FRANKLIN & PROKOPIK
A PROFESSIONAL CORPORATION
ATTORNEYS AT LAW

2325 Dulles Corner Boulevard, Suite 1150, Herndon, VA / 703.793.1800 T / 703.793.0298 F
www.fandpnet.com

VIRGINIA
Workers' Compensation
Key Forms & Dates

Commonwealth of Virginia
Workers' Compensation
Key Forms and Dates

1. First Report of Injury ("FROI") (VWC Form #3) (Exhibit No. 1)
   - Filed by employer upon notice of alleged work related injury.
   - Does not constitute filing a claim.
   - Does not bind employer or insurer to acceptance of claim.

2. Claim for Benefits ("CFB") (VWC Form # 5) (Exhibit No. 2)
   - Filed by claimant with the VWC.
   - Identifies employer, states nature of injury and average weekly wage ("AWW"), etc.
   - Must be filed by claimant within two (2) years of injury date.

3. Wage Chart (VWC Form No. 7A) (Exhibit No. 3)
   - Completed by employer for use in calculating preinjury AWW.
   - Employer may choose to submit an earnings history printout as long as it contains information sufficient to calculate the AWW.

4. Orders for Information ("Twenty-day Orders") (Exhibit No. 4)
   - Upon claimant's filing of CFB, sent to employer/insurer to assess extent of dispute.
   - Response required by employer/insurer within 20 days.
   - If no dispute, employer/insurer will be asked to circulate Award Agreement (Exhibit No. 5, below).
   - If dispute exists, matter will be referred to either Evidentiary or On-the-Record docket.

5. Award Agreement (Form #4) (Exhibit No. 5)
   - Filed when claim is accepted, must contain signatures of employer/insurer representative and claimant.
   - Pertains to both medical only Awards and wage loss Awards.
   - If Award is entered and a dispute arises shortly thereafter, an appeal may be filed to vacate the Award within thirty (30) days. If Award is sought to be vacated beyond thirty days the moving party must prove fraud, mutual mistake or imposition.

6. Termination of Wage Loss Award (Form #46) (Exhibit No. 6)
   - Filed if agreement reached with claimant as to termination of open Award.
   - Must contain signatures of claimant and representative of employer/insurer.
   - If no agreement reached, Employer's Application for Hearing (Exhibit No. 8) should be filed.

7. Award Order (Form #SN56) (Exhibit No. 7)
   - Award Order prepared by Commission and memorializes information in Award Agreement and/or Termination of Wage Loss Award
   - Award Order may be appealed/vacated within 30 days of entry.

8. Employer's Application for Hearing (Form #5A) (Exhibit No. 8)
    - Filed by employer/insurer when seeking to terminate outstanding Award.
    - Reasons for filing: claimant has returned to work (light duty or full duty); claimant has been released to return to full duty work; claimant's current disability is unrelated to the work accident; claimant has refused medical treatment; claimant has refused light duty employment; claimant has failed to cooperate with vocational rehabilitation efforts; claimant has failed to attend more than one IME.
    - Must contain documentation supporting allegation(s).
    - Benefits to be paid through the date of filing the Application, except when alleging claimant's return to work (pay through the date of the return) or claimant's refusal of light duty work or refusal of medical treatment (payment through the date of the refusal or 14 days before filing, whichever is later).

9. Joint Petition for Compromise Settlement and Order ("full and final settlement") (Exhibit No. 9)
    - Must be prepared by counsel.
    - Can have a "full and final" settlement, with or without "closed medicals", but must be approved by VWC.
    - Specified supporting documentation (e.g. Attorneys' Confidential Cover Letter, prepared by claimant's counsel or Employee's Informational Letter, completed by pro se claimant (Exhibit No. 9) must be included.
    - Now includes certain requirements with regard to potential Medicare Set Aside issues.
    - Forever closes all aspects of claim once approved by VWC, except potential medical provider applications (filed by provider to recover balance on medical bills).
    - Must reference ancillary agreements, i.e. Release and Resignation.

