MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

P.O. Box 58
Jefferson City, MO 65102-0058
labor.mo.gov/DWC

INSTRUCTIONS FOR COMPLETING CLAIM FOR COMPENSATION

Completed copies of the Claim forms may be mailed to the Division of Workers' Compensation, P.O. Box 58, Jefferson City, MO 65102-0058. **[Please see No. 5 below.]** You also have the option of filing the Claim form with any of the Division's adjudication offices. A list of the Division's adjudication offices may be obtained from the website: labor.mo.gov/DWC/contact.
Please note that if you decide to file a Claim, the Division must receive the Claim form within the time period explained below:

- Within two years from the date of injury or death, or within two years from the last payment made on account of the injury or death by the employer or its workers' compensation insurance carrier, whichever is later; OR
- If the employer does not timely file a First Report of Injury with the Division, within three years from the date of injury or death or within three years from the last payment made on account of the injury or death by the employer or its workers' compensation insurance carrier, whichever is later.

As indicated in §287.063, RSMo, in cases of occupational disease, the statute of limitation does not begin to run until it becomes reasonably discoverable and apparent that an injury has been sustained related to such exposure.

IMPORTANT CONSIDERATIONS:

1. **Updated Claim form to be used:** The Division's form must be submitted as an original document in the most current version. The updated or current version of the Claim for Compensation form WC-21 may be downloaded from the Division's website labor.mo.gov/pubs-and-forms. You may also request the Division to mail you the Claim forms by calling the toll free number 800-775-2667 or by calling one of the local offices. The Division reserves the right to reject forms that are not currently approved forms and/or do not reflect the division's official seal. The minimum font size that may be used is 10.
2. **Do not alter the form:** Claims that are submitted to the Division on a form that has been altered in any way will not be accepted for processing. Do not submit a claim form without the Division of Workers' Compensation caption appearing at the top of page 1; with the informational boxes shifted to different pages; or with the bottom half cut off any page. If a complete response does not fit within the box provided on the form, complete the response on a separate sheet of paper (noting the box the additional information applies to) and attach the additional sheet(s) to this form.
3. **Legibility:** The Claim form may be downloaded from the Division's website, printed, and completed by handwriting or printing the information in the applicable boxes. If you handwrite or print the information on the Claim form, it must be legible to meet the Division's requirements for the record to be electronically stored. You also have the option of completing the Claim form online, by typing the information needed in each field, printing the form, and mailing it to the Division's Jefferson City office or filing it in one of the adjudication offices.
4. **Amended Claim:** If the Claim, including the Claim that is being filed against the Second Injury Fund, is being amended, the Box containing the amended information must be identified in the Box "ITEM NUMBER(S) AMENDED" in order for the Division to process the amendments to the Claim.
5. **Copies:** If you are mailing the Claim form to the Division at P.O. Box 58, Jefferson City, MO 65102-0058, you need to submit the original and 3 copies of the Claim. If the Claim is being filed against more than 3 employers, please submit additional copies to enable the Division to forward the Claims to all employers named. If the Second Injury Fund is named as a party, please submit an original and 4 copies. You must copy both pages of the Claim form. You should keep one copy for your records.
   If you are filing the Claim form in one of the Division's adjudication offices, please submit the Original Claim form. Additional copies of the Claim form are not required to be provided to the adjudication office.
6. **BOX 1D:** If you know the 9-digit ZIP Code, please provide it in Box 1D.
7. **BOX 4 [Date of Injury (D/I)]:** For repetitive motion and occupational disease claims, the following guidelines will be used:
   If there are multiple dates indicated – Division will use the last date as the D/I.
   - For example, January 1 - March 17, 2001, is on the Claim, the D/I will be March 17, 2001.
   - If 1/24 - 2/15/02 and 3/14 - 6/26/02 is on the Claim, the D/I will be June 26, 2002.
   - 3/24 - Current, the Division will use the date it receives the Claim as the D/I.
   - 10/2000 - the Division will use the last date of the month, i.e. 10/31/00 as the D/I.
8. **BOX 5:** Please provide gross wages earned rather than net wages.
9. **BOX 7:** If you were injured in Missouri, it is very important that Box 7 include the ZIP Code where the accident occurred.
10. **Second Job Wage Loss:** Please include information on second job wage loss in Box 11.
11. **BOX 15:** Fill out the dependent information in Box 15 only if the employee has died.
12. Employee/Claimant must sign Box 16 unless represented by an attorney.

If you have any questions, please contact the Division's toll free number 800-775-2667.

Please visit the Division's website: labor.mo.gov/DWC which contains additional information, including the full text of the applicable Missouri Workers' Compensation Statutes and Regulations, as well as many other forms and brochures.

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
P.O. Box 58
Jefferson City, MO 65102-0058

CLAIM FOR COMPENSATION

INJURY NUMBER

+ ☐☐ - ☐☐☐☐☐☐

NOTE: This form must be completed in its entirety and must be typed or hand printed in **black ink**.

SUBMIT AN ORIGINAL AND THREE COPIES.

☐ ORIGINAL CLAIM ☐ AMENDED CLAIM ☐ SECOND INJURY FUND ONLY

Please read instructions before completing this form.

