JOEL M PRESSMAN
Commissioner

The Commonwealth of Massachusetts

Department of Industrial Accidents
600 Washington Street
Boston, Mass. 02111

CIRCULAR LETTER NUMBER 244

TO: All Interested Parties

FROM: Joel M. Pressman, Commissioner

RE: Request for Proceedings under Section 37 or 37A of G.L. c.152

DATE: October 1989

All insurers or self-insurers seeking reimbursement for benefits under G.L. c.152, §§37 and 37A, for injuries occuring on or after December 10, 1985, must petition for said reimbursement with the Office of the Attorney General at the following address:

Industrial Accident Division
Office of the Attorney General
131 Tremont Street
Boston, Massachusetts 02110

The Office of the Attorney General defends the Fund as set forth under Sections 37 and 37A.

For injuries occurring on or after December 10, 1985 and before November 1, 1986, reimbursement may be sought under §37 in an amount not to exceed 50 percent of all compensation subsequent to that paid for the first 104 weeks of disability.

For injuries on or after Novemer 1, 1986 reimbursement may be sought in an amount equal to 75 percent of all compensation or a lesser amount by agreement of the parties.

If a petition for reimbursement is denied or if 60 days pass with no determination, the insurer may file FORM 122, REQUEST FOR SECTION 37 OR 37A PROCEEDING with the Department of Industrial Accidents. The D.I.A. will schedule a conference and, if appealed, a hearing. No conciliation will be scheduled.

The department will NOT accept Form 122 until the requesting party has filed a petition with the Office of the Attorney General and at least 60 days has transpired or a denial has been received. If reimbursement is recommended by the Office of the Attorney

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Commissioner

The Commonwealth of Massachusetts

Department of Industrial Accidents

600 Washington Street
Boston, Mass. 02111

FROM:

_____

_____

_____

_____

MAIL TO:

Section 37/37A Processing
DIA Office of Administration
P.O. Box 9104, Essex Station
Boston, MA 02112-9104

Gentlemen:

Attached please find a request, pursuant to Section 65 (as amended by Chapter 572 of the Acts of 1985), for Section 37/37A Second Injury reimbursement. This request is made for monies paid on behalf of _____ claimants totaling $_____.

I hereby certify under the penalties of perjury that all laws of the Commonwealth governing assessments and regulations thereof have been complied with and observed, and that all information is, to the best of my knowledge, correct.

SIGNED: _____ NAME: _____

TITLE: _____ PHONE #: _____

DATE: _____

FOR INTERNAL USE ONLY

COMMENTS:

PAYMENT APPROVED _____

DATE: _____

MASSACHUSETTS DEPARTMENT INDUSTRIAL ACCIDENTS
SECOND INJURY REIMBURSEMENT REQUEST FORM
PLEASE CHECK: §37 12/10/85-10/31/86 /__/: §37 Post 11/1/86 /____/: §37A Post 12/10/85 /__/
PAYMENT QUARTER __/__/__ TO __/__/__

1 BOARD #	2 CLAIMANT	3 ADDRESS	4 DATE OF INJURY	5 104TH WEEK DATE	6 QUARTERLY WEEKLY COMPENSATION	7 QUARTERLY MEDICALS PAID	8 AGREEMENT REIMBURSEMENT %	9 QUARTERLY REIMBURSEMENT DUE
				TOTAL:				

INSTRUCTIONS: To compute the quarterly reimbursement due (Column 9), add Columns 6 and 7, multiply by the percentage of reimbursement, Column 8. This is the total in Column 9.

Please indicate under which section, 37 or 37A, and for which time period the reimubursements under §37 are requested. A separate Reimbursement Form should be used for each category.

The Commonwealth of Massachusetts

DEPARTMI OF INDUSTRIAL ACCIDENTS - ' irtment 122
600 Washington Street - 7th Floor, Boston, Massachuse s 02111

DIA NO:_____
FOR OFFICE USE ONLY

REQUEST FOR SECTION 37 OR 37A PROCEEDING

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

EMPLOYEE

1. Employee Name (Last, First, MI)	2. Social Security Number *	3. Date of 37 or 37A Injury (MM/DD/YY)
4. Home Address (No. & Street, City, State, Zip Code)		5. Home Telephone
6. Employee's Attorney Name (Last,First,MI) & Board of Bar Overseers' Number		7. Attorney Telephone
8. Employee's Attorney Address (No. & Street, City, State, Zip Code)		
9. Employer Name		
10. Employer Address (No. & Street, City, State, Zip Code)		

INSURER

11. Worker's Compensation Insurance Carrier Name	12. Self-Insured ? ☐ Yes ☐ No
13. Insurance Carrier Address of Branch Responsible for This Case (Not Local Agent or Adjuster)	14. Self Insurer Number
15. Insurer's Attorney Name (Last, First, MI) and Board of Bar Overseer's Number	16. Attorney Telephone
17. Insurer's Attorney Address (No. & Street, City, State, Zip Code)	

BENEFIT STATUS

18. 104th Week From Disability (MM/DD/YY)	19. Is employee still receiving compensation? ☐ Yes ☐ No	20. ☐ Section 37 Claim ☐ Section 37A Claim
21. Is pre-existing physical impairment due to ☐ Previous Accident ☐ Previous Disease ☐ Congenital Condition		

PETITION

22. Date petition was filed with the Office of the Attorney General (MM/DD/YY)	23. Preparer's Name & Title (Last, First, MI)
24. Preparer's Signature	25. Date (MM/DD/YY)

I certify by the above signature that the petition attached to this form is identical to that filed with the Office of the Attorney General

* Disclosing Social Security Number is voluntary. It will be used to coordinate all filings with the Department of Industrial Accidents and to process your report.

