FORM 3F

Send original to
Court of Existing Claims and 1 copy to
Multiple Injury Trust Fund

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 3F (Must clearly state whether amendment is in addition to, or substitute for, prior information.)

Name of Claimant (injured employee)

MULTIPLE INJURY TRUST FUND
P.O. Box 528801
Oklahoma City, OK 73152

EMPLOYEE'S NOTICE OF CLAIM FOR BENEFITS FROM THE MULTIPLE INJURY TRUST FUND

WCC FILE NO.

(Please type or print)

EMPLOYEE NAME (Last, First, Middle)	Social Security # (LAST 4 DIGITS ONLY) XXX-XX-_____	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 Compromise Settlement or Other Settlement	Rate of weekly compensation for permanent partial disability/permanent partial impairment at the time of the most recent injury	

PRIOR	Court File No.	Date of Injury	Date of Order	% of Disability & Body Part	Amount of Compromise Settlement 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.) _____

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

Name of claimant's attorney if represented:

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

Upon filing this *Employee's Notice of Claim for Benefits from the Multiple Injury Trust Fund*, 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, any matter contained in the claim, and any matter relating to the claim. The permission granted to the above named persons authorizes them access to medical records pursuant to 76 O.S., §19, 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.

I declare under penalty of perjury that I have examined this *Notice of Claim for Benefits from the Multiple Injury Trust Fund* and all statements contained herein are true, correct and complete, to the best of my knowledge. I certify a true and correct copy of this *Notice of Claim* was mailed to the MULTIPLE INJURY TRUST FUND on the date noted below.

Signed this _____day of_____,_____

_____
Signature of Attorney for Claimant

_____
Signature of Claimant (must be signed by claimant)

Rev. 06/24/2015