

Dept. of Labor & Industries
Claims Section
PO Box 44291
Olympia WA 98504-4291

Dept. of Labor & Industries
Self Insurance
PO Box 44892
Olympia WA 98504-4892

APPLICATION TO REOPEN CLAIM DUE TO WORSENING OF CONDITION

WORKER INFORMATION

Complete your portion in FULL
for prompt action

Claim number

Important:

Only use this form if your medical condition has worsened, and your claim has been closed for more than 60 days. If time loss benefits are paid before a decision about reopening is made and your claim is not reopened, you will be required to repay those benefits. Please write your claim number above. You will receive information about your reopening application within 90 days of the Department's receipt of the reopening application. If you have had a **new** injury at work, complete a new Report of Industrial Injury or Occupational Disease form in lieu of this application.

1. Name (first, middle, last)	2. Name changed since claim closed? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, list previous name	3. Home phone no.	4. Soc. Sec. No. (for ID only)
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5. Present home address	6. Mailing address (if different than home address)
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7. City State ZIP	8. City State ZIP
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8a. I prefer my correspondence go to my Representative. Name:	Address	State	ZIP
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9. Date of original injury / /	10. Employer at time of original injury
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11. What are your present physical complaints?	12. Date claim closed / /	13. Date condition became worse after claim closure? / /
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14. Full name of doctor treating you at time of claim closure	15. What parts of your body are affected by this injury/ disease?
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16. Have you had any new injuries or illnesses since the date of claim closure? If yes, explain.	17. Did your condition worsen due to another injury or accident either on or off the job? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, explain.
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18. Have you received any medical treatment for this condition since claim closure? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, list name and address of treating doctor(s).
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19. Doctor Phone number	20. Doctor Phone number
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Address	Address
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City State ZIP+4	City State ZIP+4
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21. Have you applied for or are you receiving? (check correct box(es)) Unemployment <input type="checkbox"/> Public assistance <input type="checkbox"/> Sick leave <input type="checkbox"/> Retirement benefits <input type="checkbox"/> Disability insurance <input type="checkbox"/>	22. Are you working? If no, Retired <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Why? Unable to work <input type="checkbox"/> Laid off <input type="checkbox"/> Quit <input type="checkbox"/> Any other Industrial Insurance compensation? <input type="checkbox"/> (i.e., Longshore harbor workers, Jones Act, Railroad) If checked, explain.	23. Last date worked
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24. Present or last employer	28. What other employers & job titles have you had since your claim was closed?
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Address Phone number	
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City State ZIP+4	
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25. Your job title and duties	
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26. Type of business	
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27. How long have you worked for this employer?	
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NOTE: Persons making false statements in obtaining industrial insurance benefits are subject to civil and criminal penalties. I declare that these statements are true to the best of my knowledge and belief. In signing this form, I permit doctors, hospitals, clinics or others with medical information to release my medical records to the Department of Labor & Industries and/or the Self Insured Employer.

Dept. use only

Today's date / /	Claimant's signature X
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