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Laurence Hubbard, President/CEO

April 18, 2008

FILED

APR 2 1 2008

WORKERS' COMPENSATION JUDGE HELENA, MONTANA

Honorable James Jeremiah Shea Workers' Compensation Court Judge P.O. Box 537 Helena, MT 59624-0537

RE: Stavenjord notification letters

Dear Judge Shea:

Beginning next week, Montana State Fund will mail a letter and attachment to those claimants identified as part of its identification and notification process for potential Stavenjord recipients. I have enclosed a representative Stavenjord letter and attachment.

Sincerely,

Tom Martelio Legal Counsel

**Enclosure** 

c: Thomas J. Murphy (w/enc.)
Murphy Law Firm
619 Second Avenue South
P.O. Box 3226
Great Falls, MT 59403-3226

Tom Martello

DOCKET ITEM NO. 118





Date

Addressee Address City State Zip

RF:

WORKER:

**CLAIM NUMBER:** 

Dear Sir or Madam:

A Montana Supreme Court decision, *Stavenjord v. Montana State Fund*, has determined that injured workers suffering from an occupational disease are entitled to the same permanent partial disability benefits as workers suffering from an injury.

Montana State Fund (MSF) is reviewing its workers' compensation claims to determine eligibility for additional permanent partial disability benefits which may be due under *Stavenjord*.

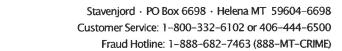
The above noted claim has been identified as potentially entitled to additional permanent partial disability benefits under *Stavenjord*.

In order to determine potential eligibility for additional permanent partial disability benefits, further information is necessary. To expedite our review, we have enclosed a questionnaire to be completed and returned in the enclosed return envelope. Your prompt attention to this matter will expedite our review of this file.

PLEASE DO NOT CALL. Completion and return of the enclosed questionnaire will assist us in reviewing the claim for entitlement. If further information is needed, we will contact you.

PLEASE NOTE: This letter is not notification of entitlement to Stavenjord permanent partial disability benefits. Rather, we have identified this claim as potentially being due additional permanent partial disability benefits. Further review of the claim is necessary and we will notify you in writing of our determination upon assessment of the necessary information.

MONTANA STATE FUND





## STAVENJORD QUESTIONNAIRE

NAME: CLAIM NUMBER:							
		RMENT (a purely medical the American Medical Asso	determination provided by a physician ciation.)	based upon the Guides to Eva	aluation of Permanent		
A. I receiv	ed an impairm	nent rating from my physician	of%.				
B. I was n physica	ot notified of a Il limitation as a	n impairment rating but do kr a result of my occupational di	now/think that I did suffer a permanent seaseYes	restriction or _ No			
			u have suffered as a result of your occ		-		
					-		
WAGE	LOSS	24					
		ss as a result of my occupatio	onally related condition when I returned	I to my time of	,		
B. I did su employ	ffer a wage los ment	ss as a result of my occupatio _YesNo	onally related condition when I returned	I to alternative			
retum to	o work. Please		(3) years of employment history from st documentation to support this in				
FROM	то	EMPLOYER	OCCUPATION	HOURLY WAGE			
	(	-			-		
				· · · · · · · · · · · · · · · · · · ·	=		
-	i ( <del>)</del> (	10		1			
	25	15		:	=:		
SUBSE	QUENT IN.	JURY / OCCUPATION	IAL DISEASE				
Have you suffered a subsequent injury and/or disease that have affected your above noted occupational disease?							
O No				J•			
O Yes							

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## STAVENJORD QUESTIONNAIRE - PG 2

NAME:	CLAIM NUMBER:	
CONTACT INFORMATION		
Please note your address below if such is diff	ferent than the address to which this information was mailed:	
Mailing address:		
Phone:		
In submitting this information, I understand if penalties as provided in Section 39-71-316 of	I obtain workers' compensation benefits that I am not entitled to I if the Montana Code Annotated.	may be subject to civil or crimina
Signed:		Date:

88-91



Stavenjord · PO Box 6698 · Helena MT 59604–6698 Customer Service: 1–800–332–6102 or 406–444–6500 Fraud Hotline: 1–888–682–7463 (888–MT–CRIME)

## **STAVENJORD QUESTIONNAIRE**

NAME:	NAME: CLAIM NUMBER:							
<del>1</del>								
PHYSICAL IMPAIRMENT (a purely medical determination provided by a physician based upon the Guides to Evaluation of Permanent Impairment published by the American Medical Association.)								
A. I received an impairm	ent rating from my physician o	of%.						
B. I was not notified of ar physical limitation as a	n impairment rating but do kno result of my occupational dis	ow/think that I did suffer a permane easeYes	ent restriction or No					
If "Yes", please explair related condition:	If "Yes", please explain what limitations you feel you have suffered as a result of your occupationally related condition:							
WACELOSS								
WAGE LOSS								
A. I did suffer a wage los injury job Y		nally related condition when I return	ned to my time of					
B. I did suffer a wage loss as a result of my occupationally related condition when I returned to alternative employment Yes No								
If "Yes" to either of the	above, please provide three (	(3) years of employment history fro	om your release to					
return to work. <b>Please</b> Please utilize a separa		t documentation to support this	s information.					
FROM TO	EMPLOYER	OCCUPATION	HOURLY WAGE					
		_						
8	<u> </u>							
	<del></del>	- S (2 9 9	_					
		TV 9 T-1	3					
EDUCATION LEV	/EL							
At the time of the onset of my occupational disease (as indicated on your claim form) my level of education was:								
O Less than 9 years								
O 9 through 12 years O More than 12 years								
VIVIOLE III ALL 12 YEARS								

## STAVENJORD QUESTIONNAIRE – PG 2

NAME: CLAIM NUMBER:	
LABOR LEVEL	
At my time of injury job. Luga ractuired to do:	
At my time of injury job, I was required to do:	
O Heavy labor activity (lift over 50# occasionally or up to 50# frequently)	
O Medium labor activity (lift up to 50# occasionally or up to 25# frequently)	
O Light labor activity (lift up to 25# occasionally or up to 10# frequently)	
O Sedentary labor activity (lift up to 10# occasionally or up to 5# frequently)	
As a result of my occupational disease, my physician permanently limited me to:	
O Medium labor activity	
O Light or sedentary labor activity	
O There was no change in my work abilities as a result of my occupational disease	
SUBSEQUENT INJURY / OCCUPATIONAL DISEASE	
Have you suffered a subsequent injury and/or disease that have affected your above noted occupational disease?	
O No	
O Yes	
	2
CONTACT INFORMATION	
Please note your current address below if such is different than the address to which this information was mailed:	
Mailing address:	
Phone:	
In submitting this information, I understand if I obtain workers' compensation benefits that I am not entitled to, I may be subject to civil or cripenalties as provided in Section 39-71-316 of the Montana Code Annotated.	iminal
Signed: Date:	