

**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  
v.

Case #  
(Office use only)

\_\_\_\_\_  
Employer/Respondent

Location of accident \_\_\_\_\_  
or last exposure City, State

\_\_\_\_\_  
Injured employee's name <sup>1</sup> Street address City, State, Zip code

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

Employee information: Social Security # \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Married \_\_\_ Single \_\_\_

# Dependents under age 18 \_\_\_\_\_ Birthdate \_\_\_\_\_ Average weekly wage \$ \_\_\_\_\_

Date of accident <sup>2</sup> \_\_\_\_\_ 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 <sup>3</sup> \_\_\_\_\_

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* <sup>4</sup> 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 # <sup>5</sup> (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 \_\_\_\_\_ **AM** 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

\_\_\_\_\_  
<sup>1</sup> 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.

<sup>2</sup> This may be the date of the accident, last exposure, disability, or death.

<sup>3</sup> If the employee has not returned to work, leave this space blank.

<sup>4</sup> 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.

<sup>5</sup> 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.