Exhibit 1

First Report of Injury

Virginia Workers' Compensation Commission
1000 DMV Drive Richmond Virginia 23220
1-877-664-2566

SEE INSTRUCTIONS ON REVERSE SIDE

www.vwc.state.va.us

Reason for filing: _____
VWC Jurisdiction Claim #: (If assigned) _____

Claim Administrator File#: _____

Employer

Employer's Legal Name	Federal Employer Identification Number (FEIN)
Employer's Mailing Address	
Name/FEIN of Entity on Policy	Nature of Business
Name and Address of Insurer or Self-Insurer for this Claim	Policy Number

Time and Place of Accident

Location where accident occurred	Date of injury	Hour of injury ☐ a.m. ☐ p.m.
Date injury or illness reported	If fatal, give date of death	If fatal, give marital status ☐ Single ☐ Divorced ☐ Married ☐ Widowed
	If fatal, give number of dependent children	

Injured Worker

Name of Injured Worker	Phone Number	Injured Worker ID Number
Injured Worker's mailing address		Type of ID ☐ Social Security No. ☐ Employment Visa ☐ Green Card ☐ Passport No. ☐ Unknown
Occupation at time of injury or illness	Date of birth	Sex ☐ Male ☐ Female

Nature and Cause of Accident

Machine, tool, or object causing injury or illness

Describe fully how injury or illness occurred

Describe nature of injury, occupational disease, or illness, including body parts affected

Signatures

Submitter (name, signature, title)	Date	Phone number
Submitter's Address		

First Report of Injury

Filing Instructions

The Virginia Workers' Compensation Act requires that **ALL** injuries occurring in the course of employment be reported to the Commission pursuant to Va. Code §65.2-900.

Employer

The employer is responsible for accurately completing all sections of this form when an employee is injured. It should be typed or legibly printed, signed, and dated by the preparer. Send the original form to the claim administrator for the insurance company who provided insurance coverage on the date of the occurrence. The claim administrator will report this information to the Commission. Contact your workers' compensation insurance provider for additional information.

Claim Administrator

Claim administrators who are EDI enabled will use the information contained on the paper form and submit electronic data to the Commission.

Claim administrators who are NOT EDI enabled must immediately file the completed form with the Commission. Please note: EDI is mandatory no later than June 30, 2009, after which time paper reports will no longer be accepted. Until you are in EDI production, mail the completed form to the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, VA 23220. At the top of the form, use a numerical code (1-7) to indicate the reason for filing the form for accidents meeting one of the filing criterion.* If none of the criteria apply, you must still report the accident, but may use either Form 45A or this form to do so. (Leave "reason for filing" blank in such a case.)

For questions or assistance in completing the form, please contact the Commission toll-free at 877-664-2566.

*Criteria for filing are: (1) lost time exceeds seven days; (2) medical expenses exceed $1,000.00; (3) compensability is denied; (4) issues are disputed; (5) accident resulted in death; (6) permanent disability or disfigurement may be involved; and (7) a specific request is made by the Virginia Workers' Compensation Commission.

Exhibit 2

Claim Form

Access your claim online: webfile.workcomp.virginia.gov

Virginia Workers' Compensation Commission

Jurisdiction Claim Number (JCN)

Claim Administrator Number

Injured Worker Information			Employer Information		
Name			Name of Company		
Address			Address		
City	State	Zip Code	City	State	Zip Code
Primary Phone	Gross Weekly Earnings		Employer's Phone		

Injury

Date of Injury*	Where Injury Occurred (City or County)	Parts of Body Injured

How Injury Occurred

***If claiming an occupational disease** (use separate claim form for Coal Workers' Pneumoconiosis)**:**

Name of Occupational Disease	Date last worked for employer	Date doctor stated the disease was caused by work

Request for Benefits

I need assistance obtaining the following benefits. If the benefits are denied, this form will serve as a hearing request.

☐ Lifetime Medical Award (coverage for related medical expenses).

