HEARING APPLICATION

Please Read Instructions.

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

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.

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 ☐ M ☐ F	2c. Nature of employer business	4. Have you applied for or are you receiving Social Security benefits? ☐ Yes ☐ 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? ☐ Yes ☐ No If Yes, Medicare claim number:
	2e. Employee gross weekly wage when injured	
	Answer Questions 5 to 5c if claim is made for death benefit	
1e. Is the Certification of Readiness included with this Application? ☐ Yes ☐ No	5. Name of deceased and date of death	5a. Are you a dependent of the deceased? ☐ Yes ☐ No
1f. Attorney's telephone no. (include area code) ( ) -	5b. Applicant's relation to deceased ☐ Spouse ☐ Child ☐ Other	5c. Did You live with the deceased? ☐ Yes ☐ 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. ☐ Temporary Total Disability (Month, Day, Year) From To	From To	
7b. ☐ Temporary Partial Disability From To	7c. ☐ Transportation costs (mileage)	
7d. ☐ Permanent Partial Disability % of Body Part	7e. ☐ Permanent Total Disability Starting Date	
7f. ☐ Medical expense denied $ Has Treatment Ended? ☐ Yes ☐ No	7g. ☐ Penalty	7h. ☐ Other
8. Names of medical practitioners who treated applicant:		9. Is the employee working now? ☐ Yes ☐ No
10. Were medical expenses paid ☐ Yes ☐ No If yes, by whom?	11. Are you currently receiving Worker's Compensation disability benefits? ☐ Yes ☐ No	
12. Have sickness and accident benefits/income continuation been paid for lost wages? ☐ Yes ☐ No	12a. If yes, indicate by whom and the amounts	
13. I will be ready for a Formal Hearing in: ☐ Due course ☐ Due course but not before this Date	14. Preferred city for hearing:	

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? ☐ Yes ☐ No

16. **FOR OFFICE USE ONLY:**

HR PT NR

Issues _____ ☐ GL35 ☐ GL35A ☐ GL48

Length_____ ☐ GL33 ☐ GL70 ☐ GL34

Date _____ ☐ GL33A ☐ GL39 ☐ GL31