

WC/PDB

WORKERS' COMPENSATION/PUBLIC DISABILITY BENEFITS SELECTION MENU

LnNo	0	1	2	3	4	5	6	7	8
1	C	COMM WORKERS' COMPENSATION/PUBLIC DISABILITY BENEFITS SELECTION MENU WPMU							
2	O	TZW							
3	L	NUMBER HOLDER SSN: SSS-SS-SSSS							
4	U	NUMBER HOLDER NAME: SSSSS SSSSSSSSSSS							
5	M	[	WC/PDB	INJURY/	SOURCE OF	WC/PDB CLAIM NUMBER		INJURY/	
6	N	[	CLAIM	ILLNESS	COMPENSATION			ILLNESS	
7	*	[		DATE				STATE	
8	O	|	1	SSSSSSSS	SS	SSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSS		SS	
9	N	|	2	SSSSSSSS	SS	SSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSS		SS	
10	E	|	3	SSSSSSSS	SS	SSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSS		SS	
11		|	4	SSSSSSSS	SS	SSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSS		SS	
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:			
23		*****APPLICATION ERROR MESSAGE*****							
24		***** (LINE 24 RESERVED FOR OPERATING SYSTEMS INFORMATION) *****							

SCREEN FR
MSOM

WC/PDB

WC/PDB CLAIM DATA

LnNo	0	1	2	3	4	5	6	7	8
1	C	COMM WC/PDB CLAIM DATA WPCL							1
2	0	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:			
23		XXXX *****APPLICATION ERROR MESSAGE*****							
24		***** (LINE 24 RESERVED FOR OPERATING SYSTEMS INFORMATION) *****							

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WC/PDB

WC/PDB CLAIM DATA EMPLOYER/PAYER NAME AND ADDRESS

LnNo	0	1	2	3	4	5	6	7	8
	1	23456789012345678901234567890123456789012345678901234567890123456789							0
1	C	COMM	WC/PDB CLAIM DATA EMPLOYER/PAYER NAME AND ADDRESS					WPAD	2
		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: SSSSSSSSSSSSSSSSSSSSSSSSS	INJURY/ILLNESS STATE: SS						
5	M								
6	N								
7	*	EMPLOYER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX							
8	O	ADDRESS 1: XXXXXXXXXXXXXXXXXXXXXXXXXXXX	ADDRESS 2: XXXXXXXXXXXXXXXXXXXXXXXX						
9	N	ADDRESS 3: XXXXXXXXXXXXXXXXXXXXXXXX	ADDRESS 4: XXXXXXXXXXXXXXXXXXXXXXXX						
10	E	CITY: XXXXXXXXXXXXXXXXXXXXXXXX	STATE: XX	ZIP: 99999					
11		CONTACT: XXXXXXXXXXXXXXXXXXXXXXXX	PHONE: XXXXXXXXXXXXX	EXTENSION: 9999					
12	R	E-MAIL: XXXXXXXXXXXXXXXXXXXXXXXX	FAX: XXXXXXXXXXXXX						
13	E								
14	S								
15	E	PAYER NAME: XXXXXXXXXXXXXXXXXXXXXXXX							
16	R	ADDRESS 1: XXXXXXXXXXXXXXXXXXXXXXXX	ADDRESS 2: XXXXXXXXXXXXXXXXXXXXXXXX						
17	V	ADDRESS 3: XXXXXXXXXXXXXXXXXXXXXXXX	ADDRESS 4: XXXXXXXXXXXXXXXXXXXXXXXX						
18	E	CITY: XXXXXXXXXXXXXXXXXXXXXXXX	STATE: XX	ZIP: 99999					
19	D	CONTACT: XXXXXXXXXXXXXXXXXXXXXXXX	PHONE: XXXXXXXXXXXXX	EXTENSION: 9999					
20		E-MAIL: XXXXXXXXXXXXXXXXXXXXXXXX	FAX: XXXXXXXXXXXXX						
21									
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

LnNo	0	1	2	3	4	5	6	7	7	8	
1	C	WC/PDB PERIODIC PAYMENTS								3	
2	0	NUMBER HOLDER SSN: SSS-SS-SSSS				NUMBER HOLDER NAME: SSSSS					
3	L	INJURY/ILLNESS DATE: SSSSSSSS				SOURCE OF COMPENSATION: SS					
4	U	WC/PDB CLAIM NUMBER: SSSSSSSSSSSSSSSSSSSSSSSSS				INJURY/ILLNESS STATE: SS					
5	M										
6	N	[*START	STOP	*PERIODIC	*FREQ	TYPE OF					
7	*	[(MMDDCCYY)	(MMDDCCYY)	AMOUNT	PAYMENT		PROOF				
8	O	| 99999999	99999999	99999.99	X	XX					
9	N	| 99999999	99999999	99999.99	X	XX		X			
10	E	| 99999999	99999999	99999.99	X	XX					
11		| 99999999	99999999	99999.99	X	XX		X			
12	R	| 99999999	99999999	99999.99	X	XX					
13	E	| 99999999	99999999	99999.99	X	XX		X			
14	S	| 99999999	99999999	99999.99	X	XX					
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:				
23		*****APPLICATION ERROR									
24		*****MESSAGE*****									
24		***** (LINE 24 RESERVED FOR OPERATING SYSTEMS INFORMATION) *****									

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WC/PDB

WC/PDB PERIODIC PAYMENTS ONGOING EXPENSES

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

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WC/PDB

ONE-TIME ONLY EXCLUDABLE EXPENSES FOR PERIODIC PAYMENTS

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

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