INSTRUCTIONS FOR ALABAMA STATE BOARD OF ADJUSTMENT CLAIM FOR PERSONAL INJURY OR ON THE JOB INJURY "SUPPLEMENTAL CLAIM"

www.bdadj.alabama.gov

NOTE: Claims must be presented to the Alabama State Board of Adjustment within one year after the date of the injury or within two years for claims for injury resulting in death. Each question must be answered. If all questions are not answered, the claim will not be accepted. Forms must be printed in ink or typed. All supporting documentation must be submitted on 8 ½ x 11 paper front side only.

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Claim forms must be accompanied by all of the required documentation or your claim will be returned requesting further information. Any delays could cause the dismissal of your claim.

- **MAIL COMPLETED FORMS TO**:
  Alabama State Board of Adjustment
  600 Dexter Avenue, Suite E-302
  Montgomery, AL 36104
- **FORMS MAY BE DELIVERED TO:**
  Alabama State Board of Adjustment
  State Capitol Building, Suite E-302
  Montgomery, Alabama
- Telephone Numbers: (334) 242-7175 Fax: (334) 242-2008

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1. Claim Number from the original claim must be included. If not included, Supplemental Claim will be returned.

2. Enter the name of the State Agency you are filing your claim against. (Example: Department of Transportation, Department of Education, etc.)

3. Enter your personal information. Enter your Name, Address, Telephone Number(s), Email Address, the last four digits of your Social Security Number or FEIN if a business. Claims without social security numbers or FEINs cannot be processed and will be returned to the claimant. If injured party is a minor, enter the name and age of the minor and the name and relationship of person with whom minor lives.

4. If you have an attorney, enter your attorney's information. (NOTE: If an attorney is listed, all correspondence will be with the attorney only.)

5. Are you still employed by the employer listed on the original claim? Check "yes" or "no".
   A. If no, enter the date employment ended.

6. Enter the date the original injury occurred.

7. Medical Expenses: Enter all medical expenses claimed in this supplemental filing. Include additional sheets if necessary. List each health care provider, including pharmacy, and the amount charged by each. You must provide evidence (itemized bills) to show what treatment was provided, when it was provided, and the charge, as well as evidence of insurance filing and payments (insurance company summary sheets). Board of Adjustment will not make awards for expenses paid by private insurance. If claimant is not covered by insurance, this should be clearly stated.
   A. Total of Medical Expenses Claimed

8. If you had medical insurance at the time of the injury, name all insurance companies and state how much each paid directly to you for the expenses claimed in this supplemental filing.
   A. Total Payments Made to You from All Insurance Companies

9. Medical Disability: If you are claiming medical disability, you MUST complete this section.

   A. If you are claiming damages for permanent disability, check "Yes"; otherwise, check "No.
   B. If you have claimed compensation for permanent disability from any source, such as Social Security Disability, Works Compensation, etc., check "Yes"; otherwise, check "No".
   C. Enter the amount you are seeking for permanent or total disability.
   D. Describe the permanent disability. Evidence (usually a letter, statement, or report from physician) that claimant has reached maximum medical improvement "MMI" and is left with a disability stated in percentage of physical impairment to the whole body or part of body involved (arm, leg, finger, etc.).

10. Wages: If you are claiming lost wages and/or compensation for leave used, list each separately. Evidence from doctor or other health care provider that claimant was unable to work because of the accident/injury stated, verification from the employer of the time lost from work or the leave deducted and verification from the employer of the claimant's rate of pay at the time of the accident/injury.

    A. Enter the amount of wages you lost due to the injury. Circle whether the amount you have entered is for hours, days or weeks. (Example: $25 for 2 Hours)
    B. Enter the amount of leave used. (Example: 16 Hours for 2 Days)
    C. Enter your rate of pay at the time of your injury. Check the box indicating whether the amount is per hour, day, or week. (Example $12.50 per hour)
    D. Enter the total of wages lost due to the injury.

11. Enter any miscellaneous expenses associated with the personal injury, such as damages to automobile, eyeglasses, mileage, etc. If claiming mileage, use the Mileage Log which is listed on the web site, www.bdadj.alabama.gov, as Alabama State Board of Adjustment Mileage Log.

    A. Provide the total amount of miscellaneous expenses claimed.
    B. If any of the listed expenses covered by insurance, please check "Yes"; otherwise, check "No".
    C. If you answered "Yes" in Item 11.B., list the amount of insurance coverage and your deductible. (For damages to personal property, it will be necessary to provide a copy of your insurance declaration page which indicates your amount of coverage and your deductible.)