☐ Wage Loss Replacement (Temporary Total Disability - Completely out of work):

From: _____ To: _____ ☐ continuing From: _____ To: _____ ☐ continuing

☐ Wage Loss Replacement (Temporary Partial Disability - Partially out of work/light duty):

From: _____ To: _____ ☐ continuing From: _____ To: _____ ☐ continuing

☐ Compensation for Permanent Loss (Permanent Partial Disability):

☐ Loss of use of a body part ☐ Disfigurement/Scarring ☐ Amputation ☐ Hearing/Vision loss ☐ Lung disease

☐ Payment/reimbursement for the following expenses (attach medical records, itemized bills, receipts, or mileage log):

☐ Medical bills ☐ Mileage/Transportation ☐ Prescriptions

☐ Death benefits to dependents and/or funeral expenses.

☐ Other: _____

Signature

I hereby file this claim to protect my right to benefits under the Virginia Workers' Compensation Act for the injury or disease described above.

SIGNATURE (Required) PRINT DATE

Claim Form Process & Instructions

Injury

When an individual has experienced an injury or an occupational disease in the workplace, it is important to give immediate notice to the employer about the injury. Employers are required to file a First Report of Injury (FROI) within ten (10) days of having knowledge of any injury.

Claim Form

Pursuant to Va. Code §65.2-601, a claim for specific benefits must be filed within two (2) years from the date of injury. Even if the Claim Administrator is voluntarily paying benefits, rights are not protected unless there is an Award Order.

Award Order

If the Claim Administrator accepts the claim, an Award Agreement is sent to the injured worker. Once signed by all parties, the Award Agreement must be filed with the Commission for entry of the Award Order. An Award Order protects the injured worker's rights to benefits.

Alternative Dispute Resolution (ADR)

Mediation is a voluntary and confidential informal dispute resolution process where a neutral third party (mediator) facilitates communication to assist the parties in mediating an agreeable solution. The purpose of mediation is to identify issues, clarify misunderstandings, explore solutions and mediate an agreement. For further information, contact the ADR Department at 804-205-3139.

Hearing

A hearing may be necessary to resolve disputed issues. A completed Claim Form and medical records* to support the claim must be filed for this to occur. The primary objective is to hear and decide disputed claims and issues arising under the Virginia Workers' Compensation Act in a prompt, fair and impartial manner.

*Medical Records & Subpoenas

Copies of medical records may be obtained from the physician. However, if copies of medical records and/or bills cannot be obtained, a subpoena can be requested by sending the name and address of the medical provider to the Clerk of the Commission. A $12 money order made payable to the Sheriff of the city or county where the medical provider is located must be included for each subpoena.

Benefits Covered under the Virginia Workers' Compensation Act

- **Lifetime Medical** - payment for medical treatment/expenses for the injury or occupational disease, now and in the future.
- **Temporary Total Disability -** wage loss replacement while completely out of work. Must be medically authorized.
- **Temporary Partial Disability -** wage loss replacement while partially out of work, or working light duty. Must be medically authorized.
- **Permanent Partial Disability -** compensation for loss of use of a body part, amputation, disfigurement/bodily scarring, loss of hearing, loss of vision or lung disease. Must be medically supported.
- **Medical Expenses -** payment/reimbursement of medical bills, or out of pocket expenses, such as prescription and mileage/transportation. Must provide bills, receipts and/or mileage logs.
- **Death Benefits -** payment/reimbursement of funeral/transportation expenses or wage loss replacement for surviving spouse, children, or certain other dependents. Death Certificate, Marriage License and/or Birth Certificate(s) must be provided.
- **Other -** benefits not previously mentioned (vocational rehabilitation, specific medical treatment/procedure, panel of physicians, etc).

Exhibit 3

Wage Chart

Employer's Statement of Wage Earnings

Virginia Workers' Compensation Commission
333 E. Franklin St., Richmond, Virginia 23219

The boxes to the right use of the insurer.	Reserved	VWC File Number
	Insurer Claim Number	

	Employee		**Address**	
Name of Employee			Date of Accident	Date of Hire
	Employer		**Address**	
Name of Employer			Employee's Social Security Number	

PLEASE REFER TO THE FILING INSTRUCTIONS PRINTED ON THE BACK OF THIS FORM

Week No.	Week Ending Date	Days Worked	Gross amount paid, including overtime	Week No.	Week Ending Date	Days Worked	Gross amount paid, including overtime	Week No.	Week Ending Date	Days Worked	Gross amount paid, including overtime
1				19				37			
2				20				38			
3				21				39			
4				22				40			
5				23				41			
6				24				42			
7				25				43			
8				26				44			
9				27				45			
10				28				46			
11				29				47			
12				30				48			
13				31				49			
14				32				50			
15				33				51			
16				34				52			
17				35							
18				36							

