State of Connecticut
Workers' Compensation Commission

Rev. 3-17-2006

HR

Please TYPE or PRINT IN INK
and SEND A COPY OF THIS REQUEST
TO ANY OTHER INTERESTED PARTY(IES)

WCC File #

Date filed in District

(for WCC use only)

Hearing Request

I hereby notify the Workers' Compensation Commission of my request for the following hearing:

☐ Informal ☐ Pre-Formal ☐ Formal ☐ Stip Approval

☐ Disfigurement / Scar — Surgery Date(s): _____

For injuries occurring ON OR AFTER July 1, 1993, disfigurement/scar benefits are available ONLY for disfigurements or scars on the face, head, neck, or any other area of the body that handicaps the employee from obtaining or continuing to work. [See Sec. 31-308(c)]

Reason(s) for the requested hearing *(required)*:

INJURED WORKER

Name _____

Soc. Sec.# *(optional)* _____

D.O.B. _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

EMPLOYER

Name _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

INSURANCE

Policy Insurer Name _____

Policy No. _____ Eff. Date _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

Administrator Name _____

Contact Person _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

Attorney for Insurance Carrier _____

Name of Firm _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

INJURY

Date of Injury _____

City/Town of Injury _____

State _____ Zip Code _____

Body Part _____

ATTORNEY OR REPRESENTATIVE OF INJURED WORKER

Name _____

Name of Firm _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

ADDITIONAL INTERESTED PARTIES FOR NOTIFICATION — List:

SIGNATURE OF REQUESTING PARTY

As the party requesting the hearing, **I CONFIRM THAT I HAVE TRIED TO RESOLVE THE ABOVE ISSUES BY TELEPHONE OR WRITTEN COMMUNICATION WITH THE OTHER PARTY**. I understand that it is improper to request a hearing without first trying to resolve the issues with the other party.

I am the *(check ONE)*:

☐ injured worker or representative

☐ insurance company or representative

☐ additional interested party *(please specify)*:

_____

Signature _____ Date _____