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Laurence Hubbard, President/CEO

April 18, 2008

FILED
APR 21 2008
OFFICE OF
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 Martello

Tom Martello
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

DOCKET ITEM NO. 118

PDF

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Date

Addressee
Address
City State Zip

RE: 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

2808

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STAVENJORD QUESTIONNAIRE

NAME: **CLAIM NUMBER:**

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 impairment rating from my physician of ____ %.

B. I was not notified of an impairment rating but do know/think that I did suffer a permanent restriction or physical limitation as a result of my occupational disease ________ Yes ____________ No

If "Yes", please explain what limitations you feel you have suffered as a result of your occupationally related condition: ____

WAGE LOSS

A. I did suffer a wage loss as a result of my occupationally related condition when I returned to my time of injury job ________ Yes ______ No

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 from your release to return to work. **Please note, we may later request documentation to support this information.** Please utilize a separate sheet if needed.

FROM	TO	EMPLOYER	OCCUPATION	HOURLY WAGE

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

Montana's insurance carrier of choice and industry leader in service.

STAVENJORD QUESTIONNAIRE – PG 2

NAME: **CLAIM NUMBER:**

CONTACT INFORMATION

Please note your 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 criminal penalties as provided in Section 39-71-316 of the Montana Code Annotated.

Signed: ______________________________ Date: ______________

88-91

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STAVENJORD QUESTIONNAIRE

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____
____

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If "Yes" to either of the above, please provide three (3) years of employment history from your release to return to work. **Please note, we may later request documentation to support this information.** Please utilize a separate sheet if needed.

FROM	TO	EMPLOYER	OCCUPATION	HOURLY WAGE

EDUCATION LEVEL

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

Montana's insurance carrier of choice and industry leader in service.

STAVENJORD QUESTIONNAIRE – PG 2

NAME: **CLAIM NUMBER:**

LABOR LEVEL

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

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 criminal penalties as provided in Section 39-71-316 of the Montana Code Annotated.

Signed: ______________________________ Date: ______________