Value of perquisites for entire year:

Total gross earning $_____ Total weeks worked _____

Bonuses $_____ Electricity $_____
Meals/Lodging $_____ Water $_____
Meals Only $_____ Telephone $_____
Temporary Lodging $_____ Uniforms $_____
House Rent $_____ Laundry $_____
Tip Income $_____

Total value of perquisites $_____

Total earnings & perquisites $_____

VWC use only:

AWW:_____
CR: _____

INSURER OR EMPLOYER (include name & signature)	Date	Telephone number

Wage Chart
VWC Form No. 7A (rev. 07-01-06)

FILING INSTRUCTIONS

(Instructions Updated 09/01/07)

Wage Chart
VWC Form No. 7A

The information at the top right of the form should be provided by the insurer. Please note that the insurer code refers to the five-digit numeric code assigned by The National Counsel on Compensation Insurance (NCCI). Self-insured employers are assigned a similar five-digit code number by the Virginia Workers' Compensation Commission.

Illegible forms will be returned to the insurer.

How to complete the Wage Chart:

- Indicate gross weekly earnings for the 52 weekly periods immediately **preceding** the date of accident.

- Note that these earnings are GROSS earnings and include overtime and tips, before any deductions are made for taxes or Social Security. If there were any perquisites, please list the TOTAL value separately at the bottom of the chart.

- If an injured employee lost more than seven consecutive calendar days, although not in the same week, these periods should be noted on the Wage Chart (VWC Form No. 7-A) using an asterisk in the Week No. column and are not to be counted in the calculations. Va. Code § 65.2-101.

- If injured employee has worked less than 12 months, the earnings for the time worked should be used. The earnings for a similar employee may be used if the employee has worked less than 60 days.

How to calculate the Wage Chart:

- If a full year's wage information **has been** provided covering the 52 week period prior to the date of accident:

  - determine the total wages earned, including yearly perquisites;
  - divide the total wages earned for this period by 52;
  - the sum will be the average weekly wage.

- If a full year's wage information **has not been** provided covering the 52 week period prior to the date of accident:

  - determine the total wages earned, including yearly perquisites;
  - divide the total wages earned by the number of weeks wages were earned (Note: if warranted, the weeks can be converted into days and calculated on that basis);
  - the sum will be the average weekly wage.

- If the form is completed on a **bi-weekly basis:**

  - determine the total wages earned, including yearly perquisites;
  - divide the total wages earned by the number of weeks worked (employee paid 26 times a year represents 52 weeks of wages);
  - the sum will be the average weekly wage.

- Samples of properly completed wage chart(s) are available through the Commission's Website at www.vwc.state.va.us under the forms menu.

- For questions or assistance with completing this form, please contact the Commission's Toll-Free number at (1-877) 664-2566.

Exhibit 4

COMMONWEALTH OF VIRGINIA
WORKERS' COMPENSATION COMMISSION
1000 DMV DRIVE, RICHMOND VA 23220
1-877-664-2566
www.workcomp.virginia.gov

Order Response Form
Payments Made

Date of this notice: April 01, 2011

[redacted] v [redacted]
[redacted] Insurance Carrier
[redacted], Claim Administrator
Jurisdiction Claim No. [redacted]
Claim Administrator File No. [redacted]
Date of Injury November 13, 2009

To Claims Administrator:

This form must be completed, signed and returned to the Commission within 20 days from the date of this letter. Please make this form the cover page when responding to the 20-day Order.

