WC/PDB

WORKERS' COMPENSATION/PUBLIC DISABILITY BENEFITS SELECTION MENU

LnNo	0 1	1 2 3 4 5 6 7 2345678901234567890123456789012345678901234567890123456789012345678901234567890123456789	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 SSSSSSSSS	
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 SSSSSSSSSSSSSSSSSSSSSS SS X	
9	N	| 2 SSSSSSSS SS SSSSSSSSSSSSSSSSSSSSSS SS X	
10	E	| 3 SSSSSSSS SS SSSSSSSSSSSSSSSSSSSSSS SS X	
11		| 4 SSSSSSSS SS SSSSSSSSSSSSSSSSSSSSSS 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 2345678901234567890123456789012345678901234567890123456789012345678901234567890123456789	8 0
1	C	COMM WC/PDB CLAIM DATA WPCL TZW	1
2	0	NUMBER HOLDER SSN: SSS-SS-SSSS NUMBER HOLDER NAME: SSSSS SSSSSSSSS	
3	L	*INJURY/ILLNESS DATE (MMDDCCYY): 99999999 *SOURCE OF COMPENSATION: XX	
4	U	*WC/PDB CLAIM NUMBER: XXXXXXXXXXXXXXXXXXXXXXXXX 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 8 0 2345678901234567890123456789012345678901234567890123456789012345678901234567890123456789	
1	C	COMM WC/PDB CLAIM DATA EMPLOYER/PAYER NAME AND ADDRESS WPAD TZW	2
2	0	NUMBER HOLDER SSN: SSS-SS-SSSS NUMBER HOLDER NAME: SSSSS SSSSSSSSS	
3	L	INJURY/ILLNESS DATE: SSSSSSSS SOURCE OF COMPENSATION: SS	
4	U	WC/PDB CLAIM NUMBER: SSSSSSSSSSSSSSSSSSSSS INJURY/ILLNESS STATE: SS	
5	M		
6	N		
7	*	EMPLOYER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXX	
8	O	ADDRESS 1: XXXXXXXXXXXXXXXXXXXXX ADDRESS 2: XXXXXXXXXXXXXXXXXXXXX	
9	N	ADDRESS 3: XXXXXXXXXXXXXXXXXXXXX ADDRESS 4: XXXXXXXXXXXXXXXXXXXXX	
10	E	CITY: XXXXXXXXXXXXXXXXXXXXX STATE: XX ZIP: 99999	
11		CONTACT: XXXXXXXXXXXXXXXXXXXXXXXXX PHONE: XXXXXXXXXXXX EXTENSION: 9999	
12	R	E-MAIL: XXXXXXXXXXXXXXXXXXXXXXXXXXX FAX: XXXXXXXXXXXX	
13	E		
14	S		
15	E	PAYER NAME: XXXXXXXXXXXXXXXXXXXXXXXXX	
16	R	ADDRESS 1: XXXXXXXXXXXXXXXXXXXXX ADDRESS 2: XXXXXXXXXXXXXXXXXXXXX	
17	V	ADDRESS 3: XXXXXXXXXXXXXXXXXXXXX ADDRESS 4: XXXXXXXXXXXXXXXXXXXXX	
18	E	CITY: XXXXXXXXXXXXXXXXXXXXX STATE: XX ZIP: 99999	
19	D	CONTACT: XXXXXXXXXXXXXXXXXXXXXXXXX PHONE: XXXXXXXXXXXX EXTENSION: 9999	
20		E-MAIL: XXXXXXXXXXXXXXXXXXXXXXXXXXX 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 8 2345678901234567890123456789012345678901234567890123456789012345678901234567890123456789 0
1	C	COMM WC/PDB PERIODIC PAYMENTS WPPR 3 TZW
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: SSSSSSSSSSSSSSSSSSSSSS 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)**********

SCREEN FR

MSOM

WC/PDB

WC/PDB PERIODIC PAYMENTS ONGOING EXPENSES

```
LnNo  0 1  2345678901234567890123456789012345678901234567890123456789012345678901234567890123456789 0
1     C    COMM              WC/PDB PERIODIC PAYMENTS ONGOING EXPENSES              WPOX              4
           TZW
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: SSSSSSSSSSSSSSSSSSSSSSS    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)***********
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SCREEN FR

MSOM

WC/PDB

ONE-TIME ONLY EXCLUDABLE EXPENSES FOR PERIODIC PAYMENTS

LnNo	01	1 2 3 4 5 6 7 7 8 2345678901234567890123456789012345678901234567890123456789012345678901234567890123456789 0
1	C	COMM ONE-TIME ONLY EXCLUDABLE EXPENSES FOR PERIODIC PAYMENTS WPEX 5 TZW
2	0	NUMBER HOLDER SSN: SSS-SS-SSSS NUMBER HOLDER NAME: SSSSS SSSSSSSSS
3	L	INJURY/ILLNESS DATE: SSSSSSSS SOURCE OF COMPENSATION: SS
4	U	WC/PDB CLAIM NUMBER: SSSSSSSSSSSSSSSSSSSSSS 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  2  3  4  5  6  7  8
      1  2345678901234567890123456789012345678901234567890123456789012345678901234567890123456789  0
 1    C  COMM                        WC/PDB LUMP SUM AWARD DATA                          WPLS      6
         TZW
 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: SSSSSSSSSSSSSSSSSSSSSSS    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)***********
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SCREEN FR

MSOM