EMPLOYER'S QUESTIONNAIRE

PAGE NUMBER: 1

CLAIMANTS NAME: _____

WORKERS' COMPENSATION COMMISSION CLAIM NUMBER: _____

State of Maryland, Uninsured Employers' Fund, pursuant to Maryland Code LE 9-1002, hereby propounds the following questions to the alleged Employer.

1. State your full company name, address and telephone number. If you operate or trade under more than one name, state each company name.

2. Is your business incorporated: YES_____ NO_____ If "yes", state:

   a) Corporate Name.

   b) Date and State of Incorporation.

   c) Name, address and telephone number of the Resident Agent:

   d) Name of the officer or person responsible for the general management of the company in Maryland.

   e) Federal Identification Number.

3. If you are not incorporated, state the following:

   a) Your full name, address, telephone number, social security number and date of birth.

   b) The name, address, phone number, date of birth, and social security number of all your partners in the business.

4. State what type of business your company is engaged in.

5. Are you licensed to do business in Maryland? YES_____ NO_____. If yes, state the following:

   a) Type of license or permit, and date issued.

   b) Name and address of agency who issued license or permit.

6. If you or your company were covered by workers' compensation insurance at the time of the claimant's injury, state the following:

    a) Name and address of insurance company.

    b) Policy number and effective date.

    c) Attach a copy of your policy.

7. If you presently have workers' compensation insurance, state the name and address of the insurance company, the policy number and effective date.

8. State the dates during which the claimant worked for you or your company.

9. At the time of claimant's injury, were you engaged as a subcontractor for another company? If yes, state the following:

    a) Name, address and telephone number of the (general) contractor.

    b) Name of the project you were working on and the address of the project.

    c) Name and address of other companies working on the project.

    d) Name and address of the customer or client of the project.

    e) Attach copies of all contracts related to this project.

10. Describe claimant's accident and identify the parts of the body which the claimant injured. State the date, time and place of claimant's accident and specify the address where the accident occurred.

11. State any reasons why you feel that this claim should be denied. State all defenses to this claim.

12. When were you first notified of the claimant's injury and who notified you?

13. State the names, addresses and telephone numbers of all witnesses to or persons who have knowledge of claimant's accident and injuries.

14. If claimant's injury involved a vehicle:

    a) State who owned the vehicle and whether the claimant leased the vehicle. If there was a signed lease agreement, attach a copy.

    b) Was a police report made? If so, attach a copy.

    c) Specify the addresses where the trip started and the trip destination.

15. Did the claimant request medical treatment for the injury? Attach a copy of all medical records, reports and bills relating to the claimant's injury.

16. State whether the claimant was hired as an employee or contracted as a subcontractor. Attach a copy of any job application or written contract with the claimant.

17. Did you provide W-2s or 1099s to the claimant both for the year before and the year of claimant's injury? If so, attach copies.

18. Regarding claimant's work:

    a) Who hired the claimant?

    b) Who was claimant's foreman or supervisor?

19. Regarding claimant's work at the time of his injury:

    a) How many hours per week did claimant work?

    b) Was claimant paid by the job or by the hour?

    c) Did you withhold taxes and social security from claimant's pay?

20. At the time of claimant's injury, what was claimant earning per week? Attach copy of pay stubs or payroll records for the 13 weeks prior to the date of claimant's injury.

21. If you, your company or any private insurance company has paid for claimant's medical treatment, lost time or disability, state who has made such payments .

22. State the dates during which the claimant has been unable to work as a result of claimant's injury. If claimant has done any work since the date of injury, state who claimant worked for, the dates worked, what claimant did and the income that claimant earned for such work.

23. Since the injury, has claimant filed for unemployment benefits? If yes, state when the claim was filed, the claim number and the dates for which claimant received benefits.

24. Either before or since this injury, has claimant been involved in any accidents, injuries or serious illness or disease? If so, provide details.

25. At the time of claimant's injury, was the claimant intoxicated or under the influence of any medication or drugs?

26. If any third party was involved in the claimant's injury, state each name and address.

27. If claimant is alleging an occupational disease, state:

    a) The first date that claimant was disabled from work.

    b) The first date that claimant was treated.

    c) The date when claimant gave you or your company notice of disability.

    d) Was the claimant exposed to the occupational hazard as alleged in the claim?

    e) Attach copies of all medical reports, records and bills.

I HEREBY CERTIFY, under the penalties of perjury, that the information provided herein is true and accurate according to the best of my information, knowledge and belief.

_____

EMPLOYER

I HEREBY CERTIFY, that the information provided herein was mailed, postage prepaid, to the Workers' Compensation Commission, 10 East Baltimore Street, Baltimore, Maryland 21202-1641, the Uninsured Employers' Fund, 300 East Joppa Road, Suite 402, Towson, Maryland 21286, and all parties to this case on this _____ day of _____, 20____.

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EMPLOYER OR ATTORNEY FOR EMPLOYER