- ☐ Agreement forms signed by all parties are attached hereto.
- ☐ Agreement forms were/will be mailed to the Injured Worker or his/her Attorney on _____.
- ☐ Agreement forms will **NOT** be mailed to the Injured Worker/Injured Workers' Attorney.
  Reason: _____

_____	_____	_____
Print Name of Individual Completing Form	Claim Administrator Name	Phone Number

Date this form was sent to Commission with copy to the injured worker/injured worker's attorney:

_____

Exhibit 5

Award Agreement

(Agreement to Pay Benefits)

Virginia Workers' Compensation Commission
333 E. Franklin St., Richmond, Virginia 23219
1-877-664-2566

SEE INSTRUCTIONS ON REVERSE SIDE

www.vwc.state.va.us

Jurisdiction Claim #: _____

Claim Administrator #: _____

Injured Worker's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: ( ) -

Employer's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer's Phone: _____

Body Parts/Injuries Accepted: _____

Date of Injury: _____ **Pre-Injury Average Weekly Wage:** _____

Payment of Compensation Check one: ☐ Initial period ☐ Additional period ☐ Corrected period
(Check all that apply)

☐ A. **Temporary Total** at the compensation rate of $_____ per week. This period of disability began on _____ (m/d/yyyy).

☐ B **Temporary Partial:** Please select option 1 or 2 below and complete.

☐ 1 - Will be paid at the compensation rate of $_____ per week. This period of disability began on _____ (m/d/yyyy)

☐ 2 - Was paid an averaged weekly compensation rate of $_____ per week from _____ through _____ and will continue to be paid at a compensation rate of $_____ per week beginning on _____ (m/d/yyyy)

☐ C. **Permanent Partial** at the compensation rate of $_____ per week. This period of disability began on _____ (m/d/yyyy) for _____%
☐ loss of use, ☐ loss, or ☐ disfigurement of the _____. **Note: Medical report(s) or amputation chart must be attached.**

Do the parties agree to have this award paid in a lump sum with the 4% discount deducted? ☐Yes ☐No

☐ D. **Permanent Total** the compensation rate of $_____ per week. This period of disability began on _____ (m/d/yyyy) .

☐ E. **Medical Only**. The parties agree to an award for payment of medical benefits that are reasonable, necessary, authorized and causally related to the compensable injury.

THIS AGREEMENT IS SUBJECT TO ADJUSTMENT AND APPROVAL BY THE COMMISSION PURSUANT TO THE VIRGINIA WORKERS' COMPENSATION ACT

Signatures REQUIRED

By signing below, we certify that the facts relating to this accident are correct as presented on this form and agree that the Injured Worker shall receive compensation or benefits indicated until suspended in accordance with the provisions of the Virginia Workers' Compensation Act.

Signature of Injured Worker	Print Name	Date (m/d/yyyy)
Signature of Claim Administrator	Print Name	Date (m/d/yyyy)
Print Name and Address of Claim Administrator		Phone Number
Print Name and Address of Injured Worker's Attorney		Phone Number

Award Agreement
Form #50

Filing Instructions

1. This form is to be completed whenever a claim has been accepted as compensable and the Injured Worker is entitled to an award. This Award Agreement provides the basis for the award of compensation and contains sufficient information to establish the essential elements of a compensable claim. Submit the completed form to the Virginia Workers' Compensation Commission, 333 E. Franklin St., Richmond, Virginia 23219. For subsequent periods of compensation benefits, this form should be used or a Varying Temporary Partial Award Agreement (VWC Form No. 4G) must be filed.

2. Definitions of Benefit Types:

   Temporary total (TT) disability – Injured Worker is totally disabled from work and is entitled to receive compensation for a period of total wage loss based upon 66 2/3% (.66667) of the pre-injury average weekly wage.*
   Temporary partial (TP) disability – Injured Worker is partially disabled from work but is entitled to receive compensation for a period of partial wage loss based upon 66 2/3% of the difference between the pre-injury average weekly wage and the post (current) average weekly wage. Forms received without specific dollar amounts or those that reflect the word "various" will be rejected. *

Calculation of Temporary Partial Rate:		Average weekly wage before injury	$
	–	Current weekly wage	$
All Amounts are Based on Weekly Figures	=	Difference in wages before injury and now	$
	x	.66667	$
		Temporary Partial Compensation Rate	**$**

