STATE OF WEST VIRGINIA
STATE AGENCY
WORKERS' COMPENSATION PROGRAM

Send Completed Form To:
Zurich Insurance
PO Box 66941
Chicago, IL 60666-0941
FAX: 847-240-8172

General Instructions for Completing the Claim Reopening Application for Temporary Total Disability/Wage Replacement Benefits

Please Read Carefully

A reopening cannot be initiated until the reopening form has been completed in its entirety and submitted to Zurich Insurance.

SECTION I: EMPLOYEE SECTION

7 – Check **first** box if there is an aggravation/progression of the condition or disability that resulted from the compensable injury.

Check the **second** box if **new** facts pertaining to the disability or condition were not previously considered by Zurich Insurance.

Once form is completed, go to line 13 and sign and date.

SECTION II: EMPLOYER SECTION (OPTIONAL)

This section is optional, complete as needed.

This section should be completed by the employer for whom the claimant was working at the time of the injury or occupational disease covered by this claim. Although this section is optional, completing it may expedite the consideration of the petition.

As the employer, you can expedite the reopening of the claim by waiving the 10 day notice.

SECTION III: PHYSICIAN SECTION

Complete all information requested in questions 1 – 10.

Physician must sign and date the form on the date of the examination.

STATE OF WEST VIRGINIA
STATE AGENCY
WORKERS' COMPENSATION PROGRAM

Send Completed Form To:
Zurich Insurance
PO Box 66941
Chicago, IL 60666-0941
FAX: 847-240-8172

CLAIM REOPENING APPLICATION FOR TEMPORARY TOTAL DISABILITY / WAGE REPLACEMENT BENEFITS

PLEASE PRINT OR TYPE

Step 1 **Claimant** – Complete Section I and take this form to your doctor.
Step 2 **Physician** – Complete Section III and return this form to the claimant for delivery to employer at time of injury, or send to Zurich Insurance at PO Box 66941, Chicago, IL 60666-0941.
Step 3 **(Optional) Claimant** – Take this form to the employer for whom you worked at the time of your injury to complete Section II.
Step 4 **Claimant** – Send completed form to Zurich Insurance at PO Box 66941, Chicago, IL 60666-0941. It is your responsibility to ensure Zurich Insurance receives the completed form.

SECTION I – TO BE COMPLETED BY CLAIMANT

1. Claimant's Name (First, Middle, Last)	2. Social Security Number – Last four digits only.	3. Date of Injury
4. Mailing Address (Street or PO Box, City, State, Zip)	5. Telephone Number (include area code)	6. Claim Number

7. Please check the appropriate box:
I am requesting additional Temporary Total Disability (TTD)/Wage Replacement benefits due to:
___ Aggravation and/or progression of condition or disability resulting from the compensable injury or occupational disease.
___ Fact or factors pertaining to the disability or condition not previously considered by Zurich Insurance in previous findings.

8. Have you suffered any other illness and/or injuries since the injury upon which this claim is based? ___yes ___no
If yes, specify the nature of the illness and/or injuries, the dates of the illnesses and/or injuries. Please list the names and address of the physicians who treated you.

9. Have you filed any other workers' compensation claim in West Virginia or any other state? ___Yes ___No
If yes, list all claim numbers and/or dates of injuries or occupational disease.

10. Have you drawn either unemployment or other wage replacement benefits since you were last paid TTD benefits in this claim?
___Yes ___ No

If yes, please state the source (s) and for what time periods you received other benefits.

11. Have you earned wages since you were last paid TTD benefits in this claim? ___Yes ___No
If yes, please list who you worked for and provide time periods of earned wages.

12. Have you retired? ___Yes ___No If yes, please list employer's name and any benefits (i.e. Social Security, pension, etc.) you are receiving.

13. Claimant's Signature	**Date**

SECTION II
EMPLOYER -optional

1. Employer's Name, Address and Telephone Number (include area code)	2. Do you disagree with any of the information contained in Section I or III of this form? ___Yes___No If yes, explain the information with which you disagree. Be specific.
3. The claimant began missing work again on:	4. The employer waives the 10 day notice period and does not object to Zurich's immediate ruling on the claimant's petition. ___Yes___No

5. Employer's Signature	**Title**	**Date**

SECTION III – TO BE COMPLETED BY THE PHYSICIAN IN DETAIL AND A NARRATIVE REPORT ATTACHED IF NECESSARY

1. Physician's Name, Address and Telephone Number	2. Physician's FEIN or Vendor Number
3. Are you the previously authorized attending physician in this claim? ___ Yes ___ No	4. Date of examination upon which these findings are based

5. List the current diagnosis (include specific ICD10-CM codes and description), and indicate if you are requesting that a new body part be added.

6. List the claimant's complaints as it relates to the compensable injury or occupational disease.

7. Has there been an aggravation or progression of the claimant's disability since being released to resume employment or being certified as having
reached maximum degree of medical improvement? ___Yes___No

If yes, list the physical findings that relate to the aggravation/progression of the injury or occupational disease.
Please indicate the date and location for any diagnostic testing that was administered, as well as the results.

8. List any requests for authorizations as it relates to the compensable injury or occupational disease. Please attach any office notes or medical reports.

9. Can the claimant now perform regular duty? ___Yes ___No If no, under what restrictions could the claimant work?

If yes, list any work restrictions on the patient's functional abilities.

10. Please list exact periods of Temporary Total Disability: From ____________ To ____________

11. Physician's Signature	**Date**