

ILLINOIS WORKERS' COMPENSATION COMMISSION
APPLICATION FOR ADJUSTMENT OF CLAIM (APPLICATION FOR BENEFITS)

ATTENTION. Please type or print. Answer all questions. File three copies of this form.

Workers' Compensation Act ___ Occupational Diseases Act ___ Fatal case? No ___ Yes ___ Date of death _____

Employee/Petitioner

Case #
(Office use only)

v.

Employer/Respondent

Location of accident _____
or last exposure City, State

Injured employee's name ¹ Street address City, State, Zip code

Employer's name Street address City, State, Zip code

Employee information: State Employee? Yes ___ No ___ Male ___ Female ___ Married ___ Single ___

Dependents under age 18 _____ Birthdate _____ Average weekly wage \$ _____

Date of accident ² _____ The employer was notified of the accident orally ___ in writing ___

How did the accident occur? _____

What part of the body was affected? _____

What is the nature of the injury? _____ Return-to-work date ³ _____

Is a *Petition for an Immediate Hearing* attached? Yes ___ No ___

Is the injured employee currently receiving temporary total disability benefits? Yes ___ No ___

If a prior application was ever filed for this employee, list the case number and its status _____

ATTENTION, PETITIONER. This is a legal document. Be sure all blanks are completed correctly and you understand the statements before you sign this. Refer to the Commission's *Handbook on Workers' Compensation and Occupational Diseases* ⁴ for more information.

Signature of petitioner

Date

APPEARANCE OF PETITIONER'S ATTORNEY
Please attach a copy of the *Attorney Representation Agreement*.

Signature of attorney

Street address

Attorney's name and IC code # ⁵ (please print)

City, State, Zip code

Firm name

Telephone number E-mail address

PROOF OF SERVICE

If the person who signed the *Proof of Service* is not an attorney, this form must be notarized.
If you prefer, you may submit the front of this application form with the *Proof of Service* on a separate page.

I, _____, affirm that I delivered _____ mailed with proper postage _____
in the city of _____ a copy of this form
at _____ on _____ to the respondent listed on this application and to each
additional party, if any, at the address listed below.

Signature of person completing *Proof of Service*

Signed and sworn to before me on _____

Notary Public

¹ In most cases, the injured employee files this application and is referred to as the petitioner. If the injury was fatal, or if the worker is a minor or incapacitated, another person (as allowed by law) may file. In those cases, the person filing the application is the petitioner, and the worker is referred to as the injured employee. Please complete information related to age, etc., for the injured employee.

² This may be the date of the accident, last exposure, disability, or death.

³ If the employee has not returned to work, leave this space blank.

⁴ The Commission publishes a handbook that explains the workers' compensation system. If you would like a copy, please call any of the Commission offices listed on the other side of this form.

⁵ The Commission assigns code numbers to attorneys who regularly practice before it. To obtain or look up a code number, contact the Information Unit in Chicago or any of the downstate offices at the telephone numbers listed on this form.