   Permanent partial (PP) disability – Injured Worker is entitled to receive compensation based upon the loss of use or the loss of a ratable body part, based upon 66 2/3% (.66667) of the pre-injury average weekly wage for a specified number of weeks, pursuant to Va. Code §65.2-503. Please attach a copy of the medical report or the amputation chart that supports the permanency rating to the agreement form. If Permanent Partial is for disfigurement, the Commission must set the rating based on submitted photographs.*
   Permanent Total – Injured Worker is permanently and totally disabled from work and is entitled to receive compensation for the remainder of his/her life based upon 66 2/3% (.66667) of the pre-injury average weekly wage.*
   Medical Only – The parties agree that the Injured Worker sustained a compensable injury for which the employer and insurer will accept responsibility only for the medical expenses incurred as a result of a work related injury or occupational disease.

   * Compensation rate is subject to yearly maximum and minimum allowances.
   ** All wage information and compensation rate(s) reflected on the form(s) should be based on weekly figures.

3. For questions or assistance with completing this form, please contact Customer Assistance using the Commission's toll-free number 877-664-2566.

Exhibit 6

Termination of Wage Loss Award

Virginia Workers' Compensation Commission
333 E. Franklin St., Richmond, Virginia 23219
1-877-664-2566

SEE INSTRUCTIONS ON REVERSE SIDE

www.vwc.state.va.us

Jurisdiction Claim #: _____

Claim Administrator #: _____

Injured Worker's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: ( ) -

Employer's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer's Phone: _____

Date of Injury: _____ **Pre-Injury Average Weekly Wage:** _____

Payment of Compensation pursuant to the open award is terminated for the reason indicated below. (Choose A or B)

☐ A. The Injured Worker **returned to work** on _____ (m/d /yyyy) at a wage equal to or greater than the pre-injury average weekly wage.

☐ B. The Injured Worker **was able to return to pre-injury work** on _____ (m/d/yyyy). (Documentation supporting release must be attached.)

THIS AGREEMENT IS SUBJECT TO VERIFICATION BY THE COMMISSION PURSUANT TO THE VIRGINIA WORKERS' COMPENSATION ACT

Signatures REQUIRED

Signing this form indicates the parties agree that the injured worker returned to work at the pre-injury wage or is able to return to pre-injury work.

Signature of Injured Worker _____ Print Name _____ Date (m/d/yyyy) _____

Signature of Claim Administrator _____ Print Name _____ Date (m/d/yyyy) _____

Print Name and Address of Claim Administrator _____ Phone Number _____

Print Name and Address of Injured Worker's Attorney _____ Phone Number _____

Termination of Wage Loss Award
Form #133

Filing Instructions

Claim Administrator or Authorized Representative:

1. This form is to be completed when the Injured Worker returns to work at the pre-injury wage or is able to return to pre-injury work. Submit the completed for to the Virginia Workers' Compensation Commission, 333 E. Franklin St., Richmond, Virginia 23219.

2. Check the appropriate reason for the termination of the Award and provide the return to work date and wage information, if applicable.

3. If the basis for terminating benefits is for reasons other than what is contained on this form, you may need to file an Employer's Application for Hearing (VWC Form No. 5A) to terminate the outstanding Award. This form may not be modified to meet a specific case, or the form will be rejected.

Injured Worker:

Signing this document is NOT a requirement for payment. If you do not agree with the information contained and make modifications, it will be rejected. If you have any additional disability from work in the future, your claim can be reopened with the following limitations:

* For questions or assistance with completing this form, please contact Customer Assistance at the Commission's toll-free number 877-664-2566.

Exhibit 7

COMMONWEALTH OF VIRGINIA
WORKERS' COMPENSATION COMMISSION
1000 DMV DRIVE, RICHMOND VA 23220
1-877-664-2566
www.workcomp.virginia.gov

Award Order

Date of this Award Order: July 21, 2017

[redacted] v. [redacted]
[redacted] Insurance Carrier
[redacted] Claim Administrator
Jurisdiction Claim No. VA00001298141
Claim Administrator File No [redacted]
Date of Injury February 02, 2017

To All Interested Parties:

The Virginia Workers' Compensation Commission has approved your agreement form for the payment of compensation under the Workers' Compensation Act.

