North Dakota Workforce Safety & Insurance

THIRD PARTY NOTICE – SLIP AND FALL QUESTIONNAIRE

LEGAL DIVISION
SFN 54052 (07/2014)

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	
Claim Number	Injury Date

1. Please state how and when the injury occurred (i.e. time of day, etc.).

2. Please state the location of where you fell (i.e. sidewalk, street, parking lot, or name of business). Please provide address of location.

3. Please describe the weather conditions and the condition of the property where you fell (i.e. had the property been maintained, shoveled, salted, or was the sidewalk uneven).

4. Please describe the type of footwear you were wearing and the activity you were engaged in immediately prior to the injury (i.e. cell phone, texting, carrying items, running, etc.).

5. Who is responsible for the maintenance and repair of the property where you fell? Please provide name, address, telephone number of the property owner and/or insurance company, if known.

6. Please list any witnesses and/or anyone who may have information to the incident and injury. Please provide names, addresses, and telephone numbers, if known.

Injured Worker	Claim Number

7. Do you believe a third party was at fault and caused the incident and injury? If so, please explain why. Please provide the name, address, and telephone number of the third party or parties likely responsible for your injury.

_____

_____

8. Have you been in contact with any third party or their insurance company, in connection with this injury? ☐ Yes ☐ No

   If yes, please provide the following:
   a. Name, address, telephone number and email address of the insurance carrier and contact person.

   _____

   _____

   b. Policy number and claim number if known.

   _____

   _____

9. Do you intend to pursue legal action against a third party in connection with this injury?
   ☐ Yes ☐ No ☐ Undecided

10. Please identify the name, address, telephone number, and email address of your attorney if you have retained one in connection with this injury and third party claim.

    _____

    _____

11. Have you received a monetary settlement from a third party or their insurance company in connection with this injury?
    ☐ Yes ☐ No ☐ In progress

    If yes, please state the amount of the settlement:

    _____

    The date the settlement was received:

    _____

Injured Worker	Claim Number

By signing this document, I certify that the information provided herein is true and correct to the best of my knowledge. I understand that I must notify WSI at the time I begin to pursue settlement negotiations and/or seek the assistance of an attorney in this matter.

I also acknowledge I have carefully reviewed the following Lien Notice: *WSI has a lien in the full amount it has paid in all benefits for this claim. This lien attaches to all claims, demands, settlement proceeds, judgment awards, or insurance payable by reason of a legal liability of a third person. If you receive any money in regard to this claim from a third person or their insurance company, and WSI does not receive payment of its lien within thirty days of their payment to you, WSI may sue you and/or your personal injury attorney for the full amount of the lien. No release of liability or satisfaction of any judgment, claim or demand is valid or effective against WSI's lien.*

Injured Worker's Signature	Date