James J. Campbell
Commissioner

The Commonwealth of Massachusetts

Department of Industrial Accidents

600 Washington Street
Boston, Mass. 02111

CIRCULAR LETTER NO. 269

TO: ALL INTERESTED PERSONS
FROM: JAMES J. CAMPBELL, COMMISSIONER
RE: NEW FORMS
DATE: MARCH 26, 1993

The Department has revised the following forms:

101 Employer's First Report of Injury or Fatality
103 Insurer's Notification of Payment
104 Insurer's Notification of Denial
105 Agreement to Extend 180 Day Payment-Without-Prejudice Period
106 Insurer's Notification of Termination or Modification of Weekly Compensation During Payment-Without-Prejudice Period
107 Insurer's Notification of Acceptance, Resumption, Termination or Modification of Weekly Compensation
108 Insurer's Complaint for Modification, Discontinuance, or Recoupment of Compensation
109 Notification of Withdrawal of Claim or Complaint
110 Employee's Claim
112 Appeal to Reviewing Board
112A Affidavit Supporting Request for Waiver of Filing Fee under § 11C
113 Agreement to Pay Compensation
114 Notice of Change/Appearance of Counsel
115 Third Party Claim/Notice of Lien
116 Request for Lump Sum Conference
116A Employer's Consent to Lump Sum Agreement
116B Addendum to Lump Sum Agreement: Vocational Rehabilitation Status
116C Lien Disclosure Form
121 Appeal of Conference Proceeding
124A Notification of Arbitration Award
126 Employee's Earnings Report
131 Request for Speedy Conference Because of Hardship
132 Affidavit in Support of Employee's Request for Speedy Conference Because of Hardship

- **DO NOT USE THESE FORMS PRIOR TO JUNE 1, 1993.**

- **ONLY THESE FORMS WILL BE ACCEPTED AT THE DEPARTMENT OF INDUSTRIAL ACCIDENTS AS OF JUNE 1, 1993.**

- **FOR ASSISTANCE REGARDING THESE NEW FORMS CALL: 1-800-323-3249.**

- **WHEN RULES ARE PROMULGATED SETTING FORTH THE REQUIRED DOCUMENTATION TO BE ATTACHED TO ANY CLAIM FOR BENEFITS OR COMPLAINT FOR MODIFICATION OR DISCONTINUANCE OF BENEFITS, THE ATTACHMENT OF ALL REQUIRED DOCUMENTATION SHALL BE PREREQUISITE FOR THE ACCEPTANCE OF SAID CLAIM OR COMPLAINT FOR PROCESSING BY THE OFFICE OF CLAIMS ADMINISTRATION.**

- **NOTE: THE FORMS ARE TO BE REPRODUCED, AS NEEDED.**

FORM 101

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS - DEPARTMENT 101
600 WASHINGTON STREET - 7TH FLOOR, BOSTON, MA 02111

EMPLOYER'S FIRST REPORT OF INJURY OR FATALITY

DIA BOARD NO.:

ENTER IF KNOWN

File this form if injury has resulted in death or in 5 or more calendar days of total or partial incapacity from earning wages.

INSTRUCTIONS AND CODES ON THE REVERSE SIDE. PLEASE PRINT OR TYPE:

EMPLOYEE

1. Employee's Name (Last, First, MI)
2. Home Telephone ( ) -
3. Social Security Number* - -
4. Sex M ☐ F ☐
5. Home Address (No. and Street, City, State, Zip)
6. Marital Status M ☐ S ☐
7. Number of Dependents
8. Date of Hire (mm/dd/yy) / /
9. Date of Birth (mm/dd/yy) / /
10. Average Weekly Wage $ _____ ☐ Estimated ☐ Actual

EMPLOYER

11. Employer's Name
12. Federal Tax I.D. Number
13. Employer's Address (No. and Street, City, State, Zip)
14. Employer's Telephone ( ) -
15. Industry Code
16. Workers' Compensation Insurance Carrier (Not Local Agent/Adjuster)
17. W.C. Policy Number
18. Self-Insured? ☐ Yes ☐ No
19. Self-Insurer Number:
20. Describe Nature of Business or Article Manufactured (check one) ☐ Service ☐ Wholesale ☐ Retail ☐ Manufacturing
21. Dept. No. Floor No.

INJURY INFORMATION

22. Date of Injury (mm/dd/yy) / /
23. Location Where Injury Occurred (If Different Than #13)
24. Injured on Employer's Premises? ☐ Yes ☐ No
25. Employer's Location Code
26. If Employee Has Died, Date of Death (mm/dd/yy) / /
27. First Day of Total or Partial Incapacity to Earn Wages (mm/dd/yy) / /
28. Fifth Day of Total or Partial Incapacity to Earn Wages (mm/dd/yy) / /
29. Source of Injury (Chemicals, Machinery, Etc.)
30. Describe How Injury/Exposure Occurred (Struck By...Fell From...Exposed To...)
31. To Whom Was Injury/Death Reported? Position:
32. Date Reported (mm/dd/yy) / /
33. Date Reported as Work Related (mm/dd/yy) / /
34. Injury Code(s) a. b. c.
35. Body Part Code(s) a. b. c.
36. Description (Left Leg...Lower Back...)
37. Witness(es) To The Injury? ☐ Yes ☐ No If "YES" Please Specify.
38. Has Employee Returned to Work? ☐ Yes ☐ No
39. Date of Return (mm/dd/yy) / /
40. Employee's Regular Occupation
40A. Returned to Regular Occupation? ☐ Yes ☐ No

41. Preparer for Employer (Please Print or Type)
42. Title
43. Preparer's Signature
44. Date Prepared (mm/dd/yy) / /

*Disclosing Social Security Number is voluntary. It will assist in the processing of your report.

REPRODUCE AS NEEDED

LOYER'S FIRST REPORT OF INJURY OR F LITY

FILING INSTRUCTIONS

1. WHEN TO FILE: File this form within 7 calendar days, not including Sundays and legal holidays, of receipt of notice of any injury alleged to have arisen out of and, in the course, of employment which totally or partially incapacitates an employee for a period of 5 or more calendar days from earning wages. This form is not an admission of liability but must be filed even though the Employer may believe that the Employee is not injured, or that the Employee is not entitled to benefits under Chapter 152.

2. WHERE TO FILE: The form should be mailed to the Department of Industrial Accidents at the address shown on the front of the form. Copies must also be provided to the Employee and to the Employer's Workers' Compensation Insurer.

3. PENALTIES: Failure to report injuries on this form may result in a fine of $100.00 in accordance with Massachusetts General Laws, Chapter 152, Section 6.

INDUSTRY CODES

Agriculture, Forestry and Fishing
01 Agriculture Production-Crops
02 Agriculture Production-Livestock
07 Agriculture Services
08 Forestry
09 Fishing, Hunting and Trapping

Mining
10 Metal Mining
12 Coal Mining
13 Oil and Gas Extraction
14 Nonmetallic Minerals, Except Fuels

Construction
15 General Building Contractors
16 Heavy Construction, Ex. Building
17 Special Trade Contractors

Manufacturing
20 Food and Kindred Productions
21 Tobacco Products
22 Textile Mill Products
23 Apparel and Other Textile Products
24 Lumber and Wood Products
25 Furniture and Fixtures
26 Paper and Allied Products
27 Printing and Publishing
28 Chemicals and Allied Products
29 Petroleum and Coal Products
30 Rubber and Misc. Plastics Products
31 Leather and Leather Products
32 Stone, Clay, and Glass Products
33 Primary Metal Industries
34 Fabricated Metal Products
35 Industrial Machinery and Equipment
36 Electronic and Other Electric Equipment
37 Transportation Equipment
38 Instruments and Related Products
39 Miscellaneous Manufacturing Industries

Transportation and Public Utilities
40 Railroad Transportation
41 Local and Interurban Passenger Transit
42 Trucking and Warehousing
43 U.S. Postal Service
44 Water Transportation
45 Transportation by Air
46 Pipelines, Except Natural Gas
47 Transportation Services
48 Communications
49 Electric, Gas and Sanitary Services

Wholesale Trade
50 Wholesale Trade-Durable Goods
51 Wholesale Trade-Nondurable Goods

Retail Trade
52 Building Materials and Garden Supplies
53 General Merchandising Stores
54 Food Stores
55 Automotive Dealers and Service Stations
56 Apparel and Accessory Stores
57 Furniture and Homefurnishing Stores
58 Eating and Drinking Places
59 Miscellaneous Retail

Finance, Insurance and Real Estate
60 Depository Institutions
61 Nondepository Institutions
62 Security and Commodity Brokers
63 Insurance Carriers
64 Insurance Agents, Brokers and Service
65 Real Estate
67 Holding and Other Investment Offices

Services
70 Hotels and Other Lodging Places
72 Personal Services
73 Business Services
75 Auto Repair Services and Parking
76 Miscellaneous Repair Services
78 Motion Pictures
79 Amusement and Recreation Services
80 Health Services
81 Legal Services
82 Educational Services
83 Social Services
84 Museums, Botanical, Zoological Gardens
86 Membership Organizations
87 Engineering and Management Services
88 Private Households
89 Services, NEC

Public Administration
91 Executive, Legislative, and Garden
92 Justice, Public Order, and Safety
93 Finance, Taxation, and Monetary Policy
94 Administration of Human Resources
95 Environmental Quality and Housing
96 Administration of Economic Programs
97 National Security and International Affairs

Nonclassifiable Establishments
99 Nonclassifiable Establishments

NATURE OF INJURY OR ILLNESS CODES

100 Amputation or Enucleation
110 Asphyxia, Strangulation, Etc.
120 Burn (Heat)
130 Burn (Chemical)
140 Concussion
160 Contusion, Crushing, Bruise
170 Cut, Laceration, Puncture
190 Dislocation
200 Electric Shock, Electrocution
210 Fracture
250 Hernia, Rupture
300 Scratches, Abrasions
310 Sprains, Strains
400 Multiple Injuries
900 No Injury
950 Damage to Prosthetic Devices
995 No Other Injury, NEC**
999 Non-classifiable

Infective or Parasitic Disease
150 Infective or Parasitic Disease, UNS*
151 Amebiasis
152 Anthrax
153 Brucellosis
154 Conjunctivitis and Ophthalmia
156 Tetanus
157 Tuberculosis
159 Other Infective or Parasitic Disease

Dermatitis
180 Dermatitis, UNS*
183 Primary Infections of the Skin
184 Other Skin Conditions
185 Dermatitis, Allergenic or Contact
189 Skin Condition, NEC**

Poisoning, Systemic
270 Poisoning, Systemic, UNS*
271 Due to Toxic Materials other than Lead
272 Diseases of the Blood and Blood Forming Organs
273 Upper Respiratory Conditions
274 Influenza, Pneumonia, Etc.
276 Other Diseases of the Gastro-Intestinal Tract
278 Effects of Lead
279 Other Toxic Effects of One System Only

Respiratory System, Conditions of
570 Respiratory System, Conditions of UNS*
571 Upper Respiratory
572 Asthma, Influenza, Pneumonia

Pneumoconiosis
280 Pneumoconiosis
281 Aluminosis
282 Anthracosis
283 Asbestosis
284 Byssinosis
285 Siderosis
286 Silicosis
287 Other Pneumoconioses
289 Pneumoconiosis with Tuberculosis

Nervous System Conditions of
560 Nervous System, Conditions of, UNS*
561 Diseases of the Central Nervous System
562 Diseases of the Nerves and Peripheral Ganglia

Neoplasm, Tumor
550 Neoplasm, Tumor UNS*
551 Malignant
552 Benign

Radiation Effects
290 Radiation Effects, UNS*
291 Non-Ionizing Radiation
292 Microwave
293 Ionizing Radiation - X-Ray
294 Ionizing Radiation - Isotopes
295 Welder's Flash

