WC/PDB

WORKERS' COMPENSATION/PUBLIC DISABILITY BENEFITS SELECTION MENU

LnNo	0 1	1 2 3 4 5 6 7 7 234567890123456789012345678901234567890123456789012345678901234567890123456789	8 0
1	C	COMM WORKERS' COMPENSATION/PUBLIC DISABILITY BENEFITS SELECTION MENU WPMU TZW	0
2	0	NUMBER HOLDER SSN: SSS-SS-SSSS NUMBER HOLDER NAME: SSSSS SSSSSSSSSS	
3	L		
4	U		
5	M	[WC/PDB INJURY/ SOURCE OF WC/PDB CLAIM NUMBER INJURY/ SSSSSS	
6	N	[CLAIM ILLNESS COMPENSATION ILLNESS	
7	*	[DATE STATE	
8	O	| 1 SSSSSSSS SS SSSSSSSSSSSSSSSSSSSSSSSS SS X	
9	N	| 2 SSSSSSSS SS SSSSSSSSSSSSSSSSSSSSSSSS SS X	
10	E	| 3 SSSSSSSS SS SSSSSSSSSSSSSSSSSSSSSSSS SS X	
11		| 4 SSSSSSSS SS SSSSSSSSSSSSSSSSSSSSSSSS SS X	
12	R		
13	E	_	
14	S	WC/PDB CLAIM 1 SCREENS: SSSS SSSS SSSS SSSS SSSS SSSS	
15	E	WC/PDB CLAIM 2 SCREENS: SSSS SSSS SSSS SSSS SSSS SSSS	
16	R	WC/PDB CLAIM 3 SCREENS: SSSS SSSS SSSS SSSS SSSS SSSS	
17	V	WC/PDB CLAIM 4 SCREENS: SSSS SSSS SSSS SSSS SSSS SSSS	
18	E		
19	D	ADD NEW OCCURRENCE (Y/N): X	
20			
21			
22		PF1 HELP AVAILABLE TRANSFER TO: XXXX	
23		***********************APPLICATION ERROR MESSAGE******************************	
24		*************(LINE 24 RESERVED FOR OPERATING SYSTEMS INFORMATION)***********	

SCREEN FR
MSOM

WC/PDB

WC/PDB CLAIM DATA

LnNo	0 1	1 2 3 4 5 6 7 7 234567890123456789012345678901234567890123456789012345678901234567890123456789	8 0
1	C	COMM WC/PDB CLAIM DATA WPCL TZW	1
2	O	NUMBER HOLDER SSN: SSS-SS-SSSS NUMBER HOLDER NAME: SSSSS SSSSSSSSSS	
3	L	*INJURY/ILLNESS DATE (MMDDCCYY): 99999999 *SOURCE OF COMPENSATION: XX	
4	U	*WC/PDB CLAIM NUMBER: XXXXXXXXXXXXXXXXXXXXXXXX INJURY/ILLNESS STATE: XX	
5	M		
6	N	*PERIODIC PAYMENTS AWARDED (Y/N): X *LUMP SUM AWARDED (Y/N): X	
7	*	*WC/PDB CLAIM PENDING (Y/N): X *CLAIM DENIED (Y/N): X	
8	O	*APPEAL PENDING (Y/N): X IF YES, EXPECTED DECISION DATE (MMDDCCYY): 99999999	
9	N	INTEND TO FILE (Y/N): X	
10	E	______________________ WILL BE DELETED FROM THIS INJURY - CONTINUE (Y/N): X	
11		*REVERSE JURISDICTION INVOLVED (Y/N): X	
12	R	IF YES, START (MMDDCCYY): 99999999 STOP (MMCCYY): 999999	
13	E		
14	S	DO THE PDB'S MEET THE COVERED SERVICE EXCLUSION (Y/N): X	
15	E	COVERED EARNINGS PERCENTAGE: 999	
16	R	DO YOU NEED TO MANUALLY ENTER A HIGHER ACE (Y/N): X	
17	V	IF YES, MANUAL 100 PERCENT ACE: 99999	
18	E	SELECT METHOD USED: 9	
19	D	1=HIGH 1 2=HIGH 5 3=AVERAGE MONTHLY WAGE.	
20		DELETE THIS CLAIM (Y/N): N	
21		THIS OCCURRENCE OF DATA WILL BE DELETED FROM CLIENT AND MBR-CONTINUE (Y/N): X	
22		PF1 HELP AVAILABLE TRANSFER TO: XXXX	
23		**************************APPLICATION ERROR MESSAGE**************************	
24		**************(LINE 24 RESERVED FOR OPERATING SYSTEMS INFORMATION)***********	

