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

3315 West Truman Blvd.,
P.O. Box 58
Jefferson City, MO 65102-0058
www.labor.mo.gov/DWC

INSTRUCTIONS FOR COMPLETING CLAIM FOR COMPENSATION

This form is to be used for accidents, injuries, or occupational diseases occurring on or after January 1, 2014.

Completed copies of the Claim forms may be mailed to the Division of Workers' Compensation, P.O. Box 58, Jefferson City, MO 65102-0058. **[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: www.labor.mo.gov/DWC/contact.
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 www.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 must be 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 one; 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 "BOX 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, 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, 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, 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, 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:** 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. **BOX 14:** Fill out the dependent information in Box 14 only if the employee has died.
11. Employee/Claimant must sign **BOX 15** unless represented by an attorney.

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

Visit the Division's website: www.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 Division of Workers' Compensation is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. TDD/TTY: 800-735-2966 Relay Missouri: 711

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 should be used to file a Claim for Compensation for accident or injury including occupational diseases and occupational diseases due to toxic exposure that occur on or after January 1, 2014.

This form should 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

Read instructions before completing this form.

BOX 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. Check the appropriate box if you are filing a Claim due to an Occupational Disease due to Toxic Exposure:

- ☐ asbestosis
- ☐ berylliosis
- ☐ coal worker's pneumoconiosis
- ☐ bronchiolitis obliterans
- ☐ silicosis
- ☐ silicotuberculosis
- ☐ manganism
- ☐ acute myelogenous leukemia
- ☐ myelodysplastic syndrome.

☐ Check this box ONLY if you are filing a Claim due to an Occupational Disease due to **toxic exposure resulting in a diagnosis of mesothelioma.**

9. PART(S) OF BODY INJURED

10. 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.

11. EMPLOYER(S) AGAINST WHOM THIS CLAIM IS FILED. THIS IS THE EMPLOYER IN WHOSE EMPLOYMENT THE INJURY OR OCCUPATIONAL DISEASE OR OCCUPATIONAL DISEASE DUE TO TOXIC EXPOSURE OCCURRED.

EMPLOYER A:	MAILING ADDRESS	
CITY	STATE	ZIP CODE
EMPLOYER B:	MAILING ADDRESS	
CITY	STATE	ZIP CODE
EMPLOYER C:	MAILING ADDRESS	
CITY	STATE	ZIP CODE

DIVISION USE ONLY

Date Stamp

BE SURE TO COMPLETE NEXT PAGE.

INJURY NUMBER

		-						

12. ☐ CHECK THIS BOX IF YOU ARE FILING A CLAIM AGAINST THE SECOND INJURY FUND FOR PERMANENT TOTAL DISABILITY BENEFITS

13. DID INJURY RESULT IN DEATH? ☐ YES ☐ NO 13A. DATE OF DEATH ____/_____/_____

IF DEATH OCCURRED, **EMPLOYEE'S DEPENDENTS (SPOUSE, MINOR CHILDREN, OR OTHER PERSONS DEPENDENT ON EMPLOYEE).**
IF YOU NEED TO LIST DEPENDENTS IN ADDITION TO THESE LISTED BELOW, PLEASE ATTACH A SEPARATE SHEET.

14. NAME	DATE OF BIRTH	RELATIONSHIP	
MAILING ADDRESS	CITY	STATE	ZIP CODE
14A. NAME	DATE OF BIRTH	RELATIONSHIP	
MAILING ADDRESS	CITY	STATE	ZIP CODE
14B. NAME	DATE OF BIRTH	RELATIONSHIP	
MAILING ADDRESS	CITY	STATE	ZIP CODE

CLAIM IS HEREBY MADE FOR ALL COMPENSATION AS PROVIDED UNDER THE MISSOURI WORKERS' COMPENSATION LAW, RELATING TO INJURY OR OCCUPATIONAL DISEASE OR OCCUPATIONAL DISEASE DUE TO TOXIC EXPOSURE (OR DEATH) OF THE EMPLOYEE ARISING OUT OF AND IN THE COURSE OF THE EMPLOYMENT.

15. INJURED EMPLOYEE OR CLAIMANT'S SIGNATURE	16. EMPLOYEE/CLAIMANT TELEPHONE NO.	17. DATE

18. ATTORNEY SIGNATURE	18A. ATTORNEY NAME *(type or print)*	18B. BAR NUMBER

19. ATTORNEY PHONE NUMBER	19A. ATTORNEY FAX NUMBER	19B. ATTORNEY E-MAIL ADDRESS

20. ATTORNEY MAILING ADDRESS	20A. CITY	20B. STATE	20C. ZIP CODE

21. ADDITIONAL STATEMENTS –Use this Box to add any further information that will assist you in filing your Claim.

Do not submit Confidential Documents at the time of filing the Claim for Compensation.