Other
265 Carpal Tunnel Syndrome
510 Cerebrovascular and other Conditions of the Circulatory System
520 Complications Peculiar to Medical Care
500 Effects of Changes in Atmospheric Pressure
240 Effects of Environmental Heat
220 Effects of Exposure to Low Temperature
530 Eye, other Diseases of the Eye
230 Hearing Loss or Impairment
991 Heart Condition, Excludes Heart Attack
320 Hemorrhoids
330 Hepatitis, Serum and Infective
275 Hepatitis, Toxic
260 Inflammation of Joints, Etc.
540 Mental Disorders
900 No Illness
999 Non-classifiable
990 Occupational Disease, NEC**
580 Symptoms and Ill-defined Conditions

BODY PART AFFECTED CODES

Head
100 Head, UNS*
110 Brain
120 Ear(s), UNS*
121 Ear(s), External
124 Ear(s), Internal
130 Eye(s)
140 Face, UNS*
141 Jaw, Chin
144 Mouth & Throat (vocal cords, larynx)
146 Nose
148 Face, Multiple Parts
149 Face, NEC**
150 Scalp
160 Skull
198 Head, Multiple
200 Neck & Cervical Vertebrae

UPPER EXTREMITIES
300 Upper Extremities, UNS*
310 Arm(s), UNS*
311 Upper Arm(s)
313 Elbow(s)
315 Forearm(s)
318 Arm(s), Multiple
319 Arm(s), NEC**
320 Wrist(s)
330 Hand(s) Not Wrists or Fingers
340 Finger(s)
398 Upper Extremities, Multiple
400 Trunk, UNS*
410 Abdomen...Internal Organs, Inguinal Hernia
420 Back
430 Chest...Ribs, Breastbone, Internal Organs
440 Hip(s)...Pelvis, Organs, and Buttocks
450 Shoulder(s)
498 Trunk, Multiple

LOWER EXTREMITIES
500 Lower, Extremities, UNS*
510 Leg(s), UNS*
511 Thigh(s)
513 Knee(s)
515 Lower Leg(s)
518 Leg(s), Multiple
519 Leg(s), NEC**
520 Ankle(s)
530 Foot or Feet... Not Ankle or Toes
540 Toe(s)
598 Lower Extremities, Multiple
700 MULTIPLE PARTS
Applies when more than one major body part has been affected such as an arm and a leg.

NONCLASSIFIABLE
999 Insufficient information to identify part of body affected. Includes damage to prosthetic devices.

*UNS-UNSPECIFIED

**NEC-NOT ELSEWHERE CLASSIFIED

FORM 103

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS - DEPARTMENT 103
600 WASHINGTON STREET - 7TH FLOOR, BOSTON, MA 02111

DIA BOARD NO.:

ENTER IF KNOWN

INSURER'S NOTIFICTION OF PAYMENT

FILE THIS FORM WHEN WEEKLY BENEFITS ARE PAID WITHIN 14 DAYS OF INSURER'S RECEIPT OF A FIRST REPORT OF INJURY OR AN INITIAL WRITTEN CLAIM FOR WEEKLY BENFITS

INSTRUCTIONS ARE ON THE REVERSE SIDE. PLEASE PRINT OR TYPE:

INSURER

1. Insurance Carrier's Name and Address

2. Self-Insured? ☐ Yes ☐ No

3. Self-Insurer Number:

4. Claims Representative's Name

5. Claims Representative's Telephone ( ) -

6. Insurer's Case File Number

7. Did Insurer Receive First Report of Injury from Employer? ☐ Yes ☐ No

8. Date Received (mm/dd/yy) / /

9. Did Insurer Receive a Written Claim for Weekly Benefits from the Employee? ☐ Yes ☐ No

10. Date Received (mm/dd/yy) / /

EMPLOYEE

11. Employee's Name (Last, First, MI)

12. Social Security Number* - -

13. Employee's Address (No. and Street, City, State, Zip)

14. Date of Birth (mm/dd/yy) / /

15. Employer's Name

16. Employer's Address (No. and Street, City, State, Zip)

INJURY

17. Date of Injury / /

18. First Date of Total or Partial Incapacity to Earn Wages (mm/dd/yy) / /

19. Injury Code(s) a. b. c.

20. If Employee has Died Date of Death (mm/dd/yy) / /

21. Fifth Date of Total or Partial Incapacity to Earn Wages (mm/dd/yy) / /

22. Body Part Code(s) a. b. c.

23. Description (left Leg...Lower Back...)

COMPENSATION

24. ☐ ACCEPTED ☐ PAID WITHOUT PREJUDICE

Average Weekly Wage: $_____ ☐ Estimated ☐ Actual
(See M.G.L. Chapter 152, section 1(1) for definition.)

Date Insurer Mailed First Payment (mm/dd/yy) / /

Amount Paid to Date: $_____

Paid Through (mm/dd/yy) / /

Type of Weekly Compensation	Weekly Compensation Amount
a. ☐ Temporary, Total Incapacity (s.34)	$
b. ☐ Permanent & Total Incapacity (s.34A)	$
c. ☐ Partial Incapacity (s.35)	$
d. ☐ Dependency Coverage (s.35A)	$
e. ☐ Survivor's Benefits (s.31)	$

25. Insurer's Signature

26. Date Prepared (mm/dd/yy) / /

*Disclosing Social Security Number is voluntary. It will assist in the processing of your report.

REPRODUCE AS NEEDED

INSURER'S NOTIFICATION OF PAYMENT

FILING INSTRUCTIONS

1. WHEN TO FILE: File this form within 30 days of the Insurer's receipt of the Employer's First Report of Injury (Form 101) or a written claim for weekly benefits on a form prescribed by the Department (Form 110). 452 CMR 1.05(1).

2. WHERE TO FILE: This form should be mailed to the Department of Industrial Accidents at the address shown on the front of the form, with a copy to the Employee and to the Employer.

INDUSTRY CODES

Agriculture, Forestry and Fishing
01 Agriculture Production-Crops
02 Agriculture Production-Livestock
07 Agriculture Services
08 Forestry
09 Fishing, Hunting and Trapping

Mining
10 Metal Mining
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152 Anthrax
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156 Tetanus
157 Tuberculosis
159 Other Infective or Parasitic Disease

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180 Dermatitis, UNS*
183 Primary Infections of the Skin
184 Other Skin Conditions
185 Dermatitis, Allergenic or Contact
189 Skin Condition, NEC**

Poisoning, Systemic
270 Poisoning, Systemic, UNS*
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272 Diseases of the Blood and Blood Forming Organs
273 Upper Respiratory Conditions
274 Influenza, Pneumonia, Etc.
276 Other Diseases of the Gastro-Intestinal Tract
278 Effects of Lead
279 Other Toxic Effects of One System Only

Respiratory System, Conditions of
570 Respiratory System, Conditions of UNS*
571 Upper Respiratory
572 Asthma, Influenza, Pneumonia

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280 Pneumoconiosis
281 Aluminosis
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283 Asbestosis
284 Byssinosis
285 Siderosis
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289 Pneumoconiosis with Tuberculosis

Nervous System Conditions of
560 Nervous System, Conditions of, UNS*
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562 Diseases of the Nerves and Peripheral Ganglia

Neoplasm, Tumor
550 Neoplasm, Tumor UNS*
551 Malignant
552 Benign

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290 Radiation Effects, UNS*
291 Non-Ionizing Radiation
292 Microwave
293 Ionizing Radiation - X-Ray
294 Ionizing Radiation - Isotopes
295 Welder's Flash

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520 Complications Peculiar to Medical Care
500 Effects of Changes in Atmospheric Pressure
240 Effects of Environmental Heat
220 Effects of Exposure to Low Temperature
530 Eye, other Diseases of the Eye
230 Hearing Loss or Impairment
991 Heart Condition, Excludes Heart Attack
320 Hemorrhoids
330 Hepatitis, Serum and Infective
275 Hepatitis, Toxic
260 Inflammation of Joints, Etc.
540 Mental Disorders
900 No Illness
999 Non-classifiable
990 Occupational Disease, NEC**
580 Symptoms and Ill-defined Conditions

BODY PART AFFECTED CODES

Head
100 Head, UNS*
110 Brain
120 Ear(s), UNS*
121 Ear(s), External
124 Ear(s), Internal
130 Eye(s)
140 Face, UNS*
141 Jaw, Chin
144 Mouth & Throat (vocal cords, larynx)
146 Nose
148 Face, Multiple Parts
149 Face, NEC**
150 Scalp
160 Skull
198 Head, Multiple
200 Neck & Cervical Vertebrae

UPPER EXTREMITIES
300 Upper Extremities, UNS*
310 Arm(s), UNS*
311 Upper Arm(s)
313 Elbow(s)
315 Forearm(s)
318 Arm(s), Multiple
319 Arm(s), NEC**
320 Wrist(s)
330 Hand(s) Not Wrists or Fingers
340 Finger(s)
398 Upper Extremities, Multiple
400 Trunk, UNS*
410 Abdomen...Internal Organs, Inguinal Hernia
420 Back
430 Chest...Ribs, Breastbone, Internal Organs
440 Hip(s)...Pelvis, Organs, and Buttocks
450 Shoulder(s)
498 Trunk, Multiple

LOWER EXTREMITIES
500 Lower, Extremities, UNS*
510 Leg(s), UNS*
511 Thigh(s)
513 Knee(s)
515 Lower Leg(s)
518 Leg(s), Multiple
519 Leg(s), NEC**
520 Ankle(s)
530 Foot or Feet... Not Ankle or Toes
540 Toe(s)
598 Lower Extremities, Multiple
700 MULTIPLE PARTS
Applies when more than one major body part has been affected such as an arm and a leg.

NONCLASSIFIABLE
999 Insufficient information to identify part of body affected. Includes damage to prosthetic devices.

*UNS-UNSPECIFIED

**NEC-NOT ELSEWHERE CLASSIFIED

FORM 104

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS - DEPARTMENT 104
600 WASHINGTON STREET - 7TH FLOOR, BOSTON, MA 02111

DIA BOARD NO.:

ENTER IF KNOWN

INSURER'S NOTIFICATION OF DENIAL

INSTRUCTIONS ON REVERSE SIDE. PLEASE PRINT OR TYPE:

INSURER

1. Insurance Carrier's Name and Address

2. Insurer's Attorney's Name and Board of Bar Overseers Number

3. Insurer's Attorney's Address (No. and Street, City, State, Zip)

4. Insurer's Attorney's Telephone ( ) -

5. Claims Representative's Name

6. Claims Representative's Telephone ( ) -

7. Self-Insured? Yes ☐ No ☐

8. Self-Insurer Number:

9. Insurer's Case File Number

10. Did Insurer Receive First Report of Injury from Employer? ☐ Yes ☐ No

11. Date Received: (mm/dd/yy) / /

EMPLOYEE

12. Employee's Name (Last, First, MI)

13. Social Security Number* - -

14. Home Address (No. and Street, City, State, Zip)

15. Date of Birth (mm/dd/yy) / /

16. Employer's Name

17. Employer's Address (No. and Street, City, State, Zip)

18. Date of Alleged Injury / /

19. If Employee has Died, Date of Death (mm/dd/yy) / /

GROUNDS

20. Specify grounds for denial and give a short and plain statement of the specific facts supporting the grounds for denial. Failure to do so may cause loss of defenses under M.G.L, Chapter 152, Sections 7(1) and 7(2).

