# HEARING APPLICATION

Please Read Instructions.

**Department of Workforce Development**
**Worker's Compensation Division**
201 E. Washington Ave.
P.O. Box 7901
Madison, WI 53707
Telephone: (608) 266-1340
Litigated Fax: (608) 260-3053
https://dwd.wisconsin.gov/wc

Provision of your Social Security Number (SSN) is mandatory under Section 111 of Medicare, Medicaid and SCHIP Extension Act 2007 (42 U.S.C. s. 1395y (b) (7) & (8)) and will be used to identify the claimant. Failure to provide it may result in penalties and delayed payment of benefits.

The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats. The purpose of this form is to assist with the procurement of information related to or required by Chapter 102. Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102. DWD may use the personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

| | | |
|---|---|---|
| 1. Employee name, address, city, state, zip code | 2. Employer name, address, city, state, zip code (at time of injury) | 3. WC insurance carrier name, address, city, state, zip code |
| | | 3a. Insurance carrier telephone no. (area code) |
| | | 3b. Date of injury (Mo/Day/Yr) |
| 1a. Employee Social Security Number | 2a. Federal Employer Identification Number (if known) | 3c. Last date employee worked before disability |
| 1b. Employee telephone no. (include area code) | 2b. Employer telephone no. (include area code) | 3d. Date notice of injury given to employer |
| 1c. Date of birth (Mo/Day/Yr) Sex ☐ M ☐ F | 2c. Nature of employer business | 4. Have you applied for or are you receiving Social Security benefits? ☐ Yes ☐ No |
| 1d. Employee attorney (if any) name & full address | 2d. Employee occupation when injured | 4a. Have you applied for or are you covered under Medicare? ☐ Yes ☐ No |
| | 2e. Employee gross weekly wage when injured | If Yes, Medicare claim number: |
| | **Answer Questions 5 to 5c if claim is made for death benefit** | |
| 1e. Is the Certification of Readiness included with this Application? ☐ Yes ☐ No | 5. Name of deceased and date of death | 5a. Are you a dependent of the deceased? ☐ Yes ☐ No |
| 1f. Attorney's telephone no. (include area code) | 5b. Applicant's relation to deceased ☐ Spouse ☐ Child ☐ Other | 5c. Did you live with the deceased? ☐ Yes ☐ No |

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| 6. How did the injury or death occur? If possible, specify if single event or long-term exposure. | 6a. Describe parts of the body affected. |

7. Check the boxes below for which compensation is being sought and specify detail, if known:

| | | |
|---|---|---|
| 7a. ☐ Temporary Total Disability (Month, Day, Year) From To | From To | |
| 7b. ☐ Temporary Partial Disability From To | 7c. ☐ Transportation costs (mileage) | |
| 7d. ☐ Permanent Partial Disability % of Body Part | 7e. ☐ Permanent Total Disability Starting Date | |
| 7f. ☐ Medical expense denied $ Has treatment ended? ☐ Yes ☐ No | 7g. ☐ Penalty | 7h. ☐ Other |

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| 8. Names of medical practitioners who treated applicant: | 9. Is the employee working now? ☐ Yes ☐ No |
| 10. Were medical expenses paid? ☐ Yes ☐ No If Yes, by whom? | 11. Are you currently receiving Worker's Compensation disability benefits? ☐ Yes ☐ No |
| 12. Have sickness and accident benefits/income continuation been paid for lost wages? ☐ Yes ☐ No | 12a. If Yes, indicate by whom and the amounts |
| 13. I will be ready for a Formal Hearing in: ☐ Due course ☐ Due course but not before this date | 14. Preferred city for hearing: / 14a. I request a pre-hearing ☐ Yes ☐ No |

15. _____ Employee Signature _____ Date Signed

If represented, do you agree that an attorney's fee, fixed by the department at no more than 20% of your recovery, may be paid directly from the compensation you recover? ☐ Yes ☐ No

16. **FOR OFFICE USE ONLY:**

HR PT NR

Issues _____ ☐ GL35 ☐ GL35A ☐ GL48

Length _____ ☐ GL33 ☐ GL70 ☐ GL34

Date _____ ☐ GL33A ☐ GL39 ☐ GL31