12. Enter the GRAND TOTAL amount you are claiming for all items described in Items 7.A., 9.C., 10.D., & 11.A.

13. Sign the claim form in the presence of a Notary Public, print your name and have the notary complete the verification section.

ALABAMA STATE BOARD OF ADJUSTMENT
CLAIM FOR PERSONAL INJURY OR ON THE JOB INJURY
"SUPPLEMENTAL CLAIM"

See Page 1-2 of this form for instructions. Each number on the form corresponds with numbers on instruction sheets. Read all instructions carefully to ensure your claim is not returned for additional supporting documentation. See INSTRUCTIONS for mailing or hand delivering this form to the Board of Adjustment (Page 1).	**DO NOT WRITE IN THIS SPACE. FOR ALABAMA STATE BOARD OF ADJUSTMENT USE ONLY.** Claim No.: _____ Supplement No.:_____

1. Original Claim No.: _____

2. Department or Agency of the State of Alabama against which you are making this claim:

   _____

3. Claimant's Personal Information:

   Name: _____

   Street Address or P.O. Box: _____

   City, State, Zip Code: _____

   E-mail Address: _____

   Home Telephone No.: _____ Office Telephone No.: _____

   Cellular Telephone No.: _____Fax No.: _____

   Claimant's Last Four Digits of Social Security No. or last four digits of Business FEIN:

   XXX-XX-_____ or XX-XXX_____

   If injured party is a minor (under 19 years of age), CLAIM MUST BE SIGNED AND FILED BY PARENT OR GUARDIAN AS CLAIMANT. Give name and age of minor and the name and relationship of person with whom minor lives.
   Name of Minor: _____ Age of Minor: _____

   Name of Person with whom Minor Lives: _____

   Relationship of Person to Minor: _____

4. Claimant's Attorney (NOTE: If an attorney is listed, all correspondence will be with the attorney only.)

   Attorney Name: _____

   Street Address of P.O. Box: _____

   City, State, Zip Code: _____

   E-mail Address: _____

   Office Telephone No.: _____Fax No.: _____

5. Are you still employed by the employer listed on the original claim? ☐ Yes ☐ No

   A. If no, enter the date employment ended: _____

6. Enter the date the original injury occurred: _____

Claimant's Name_____

7. Medical Expenses (List each health care provider, including pharmacy, and the amount charged by each. Include additional sheets if necessary):

Provider	Amount of Expense

A. Total of Medical Expenses Claimed: _____

8. If you had medical insurance at the time of the injury, name all insurance companies and state how much each paid directly to you for the expenses claimed in this supplemental filing:

Name of Insurance Company	Amount Paid To You

A. Total Payments Made To You From All Insurance Companies:_____

9. Medical Disability:

A. Are you claiming damages for permanent disability? ☐ Yes ☐ No

B. Have you claimed compensation for permanent disability for this injury from any other source, such as Social Security Disability, Workers Compensation, etc.? ☐ Yes ☐ No

C. What is the amount you are seeking for permanent or total disability? _____

D. Describe the permanent disability: _____

_____

_____

_____

10. Wages (If you are claiming lost wages and/or compensation for leave used, list each separately):

A. Amount of lost wages: _____ for _____ hours/days/weeks

B. Amount of leave used: _____ for _____ hours/days/weeks

C. Rate of Pay at time of Injury: _____ per ☐ Hour ☐ Day ☐ Week

D. Total Wages Claimed: _____

11. Miscellaneous Expenses (List other expenses you are claiming and the amount for each such as damages to auto, eyeglasses, mileage, etc.) If claiming mileage, use the Mileage Log which is listed on the web site, www.bdadj.alabama.gov, as Alabama State Board of Adjustment Mileage Log.

Item	Amount of Expense

A. Total Amount of Miscellaneous Expenses Claimed: _____

B. Are any of the expenses listed above covered by insurance? ☐ Yes ☐ No

C. If yes, list amount of coverage and deductible amount:

Amount of Coverage: _____

Comprehensive Deductible: _____ Collision Deductible: _____

12. What is the **GRAND TOTAL** amount you are claiming for all items described in Items 7.A., 9.C., 10.D., & 11.A.?

_____

13. Signature of Claimant/Authorized Representative: _____

Please Print Name: _____

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VERIFICATION

STATE OF _____

COUNTY OF _____

Before me, a Notary Public in and for said state and county, personally appeared the person whose name is signed above who being made known to me and being duly sworn to give true testimony, affirmed that all of the above stated facts are true and correct.

Sworn and subscribed before me this _____ day of _____, 20 _____

Signature of Notary Public _____

AFFIX SEAL Printed Name _____