Claim For Benefits

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

www.workcomp.virginia.gov

Jurisdiction Claim #: ____________________

Claim Administrator #: ____________________

PLEASE PROVIDE INFORMATION BELOW

PART A – CLAIM FORM (REQUIRED)

All injured workers should complete this section for workers' compensation injuries

SEE "FILING INSTRUCTIONS" AND "BENEFITS COVERED" ON REVERSE SIDE

Injured Worker's Name: ____________________

Address: ____________________

City: ____________ State: ______ Zip: ________

Home Phone: ____________ Work Phone: ____________

Employer's Name: ____________________

Address: ____________________

City: ____________ State: ______ Zip: ________

Employer's Phone: ____________________

Parts of Your Body Injured: ____________________

How injury occurred: ____________________

Date of Injury: ____________________ Average Gross Earnings per week: $ ____________

Location of accident (City or County): ____________ State ____________

If claiming an occupational disease:

- *name of occupational disease:*____________________
- *date you last worked for this employer:* / /
- *date doctor told you disease was caused by work:* / /

I hereby file this claim to protect my rights under the Virginia Workers' Compensation Act for the injury or disease described above. Unless indicated in Part B below, I am not requesting the Commission take any specific action at this time.

____________________ Injured Worker's Signature (Required)　____________________ Print Name　____________ Date

PART B - REQUEST FOR BENEFITS (Optional)

I need assistance obtaining the following benefits and request a hearing if necessary:

- ☐ I need a lifetime Award of medical benefits for my injury (including any treatment already received & paid for) **
- ☐ I missed work because of my injury for the periods: From:__________ To:__________**
  From:__________ To:__________
- ☐ I earned less pay while at work because of my injury for the periods: From: __________To:__________**
  From: __________To:__________
- ☐ I have a loss of use or amputation of a body part, loss of hearing/vision, lung disease or bodily scarring/disfigurement. **
- ☐ I have unpaid medical bills or out of pocket medical/prescription/transportation expenses relating to my injury. **
- ☐ I am requesting death benefits to dependents or funeral expenses.
- ☐ Other ____________________
  (i.e. Change in Condition, Permanent Total Disability, etc.)

** Attach medical records, itemized bills, or receipts.
If there are any questions regarding this form, please contact the Commission toll-free at **1-877-664-2566**.

VWC Form #5
Rev. 11/09

Claim for Benefits
VWC Form #5

Filing Instructions

1. If you have been paid by your employer or claim administrator for time missed from work because of your injury or for medical treatment for your injury, you must file a claim with the Virginia Workers' Compensation Commission to protect your right to benefits under Virginia law. Even if you are not requesting specific benefits at this time, you should still submit this form with Part A completed within two years of the date of your accident or diagnosis of disease.

2. If you are requesting specific benefits or if the claim administrator has denied your claim, complete Part B of this form and submit the medical reports either attached to the form, or as soon as possible. You may obtain copies of your medical records directly from your physician.

   Importance of Medical Records:

   Medical records showing that your accidental injury or disease is work related must be filed with the Commission. File these medical records with your claim or as soon as possible. If you are unable to obtain copies of your medical reports and bills, you may request a subpoena by sending the name and address of the medical provider to the Clerk of the Virginia Workers' Compensation Commission. A $12.00 money order made payable to "Sheriff" must be included for each subpoena. The Commission cannot issue subpoenae outside Virginia.

3. For questions or assistance with completing this form, please contact the Virginia Workers' Compensation Commission toll free at 1-877-664-2566 or visit our website at www.workcomp.virginia.gov

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Benefits Covered under the Virginia Workers' Compensation Act:

- Lifetime Medical Benefits – Payment for expenses related to the injury or occupational disease. Includes payment/reimbursement of out of pocket medical, prescription and transportation expenses.
- Wage Loss Replacement (Temporary Total/Temporary Partial Disability): Full or partial wage loss replacement for medically authorized disability from work.
- Permanent Partial Disability – Compensation for loss of use of a body part, loss of hearing/vision, amputation, lung disease or bodily disfigurement/scarring.
- Permanent Total Disability – Lifetime wage replacement for loss of both hands, arms, feet, legs, eyes or any two in the same accident, or is paralyzed or disabled from a severe brain injury.
- Death Benefits – In cases where injury results in death, surviving spouse, children, or certain other dependants may be entitled to wage loss replacement benefits and payment of funeral/transportation expenses.
- Other: Mileage reimbursement, Cost of Living Increases, if eligible. (total wage loss and fatal benefits)