

Mail to: STATE OF ALABAMA  
Workers' Compensation Division  
Department of Labor  
Montgomery, Alabama 36131

**The original of this form must be filed with this office. Copies will not be accepted.  
The use of this form is required under the provisions of the Alabama Workers' Compensation Law.**

## CLAIMS SUMMARY FORM

PLEASE TYPE OR PRINT

SUSPENSION

SETTLEMENT

AMENDED

1. Employee: \_\_\_\_\_ 2. S.S.N. \_\_\_\_\_  
3. Employer: \_\_\_\_\_ 4. Unemployment Compensation # \_\_\_\_\_  
5. Date of Injury: \_\_\_\_\_ 6. Date disability began this period \_\_\_\_\_  
7. Insurance carrier: \_\_\_\_\_ 8. Claim # \_\_\_\_\_ 9. Service Co # \_\_\_\_\_  
10. Name, address and telephone number of office filing this report: \_\_\_\_\_

Phone: \_\_\_\_\_

Ext: \_\_\_\_\_

**(DO NOT INCLUDE ANY PAYMENTS PREVIOUSLY FILED ON A CLAIM SUMMARY FORM)**

11. Date last day comp paid \_\_\_\_\_ RTW \_\_\_\_\_ MMI \_\_\_\_\_  
12. Did claimant work during this period of disability? YES  NO  If so, from \_\_\_\_\_  
13. AWW \_\_\_\_\_ CR (66.67%) \_\_\_\_\_ 14. Medical pd this period \_\_\_\_\_  
15. Amount and type of comp paid:  
TTD \$ \_\_\_\_\_ WKS \_\_\_\_\_ Days \_\_\_\_\_  
TPD \$ \_\_\_\_\_ WKS \_\_\_\_\_  
PPD \$ \_\_\_\_\_ WKS \_\_\_\_\_ Days \_\_\_\_\_ % \_\_\_\_\_ POB \_\_\_\_\_  
PTD \$ \_\_\_\_\_ WKS \_\_\_\_\_ Days \_\_\_\_\_  
Death \$ \_\_\_\_\_ WKS \_\_\_\_\_ Days \_\_\_\_\_  
Estate Pmt \$ \_\_\_\_\_ Burial Payment \$ \_\_\_\_\_ Future Med \$ \_\_\_\_\_  
LSP \$ \_\_\_\_\_ Date Pd \_\_\_\_\_ WKS \_\_\_\_\_ Days \_\_\_\_\_  
% \_\_\_\_\_ Part of Body \_\_\_\_\_  
16. Ombudsman Yes No Court CV# \_\_\_\_\_ Location (County) \_\_\_\_\_  
17. Legal: Pltf Fees \$ \_\_\_\_\_ Exp \$ \_\_\_\_\_ Def Fees \$ \_\_\_\_\_ Exp \$ \_\_\_\_\_

Date \_\_\_\_\_

Signature and Title \_\_\_\_\_

WC 4 Revised 10-12