WORKERS' COMPENSATION EMPLOYEE QUESTIONNAIRE

Please answer all questions to the best of your ability. If you do not know, write "unknown."

EMPLOYEE INFORMATION

Name:	Phone:
	Email:
Address:	Date of Birth:
	Marital Status: ____Single _____Married ____Divorced _____Widowed

List ages of any dependents:

Highest level of education:

List any hobbies or activities:

List any special skills, licenses, or training:

List any military service with dates:

List any previous workers' compensation claims with approximate date and body part:

MEDICAL INFORMATION

Family Physician Name:		Family Physician Phone:
Height:	Weight:	Dominant hand:

List any chronic medical conditions for which you have been diagnosed:

List any previous surgeries/procedures:

List any medications you take on a regular basis:

Do you use any tobacco products? _________Yes ________No

List any physicians you have treated with in the past 5 years:

EMPLOYMENT INFORMATION

Employer for this injury:	Date of Hire:
Job Title:	Supervisor:

Normal shift/schedule:

List your job duties:

Previous employer:	List any other current employment:

ACCIDENT INFORMATION	
Date & time of accident:	List any witnesses:
To whom was accident reported?	When?
Were you at your regular occupation at time of injury? ____________Yes ______No If not, please explain:	
Describe how accident occurred:	
If auto accident, please provide other driver information:	
If accident was reported later than 48 hours after the incident, please explain delay:	
List all body parts injured:	
Date of initial treatment:	Facility/Physician:
List any other physicians who have treated you for this injury:	
Date of next appointment:	Facility/Physician:
Are you currently off work for this injury: _____Yes _____No If yes, last date worked: ______________________ If no, date returned to work: __________________________ If no, are you working ____full duty or ____with restrictions	
Have you received treatment for these body parts prior to this injury? ____Yes ____No If yes, please explain:	
Please provide any additional information that you feel important to the processing of your claim:	

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

I have read and fully understand each of the questions on this questionnaire and the answers I have provided are true and correct.

_______________________________ Signature

__________________ Date

Return to: KLC
PO Box 1720
Lexington, KY 40588

Call 1-800-382-7729 with any questions