



DIA Board #
(If Known):

EMPLOYEE'S CLAIM

FOR USE BY EMPLOYEES OR DEPENDENTS CLAIMING BENEFITS AS A RESULT OF INJURY OR DEATH.
ALL OTHER CLAIMANTS SHOULD USE FORM 115

IMPORTANT - INSTRUCTIONS AND CODES ON THE REVERSE SIDE - Please Print Legibly or Type - Unreadable forms will be returned.

E M P L O Y E E	1. Employee's Name (Last, First, MI):		2. Social Security Number*:		3. Home Telephone No.:		4. Date of Birth:		5. # of Dependents:		
	6. Home Address (No., Street, City, State & Zip Code):					7. Employee's E-mail address (if available):			7a. Employee's Native Language Code:		
	8. Name, Address and BBO# of Employee's Attorney (if no attorney leave blank)**:										
	9. Attorney's E-mail address (Required):						9a. Attorney's Telephone No.:				
E M P L O Y E R	10. Employer's Name & Address (No., Street, City, State & Zip Code):						10a. Industry Code (See Reverse Side):				
	11. Workers' Compensation Insurance Carrier's Address and Tel. No. (NOT LOCAL AGENT/ADMINISTRATOR - See Instructions on reverse side):										
I N J U R Y	12. DATE OF INJURY (mm/dd/yyyy):					12a. Insurer's Case/Claim #:					
	13. FIRST day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):					14. FIFTH day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):					
	15. If Employee has Died, Date of Death (mm/dd/yyyy):					16. Describe Injury (Lower Back..., leg..., arm... etc.):					
	17. Briefly Describe How Injury/Exposure Occurred and Body Part(s) involved:						17a. Injury Code(s) Body Part Code(s)				
I N F O R M A T I O N	18. Name(s) of Witness(es):						a. _____ to body part a.				
							b. _____ to body part b.				
							c. _____ to body part c.				
	19. Employee's Regular Occupation:		20. Average Weekly Wage: <input type="checkbox"/> Actual				21. Has Employee Returned to Work?:				
		\$ _____ <input type="checkbox"/> Estimated				<input type="checkbox"/> Yes <input type="checkbox"/> No					
22. Has the Insurer Made Any Payments On Your Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes - Indicate Type of Benefits and Amounts (Medical Bills, Wages, etc.):											
_____ in the amount of \$ _____											
B E N E F I T S C L A I M E D	23. Section(s) of Law Claimed. Check all appropriate boxes below and attach documentation as required by M.G.L. c 152, § 7G, §10(1) and 452 CMR 1.07.										
	a. Sec. 34 <input type="checkbox"/> Total, Temporary Incapacity Comp. from (date): from _____ to _____ and _____										
	b. Sec. 35 <input type="checkbox"/> Partial Incapacity Comp. from (date): from _____ to _____ and _____										
	c. Sec. 36 <input type="checkbox"/> Specific Comp. in the Amount of \$ _____										
	d. Sec. 31 <input type="checkbox"/> Survivor's Benefits e. Sec. 33 <input type="checkbox"/> Burial Expenses f. Secs. 13 & 30 <input type="checkbox"/> Medical Expenses g. <input type="checkbox"/> Other (Specify Sec): _____										
	24. Name and Address of Facility Where Employee was First Treated:						25. Name of Treating Physician:				
	26. Employee's/Claimant's Signature:						27. Date (mm/dd/yyyy):				
28. Attorney's Signature (if applicable):						29. Date (mm/dd/yyyy):					

EMPLOYEE'S CLAIM FILING INSTRUCTIONS

1. **WHEN TO FILE:** File this form if you have been injured on the job and your employer's workers' compensation insurer (the insurer) has **denied your initial claim** and/or is disputing any part of your claim and refuses to pay the compensation that you believe you are entitled. **Please fill out the form completely and accurately.** The Department of Industrial Accidents (DIA) is the agency that handles all disputed workers' compensation claims. **You do not need to be represented by an attorney in order to file a Form 110.** You may represent yourself in your claim. The term that applies to self representation is **PRO SE**. Initiating a claim **PRO SE** does not prevent you from getting an attorney later. **If you need assistance, please call 1-800-323-3249 ext. 470.**
2. **WHERE TO FILE:** The original form must be mailed to the DIA at the address shown on the front of the form. A copy must also be provided to the employer as well as the insurer. We recommend that the employee keep a third copy for their own records. When an employee is represented by counsel, this form must be sent via certified mail to the insurer. **Please be advised** - claims for compensation **must** be accompanied by proper documentation in accordance with M.G.L. c. 152, §7G & 452 CMR 1.07.
3. **EMPLOYER'S REQUIREMENTS:** The law requires that all employers in Massachusetts carry a valid workers' compensation insurance policy at all times for all of their employees in the event of an industrial injury. Also, the employer must provide the name and address of the workers' compensation insurer upon request of an employee. **If the employer refuses to provide this information or does not carry workers' compensation insurance, notify the DIA immediately.**
4. **EMPLOYEE'S SIGNATURE & DATE IN BOXES 26 & 27:** This form may be filed by the Employee or the Employee's Attorney (if applicable). However, in all cases the Employee must sign and date this form.

