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 _____

_____ Case #
Employee/Petitioner (Office use only)

v.

_____ Location of accident _____
Employer/Respondent or last exposure City, State

_____
Injured employee's name [1] Street address City, State, Zip code

_____
Employer's name Street address City, State, Zip code

Employee information: State Employee? Yes ____ No ____ Male ____ Female ____ Married ____ Single ____

Dependents under age 18 _____ Birthdate _____ Average weekly wage $ _____

Date of accident [2] _____ 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 [3] _____

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* [4] 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 # [5] (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

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[1] 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.

[2] This may be the date of the accident, last exposure, disability, or death.

[3] If the employee has not returned to work, leave this space blank.