SCREEN FR

MSOM

WC/PDB

WC/PDB CLAIM DATA EMPLOYER/PAYER NAME AND ADDRESS

LnNo	0 1	1 2 3 4 5 6 7 7 234567890123456789012345678901234567890123456789012345678901234567890123456789	8 0
1	C	COMM WC/PDB CLAIM DATA EMPLOYER/PAYER NAME AND ADDRESS WPAD TZW	2
2	O	NUMBER HOLDER SSN: SSS-SS-SSSS NUMBER HOLDER NAME: SSSSS SSSSSSSSSS	
3	L	INJURY/ILLNESS DATE: SSSSSSSS SOURCE OF COMPENSATION: SS	
4	U	WC/PDB CLAIM NUMBER: SSSSSSSSSSSSSSSSSSSSSSSS INJURY/ILLNESS STATE: SS	
5	M		
6	N		
7	*	EMPLOYER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	
8	O	ADDRESS 1: XXXXXXXXXXXXXXXXXXXXXX ADDRESS 2: XXXXXXXXXXXXXXXXXXXXXX	
9	N	ADDRESS 3: XXXXXXXXXXXXXXXXXXXXXX ADDRESS 4: XXXXXXXXXXXXXXXXXXXXXX	
10	E	CITY: XXXXXXXXXXXXXXXXXXXXXX STATE: XX ZIP: 99999	
11		CONTACT: XXXXXXXXXXXXXXXXXXXXXXXXXX PHONE: XXXXXXXXXXXX EXTENSION: 9999	
12	R	E-MAIL: XXXXXXXXXXXXXXXXXXXXXXXXXXXX FAX: XXXXXXXXXXXX	
13	E		
14	S		
15	E	PAYER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXX	
16	R	ADDRESS 1: XXXXXXXXXXXXXXXXXXXXXX ADDRESS 2: XXXXXXXXXXXXXXXXXXXXXX	
17	V	ADDRESS 3: XXXXXXXXXXXXXXXXXXXXXX ADDRESS 4: XXXXXXXXXXXXXXXXXXXXXX	
18	E	CITY: XXXXXXXXXXXXXXXXXXXXXX STATE: XX ZIP: 99999	
19	D	CONTACT: XXXXXXXXXXXXXXXXXXXXXXXXXX PHONE: XXXXXXXXXXXX EXTENSION: 9999	
20		E-MAIL: XXXXXXXXXXXXXXXXXXXXXXXXXXXX FAX: XXXXXXXXXXXX	
21			
22		PF1 HELP AVAILABLE TRANSFER TO: XXXX	
23		**************************APPLICATION ERROR MESSAGE***************************	
24		**************(LINE 24 RESERVED FOR OPERATING SYSTEMS INFORMATION)***********	

