



Claimant's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Employer's Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Carrier: \_\_\_\_\_  
 Preparer's Name: \_\_\_\_\_ Preparer's Phone #: \_\_\_\_\_

**Check applicable claims and complete all blanks.**

1. The employee sustained a compensable accidental injury to the \_\_\_\_\_ (part of the body) ON \_\_\_\_\_ (date) in \_\_\_\_\_ (county), State of \_\_\_\_\_ (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 Section 42-9-400(d):
  - a. Listed Impairment – (1) – (33) \_\_\_\_\_
  - b. (34) (a) \_\_\_\_\_
  - c. (34) (b) \_\_\_\_\_
5.  a. That the impairment preexisted;  
 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 impairment was a hindrance or obstacle to employment or re-employment.
9.  a. That 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 Section 42-9-410 because:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
12. Other grounds for claim: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date