A. ☐ No Personal Injury _____

B. ☐ No Injury Arising Out of and in the Course of Employment _____

C. ☐ No Disability _____

D. ☐ No Causal Relation Between Personal Injury and Disability _____

G. ☐ Lack of Jurisdiction _____

X. ☐ Lack of Notice _____

Y. ☐ Late Claim _____

Z. ☐ Other (Specify) _____

21. Insurer's Signature

22. Date Prepared (mm/dd/yy) / /

*Disclosing Social Security Number is voluntary. It will assist in the processing of your report.
An Employee/Claimant seeking to secure benefits must use Department of Industrial Accidents Form 110 when filing a claim.

REPRODUCE AS NEEDED

Form #104 (2/93)

INSURER'S NOTIFICATION OF DENIAL

FILING INSTRUCTIONS

1. WHEN TO FILE: File this form within 14 calendar days of the Insurer's receipt of the Employer's First Report of Injury (Form 101) or a written claim for weekly benefits on a form prescribed by the Department (Form 110). M.G.L., Chapter 152, Section 7(1).

2. WHERE TO FILE: This form should be sent to the Department of Industrial Accidents at the address shown on the front of the form. Copies of the form must also be provided to the Employer, and sent by certified mail to the Employee.

FORM 105

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS - DEPARTMENT 105
600 WASHINGTON STREET - 7TH FLOOR, BOSTON, MA 02111

DIA BOARD NO.:

ENTER IF KNOWN

AGREEMENT TO EXTEND 180 DAY PAYMENT - WITHOUT - PREJUDICE PERIOD

FILE THIS FORM ONLY IF THE INSURER PAID WEEKLY BENFITS WITHIN 14 DAYS OF RECEIPT OF THE EMPLOYER'S FIRST REPORT OF INJURY (FORM 101) OR A CLAIM FOR WEEKLY BENEFITS (FORM 110).

PLEASE PRINT OR TYPE:

INSURER

1. Insurance Carrier's Name and Address
2. Claims Representative's Name
3. Claims Representative's Telephone ( ) -
4. Insurer's Case File Number
5. Self-Insured? Yes ☐ No ☐
6. Self-Insurer Number:

EMPLOYEE

7. Employee's Name (Last, First, MI) and Address
8. Social Security Number* - -
9. Date of Birth (mm/dd/yy) / /
10. Home Telephone ( ) -
11. Date of Injury (mm/dd/yy) / /
12. Employer's Name

COMP

13. First Date of Total or Partial Incapacity to Earn Wages (mm/dd/yy) / /
14. Has Insurer made all Payments Since the First Date of Total or Partial Incapacity to Earn Wages? Yes ☐ No ☐
15. Last Day Payment Can Be Made Pursuant to This Extension (mm/dd/yy) / /

SIGNATURES

16. Preparer for Insurer (Please Print/Type)
17. Insurer's Signature
18. Date (mm/dd/yy) / /
19. Name and Address of Employee's Attorney (Please Print/Type)
20. Signature of Employee's Attorney
21. Date (mm/dd/yy) / /
22. Employee's Signature
23. Date (mm/dd/yy) / /

THIS AGREEMENT APPROVED AS NOT DETRIMENTAL TO THE EMPLOYEE'S CASE

24. Signature of Judge or Conciliator
25. Date (mm/dd/yy) / /

*Disclosing Social Security Number is voluntary. It will assist in the processing of your report.

REPRODUCE AS NEEDED

Form #105 (2/93)

FORM 106

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS - DEPARTMENT 106
600 WASHINGTON STREET - 7TH FLOOR, BOSTON, MA 02111

INSURER'S NOTIFICATION OF TERMINATION OR MODIFICATION OF WEEKLY COMPENSATION DURING PAYMENT - WITHOUT - PREJUDICE PERIOD

DIA BOARD NO.:

ENTER IF KNOWN

USE ONLY WHEN PAYMENT HAS BEEN MADE WITHIN 14 DAYS. AT LEAST 7 DAYS WRITTEN NOTICE MUST BE GIVEN TO THE EMPLOYEE OF THE INTENT TO STOP OR MODIFY PAYMENTS, UNLESS BASED ON THE ACTUAL INCOME OF THE EMPLOYEE.

PLEASE PRINT OR TYPE:

INSURER

1. Insurance Carrier's Name and Address

2. Claims Representative's Name

3. Claims Representative's Telephone ( ) -

4. Insurer's Case File Number

5. Self-Insured? Yes ☐ No ☐

6. Self-Insurer Number:

7. Name & Address of Insurer's Attorney (No. and Street, City, State, Zip)

8. Attorney's Telephone ( ) -

EMPLOYEE

9. Employee's Name (Last, First, MI)

10. Date of Birth (mm/dd/yy) / /

11. Social Security Number* - -

12. Home Address (No. and Street, City, State, Zip)

13. Date of Injury (mm/dd/yy) / /

14. First Date of Total or Partial Incapacity to Earn Full Wages (mm/dd/yy) / /

15. Employer's Name

16. Federal Tax I.D. Number

17. Employer's Address (No. and Street, City, State, Zip)

18. Employee Returned to Work ☐ (7 days written notice not required)
Date of Return (mm/dd/yy) Actual Income of Employee $

GROUNDS

19. Specify Grounds and Factual Basis For Termination Within 180 Days Or Any Extension Of The Payment-Without-Prejudice Period. Failure To Do So May Cause Loss Of Defenses Under Chapter 152, Section 8(1).

A. ☐ No Personal Injury _____

B. ☐ No Injury Arising Out of and in the Course of Employment _____

C. ☐ No Disability _____

D. ☐ No Casual Relation Between Personal Injury and Disability _____

E. ☐ Lack of Jurisdiction _____

F. ☐ Lack of Notice _____

G. ☐ Late Claim _____

H. ☐ Other (Specify) _____

20. Last Date Through Which Payment Will Be Made (mm/dd/yy) / /

21. Date of Notification of Termination or Modification to the Employee (mm/dd/yy) / /

22. If This Is A Modification Rather Than A Termination, Please State The Grounds And Factual Basis For The Modification And The Prior Rate(s) Of Weekly Compensation Paid And The Modified Rate(s) Of Weekly Compensation.

23. Insurer's Signature

24. Date Prepared (mm/dd/yy) / /

*Disclosing Social Security Number is voluntary. It will assist in the processing of your report.

REPRODUCE AS NEEDED

FORM 107

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS - DEPARTMENT 107
600 WASHINGTON STREET - 7TH FLOOR, BOSTON, MA 02111

DIA BOARD NO.:

ENTER IF KNOWN

INSURER'S NOTIFICATION OF ACCEPTANCE, RESUMPTION, TERMINATION OR MODIFICATION OF WEEKLY COMPENSATION

USE FORM 106 AS A NOTICE TO TERMINATE OR MODIFY WEEKLY PAYMENTS BEING MADE WITHOUT PREJUDICE UNDER M.G.L, CHAPTER 152, SECTION 8(1).

PLEASE PRINT OR TYPE:

INSURER

1. Insurance Carrier's Name and Address

2. Claims Representative's Name

3. Claims Representative's Telephone ( ) -

4. Insurer's Case File Number

5. Self-Insured? ☐ Yes ☐ No

6. Self-Insurer Number:

EMPLOYEE

7. Employee's Name (Last, First, MI)

8. Date of Birth (mm/dd/yy) / /

9. Social Security Number* - -

10. Home Address (No. and Street, City, State, Zip)

11. Date of Injury (mm/dd/yy) / /

12. First Date of Total or Partial Incapacity to Earn Wages (mm/dd/yy) / /

13. If Employee has Died, Enter Date of Death (mm/dd/yy) / /

14. Average Weekly Wage $ _____ ☐ Estimated ☐ Actual

15. Employer's Name

16. Employer's Address (No. and Street, City, State, Zip)

17. Date Employee Returned to Work, if Applicable (mm/dd/yy) / /

BENEFITS

18. Date Compensation Resumed, Modified or Terminated (mm/dd/yy) / /

19. ☐ This is a Notice of Initial Acceptance of a Claim (ATTACH FORM 113)
☐ This is a Resumption/Modification of Payment of a Case Previously Accepted.
☐ This is a Resumption/Modification of Payment of a Case in the Payment-Without-Prejudice Period.
☐ This is a Resumption/Modification of Payment under Section 30G.

Type of Compensation Resumed or Modified	Former Weekly Compensation Rate	Resumed or Modified Weekly Compensation Rate
a. ☐ Temporary, Total Incapacity (s.34)	$ _____	$ _____
b. ☐ Permanent & Total Incapacity (s.34A)	$ _____	$ _____
c. ☐ Partial Incapacity (s.35)	$ _____	$ _____
d. ☐ Dependency Coverage (s.35A)	$ _____	$ _____
e. ☐ Survivor's Benefits (s.31)	$ _____	$ _____

20. If the Insurer is Terminating or Suspending Payment of Weekly Benefits Without the Assent of the Employee or the Department of Industrial Accidents, Set out the Applicable Statutory Section and Factual Basis Therefore.

_____

_____

_____

_____

_____

21. If the Insurer is Terminating or Modifying with the Assent of the Compensation Recipient, the Recipient's Signature is required.

_____
Compensation Recipient's Signature

22. Preparer's Signature

23. Date Prepared (mm/dd/yy) / /

*Disclosing Social Security Number is voluntary. It will assist in the processing of your report.

REPRODUCE AS NEEDED

Form #107 (2/93)

FORM 108

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS - DEPARTMENT 108
600 WASHINGTON STREET - 7TH FLOOR, BOSTON, MA 02111

DIA BOARD NO.:

ENTER IF KNOWN

INSURER'S COMPLAINT FOR MODIFICATION, DISCONTINUANCE OR RECOUPMENT OF COMPENSATION

SEND A COPY OF THIS NOTICE TO THE EMPLOYEE AND THE EMPLOYEE'S REPRESENTATIVE

PLEASE PRINT OR TYPE:

INSURER

1. Insurance Carrier's Name and Address
2. Insurer's Case File Number
3. Self-Insured? Yes ☐ No ☐
4. Self-Insurer Number
5. Claims Representative's Name
6. Claims Representative's Telephone ( ) -
7. Name of Insurer's Attorney (Last, First, MI)
8. Attorney's Address (No. and Street, City, State, Zip)
9. Attorney's Telephone ( ) -

EMPLOYEE

10. Employee's Name (Last, First, MI)
11. Social Security Number*
12. Home Address (No. and Street, City, State, Zip)
13. Home Telephone ( ) -
14. Date of Birth (mm/dd/yy) / /
15. Date of Injury (mm/dd/yy) / /
16. First Date of Total or Partial Incapacity to Earn Wages (mm/dd/yy) / /
17. Name of Employee's Attorney (Last, First, MI)
18. Attorney's Address (No. and Street, City, State, Zip)
19. Attorney's Telephone ( ) -
20. Employer's Name
21. Employer's Address (No. and Street, City, State, Zip)

GROUNDS

22. This is the Insurer's Request to MODIFY Weekly Compensation ☐ ATTACH PROPER DOCUMENTATION UNDER 452 CMR 1.07 (I)

    This is the Insurer's Request to DISCONTINUE Weekly Compensation ☐ ATTACH PROPER DOCUMENTATION UNDER 452 CMR 1.07 (J)

    This is the Insurer's Request to RECOUP Weekly Compensation ☐ ATTACH PROPER DOCUMENTATION UNDER 452 CMR 1.07 (K)

23. Give Specific Factual Basis For Your Complaint

24. Insurer's Signature
25. Title
26. Date (mm/dd/yy) / /

*Disclosing Social Security Number is voluntary. It will assist in the processing of your report.

