MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

INSTRUCTIONS FOR COMPLETING CLAIM FOR COMPENSATION

Completed copies of the Claim forms must be mailed to the **Division of Workers' Compensation, P.O. Box 58, Jefferson City, MO 65102-0058.** Please note that if you decide to file a Claim, the Division must receive the Claim form within the time period explained below:

- Within two years from the date of injury or death, or within two years from the last payment made on account of the injury or death by the employer or its workers' compensation insurance carrier, whichever is later, OR
- If the employer does not timely file a First Report of the Injury with the Division, within three years from the date of injury or death, or within three years from the last payment made on account of the injury or death by the employer or its workers' compensation insurance carrier, whichever is later.

IMPORTANT CONSIDERATIONS:

1. **Updated Claim form to be used:** The Division prefers that the current or updated version of the Claim for Compensation form WC-21 be used to file a Claim. This form may be downloaded from the Division's website www.dolir.mo.gov/wc/forms/forms.htm. The minimum font size must be 10.
2. **Do not alter the form:** Claims that are submitted to the Division with box numbers on page 1 carried over to page 2, or with the Division of Workers' Compensation caption not appearing on page 1 of the Claim form, or the bottom half of any page cut-off, will not be accepted for processing.
3. **Legibility:** If the employee is represented by an attorney, the Injury Number in the upper right hand corner of page 1 must be typed. The Division highly recommends that the entire Claim form be typed, particularly if an attorney represents the employee. If you print, you must print the information legibly.
4. **Amended Claims:** If the Claim including the Second Injury Fund Claim is being amended, the item numbers amended must be indicated in the box "ITEM NUMBER(S) AMENDED" in order for the Division to process the amendments to the Claim.
5. **Copies:** You need to submit the original and 3 copies of the Claim. If the Claim is being filed against more than 3 employers, please submit additional copies to enable the Division to forward the Claim to all employers named. If the Second Injury Fund is named as a party, please submit an original and 4 copies. You must copy both pages of the Claim form. You should keep one copy for your records.
6. **Box 1D:** If you know your 9-digit zip code, please provide it in box 1D.
7. **Box 3 [Date of Injury (D/I)]:** For repetitive motion & occupational disease claims, the following guidelines will be used:

   If there are multiple dates indicated – Division will use the last date as the D/I.

   - For example, January 1 - March 17, 2001, is on the Claim the D/I will be March 17, 2001.
   - If 1/24 - 2/15/02 and 3/14 - 6/26/02 is on the Claim, the D/I will be June 26, 2002.
   - 3/24 - Current, the Division will use the date it receives the Claim as the D/I.
   - 10/2000 - the Division will use the last date of the month, i.e. 10/31/00 as the D/I.
8. **Box 4:** Please provide gross wages earned rather than the net wages.
9. **Box 6:** If you were injured in Missouri, it is very important that box 6 include the name of the county in which you were injured. If you were injured in the City of St. Louis, please state: "City of St. Louis" or "St. Louis City." Please include the zip code where the accident occurred in box 6.
10. **Second Job Wage Loss:** Please include information on second job wage loss in box 10.
11. **Box 14:** Fill out the dependent information in box 14 only if the employee has died.
12. Employee/Claimant must sign Box 15 unless represented by an attorney.

If you have any questions, please contact the Division's Programs & Support Section at 573-526-4949. The injured employee may call the Division's toll free number 1-800-775-2667 with any questions.

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
P.O. Box 58
Jefferson City, MO 65102-0058

CLAIM FOR COMPENSATION

INJURY NUMBER

__ __ - __ __ __ __ __ __

NOTE: This form must be completed in its entirety and must be typed or hand printed in **black ink**.

SUBMIT AN ORIGINAL AND THREE COPIES.

☐ ORIGINAL CLAIM ☐ AMENDED CLAIM ☐ SECOND INJURY FUND ONLY

Please read instructions before completing this form.

ITEM NUMBER(S) AMENDED

EMPLOYEE INFORMATION

1. INJURED EMPLOYEE'S NAME LAST / FIRST / INITIAL OR MIDDLE NAME			1A. MAILING ADDRESS (ALSO INCLUDE STREET ADDRESS)	
1B. CITY	1C. STATE	1D. ZIP CODE	2. SOCIAL SECURITY NO.	3. DATE OF ACCIDENT OR OCCUPATIONAL DISEASE
4. AVERAGE WEEKLY WAGE	5. TIME OF ACCIDENT ☐ A.M. ____ ☐ P.M. ____		6. PLACE OF ACCIDENT *(City, County, State, Zip)*	
7. PART(S) OF BODY INJURED				
8. DESCRIBE WHAT THE EMPLOYEE WAS DOING AND HOW THE INJURY OCCURRED.				

