

The Commonwealth of Massachusetts

Division of Industrial Accidents

Leverett Saltonstall Building, Government Center

100 Cambridge Street, Boston 02202

I.A.B. FILE NO.
ATTENTION OF:

December 1, 1970

CIRCULAR LETTER NO. 175

TO: ALL INSURANCE COMPANIES, ALL SELF-INSURERS, AND WORKMEN'S COMPENSATION AGENTS OF DEPARTMENTS OF THE COMMONWEALTH AND COUNTIES, CITIES, TOWNS, AND DISTRICTS SUBJECT TO THE WORKMEN'S COMPENSATION LAW (GENERAL LAWS, CHAPTER 152, AS AMENDED), AND TO MEMBERS OF THE BAR.

The Industrial Accident Board has VOTED to adopt a new form (I.A.B. 31), which consolidates three forms presently in use namely, "Claim for Compensation", "Request for Hearing", and "Appearance of Counsel".


This new form, a copy of which is enclosed, shall be used for all claims and requests for hearing filed on or after January 2, 1971, irrespective of the date of injury.

The attention of employee's counsel is called to the instruction that the original of this form must be filed with the Division of Industrial Accidents, and three (3) copies must be sent to the insurer or self-insurer, with the employee's counsel retaining one copy.

The attention of insurers and self-insurers is called to the instruction that of the three (3) copies filed with them one completed copy must be forwarded to the Division of Industrial Accidents, and one completed copy must be sent to the employee or his counsel, if any, with the insurer or self-insurer retaining one copy.

The claim for compensation form and request for hearing form currently in use will not be accepted after January 1, 1971.

The cooperation of all parties is absolutely essential if this new form is to achieve its maximum effectiveness in advising the other party of its claim or defense.

Very truly yours,

John J. Maloney
Secretary

Enclosure
JJM/kms

The Commonwealth of Massachusetts

DIVISION OF INDUSTRIAL ACCIDENTS
LEVERETT SALTONSTALL BUILDING
GOVERNMENT CENTER, 100 CAMBRIDGE STREET
BOSTON, MASSACHUSETTS 02202

WORKMEN'S COMPENSATION ACT: GENERAL LAWS (TER. ED.), CHAPTER 152

Employee: Board Number:
Employer:
Insurer (Self-Insurer): Insurer's Number:

CLAIM — REQUEST — APPEARANCE

Note: The original of this form must be completed and filed with the Division and three (3) copies thereof must be sent to the insurance company or self-insurer. Failure to comply with this procedure will result in delayed action on the employee's claim and request. Claim should be made within one year after the injury. General Laws, Chapter 152, Sections 41 and 49.

TO BE COMPLETED BY EMPLOYEE (OR PERSON IN HIS BEHALF)

1. Date and Time of Injury
2. Place of Injury (Describe Building, Premises, Address)
3. How did injury occur? (Describe in detail)
4. When and to whom did you report injury?
5. State nature of injury
6. Is hearing requested at this time? (Check): Yes () No () .
7. If hearing is requested, indicate period(s) of compensation claimed (such as total, partial total and permanent, specific, dependency), or other reason for Request

APPEARANCE OF COUNSEL

..... (Signature of Attorney) (Signature of Employee or Claimant)
..... (Street and Number) (Street and Number)
..... (City or Town) (City or Town)
..... (Telephone Number) (Date of Claim)

INSURER'S REPLY

Note: Within 21 days of the receipt of this Claim, the Insurer or Self-Insurer must complete this portion, in triplicate, forwarding one copy to the Division, one copy to the employee (or his counsel, if any), and retain one copy.

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| <p>A. Insurer Admits:
(Check or Insert)</p> <ol style="list-style-type: none"> 1. Personal Injury 2. Disability From <li style="padding-left: 40px;">To 3. Causal Relation 4. Dependency 5. Other | <p>B. Insurer Denies:
(Check or Insert)</p> <ol style="list-style-type: none"> 1. Personal Injury 2. Disability From <li style="padding-left: 40px;">To 3. Causal Relation 4. Proper Notice 5. Proper Claim 6. Other |
|--|--|

BY
TITLE