Instructions

OCR 104A

APPLICATION FOR MEDIATION OR HEARING – FORM A

Michigan Department of Labor and Economic Opportunity
Workers' Disability Compensation Agency
P.O. Box 30016, Lansing, MI 48909

Application Type
☐ Initial ☐ Penalty Only
☐ Amended ☐ Voc Rehab Only

THIS FORM TO BE USED BY EMPLOYEES ONLY.
A SEPARATE WC-104A MUST BE FILED FOR EACH EMPLOYER. INCOMPLETE APPLICATIONS SHALL BE RETURNED.

1. NAME OF EMPLOYEE (Last, First, MI)			2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH
4. STREET NUMBER AND NAME			8. TAX FILING STATUS ☐ A. Single ☐ C. Married, Filing Joint ☐ B. Single, Head of Household ☐ D. Married, Filing Separate	
5. CITY	6. STATE	7. ZIP CODE		
			9. DATE OF DEATH (If Applicable)	
10. NAME OF DEPENDENTS			11. RELATIONSHIP TO EMPLOYEE	12. BIRTH DATE
13. NAME OF EMPLOYER			19. DATES OF EMPLOYMENT FROM: TO:	
14. FEDERAL I.D. NUMBER (If Known)			20. EARNINGS $ HOURLY/WEEKLY	
15. STREET ADDRESS			21. CITY OF INJURY	
16. CITY	17. STATE	18. ZIP CODE	22. COUNTY OF INJURY	

23. DATE(S) OF INJURY	DURATION OF DISABLEMENT FROM	DURATION OF DISABLEMENT TO	INSURANCE CARRIER (DO NOT FILL IN)

24. DESCRIBE THE NATURE OF THE DISABILITY AND THE MANNER IN WHICH THE INJURY OR DISABLEMENT OCCURRED, AND SPECIFY THE RELIEF SOUGHT.

25. DID THE EMPLOYEE HAVE ANY OTHER EMPLOYMENT AT THE TIME OF THE INJURY? ☐ YES ☐ NO
IF YES, LIST NAME AND ADDRESS OF THE EMPLOYER AND GROSS WEEKLY WAGE.

HAS A CLAIM BEEN FILED WITH THIS SECOND EMPLOYER? ☐ YES ☐ NO

26. HAS THE EMPLOYEE HAD ANY EMPLOYMENT SINCE THE DATE OF INJURY? ☐ YES ☐ NO
IF YES, LIST THE NAME AND ADDRESS OF THE EMPLOYER.

27. DOES THIS APPLICATION INVOLVE A DISPUTED CLAIM FOR MEDICAL BENEFITS? ☐ YES ☐ NO
IF YES, GIVE APPROXIMATE AMOUNT.

28. DOES THIS APPLICATION INVOLVE A DISPUTED CLAIM FOR WAGE LOSS BENEFITS? ☐ YES ☐ NO
IF YES, HAS THE DISABILITY NOW ENDED? ☐ YES ☐ NO

29. HAS THE EMPLOYEE RETURNED TO WORK? IF YES, DATE OF RETURN ____/____/____ ☐ YES ☐ NO

30. IS THIS A CASE IN WHICH WAGE LOSS BENEFITS WERE PAID VOLUNTARILY AND HAVE BEEN TERMINATED WITHIN THE LAST 60 DAYS? ☐ YES ☐ NO

31. DOES THIS INVOLVE A CLAIM FOR VOCATIONAL REHABILITATION SERVICES? ☐ YES ☐ NO

32. IS A CLAIM BEING MADE AGAINST ONE OF THE FUNDS? ☐ YES ☐ NO

IF YES, PLEASE SPECIFY THE NAME OF THE FUND AND THE SPECIFIC PROVISION OF THE ACT.

33. OTHER BENEFITS

(Please indicate which of the following benefits you are or have received based on employment with this employer during the periods of disability indicated on this application)

A. ☐ OLD AGE SOCIAL SECURITY _____ WEEKLY/MONTHLY

B. ☐ PENSION OR RETIREMENT PLAN _____ WEEKLY/MONTHLY

C. ☐ SICK AND ACCIDENT INSURANCE _____ WEEKLY/MONTHLY

D. ☐ WAGE CONTINUATION PLAN _____ WEEKLY/MONTHLY

E. ☐ UNEMPLOYMENT BENEFITS _____ WEEKLY/MONTHLY

F. ☐ DISABILITY INSURANCE POLICY _____ WEEKLY/MONTHLY

G. ☐ SELF INSURANCE PLAN _____ WEEKLY/MONTHLY

H. ☐ PROFIT SHARING PLAN _____ WEEKLY/MONTHLY

34. LIST THE NAMES AND ADDRESSES OF DOCTORS, HOSPITALS AND OTHER HEALTH CARE PROVIDERS WHO TREATED YOU FOR ANY DATE(S) OF INJURY LISTED IN #24.

