WID or SSN
DATE(S) OF CLAIMED INJURY

Minnesota Department of Labor and Industry
Workers' Compensation Division
PO Box 64218
St. Paul, MN 55164-0218
(651) 284-5030
1-800-342-5354 (DIAL-DLI)

DO NOT USE THIS SPACE

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)

PRINT IN INK or TYPE.
Enter dates in MM/DD/YYYY format.

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. § 178.291 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 on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI) 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.