SCREEN FR

MSOM

WC/PDB

WC/PDB PERIODIC PAYMENTS

LnNo	0 1	1 2 3 4 5 6 7 7 234567890123456789012345678901234567890123456789012345678901234567890123456789	8 0
1	C	COMM WC/PDB PERIODIC PAYMENTS WPPR TZW	3
2	0	NUMBER HOLDER SSN: SSS-SS-SSSS NUMBER HOLDER NAME: SSSSS SSSSSSSSSS	
3	L	INJURY/ILLNESS DATE: SSSSSSSS SOURCE OF COMPENSATION: SS	
4	U	WC/PDB CLAIM NUMBER: SSSSSSSSSSSSSSSSSSSSSSSS INJURY/ILLNESS STATE: SS	
5	M		
6	N	[*START STOP *PERIODIC *FREQ TYPE OF *PAYMENT	
7	*	[(MMDDCCYY) (MMDDCCYY) AMOUNT PAYMENT PROOF (Y/N)	
8	O	| 99999999 99999999 99999.99 X XX X	
9	N	| 99999999 99999999 99999.99 X XX X	
10	E	| 99999999 99999999 99999.99 X XX X	
11		| 99999999 99999999 99999.99 X XX X	
12	R	| 99999999 99999999 99999.99 X XX X	
13	E	| 99999999 99999999 99999.99 X XX X	
14	S	| 99999999 99999999 99999.99 X XX X	
15	E	| 99999999 99999999 99999.99 X XX X	
16	R		
17	V	IF PERIODIC PAYMENTS ARE TO BEGIN AGAIN, EXPECTED DATE (MMDDCCYY): 99999999	
18	E	ARE ONGOING PERIODIC EXPENSES INVOLVED (Y/N): X	
19	D	ARE ONE-TIME EXCLUDABLE EXPENSES FROM PERIODIC PAYMENTS INVOLVED (Y/N): X	
20		________ EXPENSES WILL BE DELETED FROM THIS INJURY - CONTINUE (Y/N): X	
21		MORE PERIODIC PAYMENTS (Y/N): X	
22		PF1 HELP AVAILABLE TRANSFER TO: XXXX	
23		**************************APPLICATION ERROR MESSAGE**************************	
24		**************(LINE 24 RESERVED FOR OPERATING SYSTEMS INFORMATION)***********	

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MSOM

WC/PDB

WC/PDB PERIODIC PAYMENTS ONGOING EXPENSES

LnNo	0 1	1 2 3 4 5 6 7 7 234567890123456789012345678901234567890123456789012345678901234567890123456789	8 0
1	C	COMM WC/PDB PERIODIC PAYMENTS ONGOING EXPENSES WPOX TZW	4
2	0	NUMBER HOLDER SSN: SSS-SS-SSSS NUMBER HOLDER NAME: SSSSS SSSSSSSSSS	
3	L	INJURY/ILLNESS DATE: SSSSSSSS SOURCE OF COMPENSATION: SS	
4	U	WC/PDB CLAIM NUMBER: SSSSSSSSSSSSSSSSSSSSSSSS INJURY/ILLNESS STATE: SS	
5	M		
6	N		
7	*	[START STOP PERIODIC FREQ TYPE OF ONGOING ONGOING PROOF	
8	O	[(MMDDCCYY) (MMDDCCYY) AMOUNT PAYMENT EXPENSES PERCENT (Y/N)	
9	N	| SSSSSSSS SSSSSSSS SSSSSSS S SS 99999.99 999 X	
10	E	| SSSSSSSS SSSSSSSS SSSSSSS S SS 99999.99 999 X	
11		| SSSSSSSS SSSSSSSS SSSSSSS S SS 99999.99 999 X	
12	R	| SSSSSSSS SSSSSSSS SSSSSSS S SS 99999.99 999 X	
13	E	| SSSSSSSS SSSSSSSS SSSSSSS S SS 99999.99 999 X	
14	S	| SSSSSSSS SSSSSSSS SSSSSSS S SS 99999.99 999 X	
15	E	| SSSSSSSS SSSSSSSS SSSSSSS S SS 99999.99 999 X	
16	R	| SSSSSSSS SSSSSSSS SSSSSSS S SS 99999.99 999 X	
17	V		
18	E		
19	D	IF PERIODIC PAYMENTS ARE TO BEGIN AGAIN, EXPECTED DATE (MMDDCCYY): PPPPPPPP	
20			
21		MORE PERIODIC PAYMENTS (Y/N): X	
22		PF1 HELP AVAILABLE TRANSFER TO: XXXX	
23		**************************APPLICATION ERROR MESSAGE**************************	
24		**************(LINE 24 RESERVED FOR OPERATING SYSTEMS INFORMATION)***********	