REPRODUCE AS NEEDED

Form #108 (2/93)

FORM 109

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS - DEPARTMENT 109
600 Washington Street - 7th Floor, Boston, MA 02111

DIA BOARD NO.:

ENTER IF KNOWN

NOTIFICATION OF WITHDRAWAL OF CLAIM OR COMPLAINT

DO NOT USE THIS FORM TO INDICATE CHANGE OF COUNSEL.
USE FORM 114 FOR THAT PURPOSE.

PEASE PRINT OR TYPE:

1. Party Filing this Form is:

Insurer ☐ Employee ☐ Employee's Attorney ☐

Third party (Describe: Physician, Hospital, Medical Vendor, Lien Holder) ☐

_____

2. Employee's Name (Last, First, MI)	3. Social Security Number* - -
4. Home Address (No. and Street, City, State, Zip)	5. Home Telephone ( ) -
6. Name of Employee's Attorney (Last, First, MI)	7. Attorney's Telephone ( ) -
8. Attorney's Address (No. and Street, City, State, Zip)	
9. Employer's Name	
10. Insurer's Name	11. Date of Injury (mm/dd/yy) / /

12. Withdrawing From:

- ☐ Claim for Benefits
- ☐ Complaint for Modification or Discontinuance
- ☐ Third Party Claim
- ☐ Claim for Illegal Discontinuance
- ☐ Complaint for Recoupment
- ☐ Other (Specify) _____

13. Preparer's Name and Address (No. and Street, City, State, Zip)	
14. Preparer's Signature	15. Date(mm/dd/yy) / /

*Disclosing Social Security Number is voluntary. It will assist in the processing of your report.

REPRODUCE AS NEEDED

Form #109 (2/93)

FORM 110

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS - DEPARTMENT 110
600 WASHINGTON STREET - 7TH FLOOR, BOSTON, MA 02111

EMPLOYEE'S CLAIM

FOR USE BY EMPLOYEES OR DEPENDENTS CLAIMING BENEFITS AS A RESULT OF INJURY OR DEATH. ALL OTHER CLAIMANTS SHOULD USE FORM 115

DIA BOARD NO.:

ENTER IF KNOWN

INSTRUCTIONS AND CODES ARE ON THE REVERSE SIDE. PLEASE PRINT OR TYPE:

1. Employee's Name (Last, First, MI)
2. Social Security Number* - -
3. Home Telephone ( ) -
4. Home Address (No. and Street, City, State, Zip)
5. Date of Birth / /
6. Name of Employee's Attorney (Last, First, MI) and Board of Bar Overseers Number
7. Attorney's Address (No. and Street, City, State, Zip)
8. Attorney's Telephone ( ) -
9. Employer's Name and Address (No. and Street, City, State, Zip)
9a. Industry Code
10. Workers' Compensation Insurance Carrier (Not Local Agent/Adjuster) and Address (No. and Street, City, State, Zip)
11. Date of Injury (mm/dd/yy) / /
12. Nature of Injury Code(s) a. b. c.
13. If Employee Has Died, Date of Death (mm/dd/yy) / /
14. Body Part Code(s) a. b. c.
15. Description of Injury (Left Leg...Lower Back...)
16. First Date of Total or Partial Incapacity to Earn Wages (mm/dd/yy) / /
17. Fifth Date of Total or Partial Incapacity to Earn Wages (mm/dd/yy) / /
18. Number of Dependents
19. Average Weekly Wage $ _____ ☐ Estimated ☐ Actual
20. Has Employee Returned to Work ☐ Yes ☐ No
21. Regular Occupation
22. Has the Insurer Made Any Payments On Your Claim? Yes ☐ No ☐
Indicate Benefits Paid $ _____
23. Describe How Injury/Expqsure Occurred (Struck By...Fell From...Exposed To...)
24. Names of any Witnesses
25. Section(s) Of Law Claimed. Check Appropriate Box(es) Below and Attach Documentation as Required by M.G.L. 152, section 7G, section 10(1) and 452 CMR 1.07.
   a. (s.34) ☐ Temporary, Total Incapacity Compensation from _____ to _____ and from _____ to _____
   b. (s.35) ☐ Partial Incapacity Compensation from _____ to _____ and from _____ to _____
   c. (s.36) ☐ Specific Compensation in the amount of $ _____
   d. (s.31) ☐ Survivors' Benefits
   e. (s.33) ☐ Burial Expenses
   f. ☐ Other (Specify Section) _____
26. Name and address of facility where medical treatment first obtained
27. Name and address of Treating Physician
28. Employee's Signature
29. Date (mm/dd/yy) / /
30. Attorney's Signature
31. Date (mm/dd/yy) / /

*Disclosing Social Security Number is voluntary. It will assist in the processing of your report.

FORM #110 (2/93)

EMPLOYEE'S CLAIM

FILING INSTRUCTIONS

If more than one Insurer is involved, file a separate claim for each Insurer. Mail this form to the Department of Industrial Accidents at the address shown on the front of the form with a copy to the Insurer. Where the Employee is represented by counsel, this claim must be sent to the Insurer by certified mail per M.G.L. 152, Section 10(1).

INDUSTRY CODES

Agriculture, Forestry and Fishing
01 Agriculture Production-Crops
02 Agriculture Production-Livestock
07 Agriculture Services
08 Forestry
09 Fishing, Hunting and Trapping

Mining
10 Metal Mining
12 Coal Mining
13 Oil and Gas Extraction
14 Nonmetallic Minerals, Except Fuels

Construction
15 General Building Contractors
16 Heavy Construction, Ex. Building
17 Special Trade Contractors

Manufacturing
20 Food and Kindred Productions
21 Tobacco Products
22 Textile Mill Products
23 Apparel and Other Textile Products
24 Lumber and Wood Products
25 Furniture and Fixtures
26 Paper and Allied Products
27 Printing and Publishing
28 Chemicals and Allied Products
29 Petroleum and Coal Products
30 Rubber and Misc. Plastics Products
31 Leather and Leather Products
32 Stone, Clay, and Glass Products
33 Primary Metal Industries
34 Fabricated Metal Products
35 Industrial Machinery and Equipment
36 Electronic and Other Electric Equipment
37 Transportation Equipment
38 Instruments and Related Products
39 Miscellaneous Manufacturing Industries

Transportation and Public Utilities
40 Railroad Transportation
41 Local and Interurban Passenger Transit
42 Trucking and Warehousing
43 U.S. Postal Service
44 Water Transportation
45 Transportation by Air
46 Pipelines, Except Natural Gas
47 Transportation Services
48 Communications
49 Electric, Gas and Sanitary Services

Wholesale Trade
50 Wholesale Trade-Durable Goods
51 Wholesale Trade-Nondurable Goods

Retail Trade
52 Building Materials and Garden Supplies
53 General Merchandising Stores
54 Food Stores
55 Automotive Dealers and Service Stations
56 Apparel and Accessory Stores
57 Furniture and Homefurnishing Stores
58 Eating and Drinking Places
59 Miscellaneous Retail

Finance, Insurance and Real Estate
60 Depository Institutions
61 Nondepository Institutions
62 Security and Commodity Brokers
63 Insurance Carriers
64 Insurance Agents, Brokers and Service
65 Real Estate
67 Holding and Other Investment Offices

Services
70 Hotels and Other Lodging Places
72 Personal Services
73 Business Services
75 Auto Repair Services and Parking
76 Miscellaneous Repair Services
78 Motion Pictures
79 Amusement and Recreation Services
80 Health Services
81 Legal Services
82 Educational Services
83 Social Services
84 Museums, Botanical, Zoological Gardens
86 Membership Organizations
87 Engineering and Management Services
88 Private Households
89 Services, NEC

Public Administration
91 Executive, Legislative, and Garden
92 Justice, Public Order, and Safety
93 Finance, Taxation, and Monetary Policy
94 Administration of Human Resources
95 Environmental Quality and Housing
96 Administration of Economic Programs
97 National Security and International Affairs

Nonclassifiable Establishments
99 Nonclassifiable Establishments

NATURE OF INJURY OR ILLNESS CODES

100 Amputation or Enucleation
110 Asphyxia, Strangulation, Etc.
120 Burn (Heat)
130 Burn (Chemical)
140 Concussion
160 Contusion, Crushing, Bruise
170 Cut, Laceration, Puncture
190 Dislocation
200 Electric Shock, Electrocution
210 Fracture
250 Hernia, Rupture
300 Scratches, Abrasions
310 Sprains, Strains
400 Multiple Injuries
900 No Injury
950 Damage to Prosthetic Devices
995 No Other Injury, NEC**
999 Non-classifiable
Infective or Parasitic Disease
150 Infective or Parasitic Disease, UNS*
151 Amebiasis
152 Anthrax
153 Brucellosis
154 Conjunctivitis and Ophthalmia
156 Tetanus
157 Tuberculosis
159 Other Infective or Parasitic Disease
Dermatitis
180 Dermatitis, UNS*
183 Primary Infections of the Skin
184 Other Skin Conditions
185 Dermatitis, Allergenic or Contact
189 Skin Condition, NEC**
Poisoning, Systemic
270 Poisoning, Systemic, UNS*
271 Due to Toxic Materials other than Lead
272 Diseases of the Blood and Blood Forming Organs
273 Upper Respiratory Conditions
274 Influenza, Pneumonia, Etc.
276 Other Diseases of the Gastro-Intestinal Tract
278 Effects of Lead
279 Other Toxic Effects of One System Only
Respiratory System, Conditions of
570 Respiratory System, Conditions of UNS*
571 Upper Respiratory
572 Asthma, Influenza, Pneumonia
Pneumoconiosis
280 Pneumoconiosis
281 Aluminosis
282 Anthracosis
283 Asbestosis
284 Byssinosis
285 Siderosis
286 Silicosis
287 Other Pneumoconioses
289 Pneumoconiosis with Tuberculosis
Nervous System Conditions of
560 Nervous System, Conditions of, UNS*
561 Diseases of the Central Nervous System
562 Diseases of the Nerves and Peripheral Ganglia
Neoplasm, Tumor
550 Neoplasm, Tumor UNS*
551 Malignant
552 Benign
Radiation Effects
290 Radiation Effects, UNS*
291 Non-Ionizing Radiation
292 Microwave
293 Ionizing Radiation - X-Ray
294 Ionizing Radiation - Isotopes
295 Welder's Flash
Other
265 Carpal Tunnel Syndrome
510 Cerebrovascular and other Conditions of the Circulatory System
520 Complications Peculiar to Medical Care
500 Effects of Changes in Atmospheric Pressure
240 Effects of Environmental Heat
220 Effects of Exposure to Low Temperature
530 Eye, other Diseases of the Eye
230 Hearing Loss or Impairment
991 Heart Condition, Excludes Heart Attack
320 Hemorrhoids
330 Hepatitis, Serum and Infective
275 Hepatitis, Toxic
260 Inflammation of Joints, Etc.
540 Mental Disorders
900 No Illness
999 Non-classifiable
990 Occupational Disease, NEC**
580 Symptoms and Ill-defined Conditions

BODY PART AFFECTED CODES

Head
100 Head, UNS*
110 Brain
120 Ear(s), UNS*
121 Ear(s), External
124 Ear(s), Internal
130 Eye(s)
140 Face, UNS*
141 Jaw, Chin
144 Mouth & Throat (vocal cords, larynx)
146 Nose
148 Face, Multiple Parts
149 Face, NEC**
150 Scalp
160 Skull
198 Head, Multiple
200 Neck & Cervical Vertebrae
UPPER EXTREMITIES
300 Upper Extremities, UNS*
310 Arm(s), UNS*
311 Upper Arm(s)
313 Elbow(s)
315 Forearm(s)
318 Arm(s), Multiple
319 Arm(s), NEC**
320 Wrist(s)
330 Hand(s) Not Wrists or Fingers
340 Finger(s)
398 Upper Extremities, Multiple
400 Trunk, UNS*
410 Abdomen...Internal Organs, Inguinal Hernia
420 Back
430 Chest...Ribs, Breastbone, Internal Organs
440 Hip(s)...Pelvis, Organs, and Buttocks
450 Shoulder(s)
498 Trunk, Multiple
LOWER EXTREMITIES
500 Lower, Extremities, UNS*
510 Leg(s), UNS*
511 Thigh(s)
513 Knee(s)
515 Lower Leg(s)
518 Leg(s), Multiple
519 Leg(s), NEC**
520 Ankle(s)
530 Foot or Feet... Not Ankle or Toes
540 Toe(s)
598 Lower Extremities, Multiple
700 MULTIPLE PARTS
Applies when more than one major body part has been affected such as an arm and a leg.
NONCLASSIFIABLE
999 Insufficient information to identify part of body affected. Includes damage to prosthetic devices.

