PAGE NUMBER: 1 **CLAIMANT'S QUESTIONNAIRE**

CLAIMANT'S NAME: _____

WORKERS' COMPENSATION CLAIM NUMBER: _____

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

BE ADVISED THAT THE WORKERS' COMPENSATION COMMISSION WILL <u>NOT</u> CONDUCT A HEARING ON YOUR CLAIM UNTIL YOU HAVE COMPLETED AND FILED THIS QUESTIONNAIRE.

1) State your full name, address, telephone number, social security number and date of birth.

2) State the full name, address and telephone number of your employer at the time of your injury.

3a) Were other companies involved in the project or jobsite on which you were injured? If yes, state each company name, address and telephone number and specify the address where the accident occurred.

3b) Specify the address where the accident occurred.

4) Regarding your job at the time of your injury:

a. What was your job title?

b. What were your job duties?

c. Who hired you?

d. When were you hired?

e. Did you sign any contracts with your employer? If so, attach a copy.

f. Who was your foreman or supervisor?

5) Regarding your job at the time of your injury:

a. Did you set your own work hours? If not, who set them?

b. How many hours per week did you work?

c. Were you paid by the job or by the hour?

d. Were you paid by check or cash?

f. Did your employer withhold taxes and social security from your pay?

6) At the time of your injury, what were your earnings per week? Did you file tax returns for both the year of and the year before your injury? To verify your employment and earnings, attach copies of your pay stubs or payroll records for the 13 weeks prior to your injury. If such records are unavailable, attach copies of your tax returns for both the year of and the year before your injury.

7) Describe your accident and identify the parts of your body injured. State the date, time and place of your accident.

8) State the names, addresses and telephone numbers of all witnesses to your accident and injuries.

9) State the name of all persons with whom you reported or discussed your accident and injuries.

10) State the name and address of any person who has or may have personal knowledge of facts relating to your accident or injuries.

11) If your injury involved a vehicle:

a) State who owned the vehicle and whether you 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) State the locations where the trip started and the destination.

12) During the 48 hours prior to your injury, had you consumed any alcohol or taken any intoxicating drugs or medications? If so, state the substance that you took and the time that you took it.

13) State the names and addresses of all doctors, hospitals and any other medical providers who have examined or treated you for this injury. Attach a copy of all records, reports and bills.

14) If your employer or any health insurance company has paid for your medical treatment, lost time or disability, state who has made such payments. If you have filed a claim against a private insurance company or anyone else for this injury, state who you filed against and when.

15) State the dates on which you have been unable to work as a result of your injury. Attach copies of all medical off-work slips. If you have done any work since the date of your injury, state who you worked for, the dates you worked, what you did, and the income that you earned for your work.

16) Since your injury, have you filed for unemployment benefits? If yes, state when you filed, the claim number and the dates for which you received benefits.

17) Either before or since this injury, if you have had any accidents, injuries or serious illness, which may affect the injury and/or disability claimed in this claim, state when and how it occurred, the part of the body injured or affected, and state the names and addresses of all doctors, hospitals and any others who treated you which may affect the injury or disability of this claim.

18) If you have ever filed a workers' compensation claim, lawsuit for an injury, Social Security claim, Veteran's claim or other disability claim, state the date filed, nature of injury or disability, claim number and where the claim was filed. If the suit or claim resulted in a settlement, recovery or award, state the results.

19) If in the past 15 years you have been convicted of a crime or moral turpitude or an infamous crime including, but not limited to, a crime of theft or perjury, and at the time of your conviction you were over the age of eighteen years and you were represented by counsel or waived your right to counsel, set forth the nature of the conviction, criminal case number, and the date and location of the conviction.

20) Was any third party involved in your accident? If so, state each party's name, address and telephone number and state whether you have made a claim against that party and state any amount recovered.

21) If you are claiming an occupational disease, state:

a) The first date you were disabled from work.

b) The first date of treatment and who treated you.

c) When did you give notice of your disability to your employer?

d) When you were last exposed to the hazard and who were you working for when last exposed.

e) State all medical treatment as a result of your disease. 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.

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CLAIMANT

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, Suite 402, 300 East Joppa Road, Towson, Maryland 21286, and all parties to the case on this _____ day of _____, 20____.

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CLAIMANT OR CLAIMANT'S ATTORNEY