NATIVE LANGUAGE CODES
1 – English / 2 – Portuguese / 3 – Haitian Creole / 04 – Spanish / 5 – Chinese / 6 – Vietnamese / 7 Cape Verdean / 9 – Other

INDUSTRY CODES			
<u>Agriculture, Forestry and Fishing</u> 01 Agriculture Production - Crops 02 Agriculture Production - Livestock 07 Agricultural Services 08 Forestry 09 Fishing, Hunting and Trapping <u>Mining</u> 10 Metal Mining 12 Coal Mining 13 Oil and Natural Gas 14 Nonmetallic Minerals, Except Fuels <u>Construction</u> 15 General Building Contractors 16 Heavy Construction, Ex. Building 17 Special Trade Contractors <u>Manufacturing</u> 20 Food and Kindred Products 21 Tobacco Products 22 Textile Mill Products 23 Apparel and Other Textile Products 24 Lumber and Wood Products 25 Furniture and Fixtures 26 Paper and Allied Products 27 Printing and Publishing	28 Chemicals and Allied Products 29 Petroleum and Coal Products 30 Rubber and Misc. Plastic Products 31 Leather and Leather Products 32 Stone, Clay and Glass Products 33 Primary Metal Industries 34 Fabricated Metal Products 35 Industrial Machinery and Equipment 36 Electronic and Other Electrical Equipment 37 Transportation Equipment 38 Instruments and Related Products 39 Miscellaneous Manufacturing Industries <u>Transportation and Public Utilities</u> 40 Railroad Transportation 41 Local and Interurban Passenger Transit 42 Trucking and Warehousing 43 U.S. Postal Service 44 Water Transportation 45 Transportation by Air 46 Pipelines, Except Natural Gas 47 Transportation Services 48 Communications 49 Electric, Gas and Sanitary Services <u>Wholesale Trade</u> 50 Wholesale Trade - Durable Goods	51 Wholesale Trade - Non-durable Goods <u>Retail Trade</u> 52 Building Materials and Garden Supplies 53 General Merchandizing 54 Food Stores 55 Automotive Dealers and Service Stations 56 Apparel and Accessory Stores 57 Furniture and Home Furnishing Stores 58 Eating and Drinking Establishments 59 Miscellaneous Retail <u>Finance, Insurance and Real Estate</u> 60 Depository Institutions 61 Non-depository Institutions 62 Security and Commodity Brokers 63 Insurance Carriers 64 Insurance Agents, Brokers and Service 65 Real Estate 67 Holding and Other Investment Officers <u>Services</u> 70 Hotels and Other Lodging Places 72 Personal Services 73 Business Services 75 Auto Repair Services and Parking 76 Miscellaneous Repair Services	78 Motion Pictures 79 Amusements and Recreation Services 80 Health Services 81 Legal Services 82 Educational Services 83 Social Services 84 Museums, Botanical, Zoological Gardens 86 Membership Organizations 87 Engineering and Management Services 88 Private Households 89 Services, NEC <u>Public Administration</u> 91 Executive, Legislative and Garden 92 Justice, Public Order, and Safety 93 Finance, Taxation, and Monetary Benefits 94 Administration of Human Services 95 Environmental Quality and Housing 96 Administration of Economic Program 97 National Security and International Affairs <u>Non-classifiable Establishments</u> 99 Non-classifiable Establishments

