North Dakota Workforce Safety & Insurance

HERNIA QUESTIONNAIRE

CLAIMS DIVISION
SFN 52960 (08/2014)

1600 EAST CENTURY AVENUE, SUITE 1
PO BOX 5585
BISMARCK ND 58506-5585
Telephone 1-800-777-5033
Toll Free Fax 1-888-786-8695
TTY (hearing impaired) 1-800-366-6888
Fraud and Safety Hotline 1-800-243-3331
www.WorkforceSafety.com

Injured Worker's Name	Claim Number	Mailing Date	**PAGE 1**

DIRECTIONS: **PLEASE PRINT OR TYPE USING BLACK OR BLUE INK.** Read and answer each question. If additional space is needed to respond, use the back of these pages or a separate sheet of paper. Please be sure to sign and date the last page and **return this questionnaire to Workforce Safety & Insurance at the address listed above within 14 days from the mailing date listed above**. Injured workers are subject to penalty for failure to comply or for any false statement.

1. When did you first notice the symptoms of the present condition and what specifically were your symptoms?

2. What were you doing at the time when you first noticed the symptoms?

3. Did you stop working? ☐ Yes ☐ No
   If yes, for how long?

4. Did the symptoms persist or disappear?

5. How did the condition then progress?

6. Which side was affected?

7. Did you mention the incident to anyone at the time it occurred? ☐ Yes ☐ No
   If yes, who?

8. Did you have a protrusion or swelling? When did you first notice the swelling or protrusion?

9. Have you ever had a hernia before? ☐ Yes ☐ No

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Claim Number	Injured Worker

If yes, when?

10. On what side was the previous hernia?

11. Was it treated or surgically repaired? ☐ Yes ☐ No
If yes, please list the dates of treatment or surgery and the names and complete addresses of the physicians who treated you for the previous hernia.

12. Have you ever had any treatment for the previous hernia since it was treated or repaired originally?
☐ Yes ☐ No
If yes, when was your last treatment for the previous hernia?

UPON COMPLETION OF THIS FORM, PLEASE SIGN, DATE, AND RETURN IT TO:

Attn: Claims Department
Workforce Safety & Insurance
PO Box 5585
Bismarck, ND 58506-5585

FRAUD WARNING – PENALTY FOR FILING FALSE CLAIMS WITH WORKFORCE SAFETY & INSURANCE (WSI)

Any person claiming benefits or compensation from WSI who files a false claim, or makes a false statement, or fails to notify WSI as to the receipt of income or an increase in income from employment in connection with any claim or application for workers compensation benefits will FORFEIT ANY FUTURE BENEFITS and may be GUILTY OF A FELONY which is punishable by IMPRISONMENT, SUBSTANTIAL FINES, OR BOTH. These criminal penalties are applicable to ALL PERSONS dealing with the Fund, including INJURED WORKERS, EMPLOYERS, MEDICAL PROVIDERS, AND ATTORNEYS.

I ACKNOWLEDGE, by my signature on this form, THAT I HAVE READ AND UNDERSTAND THE ABOVE DESCRIPTION OF THE PENALTIES FOR SUBMITTING A FALSE CLAIM FOR BENEFITS OR MAKING FALSE STATEMENTS TO WSI. I understand that WSI is relying upon the truth of my statements in awarding benefits or providing services on this claim. I CERTIFY THAT I HAVE NOT FILED A FALSE CLAIM, NOR MADE ANY FALSE STATEMENT, NOR KNOW OF ANY FALSE STATEMENT MADE IN CONNECTION WITH THIS CLAIM FOR BENEFITS WITH WSI.

Injured Worker's Signature	Date