Indiana Worker's Compensation Board
Application for Second Injury Fund Benefits

State Form 51247 (R / 3-22)

Instructions: This form must be submitted in to:
Indiana Worker's Compensation Board
402 W. Washington, Rm W-196, Indianapolis, IN 46204-2753

INDIANA WORKER'S COMPENSATION BOARD
402 West Washington Street, Room W196
Indianapolis, IN 46204
Telephone: (317) 233-3009
www.in.gov/wcb

CLAIMANT INFORMATION				
Date of Birth	Last Name	First	Middle	
Address		City	State	Zip
Phone ( )	Email			

POWER OF ATTORNEY / EMERGENCY CONTACT			
Last Name		First	
Address	City	State	Zip
Phone ( )	Email		

NEW APPLICANT ONLY				
Date of Injury	Date of Last Payment Received	Disputed Cause #	Type of Injury/Illness	Part of Body
Briefly describe the injury in your own words				

RENEWAL APPLICANT ONLY		
Date of Injury	S Cause #	Secondary Address (if Applicable)

As the injured party requesting benefits of the Second Injury Fund administered by the Indiana Worker's Compensation Board, I do hereby solemnly swear and affirm that the information given in this application is a true and accurate representation of the information regarding my work-related injury, as witnessed on this _____ day of _____, _____ .

Applicant Signature	Applicant Printed Name

APPLICATION CHECKLIST

In order to proceed in processing this application, The Board must receive from you the following items (Please Check):

☐ This completed application is signed. ☐ A current copy of the applicant's medical report.