NAME	ADDRESS (Street Number and Name)	CITY	STATE	ZIP CODE

35. LIST THE NAMES AND ADDRESSES OF ANY WITNESSES. (Do not list names of witnesses who are currently employed by the named employer)

NAME	ADDRESS (Street Number and Name)	CITY	STATE	ZIP CODE

36. I INTEND TO CALL WITNESSES WHO ARE CURRENTLY EMPLOYED BY THE NAMED EMPLOYER. ☐ Yes ☐ No

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

AUTHORITY: Workers' Disability Compensation Act, 418.222; 418.847; R 408.34
COMPLETION: Voluntary
PENALTY: None

CERTIFICATION AND SIGNATURE

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I ALSO CERTIFY THAT I HAVE, AS OF THIS DATE, MAILED TO MY EMPLOYER OR ITS INSURANCE CARRIER COPIES OF ANY MEDICAL RECORDS RELEVANT TO THIS CLAIM THAT ARE IN MY POSSESSION.

SIGNATURE OF APPLICANT	TELEPHONE NUMBER ( )	DATE

ATTORNEY IDENTIFICATION

NAME OF ATTORNEY	NAME OF LAW FIRM	ATTORNEY I.D. P.	
ADDRESS (Street Number and Name)	CITY	STATE	ZIP CODE
SIGNATURE OF ATTORNEY	TELEPHONE NUMBER ( )	DATE	

Print Reset

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INSTRUCTIONS FOR COMPLETING FORM WC-104A

Michigan Department of Labor and Economic Opportunity
Workers' Disability Compensation Agency
PO Box 30016, Lansing, MI 48909
Toll Free 1-888-396-5041

THIS FORM IS ONLY TO BE FILED BY (OR ON BEHALF OF) THE EMPLOYEE

The completed application must be **mailed** to the Workers' Disability Compensation Agency at the above address. Please send only one copy.

If you require more space than is provided on the form, use a separate sheet of paper to provide the additional information.

APPLICATION TYPE

Initial	This box is to be checked if there are **no** previously filed form 104A's pending.
Amended	This box is to be checked if there **are** previously filed form 104A's pending.
Penalty Only	This box is to be checked if the penalty provision under Section 418.801 is the only issue in dispute. Do not check this box if there is also a question of entitlement to benefits.
VR Only	This box is to be checked if entitlement to vocational rehabilitation services under Section 418.319 is the **only** issue in dispute. Do not check this box if there is a question of entitlement to benefits.

NUMBERS 1-12 – EMPLOYEE INFORMATION

Complete all information regarding the injured employee. The complete social security number must be provided.

NUMBERS 13-18 – EMPLOYER INFORMATION

Complete the name and address of the employer. If the 9-digit Federal Employer Identification Number (FEIN) is known, it should be provided. **A separate WC-104A must be filed for each employer.**

NUMBERS 19-23 – WAGE AND INJURY INFORMATION

Dates of employment should include at least the month and year. Provide wage information (circle either hourly or weekly) as well as the city and county where the injury occurred. List all alleged dates of injury or periods of disablement. Do not complete the insurance carrier information; this will be handled by the agency.

NUMBER 24 – NATURE OF DISABILITY

Describe the type of injury and how it occurred, and specify the relief sought. If this application involves a penalty issue, indicate the period of time for which a penalty is being sought.

NUMBERS 25-32

Answer yes or no and furnish additional information as applicable.

NUMBER 33 – OTHER BENEFITS

The Workers' Disability Compensation Act requires you to disclose any benefits you have or are receiving from the employer during the periods of disability indicated in line 24 of this application. Also circle whether the amount listed is a weekly or monthly amount.

NUMBER 34 – DOCTORS, HOSPITALS, HEALTH CARE PROVIDERS

List the names and addresses of those who provided health care in relation to the injury or disablement.

NUMBERS 35 AND 36 – WITNESSES

Section 222 of the Workers' Disability Compensation Act requires you to list on the application any witnesses to your work injury, however, do not include names of anyone who still works for the employer. Please also indicate whether you intend to call as witnesses any individuals who are currently employed by the employer.

CERTIFICATION AND SIGNATURE

By signing the application you are certifying that all information on the application is true to the best of your knowledge. Also, the Workers' Disability Compensation Act requires that at the time of filing an Application for Mediation or Hearing-Form A, you must provide the employer or its workers' compensation insurance carrier with any medical records relevant to this injury that are in your possession. When sending the medical records to the carrier or employer, they should be identified with your name, the employer's name and address, date of injury and any other relevant information. **Unsigned applications will be returned.**

ATTORNEY IDENTIFICATION

If you are represented by an attorney, all information in this section should be completed.

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