An award is entered in favor of [redacted] against [redacted] and [redacted] for payment of compensation as follows:

$249.00 shall be paid per week during temporary total disability beginning February 14, 2017

Lifetime Medical benefits are hereby awarded for reasonable, necessary and authorized medical treatment for the following body parts injured during the Injured Worker's workplace injury of February 02, 2017:

Right knee

If any party wishes to dispute this Award Order, a Request for Review (appeal) must be filed within 30 days of the date of this Order. If there are any questions regarding information contained in this order, please contact the Commission toll-free at 1-877-664-2566.

Exhibit 8

Virginia Workers' Compensation Commission
1000 DMV Drive, Richmond VA 23220

Employer's Application for Hearing

SEE SPECIAL INSTRUCTIONS ON THE REVERSE SIDE

Employee _____ JCN _____
Address _____ Date of Accident _____
City/State/Zip _____

The Commission is requested to suspend benefits for the following reason(s) **[attach supporting documentation]***:*

_____ The employee returned to pre-injury work on _____.

_____ The employee was released to return to pre-injury work on _____ per Dr. _____´s report dated _____.

_____ The employee returned to light-duty work on _____ at an average weekly wage of $ _____.

_____ The employee's current disability is unrelated to the industrial accident noted in Dr. _____´s report(s) dated _____.

_____ The employee failed to report to an employer-requested medical examination with Dr. _____ on _____.

_____ The employee refused selective employment within the employee's physical capacity at _____ on _____.

_____ The employee failed to cooperate with vocational rehabilitation efforts (documentation must be attached).

_____ The employee has refused medical treatment offered by Dr. _____ as noted in the medical report dated _____.

_____ Other _____

Request:

_____ Termination/suspension of the outstanding award

_____ Change of an outstanding award for temporary total to temporary partial

_____ Credit

_____ Other _____

Compensation was paid through _____ at the rate of $_____ per week.

I hereby certify under penalty of perjury that the statements in this application are true and correct to the best of my knowledge and that a copy of this application ***, INCLUDING INSTRUCTIONS ON THE REVERSE SIDE,*** *and all attached supporting documents were sent to the employee at the above address, and to the employee's attorney (if known) at _____, and to the Virginia Workers' Compensation Commission on _____ (date).*

APPLICANT'S NAME AND TITLE: _____EMPLOYER/CARRIER_____

SIGNATURE OF APPLICANT: _____DATE:_____

Registered WebFile Users: type in your signature if submitting through your WebFile account.

Notice to the employee: If the Virginia Workers' Compensation Commission approves this application, your compensation benefits will be suspended. Please refer to the additional instructions on the back of this form.

FILING INSTRUCTIONS

(Instructions Updated 04/01/09)

Employer's Application for Hearing
VWC Form No. 5A

Employer Instructions:

Complete the Employer's Application for Hearing (VWC Form No. 5A) on the reverse side of this form. The form must be signed, under penalty of perjury, and sent to the Virginia Workers' Compensation Commission with supporting documentation. You may submit this form with your electronic signature and supporting documentation via your WebFile account at https://webfile.workcomp.virginia.gov. At the time the application is filed with the Commission, a copy of the application and the supporting documentation must be sent to the employee and to the employee's attorney, if represented.

The employer must send the employee a copy of the "Employee Instructions" as shown below.

Compensation must be paid in accordance with the Virginia Workers' Compensation Commission Rule 1.4 (C). If you are relying on Rule 1.4 (F), please indicate that compensation benefits continue to be paid.

You will be notified in writing if the Virginia Workers' Compensation Commission finds it appropriate to suspend compensation benefits or if a determination is made that compensation benefits should not be suspended pending a hearing.

Employee Instructions:

If you wish to contest the suspension of compensation benefits pending a final determination by a deputy commissioner, you must provide the Virginia Workers' Compensation Commission with a written statement explaining why your compensation benefits should be continued. This statement and any supporting documentary evidence must be received at the Commission's office 15 days from the date of this application.

If after examining this application, the attached documentation, and the employee's response, the Virginia Workers' Compensation Commission determines that compensation benefits should not be suspended, you will be notified in writing and your compensation benefits will immediately be resumed.

