FORM 3E

Send original to
Court of Existing Claims and 1 copy to
Opposing Party/Counsel

COURT OF EXISTING CLAIMS
1915 NORTH STILES, STE 127
OKLAHOMA CITY, OK 73105-4918

THIS SPACE FOR COURT USE ONLY

Please check appropriate box

☐ I. Original Filing

☐ II. Amends Previously Filed Form 3E (Must clearly state whether amendment is in addition to, or substitute for, prior information.)

Name of Claimant (Injured employee)
Name of Employer
Employer's Insurance Carrier, Permit # for Court Approved Individual Self-Insured or Own Risk Group, Uninsured

NOTE: Mediation is available to address certain workers' compensation disputes. For information, call (918) 581-2714.

EMPLOYEE'S CLAIM FOR BENEFITS FOR COMBINED DISABILITIES AGAINST THE LAST EMPLOYER

WCC FILE NO.

(Please type or print)

EMPLOYEE NAME (Last, First, Middle)	Social Security #	Phone: ( )
Mailing Address (include City, State & Zip)	Date of Birth Age:	Sex:
Court File Number for most recent injury / Date of Injury / Date of Order	Percentage of Disability Awarded and Body Part	
Amount of Joint Petition or Other Settlement	Rate of weekly compensation for permanent partial disability at the time of the most recent injury	

PRIOR	Court File No.	Date of Injury	Date of Order	% of Disability & body Part	Amount of JP or Other Settlement

Are weekly benefits still being paid on any of the above orders? _____ YES _____ NO If so, when are benefits expected to terminate? _____

List and describe fully any other pre-existing disability for which no award has been made. (Pre-existing disability means any obvious and apparent disability resulting from any cause, which disability is obvious and apparent from observation of a person who is not skilled in the medical profession.)

_____

_____

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete.

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

I hereby certify that a true and correct copy of this claim was mailed to the above named employer or its counsel on the _____day of _____,_____.

Name of claimant's attorney if represented:

Type or Print Name of Attorney:	OBA #
Mailing Address:	
City / State / Zip	
Telephone #: ( )	

Upon filing this Claim For Benefits for Combined Disabilities Against the Last Employer, permission is given to the Administrator of the Court of Existing Claims, the Insurance Commissioner, the Attorney General, a district attorney or their designees to examine all records relating to the claim. The permission granted to the above named individuals or their designees authorizes them access to medical records pursuant to Section 19 of Title 76 of the Oklahoma Statutes, including waiver of any privilege granted by law concerning communications made to a physician or health care provider or knowledge obtained by such physician or health care provider by personal examination.

Signed this _____ day of_____, _____

Signature of Attorney for Claimant

Signature of Claimant (must be signed by claimant)

Rev. 06/24/2015