

HEARING APPLICATION

Please Read Instructions.

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.

**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>

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 <input type="checkbox"/> M <input type="checkbox"/> F	2c. Nature of employer business		4. Have you applied for or are you receiving Social Security benefits? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		5. Name of deceased and date of death		5a. Are you a dependent of the deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No	
1f. Attorney's telephone no. (include area code) () -		5b. Applicant's relation to deceased <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		5c. Did you live with the deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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. <input type="checkbox"/> Temporary Total Disability (Month, Day, Year)					
From		To		To	
7b. <input type="checkbox"/> Temporary Partial Disability			7c. <input type="checkbox"/> Transportation costs (mileage)		
From		To			
7d. <input type="checkbox"/> Permanent Partial Disability % of Body Part			7e. <input type="checkbox"/> Permanent Total Disability Starting Date		
7f. <input type="checkbox"/> Medical expense denied \$ Has treatment ended? <input type="checkbox"/> Yes <input type="checkbox"/> No		7g. <input type="checkbox"/> Penalty		7h. <input type="checkbox"/> Other	
8. Names of medical practitioners who treated applicant:				9. Is the employee working now? <input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Were medical expenses paid? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, by whom?			11. Are you currently receiving Worker's Compensation disability benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No		
12. Have sickness and accident benefits/income continuation been paid for lost wages? <input type="checkbox"/> Yes <input type="checkbox"/> No			12a. If Yes, indicate by whom and the amounts		
13. I will be ready for a Formal Hearing in: <input type="checkbox"/> Due course <input type="checkbox"/> Due course but not before this date			14. Preferred city for hearing:		14a. I request a pre-hearing <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			16. FOR OFFICE USE ONLY: HR PT NR Issues _____ <input type="checkbox"/> GL35 <input type="checkbox"/> GL35A <input type="checkbox"/> GL48 Length _____ <input type="checkbox"/> GL33 <input type="checkbox"/> GL70 <input type="checkbox"/> GL34 Date _____ <input type="checkbox"/> GL33A <input type="checkbox"/> GL39 <input type="checkbox"/> GL31		