NATURE OF INJURY OR ILLNESS CODES			
100 Amputation or Enucleation 110 Asphyxia or Strangulation Etc. 120 Burns (Heat) 130 Burns (Chemical) 140 Concussion 160 Contusion, Crushing, Bruise 170 Cut, Laceration, Puncture 190 Dislocation 200 Electric Shock, Electrocutation 210 Fracture 250 Hernia, Rupture 300 Scratches, Abrasions 310 Sprains, Strains 400 Multiple Injuries 900 No Injury 950 Damage to Prosthetic Devices 995 No Other Injury, NEC** 999 Non-classifiable <u>Infective or Parasitic Disease</u> 150 Infective or Parasitic Disease, UNS* 151 Amebiasis 152 Anthrax 153 Brucellosis 154 Conjunctivitis and Ophthalmia 156 Tetanus	157 Tuberculosis 159 Other Infective or Parasitic Diseases <u>Dermatitis</u> 180 Dermatitis, UNS* 183 Primary Infections of the Skin 184 Other Skin Conditions 185 Dermatitis, Allergenic or Contact 189 Skin Condition, NEC** <u>Poisoning Systemic</u> 270 Poisoning, Systemic, UNS* 271 Due to Toxic Materials other than Lead 272 Diseases of the Blood and Blood Forming Organs 273 Upper Respiratory Conditions 274 Influenza, Pneumonia, Etc. 276 Other Diseases of the Gastro-Intestinal Tract 278 Effects of Lead 279 Other Toxic Effects of One System Only <u>Respiratory Systems, Conditions of</u> 570 Respiratory Systems, Conditions of 571 Upper Respiratory 572 Asthma, Influenza, Pneumonia <u>Pneumoconiosis</u> 280 Pneumoconiosis	281 Aluminosis 282 Anthracosis 283 Asbestosis 284 Byssinosis 285 Siderosis 286 Silicosis 287 Other Pneumoconioses 289 Pneumoconiosis and Tuberculosis <u>Nervous System, Conditions of</u> 560 Nervous System, Conditions of - NEC** 561 Diseases of the Central Nervous System 562 Diseases of the Nerves and Peripheral Ganglia <u>Neoplasm Tumor</u> 550 Neoplasm Tumor, UNS* 551 Malignant 552 Benign <u>Radiation Effects</u> 290 Radiation Effects, UNS* 291 Non-Ionizing Radiation 292 Microwaves 293 Ionizing Radiation - X-Ray 294 Ionizing Radiation - Isotopes 295 Welder's Flash	<u>Other</u> 265 Carpal Tunnel Syndrome 510 Cardiovascular and Other Conditions of the Circulatory System 520 Complications Peculiar to Medical Care 500 Effects of Changes in Atmospheric Pressure 240 Effects of Environmental Heat 220 Effects of Exposure to Low Temperature 530 Eye, other Diseases of the Eye 230 Hearing Loss or Impairment 991 Heart Condition ,Excludes Heart Attack 320 Hemorrhoids 330 Hepatitis, Serum and Infective 275 Hepatitis, Toxic 260 Inflammation of Joints, Etc. 540 Mental Disorders 900 No Illness 999 Non-classifiable 990 Occupational Disease, NEC** 580 Symptoms and Ill-defined Conditions

BODY PART AFFECTED CODES			
<u>Head</u> 100 Head, UNS* 110 Brain 120 Ear(s), UNS* 121 Ear(s), External 124 Ear(s), Internal 130 Eye(s), UNS* 140 Face, UNS* 141 Jaw, Chin 144 Mouth and Throat (vocal chords, larynx) 146 Nose 148 Face, Multiple Parts 149 Face, NEC** 150 Scalp	160 Skull 198 Head Multiple 200 Neck & Cervical Vertebrae <u>UPPER EXTREMITIES</u> 300 Upper Extremities, NEC** 310 Arm(s), UNS* 311 Upper Arm 313 Elbow(s) 315 Forearm(s) 318 Arm(s), Multiple 319 Arm(s), NEC** 320 Wrist(s) 330 Hand(s), Not Wrists or Fingers 340 Finger(s)	398 Upper Extremities, Multiple 400 Trunk, UNS* 410 Abdomen, Internal Organs, Inguinal Hernia 420 Back 430 Chest, Ribs, Breastbone, Internal Organs 440 Hip(s)...Pelvis, Organs and Buttocks 450 Shoulder(s) 498 Trunk, Multiple <u>LOWER EXTREMITIES</u> 500 Lower Extremities 510 Leg(s), UNS*	513 Knee(s) 515 Lower Leg(s) 518 Leg(s), Multiple 519 Leg(s), NEC** 520 Ankle(s) 530 Foot or Feet, Not Ankle 540 Toe(s) 598 Lower Extremities, Multiple 700 MULTIPLE PARTS Applies when more than one major body part as been effected such as an arm and a leg 999 NON-CLASSIFIABLE - Insufficient information to identify part of body effected. Includes damage to prosthetic devices.

*UNS - UNSPECIFIED

**NEC - NOT ELSEWHERE CLASSIFIED