*UNS-UNSPECIFIED

**NEC-NOT ELSEWHERE CLASSIFIED

FORM 112

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS

APPEAL TO REVIEWING BOARD

DIA BOARD NO.:

ENTER IF KNOWN

INSTRUCTIONS ARE ON THE REVERSE SIDE. PLEASE PRINT OR TYPE:

1. Case Appealed By: ☐ Employee ☐ Insurer ☐ Other (Please Specify):

CASE INFORMATION

2. Date of Decision (mm/dd/yy) / /
3. Name of Judge Who Issued Decision:
4. Date of Injury (mm/dd/yy) / /
5. Employee's Name (Last, First, MI)
6. Social Security Number* - -
7. Home Address (No. and Street, City, State, Zip)
8. Employer's Name
9. Employer's Address (No. and Street, City, State, Zip)
10. Insurance Carrier's Name
11. Name of Insurer's Attorney (Last, First, MI)
12. Attorney's Telephone ( ) -
13. Attorney's Address (No. and Street, City, State, Zip)
14. Name of Employee's Attorney (Last, First, MI)
15. Attorney's Telephone ( ) -
16. Attorney's Address (No. and Street, City, State, Zip)

GROUNDS

17. Briefly set out the grounds for the appeal under C. 152, section 11c.

18. Check Where Applicable:
    - a. ☐ Filing Fee Attached.
    - b. ☐ Request Waiver of Filing Fee based upon indigency. Affidavit in Support of Waiver of Filing Fee must be submitted before your appeal will be docketed.
    - c. ☐ Request Verbatim Transcript.
    - d. ☐ Verbatim Transcript Waived.

19. Preparer's Name (Please Print or Type)
20. Preparer's Address (No. and Street, City, State, Zip)
21. Preparer's Telephone ( ) -
22. Preparer's Signature
23. Date (mm/dd/yy) / /

*Disclosing Social Security Number is voluntary. It will assist in the processing of your appeal.

REPRODUCE AS NEEDED

APPEAL TO REVIEWING BOARD

FILING INSTRUCTIONS

1. WHEN TO FILE: File with the Department of Industrial Accidents within thirty (30) days from the filing date of a hearing decision by an Administrative Judge. This form is not to be used to appeal a conference order issued by an Administrative Judge. Use Form 121 for that purpose. Affidavit in Support of Waiver of Filling Fee must be submitted before your appeal will be docketed.

2. WHERE TO FILE:

   Reviewing Board Appeals
   D.I.A. Office of Administration
   P.O. Box 9106
   Essex Station
   Boston, Massachusetts 02111-9106

3. FILING FEES: There is no filing fee for injuries occurring prior to November 1, 1986. For injuries occurring on or after November 1, 1986, this form must be accompanied by a fee of thirty (30) percent of the average weekly wage in the Commonwealth at the time of the appeal unless the filing fee is waived by the Review Board due to indigency. Please make checks payable to "Massachusetts Industrial Accidents Special Fund" and forward to the address above.

4. A copy of the Administrative Judge's decision must be attached to this appeal.

FORM 112A

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS
DEPARTMENT 112A
600 WASHINGTON STREET-7TH FLOOR
BOSTON, MA 02111

DIA BOARD NO.:

ENTER IF KNOWN

AFFIDAVIT IN SUPPORT OF REQUEST FOR WAIVER OF FILING FEE UNDER s. 11C

PLEASE SUPPLY D.I.A. BOARD NUMBER: _____

Pursuant to General Laws c. 152, s.11C, the applicant, _____

_____ swears (or affirms) as follows:

1. Applicant is indigent in that he/she is a person unable to pay the filing fee mandated by s.11C, or is unable to do so without depriving himself or his dependents of the necessities of life, including food, shelter and clothing.

2. In support of this affidavit, the applicant submits the following information:
   (a) Address of applicant: _____
   (b) Date of birth: _____
   (c) Highest grade attained in school: _____
   (d) Special training: _____
   (e) List any physical or mental disabilities: _____
   (f) Marital Status: _____
   (g) Number of dependents (if applicable) _____
   and their ages: _____
   (h) Income, Expense, Asset & Liability Information:
   Gross Income from all sources:
   $ _____ per _____ week/_____ month/_____ year.
   (check one)

   If now working, list your occupation _____
   and the name and address of your employer _____
   _____
   Source(s) of income, per _____week/_____month/_____ year if not
   from employment: _____
   Workers' Comp. Benefits $ _____ Pension $ _____
   Social Security Disability $ _____ Other $ _____
   Long Term Disability $ _____ Other $ _____

   If applicant's spouse is employed, list occupation and name and address
   of his/her employer:_____
   _____

Applicant and spouse s gross annual income for the preceding year:

$_____

Deductions

Federal Tax _____

State Tax _____

Social Security (FICA) _____

Other _____

Net Income (Specify whether monthly or weekly):

$_____ per _____

Expenses (Specify whether monthly or weekly):

Rent $ _____

Food $ _____

Clothing $ _____

Utilities $ _____

Other Expenses $ _____

TOTAL $ _____

Assets

Own car?_____ Year & Make _____

Market Value _____ Loan Amount _____

Balance Due _____ Monthly Payment Amount _____

Bank Accounts (number of & balance in each) _____

_____

Real Property?_____ (Identify Type)

Market Value _____ Loan Amount _____

Balance Due _____ Monthly Payment Amount _____

Liabilities

_____

_____

_____

(i) Other facts which may be relevant to applicant's ability to pay the filing fee?

_____

_____

SIGNED UNDER THE PENALTIES OF PERJURY:

Signature of Applicant: _____

Typed/Printed Name of Applicant: _____

Date: _____

ALL INFORMATION CONTAINED HEREIN IS CONFIDENTIAL. IT SHALL NOT BE DISCLOSED TO ANY PARTY OTHER THAN AUTHORIZED REVIEWING BOARD PERSONNEL.

FORM 113

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS - DEPARTMENT 113
600 WASHINGTON STREET - 7TH FLOOR, BOSTON, MA 02111

AGREEMENT TO PAY COMPENSATION

DIA BOARD NO.:

ENTER IF KNOWN

PENALTIES UNDER M.G.L. 152, SECTION 8(1) SHALL RESULT IF PAYMENT PURSUANT TO THIS AGREEMENT IS NOT MADE WITHIN 14 DAYS OF THE INSURER'S RECEIPT OF THIS DOCUMENT FROM THE EMPLOYEE. THIS FORM MUST BE FILED WITH THE DEPARTMENT AND WILL NOT BE RETURNED TO THE PARTIES.

CODES ARE ON THE REVERSE SIDE. PLEASE PRINT OR TYPE:

1. Employee's Name (Last, First, MI)
2. Date of Birth (mm/dd/yy) / /
3. Social Security Number* - -
4. Home Address (No. and Street, City, State, Zip)
5. Employer's Name
6. Self-Insured? ☐ Yes ☐ No
7. Self-Insurer No.:
8. Employer's Address (No. and Street, City, State, Zip)
9. Insurance Carrier's Name and Address
10. Claims Representative's Name
11. Insurer's Case File Number
12. Claims Representative's Telephone ( ) -
13. Date of Injury (mm/dd/yy) / /
14. Nature of Injury Code(s) a. b. c.
15. If Employee Has Died, Date of Death (mm/dd/yy) / /
16. Body Part Code(s) a. b. c.
17. Description of Injury (Left Leg...Lower Back...)
18. Describe How Injury/Exposure Occurred (Struck By...Fell From...Exposed To...)
19. First Date of Total or Partial Incapacity to Earn Wages (mm/dd/yy) / /
20. Fifth Date of Total or Partial Incapacity to Earn Wages (mm/dd/yy) / /
21. Average Weekly Wage $_____ ☐ Estimated ☐ Actual
22. Number of Dependents

THE PARTIES AGREE TO COMPENSATION IN ACCORDANCE WITH THE FOLLOWING SCHEDULE:

23. TYPE OF COMPENSATION	AMOUNT PAID-TO-DATE OR ONE-TIME COMPENSATION AMOUNT	AGREEMENT PERIOD FROM DATE	AGREEMENT PERIOD TO DATE (IF APPLICABLE)	WEEKLY COMPENSATION AMOUNT
a. ☐ Surviving Spouse Coverage (s.31)	$	/ /	/ /	$
b. ☐ Burial Expenses (s.33)	$	/ /	/ /	$
c. ☐ Temporary, Total Incapacity (s.34)	$	/ /	/ /	$
d. ☐ Permanent & Total Incapacity (s.34A)	$	/ /	/ /	$
e. ☐ Partial Incapacity (s.35)	$	/ /	/ /	$
f. ☐ Dependency Coverage (s.35A)	$	/ /	/ /	$

g. **SPECIFIC PERMANENT INJURIES/SECTION 36** Please set out the subsection under Section 36 and the amount of payment.

h. Other (Specify): _____

24. Preparer's Signature
25. Date (mm/dd/yy) / /
26. Name of Employee's Attorney
27. Attorney's Signature
28. Date (mm/dd/yy) / /
29. Employee's Signature
30. Date (mm/dd/yy) / /

APPROVED FOR THE DEPARTMENT BY:

NAME: _____ TITLE: _____

*Disclosing Social Security Number is voluntary. It will assist in the processing of your agreement.

