Washington State Department of Labor & Industries

Request for Discretionary Over 7/10 Disability Benefits

Claims Administration
PO Box 44291
Olympia WA 98504-4291

Dear Worker,

We've received your request for discretionary benefits on your claim. When an Over 7/10 claim is reopened, the worker has a statutory entitlement to proper and necessary medical treatment. However, there is no automatic statutory entitlement to disability benefits.

Only the Director of Labor and Industries has the authority to grant additional disability benefits for those claims that have been closed over 7 years from the first claim (10 years for eye injuries from the first claim closure). Disability benefits include:

- Temporary total disability (time-loss compensation),
- Loss of earning power,
- Vocational services,
- Permanent partial disability, and
- Total permanent disability (pension).

The Director's discretion is reserved for compelling circumstances in which the worker has incurred a significant loss as a result of the industrial injury/occupational disease.

Please complete the enclosed application. A decision on your entitlement to discretionary benefits may be delayed and/or benefits denied if this form is not filled out completely and/or supporting documentation is not attached. Please retain a copy of this application for your records.

Worker's Name	Claim Number

Section 1

Explain your circumstances and why you are requesting discretionary benefits.

Instructions for Sections 2 — 4
Answer all of the questions completely. You will be required to submit documentation to verify the information you provide. Please provide the specific, detailed information requested so that we are able to validate this information.

Failure to provide sufficient details such as dates, names, and addresses, may result in delayed processing and/or denial of your request. The information you provide may result in additional questions.

Section 2 — Workforce Attachment

Are you ***currently*** working?
☐ Yes ☐ No
If yes — list your *current* employer in Section 3.
If no — complete the following:

Last date worked: _____

Explain the reasons you are not working. Check all that apply after your last date worked and provide details for each response — include dates, names, and addresses.

☐ **Retired — Attach a copy of your retirement documents**
Date applied for retirement: _____ Effective date of retirement: _____

Employer: _____
Retirement System/Administrator: _____
Type of Retirement (early medical, full regular): _____
Reason/Basis for Retirement: _____
_____
Additional Information: _____

Worker's Name	Claim Number

☐ **Quit**

Effective Date: _____

Employer: _____

Reason: _____

Additional Information: _____

☐ **Self-Employment Ended**

Effective Date: _____

Name of Business: _____

Business UBI Number: _____

Did the business close? ☐ Yes ☐ No If yes, as of what date? _____

Reason: _____

Additional Information: _____

☐ **Laid Off or Terminated**

Effective Date: _____

Employer: _____

Reason: _____

Additional Information: _____

☐ **Received or Receiving Unemployment Compensation (UEC) — Attach a copy of documentation from the Employment Security Department showing the benefits you've received.**

Date Applied: _____

If *granted*, benefit period paid beginning _____ through _____

Were benefits exhausted? ☐ Yes ☐ No

If no, why did benefits end? _____

If *denied*, provide the determination date: _____

Reason for Denial: _____

Additional Information: _____

Worker's Name	Claim Number

☐ **Seeking Work — Attach copies of any documentation you have to support your job seeking efforts such as resume, job announcements, job applications, acknowledgement letters, interview appointment notices, emails and responses from potential employers.**

Time frames you have been seeking work: _____ through _____

Employer Contact List (attach additional pages if needed):

Additional Information: _____

☐ **Physically Unable to Work Due To Medical Condition**

Medical Condition: _____ Date of Onset: _____

What was the cause of this condition? (New injury on or off the job, effects of aging, etc.)

Did you seek medical treatment? ☐ Yes ☐ No

If yes, provide the names and addresses of medical providers and treatment facilities:

List treatment dates: _____

Briefly describe the treatment received:

Treatment was paid for by: (self, DSHS, private insurance, bill pending)

Additional Information: _____

Worker's Name	Claim Number

☐ **Received or Receiving Social Security Benefits — Attach a copy of your application, award letter, and any appeal records. Complete, sign, and return the attached release form.**

Type of Social Security Benefit: _____

Date applied: _____ Date of SSA's Determination: _____

Basis of Award: _____

_____

Additional Information: _____

☐ **Received or Receiving Any Benefits from the Department of Social and Health Services or the Department of Commerce — Attach a copy of documentation showing the benefits you received. Complete, sign, and return the attached release form.**

What type of benefit did you receive from these programs: _____

Date applied: _____ Date received: _____

Which state did you receive these benefits from: _____

Additional Information: _____

☐ **Received or Receiving Benefits from Another State or Jurisdiction such as motor vehicle accident, workers' compensation, Veterans' Administration — Attach a copy of documentation form the agency from which you are receiving benefits. You will be required to sign release forms.**

Claim Number: _____ Jurisdiction: _____

Type of Benefit: _____

Benefits paid from: _____ through _____

Are you currently receiving benefits? ☐ Yes ☐ No

Additional Information: _____

☐ **Incarcerated**

Dates held from: _____ through _____

Name of jail or penitentiary: _____

Additional Information: _____

☐ **Other:**

Dates: _____

Explanation: _____

_____

_____

_____

_____

Worker's Name	Claim Number

If you are not working, how have you been supporting yourself? (Such as Spouse works, sold assets, borrowed from friend/family).

Additional Information:

Section 3 — Employment History

List your last four employers starting with current or last employer.

Employer Name:	Date Employed (From/To):
Employer Address	
City:	State: Zip Code:
Employer Phone Number:	Your Job Title:
Reason for Leaving:	

Employer Name:	Date Employed (From/To):
Employer Address	
City:	State: Zip Code:
Employer Phone Number:	Your Job Title:
Reason for Leaving:	

Worker's Name	Claim Number

Employer Name:	Date Employed (From/To):
Employer Address	
City:	State: Zip Code:
Employer Phone Number:	Your Job Title:
Reason for Leaving:	

Employer Name:	Date Employed (From/To):
Employer Address	
City:	State: Zip Code:
Employer Phone Number:	Your Job Title:
Reason for Leaving:	

Section 4 — Temporary Total Disability/Loss of Earning Power

Specify the period you are contending temporary total disability benefits (time loss) due to your industrial injury/disease.

Beginning Date: _____ through and including: _____
Date Released for Work: _____ Date Returned to Work: _____

Did the worsening of your industrial condition result in a recommendation for surgery?
☐ Yes ☐ No
If yes, what is/was the date of surgery? _____
Type of Surgery: _____
Are you still receiving treatment?
☐ Yes ☐ No
Additional Information:

Have you been medically certified as unable to work due to your industrial injury/disease?
☐ Yes ☐ No
If yes, beginning date: _____ through and including: _____
List medical provider(s) name(s) and address(es):

Dates of Treatment: _____

Worker's Name	Claim Number

Do you have other conditions which limits or prevent your ability to work?

☐ Yes ☐ No If yes, list the condition(s):

Date of Onset: _____ Dates of Treatment: _____

List medical provider(s) name(s) and address(es):

Are you receiving disability benefits based upon this other condition?

☐ Yes ☐ No

If yes, beginning date: _____ through and including: _____

Claim Number: _____ Jurisdiction: _____

Additional Information:

Persons making false statements in obtaining industrial service benefits are subject to civil and criminal penalties. I declare that these statements are true to the best of my knowledge and belief. In signing this form, I permit doctors, hospitals, clinics, or others with medical information to release my medical records to the Department of Labor and Industries.

Worker's Signature _____ Date _____

RESET