North Dakota Workforce Safety & Insurance

THIRD PARTY NOTICE AND QUESTIONNAIRE

LEGAL DIVISION
SFN 12427 (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 incident occurred (i.e. time of day, etc). Please provide the city and county where the incident occurred.

2. Please list the name and address of any companies, other than your employer, who were associated with or present at the incident.

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

4. Please describe the activity you were engaged in immediately prior to the incident (i.e. cell phone, texting, etc.)

5. Do you believe a third party (i.e. individual or business other than you or your employer) was at fault or caused the incident? Yes No

   If yes, please explain why.

   Please provide the name, address, and telephone number of the third party or parties likely responsible for the incident.

Injured Worker	Claim Number

6. Have you been in contact with any third party or their insurance company in connection with this incident? ☐ 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.

   _____

   _____

7. Have you received a monetary settlement from a third party or their insurance company in connection with the incident? ☐ Yes ☐ No ☐ In progress

   If yes, please state the amount of the settlement

   _____

   The date the settlement was received

   _____

8. Do you intend to pursue legal action against a third party in connection with the incident?
   ☐ Yes ☐ No ☐ Undecided

9. If you have retained an attorney in connection with this incident, please identify their name, address, telephone number, and e-mail address.

   _____

   _____

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