REPRODUCE AS NEEDED

FORM #113 (2/93)

INDUSTRY CODES

Agriculture, Forestry and Fishing
01 Agriculture Production-Crops
02 Agriculture Production-Livestock
07 Agriculture Services
08 Forestry
09 Fishing, Hunting and Trapping

Mining
10 Metal Mining
12 Coal Mining
13 Oil and Gas Extraction
14 Nonmetallic Minerals, Except Fuels

Construction
15 General Building Contractors
16 Heavy Construction, Ex. Building
17 Special Trade Contractors

Manufacturing
20 Food and Kindred Productions
21 Tobacco Products
22 Textile Mill Products
23 Apparel and Other Textile Products
24 Lumber and Wood Products
25 Furniture and Fixtures
26 Paper and Allied Products
27 Printing and Publishing
28 Chemicals and Allied Products
29 Petroleum and Coal Products
30 Rubber and Misc. Plastics Products
31 Leather and Leather Products
32 Stone, Clay, and Glass Products
33 Primary Metal Industries
34 Fabricated Metal Products
35 Industrial Machinery and Equipment
36 Electronic and Other Electric Equipment
37 Transportation Equipment
38 Instruments and Related Products
39 Miscellaneous Manufacturing Industries

Transportation and Public Utilities
40 Railroad Transportation
41 Local and Interurban Passenger Transit
42 Trucking and Warehousing
43 U.S. Postal Service
44 Water Transportation
45 Transportation by Air
46 Pipelines, Except Natural Gas
47 Transportation Services
48 Communications
49 Electric, Gas and Sanitary Services

Wholesale Trade
50 Wholesale Trade-Durable Goods
51 Wholesale Trade-Nondurable Goods

Retail Trade
52 Building Materials and Garden Supplies
53 General Merchandising Stores
54 Food Stores
55 Automotive Dealers and Service Stations
56 Apparel and Accessory Stores
57 Furniture and Homefurnishing Stores
58 Eating and Drinking Places
59 Miscellaneous Retail

Finance, Insurance and Real Estate
60 Depository Institutions
61 Nondepository Institutions
62 Security and Commodity Brokers
63 Insurance Carriers
64 Insurance Agents, Brokers and Service
65 Real Estate
67 Holding and Other Investment Offices

Services
70 Hotels and Other Lodging Places
72 Personal Services
73 Business Services
75 Auto Repair Services and Parking
76 Miscellaneous Repair Services
78 Motion Pictures
79 Amusement and Recreation Services
80 Health Services
81 Legal Services
82 Educational Services
83 Social Services
84 Museums, Botanical, Zoological Gardens
86 Membership Organizations
87 Engineering and Management Services
88 Private Households
89 Services, NEC

Public Administration
91 Executive, Legislative, and Garden
92 Justice, Public Order, and Safety
93 Finance, Taxation, and Monetary Policy
94 Administration of Human Resources
95 Environmental Quality and Housing
96 Administration of Economic Programs
97 National Security and International Affairs

Nonclassifiable Establishments
99 Nonclassifiable Establishments

NATURE OF INJURY OR ILLNESS CODES

100 Amputation or Enucleation
110 Asphyxia, Strangulation, Etc.
120 Burn (Heat)
130 Burn (Chemical)
140 Concussion
160 Contusion, Crushing, Bruise
170 Cut, Laceration, Puncture
190 Dislocation
200 Electric Shock, Electrocution
210 Fracture
250 Hernia, Rupture
300 Scratches, Abrasions
310 Sprains, Strains
400 Multiple Injuries
900 No Injury
950 Damage to Prosthetic Devices
995 No Other Injury, NEC**
999 Non-classifiable

Infective or Parasitic Disease
150 Infective or Parasitic Disease, UNS*
151 Amebiasis
152 Anthrax
153 Brucellosis
154 Conjunctivitis and Ophthalmia
156 Tetanus
157 Tuberculosis
159 Other Infective or Parasitic Disease

Dermatitis
180 Dermatitis, UNS*
183 Primary Infections of the Skin
184 Other Skin Conditions
185 Dermatitis, Allergenic or Contact
189 Skin Condition, NEC**

Poisoning, Systemic
270 Poisoning, Systemic, UNS*
271 Due to Toxic Materials other than Lead
272 Diseases of the Blood and Blood Forming Organs
273 Upper Respiratory Conditions
274 Influenza, Pneumonia, Etc.
276 Other Diseases of the Gastro-Intestinal Tract
278 Effects of Lead
279 Other Toxic Effects of One System Only

Respiratory System, Conditions of
570 Respiratory System, Conditions of UNS*
571 Upper Respiratory
572 Asthma, Influenza, Pneumonia

Pneumoconiosis
280 Pneumoconiosis
281 Aluminosis
282 Anthracosis
283 Asbestosis
284 Byssinosis
285 Siderosis
286 Silicosis
287 Other Pneumoconioses
289 Pneumoconiosis with Tuberculosis

Nervous System Conditions of
560 Nervous System, Conditions of, UNS*
561 Diseases of the Central Nervous System
562 Diseases of the Nerves and Peripheral Ganglia

Neoplasm, Tumor
550 Neoplasm, Tumor UNS*
551 Malignant
552 Benign

Radiation Effects
290 Radiation Effects, UNS*
291 Non-Ionizing Radiation
292 Microwave
293 Ionizing Radiation - X-Ray
294 Ionizing Radiation - Isotopes
295 Welder's Flash

Other
265 Carpal Tunnel Syndrome
510 Cerebrovascular and other Conditions of the Circulatory System
520 Complications Peculiar to Medical Care
500 Effects of Changes in Atmospheric Pressure
240 Effects of Environmental Heat
220 Effects of Exposure to Low Temperature
530 Eye, other Diseases of the Eye
230 Hearing Loss or Impairment
991 Heart Condition, Excludes Heart Attack
320 Hemorrhoids
330 Hepatitis, Serum and Infective
275 Hepatitis, Toxic
260 Inflammation of Joints, Etc.
540 Mental Disorders
900 No Illness
999 Non-classifiable
990 Occupational Disease, NEC**
580 Symptoms and Ill-defined Conditions

BODY PART AFFECTED CODES

Head
100 Head, UNS*
110 Brain
120 Ear(s), UNS*
121 Ear(s), External
124 Ear(s), Internal
130 Eye(s)
140 Face, UNS*
141 Jaw, Chin
144 Mouth & Throat (vocal cords, larynx)
146 Nose
148 Face, Multiple Parts
149 Face, NEC**
150 Scalp
160 Skull
198 Head, Multiple
200 Neck & Cervical Vertebrae

UPPER EXTREMITIES
300 Upper Extremities, UNS*
310 Arm(s), UNS*
311 Upper Arm(s)
313 Elbow(s)
315 Forearm(s)
318 Arm(s), Multiple
319 Arm(s), NEC**
320 Wrist(s)
330 Hand(s) Not Wrists or Fingers
340 Finger(s)
398 Upper Extremities, Multiple
400 Trunk, UNS*
410 Abdomen...Internal Organs, Inguinal Hernia
420 Back
430 Chest...Ribs, Breastbone, Internal Organs
440 Hip(s)...Pelvis, Organs, and Buttocks
450 Shoulder(s)
498 Trunk, Multiple

LOWER EXTREMITIES
500 Lower, Extremities, UNS*
510 Leg(s), UNS*
511 Thigh(s)
513 Knee(s)
515 Lower Leg(s)
518 Leg(s), Multiple
519 Leg(s), NEC**
520 Ankle(s)
530 Foot or Feet... Not Ankle or Toes
540 Toe(s)
598 Lower Extremities, Multiple

700 MULTIPLE PARTS
Applies when more than one major body part has been affected such as an arm and a leg.

NONCLASSIFIABLE
999 Insufficient information to identify part of body affected. Includes damage to prosthetic devices.

*UNS-UNSPECIFIED

**NEC-NOT ELSEWHERE CLASSIFIED

FORM 114

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS - DEPARTMENT 114
600 WASHINGTON STREET - 7TH FLOOR, BOSTON, MA 02111

DIA BOARD NO.:

ENTER IF KNOWN

NOTICE OF CHANGE / APPEARANCE OF COUNSEL

DO NOT FILE THIS FORM IF YOUR APPEARANCE HAS BEEN ENTERED ON FORM 104 OR FORM 110

PLEASE PRINT OR TYPE:

*	1. Employee's Name (Last, First, MI)	2. Social Security Number* - -
*	3. Home Address (No. and Street, City, State, Zip)	4. Date of Injury (mm/dd/yy) / /
*	5. Employer's Name and Address (No. and Street, City, State, Zip)	
*	6. Insurance Carrier's Name	7. Self-Insured? ☐ Yes ☐ No 8. Self-Insurer Number:
*	9. Insurance Carrier's Address (No. and Street, City, State, Zip)	

*	10. **PLEASE ENTER MY APPEARANCE FOR:** ☐ Employee ☐ Insurer ☐ Employer ☐ Other (Specify)

*	11. **THE EMPLOYEE/CLAIMANT DISCHARGED ME AS COUNSEL** ☐
*	12. **COUNSEL HAS BEEN REPLACED BY SUCCESSOR COUNSEL** ☐ **AND IS WITHDRAWING FROM REPRESENTATION OF:** ☐ Employee ☐ Employer ☐ Insurer
*	Other (Specify) ☐ _____
*	**ATTACH APPEARANCE OF SUCCESSOR COUNSEL**

*	13. **COUNSEL FOR** ☐ **Employee** ☐ **Insurer** ☐ **Employer** ☐ **Other (Specify)** _____ REQUESTS PERMISSION TO WITHDRAW PURSUANT TO 452 C.M.R 1.18(3)
*	14. **APPROVED BY:** _____ _____ (NAME) (TITLE)
*	_____ (SIGNATURE) **ON BEHALF OF THE DIVISION OF DISPUTE RESOLUTION**

*	15. Attorney's Name (Last, First, MI)	16. Attorney's Telephone ( ) -
*	17. Attorney's Address (No. and Street, City, State, Zip)	
*	☐ Please check if this is a change of address	

*Disclosing Social Security Number is voluntary. It will assist in the processing of your report.

Send a copy of this form to all parties.

REPRODUCE AS NEEDED

Form #114 (2/93)

FORM 115

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS - DEPARTMENT 115
600 WASHINGTON STREET - 7TH FLOOR, BOSTON, MA 02111

DIA BOARD NO.:

ENTER IF KNOWN

THIRD PARTY CLAIM / NOTICE OF LIEN

COPIES OF THIS FORM SHOULD BE PROVIDED TO THE EMPLOYEE AND THE INSURER

PLEASE PRINT OR TYPE:

PROVIDER

1. Provider's Name
2. Provider's Telephone ( ) -
3. Provider's Address (No. and Street, City, State, Zip)
4. Name of Provider's Attorney (Last, First, MI)
5. Attorney's Telephone ( ) -
6. Attorney's Address (No. and Street, City, State, Zip)

EMPLOYER

7. Employee's Name (Last, First, MI)
8. Date of Birth (mm/dd/yy) / /
9. Date of Injury (mm/dd/yy) / /
10. Home Address (No. and Street, City, State, Zip)
11. Social Security Number*
12. Employer's Name
13. Employer's Address (No. and Street, City, State, Zip)

14. Insurance Carrier's Name and Address (No. and Street, City, State, Zip)

BENEFIT OR SERVICE

15. If this is a lien, please state the nature of the services rendered, the statutory basis therefore and the amount thereof.

16. If this is a claim for payment or reimbursement for services provided the employee, please state the nature of the services rendered, the statutory basis therefore and the amount thereof.

17. Preparer's Name (Please Print or Type)
18. Preparer's Signature
19. Date (mm/dd/yy) / /

*Disclosing Social Security Number is voluntary. It will assist in the processing of your report.

REPRODUCE AS NEEDED

Form #115 (2/93)

FORM 116

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS - DEPARTMENT 116
600 WASHINGTON STREET - 7TH FLOOR, BOSTON, MA 02111

DIA BOARD NO.:

ENTER IF KNOWN

REQUEST FOR LUMP SUM CONFERENCE

REQUESTING CONFERENCE BEFORE: ☐ ADMINISTRATIVE LAW JUDGE
☐ CONCILIATOR FOR APPROVAL OF SETTLEMENT AS COMPLETE

CODES ARE ON THE REVERSE SIDE. PLEASE PRINT OR TYPE:

EMPLOYEE

1. Employee's Name (Last, First, MI)	2. Social Security Number* - -	3. Home Telephone ( ) -
4. Home Address (No. and Street, City, State, Zip)		5. Date of Birth (mm/dd/yy) / /
6. Employer's Name		
7. Employer's Address (No. and Street, City, State, Zip)		
8. Name of Employee's Attorney (Last, First, MI)		9. Attorney's Telephone ( ) -
10. Attorney's Address (No. and Street, City, State, Zip)		

INJURY INFORMATION

11. Date of Injury (mm/dd/yy)	12. DIA Board Number (if known)	
13. Insurance Carrier's Name and Address (No. and Street, City, State, Zip)	14. Self-Insured? ☐ Yes ☐ No 15. Self-Insurer Number:	
16. Name of Insurer's Attorney (Last, First, MI)		17. Attorney's Telephone ( ) -
18. Attorney's Address (No. and Street, City, State, Zip)		
19. Nature of Injury Code(s) a. b. c.	20. Body Part Code(s) a. b. c.	
21. Describe How Injury/Exposure Occurred (Struck By...Fell From...Exposed To...)		

