

Indiana Worker's Compensation Board Application for Second Injury Fund Benefits State Form 51247 (2-03)

Instructions: This form must be submitted in duplicate to: Indiana Workers Compensation Board 402 W. Washington, RM W196, Indianapolis, IN 46204-2753

PRIVACY NOTICE

*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.

Accident Number

Social Security Number *		r *	Date of Birth		Last Name			11	First		Middle		
Address													
State	Zip			Phone ()									
INJURY INFORMATION													
Date of Injury Disp		Dispute	Disputed Cause #		Date of Award		Type of Injury/Illness			Part of Body			
Briefly describe the injury in your own words													
☐ Check here if you have received any second injury fund payments for this accident.													
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 thisday of, two thousand and													
Notary Seal			Notary Signature					Applicant Signature					
			Notary Printed Name					Applicant Printed Name					
			Notary Commission Expiration D				e	Date Prepared					
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 and notarized ☐ Form submitted in duplicate													
☐ A current copy of the applicant's medical report.													