ITEM NUMBER(S) AMENDED

EMPLOYEE INFORMATION

1. INJURED EMPLOYEE'S NAME LAST / FIRST / INITIAL OR MIDDLE NAME			1A. MAILING ADDRESS (ALSO INCLUDE STREET ADDRESS)	
1B. CITY	1C. STATE	1D. ZIP CODE	2. SOCIAL SECURITY NO. (Last 4 digits) XXX-XX-	3. DATE OF BIRTH
4. DATE OF ACCIDENT OR OCCUPATIONAL DISEASE	5. AVERAGE WEEKLY WAGE	6. TIME OF ACCIDENT ☐ A.M. ☐ P.M.	7. PLACE OF ACCIDENT *(City, County, State, Zip)*	
8. PART(S) OF BODY INJURED				
9. DESCRIBE WHAT THE EMPLOYEE WAS DOING AND HOW THE INJURY OCCURRED.				

EMPLOYER INFORMATION – If additional employers need to be listed or if you need more space, attach additional sheets.

10. EMPLOYER(S) AGAINST WHOM THIS CLAIM IS FILED. THIS IS THE EMPLOYER IN WHOSE EMPLOYMENT THE INJURY OR OCCUPATIONAL DISEASE OCCURRED. FOR SECOND JOB WAGE LOSS BENEFITS LIST EMPLOYER SEPARATELY IN BOX 11.			
EMPLOYER A:	MAILING ADDRESS		
CITY		STATE	ZIP CODE
EMPLOYER B:	MAILING ADDRESS		
CITY		STATE	ZIP CODE
EMPLOYER C:	MAILING ADDRESS		
CITY		STATE	ZIP CODE

11. ADDITIONAL STATEMENTS	**DIVISION USE ONLY**
	DATE STAMP

BE SURE TO COMPLETE NEXT PAGE.

INJURY NUMBER

		-						

SECOND INJURY FUND CLAIM: IF YOU ARE NOT FILING A CLAIM AGAINST THE SECOND INJURY FUND, PLEASE PROCEED TO BOX 14.

12. ONLY CHECK APPROPRIATE BOX(ES) IF YOU ARE FILING A CLAIM AGAINST THE SECOND INJURY FUND FOR ANY OF THE FOLLOWING:

☐ PERMANENT PARTIAL DISABILITY ☐ UNINSURED EMPLOYER – MEDICAL AID/DEATH BENEFITS

☐ PERMANENT TOTAL DISABILITY ☐ SECOND JOB WAGE LOSS

12A. IF YOU ARE FILING A CLAIM AGAINST THE SECOND INJURY FUND BASED UPON A PRE-EXISTING DISABILITY, YOU NEED TO PROVIDE THE FOLLOWING INFORMATION, IF AVAIILABLE:

DATE OF PREVIOUS INJURY/DISEASE	PART(S) OF BODY AFFECTED BY PREVIOUS INJURY/DISEASE

SECOND JOB WAGE LOSS:

13. IF YOU ARE FILING A CLAIM AGAINST THE SECOND INJURY FUND FOR SECOND JOB WAGE LOSS, PLEASE PROVIDE THE EMPLOYER NAME, MAILING ADDRESS, CITY, STATE, ZIP CODE, AND COUNTY FOR SECOND JOB WAGE LOSS IN BOX 11.

14. DID INJURY RESULT IN DEATH? ☐ YES ☐ NO 14A. DATE OF DEATH ___/___/___

IF DEATH OCCURRED, **EMPLOYEE'S DEPENDENTS (SPOUSE, MINOR CHILDREN, OTHER PERSONS DEPENDENT ON EMPLOYEE).**

IF YOU NEED TO LIST DEPENDENTS IN ADDITION TO THESE LISTED BELOW, PLEASE ATTACH A SEPARATE SHEET.

15. NAME	DATE OF BIRTH	RELATIONSHIP	
MAILING ADDRESS	CITY	STATE	ZIP CODE
15A. NAME	DATE OF BIRTH	RELATIONSHIP	
MAILING ADDRESS	CITY	STATE	ZIP CODE
15B. NAME	DATE OF BIRTH	RELATIONSHIP	
MAILING ADDRESS	CITY	STATE	ZIP CODE

CLAIM IS HEREBY MADE FOR ALL COMPENSATION AS PROVIDED IN THE MISSOURI WORKERS' COMPENSATION LAW, RELATING TO INJURY (OR DEATH) OF THE EMPLOYEE BY ACCIDENT ARISING OUT OF AND IN THE COURSE OF THE EMPLOYMENT.

16. INJURED EMPLOYEE OR CLAIMANT'S SIGNATURE	17. EMPLOYEE/CLAIMANT PHONE NO.	18. DATE
19. ATTORNEY SIGNATURE	19A. ATTORNEY NAME *(type or print)*	19B. BAR NUMBER
20. ATTORNEY PHONE NUMBER	20A. ATTORNEY FAX NUMBER	20B. ATTORNEY EMAIL ADDRESS *(optional)*
21. ATTORNEY MAILING ADDRESS	21A. CITY	21B. STATE / 21C. ZIP CODE

LINES 16 & 19 MUST BE SIGNED IN BLACK INK – NOT TYPED.