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WORKERS' COMPENSATION DEFENSE FILE REFERRAL FORM

Date:

CONTACT INFORMATION:

Name:

Company:

Company Address:

Phone: Fax:

E-Mail:

CLAIM INFORMATION:

Date of Injury: Type of Injury:

Claim No.: Matter ID (If Applicable):

Employer:

Employer's Address:

Employer's Contact: Employer's Phone:

Loss Location:

WC Claim No.:

Facts of Injury:

Applicant:

Applicant's Address:

Applicant's Phone No.:

Applicant's D/O/B: Applicant's S.S.N.:

Applicant's Attorney:

Proposed Fee Arrangement:

Existing Coverage Issues:

Special Handling Instructions:

Disclaimer: *Sending a file to MWL through this feature, e-mail, fax, regular mail, or by other means, doesn't guarantee our retention, as that determination will be made after MWL's evaluation of the file. Upon MWL's receipt of a new file, clients are contacted via e-mail to confirm the file has been received and that it is in the process of being evaluated for possible handling by MWL. Following said evaluation, clients receive written notification as to whether or not MWL will be willing to handle your file. If you send a file and don't hear from us within an appropriate amount of time, please contact MWL to ensure we received your file.*