22. Name of Preparer:	23. Title	
24. Preparer's Signature		25. Date (mm/dd/yy)

UNDER CERTAIN CIRCUMSTANCES, THE WRITTEN CONSENT OF THE EMPLOYER AND/OR THE WRITTEN CONSENT OF THE DIRECTOR OF THE OFFICE OF EDUCATION AND VOCATIONAL REHABILITATION MAY BE REQUIRED. SEE FORMS 116A AND 116B.

**DO NOT FILE FORMS 116A, 116B OR 116C WITH THIS FORM.
THEY SHOULD BE FILED AT THE TIME OF THE LUMP SUM PROCEEDING.**

*Disclosing Social Security Number is voluntary. It will assist in the processing of your report.

REPRODUCE AS NEEDED

INDUSTRY CODES

Agriculture, Forestry and Fishing
01 Agriculture Production-Crops
02 Agriculture Production-Livestock
07 Agriculture Services
08 Forestry
09 Fishing, Hunting and Trapping

Mining
10 Metal Mining
12 Coal Mining
13 Oil and Gas Extraction
14 Nonmetallic Minerals, Except Fuels

Construction
15 General Building Contractors
16 Heavy Construction, Ex. Building
17 Special Trade Contractors

Manufacturing
20 Food and Kindred Productions
21 Tobacco Products
22 Textile Mill Products
23 Apparel and Other Textile Products
24 Lumber and Wood Products
25 Furniture and Fixtures
26 Paper and Allied Products
27 Printing and Publishing
28 Chemicals and Allied Products
29 Petroleum and Coal Products
30 Rubber and Misc. Plastics Products
31 Leather and Leather Products
32 Stone, Clay, and Glass Products
33 Primary Metal Industries
34 Fabricated Metal Products
35 Industrial Machinery and Equipment
36 Electronic and Other Electric Equipment
37 Transportation Equipment
38 Instruments and Related Products
39 Miscellaneous Manufacturing Industries

Transportation and Public Utilities
40 Railroad Transportation
41 Local and Interurban Passenger Transit
42 Trucking and Warehousing
43 U.S. Postal Service
44 Water Transportation
45 Transportation by Air
46 Pipelines, Except Natural Gas
47 Transportation Services
48 Communications
49 Electric, Gas and Sanitary Services

Wholesale Trade
50 Wholesale Trade-Durable Goods
51 Wholesale Trade-Nondurable Goods

Retail Trade
52 Building Materials and Garden Supplies
53 General Merchandising Stores
54 Food Stores
55 Automotive Dealers and Service Stations
56 Apparel and Accessory Stores
57 Furniture and Homefurnishing Stores
58 Eating and Drinking Places
59 Miscellaneous Retail

Finance, Insurance and Real Estate
60 Depository Institutions
61 Nondepository Institutions
62 Security and Commodity Brokers
63 Insurance Carriers
64 Insurance Agents, Brokers and Service
65 Real Estate
67 Holding and Other Investment Offices

Services
70 Hotels and Other Lodging Places
72 Personal Services
73 Business Services
75 Auto Repair Services and Parking
76 Miscellaneous Repair Services
78 Motion Pictures
79 Amusement and Recreation Services
80 Health Services
81 Legal Services
82 Educational Services
83 Social Services
84 Museums, Botanical, Zoological Gardens
86 Membership Organizations
87 Engineering and Management Services
88 Private Households
89 Services, NEC

Public Administration
91 Executive, Legislative, and Garden
92 Justice, Public Order, and Safety
93 Finance, Taxation, and Monetary Policy
94 Administration of Human Resources
95 Environmental Quality and Housing
96 Administration of Economic Programs
97 National Security and International Affairs

Nonclassifiable Establishments
99 Nonclassifiable Establishments

NATURE OF INJURY OR ILLNESS CODES

100 Amputation or Enucleation
110 Asphyxia, Strangulation, Etc.
120 Burn (Heat)
130 Burn (Chemical)
140 Concussion
160 Contusion, Crushing, Bruise
170 Cut, Laceration, Puncture
190 Dislocation
200 Electric Shock, Electrocution
210 Fracture
250 Hernia, Rupture
300 Scratches, Abrasions
310 Sprains, Strains
400 Multiple Injuries
900 No Injury
950 Damage to Prosthetic Devices
995 No Other Injury, NEC**
999 Non-classifiable

Infective or Parasitic Disease
150 Infective or Parasitic Disease, UNS*
151 Amebiasis
152 Anthrax
153 Brucellosis
154 Conjunctivitis and Ophthalmia
156 Tetanus
157 Tuberculosis
159 Other Infective or Parasitic Disease

Dermatitis
180 Dermatitis, UNS*
183 Primary Infections of the Skin
184 Other Skin Conditions
185 Dermatitis, Allergenic or Contact
189 Skin Condition, NEC**

Poisoning, Systemic
270 Poisoning, Systemic, UNS*
271 Due to Toxic Materials other than Lead
272 Diseases of the Blood and Blood Forming Organs
273 Upper Respiratory Conditions
274 Influenza, Pneumonia, Etc.
276 Other Diseases of the Gastro-Intestinal Tract
278 Effects of Lead
279 Other Toxic Effects of One System Only

Respiratory System, Conditions of
570 Respiratory System, Conditions of UNS*
571 Upper Respiratory
572 Asthma, Influenza, Pneumonia

Pneumoconiosis
280 Pneumoconiosis
281 Aluminosis
282 Anthracosis
283 Asbestosis
284 Byssinosis
285 Siderosis
286 Silicosis
287 Other Pneumoconioses
289 Pneumoconiosis with Tuberculosis

Nervous System Conditions of
560 Nervous System, Conditions of, UNS*
561 Diseases of the Central Nervous System
562 Diseases of the Nerves and Peripheral Ganglia

Neoplasm, Tumor
550 Neoplasm, Tumor UNS*
551 Malignant
552 Benign

Radiation Effects
290 Radiation Effects, UNS*
291 Non-Ionizing Radiation
292 Microwave
293 Ionizing Radiation - X-Ray
294 Ionizing Radiation - Isotopes
295 Welder's Flash

Other
265 Carpal Tunnel Syndrome
510 Cerebrovascular and other Conditions of the Circulatory System
520 Complications Peculiar to Medical Care
500 Effects of Changes in Atmospheric Pressure
240 Effects of Environmental Heat
220 Effects of Exposure to Low Temperature
530 Eye, other Diseases of the Eye
230 Hearing Loss or Impairment
991 Heart Condition, Excludes Heart Attack
320 Hemorrhoids
330 Hepatitis, Serum and Infective
275 Hepatitis, Toxic
260 Inflammation of Joints, Etc.
540 Mental Disorders
900 No Illness
999 Non-classifiable
990 Occupational Disease, NEC**
580 Symptoms and Ill-defined Conditions

BODY PART AFFECTED CODES

Head
100 Head, UNS*
110 Brain
120 Ear(s), UNS*
121 Ear(s), External
124 Ear(s), Internal
130 Eye(s)
140 Face, UNS*
141 Jaw, Chin
144 Mouth & Throat (vocal cords, larynx)
146 Nose
148 Face, Multiple Parts
149 Face, NEC**
150 Scalp
160 Skull
198 Head, Multiple
200 Neck & Cervical Vertebrae

UPPER EXTREMITIES
300 Upper Extremities, UNS*
310 Arm(s), UNS*
311 Upper Arm(s)
313 Elbow(s)
315 Forearm(s)
318 Arm(s), Multiple
319 Arm(s), NEC**
320 Wrist(s)
330 Hand(s) Not Wrists or Fingers
340 Finger(s)
398 Upper Extremities, Multiple
400 Trunk, UNS*
410 Abdomen...Internal Organs, Inguinal Hernia
420 Back
430 Chest...Ribs, Breastbone, Internal Organs
440 Hip(s)...Pelvis, Organs, and Buttocks
450 Shoulder(s)
498 Trunk, Multiple

LOWER EXTREMITIES
500 Lower, Extremities, UNS*
510 Leg(s), UNS*
511 Thigh(s)
513 Knee(s)
515 Lower Leg(s)
518 Leg(s), Multiple
519 Leg(s), NEC**
520 Ankle(s)
530 Foot or Feet... Not Ankle or Toes
540 Toe(s)
598 Lower Extremities, Multiple
700 MULTIPLE PARTS
Applies when more than one major body part has been affected such as an arm and a leg.

NONCLASSIFIABLE
999 Insufficient information to identify part of body affected. Includes damage to prosthetic devices.

*UNS-UNSPECIFIED

**NEC-NOT ELSEWHERE CLASSIFIED

FORM 116A

DIA BOARD NO.:
ENTER IF KNOWN

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS
DEPARTMENT 116A
600 WASHINGTON STREET - 7TH FLOOR
BOSTON, MA 02111

I, _____ , sole proprietor/

partner/corporate officer of _____

Company of _____ ,

_____ (city), _____ (state) ,

experience-modified insured of _____ (insurer)

Company, hereby consent to the payment of a lump sum settlement in the gross amount of $ _____ in the workers' compensation case of _____ . The terms of such settlement are more fully set forth in the attached lump sum agreement.

Signed this _____ day of _____,

19 _____, pursuant to the provisions of Section 48 of Chapter 152 of the General Laws of Massachusetts as most recently amended by Section 74 of Chapter 398 of the Acts of 1991.

_____
(signature)

FORM 116B

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS
DEPARTMENT 116B
600 WASHINGTON STREET-7TH FLOOR
BOSTON, MA 02111

DIA BOARD NO.:

ENTER IF KNOWN

ADDENDUM TO LUMP SUM SETTLEMENT AGREEMENT
PURSUANT TO c. 398, s.75 OF THE ACTS OF 1991,
EFFECTIVE DECEMBER 24, 1991
VOCATIONAL REHABILITATION STATUS

Employee Name: _____ Board #: _____

Written consent of the Office of Education and Vocational Rehabilitation is not required as a condition precedent to the validity of the lump sum agreement where:

PLEASE CHECK ONE:

- ☐ No determination has been made with respect to the employee's suitability for vocational rehabilitation pursuant to s. 30G.
- ☐ The employee has been found unsuitable by the Office of Education and Vocational Rehabilitation for vocational rehabilitation services pursuant to s. 30G.
- ☐ The employee has returned to continuous employment for a period of six or more months.
- ☐ The employee has completed an approved rehabilitation plan.

Signed, this _____ day of _____ 19_____

SIGNATURE	ADDRESS
_____	_____
CLAIMANT	
_____	_____
CLAIMANT'S COUNSEL	
_____	_____
INSURER'S COUNSEL	

Where the employee has been found suitable for vocational rehabilitation services and has not returned to continuous employment for a period of six or more months or completed an approved rehabilitation plan, the Office of Education and Vocational Rehabilitation may nevertheless consent in writing to the lump sum, or an administrative judge or administrative law judge, by order or decision may authorize such agreement.

Consented To: _____ Date: _____
Office of Education and Vocational Rehabilitation

OEVR Comments: _____

Order/Decision: _____
Administrative Judge/Administrative Law Judge

REPRODUCE AS NEEDED

FORM #116B (2/93)

FORM 116C

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS
DEPARTMENT 116C
600 WASHINGTON STREET-7TH FLOOR
BOSTON, MA 02111

LIEN DISCLOSURE FORM

(To be completed by the Employee)

I, _____ ,

(Print Name)

certify that, to the best of my knowledge, there are no outstanding liens or claims for reimbursement out of the proceeds of my workers' compensation settlement by the Department of Public Welfare, Department of Revenue Child Support Unit, Veterans Services, prior counsel, or any medical, dental, hospital or disability income provider. My workers' compensation case Board number (s):_____ .