If the Virginia Workers' Compensation Commission finds it is appropriate to suspend benefits until a final determination can be made by a deputy commissioner, you will be notified either that the case is being referred to the evidentiary docket or that a final decision will be made based on the written record.

For questions or assistance with completing the form, please contact the Customer Assistance Department at 1-877-664-2566.

Exhibit 9

A Form Confidential Informational Letter for an Employee who is* NOT *Represented by Counsel

To: P & O Department
Virginia Workers' Compensation Commission

Name of Employee: _____
Re: VWC File No._____:

I submit the following information in order to assist the Virginia Workers' Compensation Commission in determining whether to approve the proposed settlement of my pending workers' compensation claim. I understand that this information will be sealed and held in confidence by the Commission.

1. Date and nature of my injury or disease: _____
2. Age:___years.
3. Family status: _____ (married, single, divorced, widowed).
4. Names and ages of all dependents:

Name	Age	Relationship to Employee, i.e., son, daughter, or spouse

1. Are you currently working? (yes or no) (circle one) If yes, please provide the following:

Employer	**Weekly Wages and Date of Return to Work**

6. Please indicate the amount and source of any other income: (If you have no other income sources, please indicate "none" in the area below.)

Source	**Amount**

7. Are you able to read, write and understand the English language? (yes or no) (circle one).

(a) If you are not literate in English, state the name of the person reading, and/or translating, and explaining the settlement papers to you.

Name of Person	**Address**	**Telephone Number**

8. Are you currently receiving medical treatment? (yes or no) (circle one)

Date of last medical treatment _____

(a) Please describe the type of treatment and how often you visit your treating physician:

(b) Identify the doctor(s) in the space below.

Name	Address	Telephone Number

(c) Are there any outstanding medical expenses? (yes or no) If yes, please state the name of the medical provider and the amount due.

9. Do you expect future medical expenses? (yes or no).(circle one)

(a) If you anticipate future medical expenses please describe below:

Type of Medical Expense & Treatment	When or How Often Anticipated

10. Do you have any other insurance that will cover your medical expenses after the settlement? (yes or no) (circle one). Please give the name of the company. _____

11. What is your intended use of the settlement proceeds?

(a) If you have any outstanding debts, please itemize your major debts (over $1000.00) and the amounts, and indicate which of these debts you plan to pay from the settlement.

Creditor	Amount Owed	Amount That You Plan to pay from the Proceeds

12. Please list all of your major financial assets (over $1000.00), including your home, land, equipment of all kinds, bank accounts, certificates of deposits, stocks, bonds and any other type of investments.

Major Financial Asset	Value

1. Are you receiving Social Security Disability benefits? (yes or no) (circle one) $ _____

If you are not receiving benefits, do you intend to apply for such benefits? (yes or no) (circle one)

Are you currently receiving Medicare benefits? (yes or no) (circle one) If yes, [ ] disability or [ ] old age retirement.

1. Please explain, in your own words in the space provided below, why you believe the settlement proposal is in your best interest.

Please provide the following: (required)

Employee's Signature :	Address:	Telephone Number: Date:

Please attach additional sheets to supplement your answers to any of the above questions.

Please return this completed form to:

P & O Department
Virginia Workers' Compensation Commission
1000 DMV Drive
Richmond, Virginia 23220

FRANKLIN & PROKOPIK
A PROFESSIONAL CORPORATION
ATTORNEYS AT LAW

The B & O Building
2 N. Charles Street, Suite 600
Baltimore, Maryland 21201
410.752.8700
410.752.6868 Fax

111 North West Street
Suite 200
Easton, Maryland 21601
410.820.0600
410.820.0300 Fax

1101 Opal Court
Hub Plaza, Suite 210
Hagerstown, Maryland 21740
301.745.3900
301.766.4676 Fax

2325 Dulles Corner Boulevard
Suite 1150
Herndon, Virginia 20171
703.793.1800
703.793.0298 Fax

800 Creek View Road
Suite 300
Newark, Delaware 19711
302.594.9780
302.594.9785 Fax

5516 Falmouth Street
Suite 203
Richmond, Virginia 23230
804.932.1996
804.403.6007 Fax