BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

ORIGINAL NOTICE AND PETITION
FORM NO. 100 -- (14-0005) 12-04

FILE NUMBER _____

CLAIMANT'S SOCIAL SECURITY NUMBER _____

(SEE INSTRUCTIONS ON REVERSE SIDE)

Claimant vs. Employer Insurance Carrier	☐ Arbitration (86.14) ☐ Reviewing-Reopening (86.14) ☐ Medical Benefits (85.27 Benefits) ☐ Death Benefits (85.28, 29 31) ☐ Dependency (85.42, 43, 44) ☐ Equitable Apportionment (85.43) ☐ Second Injury Fund (85.63 et seq.) ☐ Other (attach petition)

You are notified that an action has been commenced before the Workers' Compensation Commissioner seeking relief under the Chapters of the Iowa Code relating to workers' compensation, occupational disease and occupational hearing loss (Chapters 85, 85A, 85B, 86, and 87). A hearing will be held in the judicial district indicated in No. 17 below. **You are required to file an answer within 20 days of the receipt of this document** or to otherwise move or respond as provided by rule 876-4.9 of the Workers' Compensation Rules. Failure to comply may result in the imposition of the sanctions of Workers' Compensation Commissioner's rule 876-4.36 such as barring you from further activity for failure to appear and respond as required.

The information provided will be open for public inspection under Iowa Code §22.11
IF ADDITIONAL SPACE IS NEEDED, USE REVERSE SIDE; IDENTIFY BOX NUMBER

1. Claimant's Address Street City State Zip	2. Employer's Address Street City State Zip	3. Ins. Co. Address Street City State Zip

4. Inj. Date(s)	DEATH	5. Deceased Name	6. Relationship of claimant	7. Other Dependents (state relationship): a. _____ b. _____
		8. Date of Death	9. Funeral Expense	

10. How did injury occur?

11. Parts of body affected or disabled	12. Have weekly payments been made? a. Voluntary? _____ b. Compensation? _____
13. Time disabled (give dates)	14. Nature and extent of permanent disability

15. 85.27 expenses: With whom incurred and amount
a. _____
b. _____

16. State the dispute in this case

17. County and judicial district where injury occurred (or Polk county if out of state)	18. Petitioner requests respondent to agree hearing may be held in the following judicial district

19. If second injury fund benefits a. date of first loss _____ b. member affected (first loss _____ c. how effected _____

The petitioner incorporates by this reference the statutory provisions applicable to the relief sought and prays the Workers' Compensation Commissioner grant the relief sought, set a time and place for the hearing and request the respondents to respond or incur the sanctions noted above.

Petitioner's Attorney (Please Print) | Phone of Attorney | Signature (of attorney, or petitioner if unrepresented) | Date

Address of Attorney | Phone of Petitioner _____

INSTRUCTIONS

1. All boxes and blanks appropriate to your claim must be checked and completed. All addresses must be given. You or your attorney must sign where indicated. PLEASE TYPE OR PRINT LEGIBLY.

2. This form with the original signature is to be filed with the Workers' Compensation Commissioner.

3. Delivery of a copy of this form to the employer is to be by certified mail, return receipt requested or by personal service as in civil actions, rule 876 - 4.7.

4. A copy of this form, with proof of delivery, must be filed with the Workers' Compensation Commissioner. Rule 876 4.7

5. On or after July 1, 1988, for all original notices and petitions for arbitration or review-reopening seeking weekly benefits filed on account of each injury, gradual injury, occupational disease or occupational hearing loss alleged by an employee, a filing fee of $65 shall be paid at the time of filing.

6. A separate petition shall be filed for each occurrence of claimed injury, occupational disease or occupational hearing loss and the petition must allege a specific day, month, and year of each occurrence. See rule 876 1AC 4.6 regarding pleading alternative or multiple dates of occurrence and joinder.

7. See rule 876 - 4.8 for further information.

The following space is to be used for additional information for which inadequate space exists on the front of this form. Please indicate the box number that requires the additional information. TYPE OR PRINT LEGIBLY.

14-0005 Backer (12-04)

IOWA WORKFORCE DEVELOPMENT