The Commonwealth of Massachusetts

DEPARTMENT OF INDUSTRIAL ACCIDENTS - Dept. 123

600 Washington Street - 7th Floor, Boston, Massachusetts 02111

AGREEMENT UNDER Section 37 or 37A

DIA USE ONLY

STRUCTIONS ARE ON THE REVERSE SIDE. PLEASE PRINT OR TYPE.

1. Insurance Carrier Name	2. Insurance Company Address
3. Name & Address of Person Able to Verify Information	
4. Telephone	

EMPLOYEE

5. Employee Name (Last, First, MI)	6. Social Security Number*
7. Home Address (No. & Street, City, State, Zip Code)	
8. Employer Name	
10. Employer Address (No. & Street, City, State, Zip Code)	

11. Date of Injury (MM/DD/YY)	12. First Date of Disability (MM/DD/YY)	13. If Employee Died, Enter Date of Death

14. Total Amount Paid by Insurer/Self Insurer to Date: $_____

15. Date of last payment: (MM/DD/YY) _____

16. Total Amount to be reimbursed under Section 37 ☐ or 37A ☐ (Check One) $_____ _____%

17. Reimbursement as of: (MM/DD/YY) _____

18. Is employee still receiving weekly compensation benefits? ☐ Yes ☐ No If yes, please fill out the following:

TYPE OF WEEKLY COMPENSATION	WEEKLY COMPENSATION AMOUNT
a. ☐ Total Disability-Temporary (s34)	$_____
b. ☐ Total Disability-Permanent (s34a)	$_____
c. ☐ Partial Disability (s35)	$_____
d. ☐ Dependent Coverage (35A)	$_____
e. ☐ Surviving Dependents Coverage (s31)	$_____
f. ☐ Other (Meds, s36, etc.)	$_____

19. Indicate percentage of continuing benefits to be reimbursed, if any: _____%

I hereby certify that the information contained herein is a true accounting of all payments made to the above named employee.

_____ _____

Signature of Insurer's Authorized Representative Date (MM/DD/YY)

_____

Name & Title (Last, First, MI)

I hereby agree to and authorize the following reimbursement to be made per the provisions of this agreement.

_____ _____ _____

Signature for the Office of The Attorney General Date (MM/DD/YY) Name & Title (Last, First, MI)

* Disclosing Social Security Number is voluntary. It will be used to coordinate all filings with the Department of Industrial Accidents and to process your report

COMMONWEALTH OF MASSACHUSETTS

BOSTON, SS.

DEPARTMENT OF INDUSTRIAL ACCIDENTS
NO.

- EMPLOYEE

- EMPLOYER

- INSURER

SECTION 37A PETITION FOR REIMBURSEMENT UNDER WORKERS' COMPENSATION TRUST FUND

(1) Date of Military or Naval Certification of Disability attached

(2) Description of Military or Naval disability

(3) Description of personal injury aggravated or prolonged by above-referenced disability

(4) Summary of Medical Evidence attached

(5) Amount of Compensation Paid first 104 weeks

(a) Amount of reimbursement claimed (50% of item 5)

(6) Amount of Compensation paid after first 104 weeks

(a) Amount of reimbursement claimed (100% of item 6)

(7) Amount of Medical expenses incurred during the first 104 weeks

(a) Amount of reimbursement claimed (50% of item 7)

(8) Amount of Medical expenses incurred after the first 104 weeks

(a) Amount of reimbursement claimed (100% of item 8)

(9) Total reimbursement claimed (items 5(a), 6(a), 7(a) & 8(a))

_____
Signature

_____
Address

CERTIFICATE OF SERVICE

I,_____, hereby certify that on the_____, 1989, I served a Section 37A Workers' Compensation Trust Fund Petition for Reimbursement, upon the Attorney General, by mailing a copy thereof, postage prepaid, to:_____

_____

SIGNED UNDER THE PENALTIES OF PERJURY.

_____

COMMONWEALTH OF MASSACHUSETTS

WORCESTER, SS.

DEPARTMENT OF
INDUSTRIAL ACCIDENTS
NO.

- EMPLOYEE

- EMPLOYER

- INSURER

SECTION 37 PETITION FOR REIMBURSEMENT
UNDER WORKERS' COMPENSATION TRUST FUND

(1) Pre-Existing Impairment

(2) Employer's Knowledge Regarding the Pre-Existing Impairment

OR

Summary of Medical Record Establishing Pre-Existing Impairment

(3) Subsequent Injury and Date

(4) Summary of Medical Evidence Attached

(5) Amount of Compensation Paid-Initial 104 Weeks

(6) Amount of Medical Expenses Paid-Initial 104 Weeks

(7) Amount of Compensation Paid After Initial 104 weeks

(a) Amount of reimbursement claimed

(8) Amount Medical Expenses incurred after initial 104 weeks

(a) Amount of reimbursement claimed

(9) Total reimbursement claimed (items 7(a) & 8(a)

_____
Signature

_____
Address

CERTIFICATE OF SERVICE

I,_____, hereby certify that on the_____, 1989, I served a Section 37 Worker's Compensation Trust Fund Petition for Reimbursement, upon the Attorney General, by mailing a copy thereof, postage prepaid, to:_____

_____

SIGNED UNDER THE PENALTIES OF PERJURY.

_____