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: 251-343-6855
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 5-95