South Carolina Workers' Compensation Commission
P.O. Box 1715 ◦ 1612 Main Street
Columbia, South Carolina 29202-1715

WCC File # ______________________________
Carrier File # ______________________________
Carrier Code * ______________________________
Employer FEIN ______________________________

______________________________ ______________________________
Employer's Name Address

______________________________ ______________________________
Insurance Carrier's Name Address

______________________________ ______________________________
Employee's Name Address

Check applicable claims and complete all blanks.

1. The Employee sustained a compensable accidental injury to the ______________________________ on
Part of the Body
______________________ in ____________________ ________________
Date County State

2. That the Second Injury Fund was put on notice of the claim on ________________________
Date

3. That the Carrier concluded the disability claim by (Award) (Agreement) on ________________________
Date

4. That the subsequent injury combined with or was aggravated by the below-named permanent impairment under S.C. code §42-9-40 (d):

a. Listed Impairment - (1) - (33) ____

____

b. (34) (a) ____

c. (34) (b) ____

5. _____ a. That the impairment pre-existed;

_____ b. That the impairment was permanent; and

_____ c. That the impairment is a physical condition.

6. _____ That the prior impairment combined with or was aggravated by the subsequent injury.

7. _____ That the combination/aggravation substantially increased the liability of the Carrier for (disability), (medical) or (both).

8. _____ That the prior impairment was a hindrance of obstacle to employment or re-employment.

9. _____ a. T'hat the Employer has knowledge of the prior impairment;

_____ b. That the impairment was unknown to the Employee and the Employer; or

_____ c. That the Employee concealed the prior impairment from the employer.

10. _____ That the subsequent injury would not have occurred "but for " the prior impairment.

11. That the above claim qualifies for reimbursement under S.C. code §42-9-410 because

____

____

12. Other grounds for claim:

____

____

______________________________ ______________
Signature Date