Instructions: This form must be submitted in duplicate to: Indiana Workers Compensation Board 402 W. Washington, RM W196, Indianapolis, IN 46204-2753
*This agency is requesting disclosure of your Social Security number in accordance with IC 22-3-4-13. This disclosure is not mandatory and you will not be penalized for refusing.


## CLAIMANT'S AFFIDAVIT

As the injured party requesting benefits of the second injury fund administered by the Indiana Worker's Compensation fund, 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 $\qquad$ day of $\qquad$ , two thousand and $\qquad$ .

| Notary Seal | Notary Signature | Applicant Signature |
| :--- | :--- | :--- |
|  | Notary Printed Name | Applicant Printed Name |
|  | Notary Commission Expiration Date | Date Prepared |

## APPLICATION CHECKLIST

In order to proceed in processing this application, The Board must receive from you the following items (Please Check):
$\square$ This completed application is signed and notarized $\square$ Form submitted in duplicate
$\square$ A current copy of the applicant's medical report.

