

_______________________________________ *(Date)*

**STATE OF NEW JERSEY**

**COUNTY OF ________________________**

**Subscribed and sworn before me on this _______ day of**

**__________________ , __________.**

**____________________________________________________________**

The Privacy Act, 5 U.S.C. §522a, the Social Security Act, 42 U.S.C. § 405, and <u>N.J.S.A.</u> 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.

***NOTE: Attach copies of all proposed expert witnesses' reports. Pursuant to Division Rules, do not attach hospital records. Attach index of medical records only.***