



**THIRD PARTY NOTICE AND QUESTIONNAIRE**  
 LEGAL DIVISION  
 SFN 12427 (12/2016)

1600 E Century Ave, Ste 1  
 PO Box 5585  
 Bismarck ND 58506-5585  
**Telephone 800-777-5033**  
 Toll Free Fax 888-786-8695  
 TTY (hearing impaired) 800-366-6888  
 Fraud and Safety Hotline 800-243-3331  
 www.workforcesafety.com

**SECTION 1 – Injured worker information**

Claim number	Injured worker's (First name)	(Last name)	Date of injury
--------------	-------------------------------	-------------	----------------

**SECTION 2 – Questions**

Describe how and when the injury occurred (Example: time of day, etc). Provide the address, city, county, and state where the injury occurred.

List the names and addresses of all companies, other than your employer, who were working on the project or present at the injury.

List all witnesses and anyone who has information about the injury. Provide names, addresses, and telephone numbers.

Describe what you were doing immediately before the injury.

Do you believe someone else (an individual or business other than you or your employer) was at fault or caused your injury?  
 Yes  No

If yes, explain why

List the names, addresses, and telephone numbers of the individuals or businesses who may be responsible for your injury.

Form is continued on next page. Submit all pages to WSI.

**SFN 12427 (12/2016)**

Claim number <b>Error! Reference source not found.</b>	Injured worker's (First name)	(Last name)
---	-------------------------------	-------------

Have you been in contact with any individual, business, or an insurance company about the incident?  
 Yes  No

If yes, list the name, address, company, telephone number, and email address.

If known, provide the policy number and claim number.

Have you received money from an individual, business, or an insurance company in connection with your injury?  
 Yes  No  In progress

If yes, provide the amount.	Date the money was received.
-----------------------------	------------------------------

Do you intend to pursue legal action against anyone because of your injury?  
 Yes  No  Undecided

Have you hired an attorney because of your injury?  
 Yes  No

If yes, provide their name, address, telephone number, and email address.

**SECTION 3 – Lien notice/signature**

**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 30 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.

**Signature**  
 By signing this document, I acknowledge that the information provided here 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 or seek the assistance of an attorney in this matter.

<b>Injured worker's signature</b>	<b>Date</b>
-----------------------------------	-------------