Notice of Claim Denial or Acceptance
Form 111- OD
Adopted 1/1/97

Filed:

Do Not Write In This Space

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF WORKERS CLAIMS
Before Arbitrator _____
Claim Number _____
NOTICE OF CLAIM DENIAL OR ACCEPTANCE

_____ **Plaintiff/Employee**

vs.

_____ **Defendant/Employer**

Comes the defendant, _____, as insured by _____, and in response to the Application for Resolution of Claim, states as follows:

_____ 1. This claim is accepted as compensable in its entirety. A settlement agreement will be filed. (Note: if claim is accepted, do not complete paragraphs 2 - 7).

_____ 2. This claim is accepted as compensable, but there is a dispute concerning the amount of compensation owed to the plaintiff.

_____ 3. This claim is denied for the following reasons:

_____ (a) Plaintiff's last injurious exposure to the risks of the occupational disease alleged did not occur in the employment of this defendant.
Explain:

_____ (b) The plaintiff did not give due and timely notice to employer of the alleged occupational disease.
Explain:

_____ (c) The claim is barred by limitations.
Explain:

_____ (d) Plaintiff has not contracted the occupational disease alleged.
Explain:

_____ Other reason for denial.
Explain:

4. The plaintiff's average weekly wage at the time of the alleged exposure was $_____.
Completed AWW-1 to support this calculation is attached.

5. The following witnesses may present testimony relevant to denial of this claim.
1.
2.
3.
4.

6. The following are admitted by the employer:

Yes	No	
___	___	This claim is covered by the Workers Compensation Act.
___	___	Plaintiff was an employee of this defendant on the date alleged in the Application for Resolution of Claim.
___	___	Plaintiff was exposed to the hazards of the disease during employment by more than one employer.
___	___	Plaintiff has returned to work for this employer and is earning $_____ per week.

7. For alleged occupational diseases other than coal workers' pneumoconiosis, describe in detail the physical requirements of plaintiff's job on the alleged date of last exposure. If an official job description exists, a copy must be attached.

8. The following persons have gathered information for completion of this form.

For the employer:

_____
Name Title

_____
Address Street

_____
City State Zip Code

(_____) _____
Telephone Number

For the insurance carrier:

_____
Name Title

_____
Address Street

_____
City State Zip Code

(_____) _____
Telephone Number

Being duly sworn, the undersigned states that the statements in this form are true and correct to the best of my knowledge and belief. This the _____ day of _____, 199 ___.

_____
Signature **Title**

_____
Address

_____
Phone Number

Subscribed and sworn to before me this _____ day of _____, 199___
My commission expires:_____
County:_____

_____
Notary Public

Prepared and submitted by:

_____
Representative/Title Address Phone Number