SCREEN FR

MSOM

WC/PDB

ONE-TIME ONLY EXCLUDABLE EXPENSES FOR PERIODIC PAYMENTS

LnNo	0 1	1 2 3 4 5 6 7 7 234567890123456789012345678901234567890123456789012345678901234567890123456789	8 0
1	C	COMM ONE-TIME ONLY EXCLUDABLE EXPENSES FOR PERIODIC PAYMENTS WPEX TZW	5
2	O	NUMBER HOLDER SSN: SSS-SS-SSSS NUMBER HOLDER NAME: SSSSS SSSSSSSSSS	
3	L	INJURY/ILLNESS DATE: SSSSSSSS SOURCE OF COMPENSATION: SS	
4	U	WC/PDB CLAIM NUMBER: SSSSSSSSSSSSSSSSSSSSSSS INJURY/ILLNESS STATE: SS	
5	M		
6	N		
7	*		
8	O		
9	N	ONE-TIME EXCLUDABLE ATTORNEY EXPENSES: 9999999.99 PROOF (Y/N): X	
10	E		
11		ONE-TIME EXCLUDABLE MEDICAL EXPENSES: 9999999.99 PROOF (Y/N): X	
12	R		
13	E	ONE-TIME EXCLUDABLE RELATED EXPENSES: 9999999.99 PROOF (Y/N): X	
14	S		
15	E		
16	R	*SPECIFIED EXPENSE PERIOD START DATE (MMDDCCYY): 99999999	
17	V		
18	E		
19	D		
20			
21			
22		PF1 HELP AVAILABLE TRANSFER TO: XXXX	
23		**************************APPLICATION ERROR MESSAGE**************************	
24		**************(LINE 24 RESERVED FOR OPERATING SYSTEMS INFORMATION)***********	

SCREEN FR

MSOM

WC/PDB

WC/PDB LUMP SUM AWARD DATA

LnNo	0 1	1 2 3 4 5 6 7 7 234567890123456789012345678901234567890123456789012345678901234567890123456789	8 0
1	C	COMM WC/PDB LUMP SUM AWARD DATA WPLS TZW	6
2	O	NUMBER HOLDER SSN: SSS-SS-SSSS NUMBER HOLDER NAME: SSSSS SSSSSSSSSS	
3	L	INJURY/ILLNESS DATE: SSSSSSSS SOURCE OF COMPENSATION: SS	
4	U	WC/PDB CLAIM NUMBER: SSSSSSSSSSSSSSSSSSSSSSSS INJURY/ILLNESS STATE: SS	
5	M		
6	N		
7	*	*LUMP SUM AMOUNT: 9999999.99 *PROOF (Y/N): X	
8	O	*LUMP SUM START DATE (MMDDCCYY): 99999999	
9	N	*RATE AT WHICH LUMP SUM IS TO BE PRORATED: 99999.99	
10	E	*FREQUENCY FOR LUMP SUM PRORATION: X	
11		TYPE OF PAYMENT: XX	
12	R		
13	E	EXCLUDABLE ATTORNEY EXPENSES: 9999999.99 PROOF (Y/N): X	
14	S	EXCLUDABLE MEDICAL EXPENSES: 9999999.99 PROOF (Y/N): X	
15	E	EXCLUDABLE RELATED EXPENSES: 9999999.99 PROOF (Y/N): X	
16	R	SPECIAL AMOUNTS TO BE DEDUCTED FROM LUMP SUM: 9999999.99 PROOF (Y/N): X	
17	V		
18	E	IF DESIRED, SELECT PRORATION METHOD TO BE USED IN COMPUTATION: 9	
19	D	1=METHOD A 2=METHOD B 3=METHOD C.	
20			
21			
22		PF1 HELP AVAILABLE TRANSFER TO: XXXX	
23		**************************APPLICATION ERROR MESSAGE**************************	
24		**************(LINE 24 RESERVED FOR OPERATING SYSTEMS INFORMATION)***********	

SCREEN FR

MSOM