Signed under the pains and penalties of perjury.

_____
Signature of Employee

_____
Address of Employee

_____
Social Security Number*

_____
Date

*Disclosing Social Security Number is voluntary. It will assist in the processing of your report.

REPRODUCE AS NEEDED FORM #116C (2/93)

FORM 121

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS - DEPARTMENT 121
600 WASHINGTON STREET - 7TH FLOOR, BOSTON, MA 02111

APPEAL OF CONFERENCE PROCEEDING

DIA BOARD NO.:
ENTER IF KNOWN

A COPY OF THE ADMINISTRATIVE JUDGE'S ORDER SHOULD BE ATTACHED TO THIS APPEAL.

PLEASE PRINT OR TYPE:

1. Case Appealed By: ☐ Employee ☐ Insurer ☐ Other (Please Specify): _____

2. Medical Issue ☐
   ☐ Appeal fee attached
   ☐ Appeal fee to be submitted to the Department within 10 days of appeal pursuant to MGL 152, section 11A(2)

3. Non-Medical Issue ☐

CASE INFORMATION

4. Date of Order (mm/dd/yy) ___/___/___

5. Name of Judge Who Issued Order:

6. Date of Injury (mm/dd/yy) ___/___/___

7. Employee's Name (Last, First, MI)

8. Social Security Number* ___-___-___

9. Home Address (No. and Street, City, State, Zip)

10. Employer's Name

11. Employer's Address (No. and Street, City, State, Zip)

12. Insurance Carrier's Name

13. Insurance Carrier's Address (No. and Street, City, State, Zip)

14. Name of Insurer's Attorney (Last, First, MI) and Board of Bar Overseers Number

15. Attorney's Telephone ( ) -

16. Attorney's Address (No. and Street, City, State, Zip)

17. Name of Employee's Attorney (Last, First, MI) and Board of Bar Overseers Number

18. Attorney's Telephone ( ) -

19. Attorney's Address (No. and Street, City, State, Zip)

20. Preparer's Name (Please Print or Type)

21. Preparer's Address (No. and Street, City, State, Zip)

22. Preparer's Telephone ( ) -

23. Preparer's Signature

24. Date (mm/dd/yy) ___/___/___

*Disclosing Social Security Number is voluntary. It will assist in the processing of your report.

FORM 124A

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS - DEPARTMENT 124A
600 WASHINGTON STREET - 7TH FLOOR
BOSTON, MA 02111

DIA BOARD NO.:
ENTER IF KNOWN

NOTIFICATION OF ARBITRATION AWARD

ATTACH COPY OF ARBITRATION AWARD TO THIS FORM. SEND COPIES TO ALL PARTIES.

PLEASE PRINT OR TYPE:

*	1. Employee's Name (Last, First, MI)	
*	2. Home Address (No. and Street, City, State, Zip)	
*	3. Social Security Number* - -	4. Home Telephone ( ) -
*	5. Name of Employee's Attorney	
*	6. Attorney's Address (No. and Street, City, State, Zip)	
*	7. Employer's Name	
*	8. Employer's Address (No. and Street, City, State, Zip)	
*	9. Insurance Carrier's Name	
*	10. Insurance Carrier's Address (No. and Street, City, State, Zip)	
*	11. Name of Insurer's Attorney	
*	12. Attorney's Address (No. and Street, City, State, Zip)	
*	13. Arbitrator's Name (Please Print)	
*	14. Arbitrator's Firm Name	
*	15. Arbitrator's Business Address (No. & Street, City, State, Zip)	
*	16. Arbitrator's Signature	17. Date(mm/dd/yy)

*Disclosing Social Security Number is voluntary. It will assist in the processing of your report.

REPRODUCE AS NEEDED

Form #124A (2/93)

FORM 126

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS
600 WASHINGTON STREET - 7TH FLOOR, BOSTON, MA 02111

EMPLOYEE'S EARNINGS REPORT

DIA BOARD NO.:
ENTER IF KNOWN

PLEASE PRINT OR TYPE:

1. Employee's Name (Last, First, MI)	2. Social Security Number* - -	3. Date of Injury (mm/dd/yy) / /
4. Employee's Mailing Address (No. and Street, City, State, Zip)		
5. Employee's Residential Address (If Different from Mailing Address)		
6. Name of Employee's Attorney (Last, First, MI) and Address (No. and Street, City, State, Zip)		
7. D.I.A. Board Number (If Known)	8. Date of Birth (mm/dd/yy) / /	

As an employee entitled to receive weekly compensation, you have an affirmative duty to report to the insurer all earnings, including wages or salary from self-employment. If you fail to report any earnings whether paid in cash or otherwise, you may be subject to civil or criminal penalties. If you fail to return this form within 30 days of this request, the insurer may suspend your weekly benefits M.G.L. Chapter 152, section 11D(1).

You cannot be required to file an earnings report more often than once every six months.

Please Report Your Earnings Below:

9.

Week No.	Year: Week Ending Month	Day	Gross Amount Before Taxes
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			

Week No.	Year: Week Ending Month	Day	Gross Amount Before Taxes
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
		TOTAL:	

10. Name/Address of Employer or Other Payor of Wages, Commissions, Etc. If more than one Payor, please list additional names and addresses on back.

11. I have not received earnings for any period in which I was entitled to receive Workers' Compensation Benefits.

☐ (X if Appropriate)

12. Employee's Signature

THE EMPLOYEE MUST MAIL THIS COMPLETED FORM TO THE INSURER AT THE ADDRESS INDICATED BELOW:

13. Insurance Carrier's Name	14. Insurer's Address (No. and Street, City, State, Zip)

*Disclosing Social Security Number is voluntary. It will assist in the processing of your report.

REPRODUCE AS NEEDD

FORM #126 (2/93)

FORM 131

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS
DEPARTMENT 131
600 WASHINGTON STREET, 7TH FLOOR
BOSTON, MA 02111

DIA BOARD NO.:

ENTER IF KNOWN

REQUEST FOR SPEEDY CONFERENCE BECAUSE OF HARDSHIP

RE: DIA Board# _____ Employee: _____

Employer: _____ Insurer: _____

Date of Injury: _____ DIA Region: _____

Please check which of the following **Hardship Criteria** apply and follow **Instructions** below:

- ☐ You are presently unemployed;
- ☐ You have exhausted others benefit sources (Public Assistance, Veterans Administration Benefits, Private Insurance, Social Security, Unemployment Insurance), or do not qualify for same;
- ☐ You and your family are unable to provide basic necessities and comforts of life for your dependents;
- ☐ You and your family have income and assets which are inadequate to provide basic necessities and comforts of life for you and for your dependents;
- ☐ You have a foreclosure/eviction proceeding pending against you (copy attached);
- ☐ You received a notice of utility termination for non-payment (copy attached) and have exhausted other sources of relief (explain briefly).

☐ State briefly specific facts which support your **Request for Speedy Conference** Because of Hardship for reason(s) checked above or for other reason: (use additional space on other side of this form if necessary)

_____

_____

_____

_____

_____

_____

****

INSTRUCTIONS

1. Attach completed AFFIDAVIT FORM and documentation supporting hardship.
2. You may not file **Request for Speedy Conference** Because of Hardship until claim has been conciliated.
3. Mail to:

Deputy Director, Division of Dispute Resolution
The Commonwealth of Massachusetts
Department of Industrial Accidents
600 Washington Street
Boston, Massachusetts 02111

Employee's Signature: _____ Date of Request: _____

****

For Department Use Only

☐ REQUEST ALLOWED ☐ REQUEST DENIED

DEPUTY DIRECTOR, DIVISION OF DISPUTE RESOLUTION _____

DATE: _____

REPRODUCE AS NEEDED

FORM #131 (2/93)

ADDITIONAL SPACE

FORM 132

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS - DEPARTMENT 132
600 WASHINGTON STREET, 7TH FLOOR, BOSTON, MA 02111

AFFIDAVIT IN SUPPORT OF EMPLOYEE'S REQUEST FOR SPEEDY CONFERENCE BECAUSE OF HARDSHIP

DIA BOARD NO.:

ENTER IF KNOWN

All questions must be answered. If more space is needed, attach additional sheet(s).

1. INFORMATION ON YOUR CLAIM:

DIA Region: _____ Social Security No.: _____ *

DIA Board No.: _____ Date of Injury: _____

Your Address: _____ Your Telephone No.: _____

_____ Comp. Insurer: _____

Your Employer: _____

2. INFORMATION ON YOUR HOUSEHOLD

A. Names and Ages of Minor Children Living With You:

1. _____ ; 2. _____ ; 3. _____ ;

4. _____ ; 5. _____ ; 6. _____ ;

B. Names and Ages of Persons Over 18 Who Live With You and Who are Dependent Financially on You Now:

1. _____ ; 2. _____ ; 3. _____ ;

C. I Live With My: [check applicable box(es)]

- ☐ Spouse
- ☐ Parents
- ☐ Other

3. CURRENT GROSS WEEKLY INCOME FROM ALL SOURCES:

	You	Spouse	Other Source
A. Workers' Compensation	$ _____	$ _____	$ _____
B. Unemployment Insurance	$ _____	$ _____	$ _____
C. Private Disability Insurance	$ _____	$ _____	$ _____
D. Public Assistance (Welfare, A.F.D.C. Payments)	$ _____	$ _____	$ _____
E. Food Stamps (Gross Value of Weekly Allotment)	$ _____	$ _____	$ _____
F. Social Security	$ _____	$ _____	$ _____
G. Dividends and Interest	$ _____	$ _____	$ _____
H. Income from Trusts or Annuities	$ _____	$ _____	$ _____
I. Pensions and Retirement Funds	$ _____	$ _____	$ _____
J. Alimony and/or Child Support	$ _____	$ _____	$ _____
K. Contribution/Income from other sources	$ _____	$ _____	$ _____
L. All other income not set forth above	$ _____	$ _____	$ _____
M. TOTAL GROSS WEEKLY INCOME (A-L)	$ _____	$ _____	$ _____

* Disclosing Social Security Number is voluntary. It will assist in the processing of your request.

4. WEEKLY EXPENSES

A.	Rent or Mortgage (Principle, Interest & Taxes)	$ _____
B.	Homeowners or Tenant's Insurance	$ _____
C.	Maintenance and Repair of Dwelling	$ _____
D.	Heat	$ _____
E.	Electricity	$ _____
F.	Telephone	$ _____
G.	Water/Sewer	$ _____
H.	Food	$ _____
I.	Clothing	$ _____
L.	Life and Health Insurance Premiums	$ _____
M.	Court Judgment on which you pay regular amount	$ _____
N.	Auto Insurance	$ _____
O.	Auto Payment	$ _____
P.	Child Care	$ _____
Q.	Credit Cards	$ _____
R.	Other (explain) _____	$ _____

TOTAL WEEKLY EXPENSES

5. PERSONAL PROPERTY/LIQUID ASSETS:

A.	IRA, Keough	$ _____
B.	Stocks, Bonds	$ _____
C.	Life Insurance: Present Cash Value	$ _____
D.	Savings & Checking Accounts, Money Market, CDs	$ _____
E.	Automobiles	
1.	Fair Market $_____ - Loan $_____ = Equity	$ _____
2.	Fair Market $_____ - Loan $_____ = Equity	$ _____
F.	Other Personal Property	$ _____

TOTAL PERSONAL PROPERTY/LIQUID ASSETS: $ _____

I CERTIFY UNDER PENALTIES OF PERJURY THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE.

DATE: _____ YOUR SIGNATURE: _____