THE COMMONWEALTH OF MASSACHUSETTS
Department of Industrial Accidents
1 Congress Street, Suite 100
Boston. Massachusetts 02114

WHEN/HOW TO FILL OUT THE EMPLOYEE CLAIM FORM (FORM 110)

WHEN TO FILL OUT THIS EMPLOYEE'S CLAIM FORM

This Employee Claim form should be completed whenever you believe you are not getting all of the workers' compensation benefits you are entitled to. The **ONLY** reason for completing this form is to request a **judicial proceeding** before and Administrative Judge to obtain workers' compensation benefits.

When submitting this form, REQUIRED DOCUMENTATION must be attached, as required by Mass. Law, 452 CMR 1.07. A list of requirements, and other information, is available on the DIA's website: www.mass.gov/dia. Employee Claim forms filed without the required documentation will be rejected. Essentially, you need to attach copies of any information that relates your injury to work, and what the injury (or injuries) is. There are four (4) levels in the process of settling your dispute within the Department of Industrial Accident (DIA).

LEVEL #1 – **CONCILIATION SESSION:** This is an informal meeting between you and your company's insurer. Results of conciliation WON'T be binding unless you agree to them. Even when you are satisfied that you are being paid everything required by law, you MAY get a notice to attend a conciliation that you DID NOT request. This means that either the insurance company thinks it is paying TOO MUCH and would like to REDUCE your benefits or STOP your benefits. These insurance company requests are called "Complaints to Reduce or Discontinue Compensation." Once again, conciliations CANNOT result in changes in compensation rates unless both parties agree.

LEVEL #2 – **CONFERENCE:** If your case is referred to an Administrative Judge by the conciliator, a CONFERENCE is scheduled. This conference is also informal, with discussion between parties. If the matter is NOT settled, the Judge will issue a temporary order indicating whether or not the insurer must pay you compensation. If you are not satisfied with the Judge's order you may appeal it within 14 days of the filing date of the decision. The insurance company also has the right to appeal.

LEVEL #3 – **HEARING:** If your case is appealed by the insurer OR yourself, it will go to the HEARING stage, where the Administrative Judge conducts a FORMAL hearing of all evidence. Hearings are like regular trials; witnesses are called and sworn in and testimony is taken by stenographers.

LEVEL # 4 – **REVIEW BOARD:** Whichever party loses at a hearing may APPEAL the Administrative Judge's decision to the REVIEW BOARD within 30 days. Three (3) Administrative Law Judges will examine the hearing transcripts. They may ask for oral arguments. The Review Board will reverse the previous decision ONLY if the decision was beyond the Administrative Judge's authority, conflicted with the law, or was without any justification.

HOW TO FILL OUT FORM 110

YOU SHOULD FILL IN AS MANY OF THE BOXES ON THIS FORM AS YOU CAN. HOWEVER, THOSE LISTED BELOW ARE PARTICULARLY IMPORTANT TO GETTING YOUR REQUEST PROCESSED QUICKLY BY THE DIA. IF YOU HAVE ANY QUESTIONS PLEASE CALL THE INFORMATION DESK ON THE TOLL-FREE HOTLINE (In Mass. Only) AT 1-800-323-3249, ext. 7470, MONDAY – FRIDAY 8:00 AM – 5:00 PM.

Box #1: Please print or type your full last name, first name and middle initial.

Box #2: Your 9 digit social security number. **Disclosing your number is purely voluntary, but will be helpful to the DIA in keeping your records separate from others with the same name.**

Box #3: Print or type your home telephone number.

Box #4: Please print or type your date of birth.

Box #5: Please print or type your number of dependents.

Box #6: Please print or type your FULL home address. This is important because ALL notices, orders and decisions regarding your case will be sent to this address.

Box #7: If you wish to, you may provide your e-mail address to us, but your notices will still go through the regular postal service mail.

Box #7a: If English is not your native language, please print your native language using the NATIVE LANGUAGE CODES located on the back of the form.

Box #10: Please print or type your employer's business name and address. If your company has more than one address, use the address of their business office.

Box 10a: Please try to determine from the INDUSTRY CODES on the back of the form your employer's type of business. IF you CANNOT, just print or type number 99.

Box #11: Please print or type your employer's workers' compensation insurance company. (NOT the insurance agent, but the name of the carrier that will be paying your benefits to you.) We cannot schedule a conciliation without this information. If your employer will not tell you the name of the insurer, call our Office of Insurance, 617-626-5480 or 617-626-5481.

Box #12: Please print or type the date that you believe that you were originally hurt on the job or became ill because of a work-related illness. Use the date your first got medical treatment, or the last day you worked if you are unsure of the exact date.

Box #12a: Please print or type the case number/claim number that your employer's workers' compensation insurance company assigned your claim.

Box #13: Please print or type the first day that you were incapable of earning full wages because of your injury or illness.

Box #14: Please print or type the fifth day that you were incapable of earning full wages because of your injury or illness.

Box #17a: Please print or type the nature of injury or illness and the body part that has been affected by your injury or illness, from the codes printed on the back of the form. You may have more than one injury or illness listed (e.g. – a. 300, b. 310, c. 210), but the type of injury or illness listed in a MUST match the body part listed in a, and so on.

Box #23: Please check the benefits that you are claiming are due to you under the law. Other sections of the law include Sec. 30 – Medical Bills; Sec. 28 – Willful Misconduct of Employer, and Sec. 7 – Penalties and Interest for late payments.

Box #26: Please sign this form.

Box #27: Please date this form.

Box #28: If you have an attorney, they may sign here, otherwise leave this box blank.

WHAT TO DO WITH THIS CLAIM FORM

You should make 2 copies of this form. Mail the original to:

Department of Industrial Accidents – Dept. 110
1 Congress St., Suite 100
Boston, MA 02114-2017

One (1) copy should be mailed to the insurance carrier, complete with copies of all supporting documentation you send to the DIA. You should keep one (1) copy for your records. You can send a copy of your employer, but you are not required to send them a copy, unless you are filing for double compensation under Sec. 28 (Willful Misconduct). **You must also attach documentation as required by 452 CMR 1.07.** This rule, and other information, is available on the DIA's website – www.mass.gov/dia

When the DIA received your form, a conciliation will be scheduled for you within a few weeks. This session will be held in the department office closest to your home.

Best wishes for a prompt and full recovery.

Revised: 7/2013