Washington State Department of Labor & Industries

Pension Review Coversheet

Claim Number: _____ Worker's Name: _____

Request submitted by:_____ Phone Number: _____Ext.____

Claim File Documentation

I have: (pick one option)

- ☐ Attached a copy of the complete claim file
- ☐ Attached a copy of all claim file information not previously submitted to the department.
- ☐ Already submitted a complete copy of the claim file. There is no additional claim file information to submit to the department.

Vocational Documentation

I confirm that: (pick one option)

- ☐ I have attached a copy of the complete vocational work-up (Self-Insurance Vocational Reporting Form (SIVRF)), including all existing vocational documentation for this claimant.
- ☐ I already submitted a copy of the complete vocational work-up (SIVRF), including all existing vocational documentation for this claimant to the department on the following date:_____.

I confirm I have reviewed the vocational summary and that: (pick one option)

- ☐ I have attached a copy of every document mentioned or discussed in the vocational summary narrative.
- ☐ I already submitted a copy of every document mentioned or discussed in the vocational summary narrative to the department on the following date:_____.

Time-Loss and LEP

I confirm that I have:

- ☐ Attached a Claim Closure (CCR) form.
- ☐ Included a payment ledger that shows all compensation periods paid, with an explanation for any unpaid periods.
- ☐ For all open claims without a wage order: attach a SIF5-A and required documentation.
- ☐ Listed date(s) health care benefits ended.

Medical – date contribution ended	
Dental – date contribution ended	
Vision – date contribution ended	

Medical

I have listed all **accepted and/or treated conditions** (including psych conditions) below:

(Space is limited, attach additional page if needed.)

☐ Yes, I have attached medical documentation to this coversheet which confirms that each of the above listed accepted condition(s) is fixed and stable or at maximum medical improvement.

Post Pension Medical Treatment (Pick one option)

☐ Claimant does **not** need ongoing medical monitoring/treatment for an accepted condition.

☐ Claimant does need ongoing medical monitoring/treatment for an accepted condition (life sustaining treatment needs and/or treatment required to alleviate chronic pain from the industrial injury). If so, complete information below in detail.

List all ongoing Medical Monitoring/Treatment (i.e. a complete list of the necessary prescriptions + frequency needed for medical monitoring. (Space is limited, attach additional page if needed.)

Second Injury Fund Relief (Pick one option)

☐ I am **not** requesting second injury fund relief be granted.

☐ I am requesting second injury fund relief be granted. Complete **all** information below in detail, failure to provide this information will lead to a review for pension without second injury fund relief.
Note: The department will not consider this information, unless it first determines the worker is entitled to a pension.

List all pre-existing conditions & any formal or informal accommodations given. (Space is limited, attach additional page if needed.)

Both boxes below are required if requesting second injury fund relief.

☐ Yes, I certify I have attached **all medical reports or other documentation** to this coversheet which documents pre-existing disabling conditions.

☐ Yes, I further confirm I have attached medical reports to this coversheet which document a permanent partial disability (PPD) rating for ALL of the accepted conditions (including psych).

If you have any questions and don't know the pension adjudicator's name and contact information, call the receptionist at 360-902-6901.