EMPLOYER INFORMATION – If additional employers need to be listed or if you need more space, attach additional sheets.

9. EMPLOYER(S) AGAINST WHOM THIS CLAIM IS FILED. THIS IS THE EMPLOYER IN WHOSE EMPLOYMENT THE INJURY OR OCCUPATIONAL DISEASE OCCURRED. FOR SECOND JOB WAGE LOSS BENEFITS LIST EMPLOYER SEPARATELY IN BOX 10.			
EMPLOYER A:	MAILING ADDRESS		
CITY		STATE	ZIP CODE
EMPLOYER B:	MAILING ADDRESS		
CITY		STATE	ZIP CODE
EMPLOYER C:	MAILING ADDRESS		
CITY		STATE	ZIP CODE

10. ADDITIONAL STATEMENTS	**DIVISION USE ONLY**
	DATE STAMP

BE SURE TO COMPLETE NEXT PAGE.

SECOND INJURY FUND CLAIM: IF YOU ARE NOT FILING A CLAIM AGAINST THE SECOND INJURY FUND, PLEASE PROCEED TO BOX 13.

11. ONLY CHECK APPROPRIATE BOX(ES) IF YOU ARE FILING A CLAIM AGAINST THE SECOND INJURY FUND FOR ANY OF THE FOLLOWING:

☐ PERMANENT PARTIAL DISABILITY ☐ UNINSURED EMPLOYER – MEDICAL AID/DEATH BENEFITS

☐ PERMANENT TOTAL DISABILITY ☐ SECOND JOB WAGE LOSS

11A. IF YOU ARE FILING A CLAIM AGAINST THE SECOND INJURY FUND BASED UPON A PRE-EXISTING DISABILITY, YOU NEED TO PROVIDE THE FOLLOWING INFORMATION, IF AVAIILABLE:

DATE OF PREVIOUS INJURY/DISEASE	PART(S) OF BODY AFFECTED BY PREVIOUS INJURY/DISEASE

SECOND JOB WAGE LOSS:

12. IF YOU ARE FILING A CLAIM AGAINST THE SECOND INJURY FUND FOR SECOND JOB WAGE LOSS, PLEASE PROVIDE THE EMPLOYER NAME, MAILING ADDRESS, CITY, STATE, ZIP CODE, AND COUNTY FOR SECOND JOB WAGE LOSS IN BOX 10.

13. DID INJURY RESULT IN DEATH? ☐ YES ☐ NO 13A. DATE OF DEATH ___/___/___

IF DEATH OCCURRED, **EMPLOYEE'S DEPENDENTS (SPOUSE, MINOR CHILDREN, OTHER PERSONS DEPENDENT ON EMPLOYEE).**

IF YOU NEED TO LIST DEPENDENTS IN ADDITION TO THESE LISTED BELOW, PLEASE ATTACH A SEPARATE SHEET.

14. NAME	DATE OF BIRTH	RELATIONSHIP	
MAILING ADDRESS	CITY	STATE	ZIP CODE
14A. NAME	DATE OF BIRTH	RELATIONSHIP	
MAILING ADDRESS	CITY	STATE	ZIP CODE
14B. NAME	DATE OF BIRTH	RELATIONSHIP	
MAILING ADDRESS	CITY	STATE	ZIP CODE

CLAIM IS HEREBY MADE FOR ALL COMPENSATION AS PROVIDED IN THE MISSOURI WORKERS' COMPENSATION LAW, RELATING TO INJURY (OR DEATH) OF THE EMPLOYEE BY ACCIDENT ARISING OUT OF AND IN THE COURSE OF THE EMPLOYMENT.

15. INJURED EMPLOYEE OR CLAIMANT'S SIGNATURE	16. EMPLOYEE/CLAIMANT TELEPHONE NO.	17. DATE
18. ATTORNEY SIGNATURE	18A. ATTORNEY NAME *(type or print)*	18B. BAR NUMBER
19. ATTORNEY PHONE NUMBER	19A. ATTORNEY FAX NUMBER	19B. ATTORNEY E-MAIL ADDRESS *(optional)*
20. ATTORNEY MAILING ADDRESS	20A. CITY	20B. STATE / 20C. ZIP CODE

LINES 15 & 18 MUST BE SIGNED IN BLACK INK – NOT TYPED.