



APPLICATION FOR ADJUSTMENT OF CLAIM

State Form 29109 (R5 / 6-05)

FOR STATE USE ONLY
Application number

INDIANA WORKER'S COMPENSATION BOARD 402 W. Washington St., Rm. W196 Indianapolis, IN 46204-2753

INSTRUCTIONS: Please TYPE or PRINT.
File ORIGINAL and 4 COPIES.

* The request for your Social Security number is VOLUNTARY and you will not be penalized for refusing to supply it.

Name of plaintiff / employee		vs.	Name of defendant / employer	
Address (number and street)			Address (number and street)	
City, state, ZIP code			City, state, ZIP code	
Telephone number ()	Social Security number *		Telephone number ()	
Employer's Worker's Compensation insurance company (if known)				

The undersigned petitioner respectfully requests a hearing before a member of the Board for the following reasons. (please check one)

Worker's Compensation Claim Occupational Disease Claim Change of Condition

ATTENTION: ONLY ONE INJURY DATE PER FORM

Date of injury / last exposure / death	Date employer notified of illness / injury / death	If not within 30 days explain
Actual location of incident (number and street, city, state, ZIP code)		County of incident
Average weekly earning of the employee at the time of illness / injury / death \$		
Briefly describe how the accident / exposure occurred.		

If an employee has died as a result of the injury / exposure, complete this section for all persons surviving as all and only dependents. (attach extra information on dependents if needed)

NAME	AGE	RELATIONSHIP	WHOLLY OR PARTIALLY DEPENDENT	ADDRESS

Comments or additional information that you feel is pertinent to this claim.

Name of attorney	Attorney number
Address (number and street, city, state, ZIP code)	
Telephone number ()	

Signature of petitioner
SIGN HERE
Date signed (month, day, year)