



Application for Determination or Increase of Percentage of Permanent Partial Disability (C-92)

Claim number

Instructions

Complete this form and fax it to 1-866-336-8352, or send it to your local BWC claims office.

Application designation

I am applying for one of the options listed below.

- Options for application designation: initial %PPD, newly allowed condition, or increase in %PPD.

Injured worker information

Form fields for injured worker information: Name, Date of injury, Address, City, State, ZIP code, Contact number, Preferred method of contact, Email address.

Exam availability: Mornings (7 a.m. to 12 p.m.), afternoons (12 p.m. to 5 p.m.) We will attempt to accommodate your requested exam availability. WARNING! — BWC may dismiss this application if the injured worker fails to respond to an attempt to schedule an exam or fails to attend the exam

Form fields for exam availability: Please check all days of the week and times of the day that you can attend an examination. Includes checkboxes for days and times, and a note for Saturday appointments.

Injured worker signature

- I certify the information on this form is true and correct. I understand that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain benefits/compensation as provided by BWC or self-insuring employers, or who knowingly accepts compensation to which that person is not entitled, is subject to criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Signature of injured worker/injured worker representative and Date

Authorized to receive workers' compensation check

Injured worker representative name and Representative ID number

- I hereby authorize and direct BWC to mail directly to my attorney the compensation payment in the above numbered claim any accrued monetary award generated by this application.

Signature of injured worker and Date