STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

INSTRUCTION SHEET FOR FORM WC-5
EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

Instructions

IMPORTANT:
If information provided is incomplete, this claim will not be processed and will be returned to the employee. Please complete the form in triplicate. Please distribute the form as follows: original and one copy to the appropriate District Office (see next page) and one copy for employee's records.

Ensure information indicated is CLEAR, LEGIBLE, COMPLETE AND ACCURATE.

INJURED PERSON:
Name: Enter full, complete name shown on injured person's social security identification card (no nicknames). Address: Enter mailing address.

EMPLOYER:
Name: Enter the complete business name of the employer.
Address: Enter full address of employer including city, state and zip code.

INSURANCE CARRIER:
Name: Enter the name of the insurance company that handles workers' compensation for the employer.

INJURY:
Date of Accident: Enter specific date injury occurred.
Time: Specify time and include a.m. or p.m.
Describe Injury/Illness: How and where did the accident occurred?
Reason for Filing: Specify reason(s) for filing this claim.

WITNESS:
Enter name and address of someone who saw accident, if any.

NOTICE:
Indicate whether you notified your employer of the injury.

ATTENDING PHYSICIAN:
Enter name and address of the physician who treated you for this injury and attach available medical reports to this claim.

REPRESENTED BY:
You may leave this part blank, but if you are represented, enter the name and address of attorney/union agent, or other representative.

Address: Enter full address of your representative to include city, state and zip code.

SIGNATURE OF CLAIMANT:
Sign your name and date.

ATTACHMENTS: (if available)
(i.e. Physician medical reports, Attorney letter of representation, etc.)

Visit our Website at www.hawaii.gov/labor for ALL interactive and downloadable forms.

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The **Delivery Information** section below lists various delivery options. Please select the most convenient method and submit the completed form accordingly.

Please remember to sign and date the form before submitting it.

Delivery Information

Delivery by U.S. Mail, In-Person, or via Fax

Department of Labor and Industrial Relations, Disability Compensation Division

Oahu	Kauai	Maui
Princess Keelikolani Building 830 Punchbowl Street, Room 209 Honolulu, Hawaii 96813 Mailing Address: P.O. Box 3769 Honolulu, Hawaii 96812-3769 Phone: (808) 586-9161 Fax: (808) 586-9219	3060 Eiwa Street, Room 202 Lihue, Hawaii 96766 Phone: (808) 274-3351 Fax: (808) 274-3355	2264 Aupuni Street, #2 Wailuku, Hawaii 96793 Phone: (808) 984-2072 Fax: (808) 984-2071
Hawaii	**West Hawaii**	
75 Aupuni Street, Room 108 Hilo, Hawaii 96720 Phone: (808) 974-6464 Fax: (808) 974-6460	Ashikawa Building 81-990 Halekii Street, Room 2087 Kealakekua, Hawaii 96750 If Mailing, Please Mail to This Address: P.O. Box 49, Kealakelua, Hawaii 96750 Phone: (808) 322-4808 Fax: (808) 322-4813	

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FORM WC-5
EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

Injured Person

Name	
Address	
Occupation	
Telephone No. ( )	Social Security No.

Employer

Name	
Address	
Nature of Business	Telephone No. ( )

Insurance Carrier

Name
Address

Injury

Date of Accident	Time of Injury a.m. p.m.	Date Disability Began
If not on employer's premises, indicate place where accident occurred		
Describe how accident occurred		
Describe injury/illness		
Reason for filing: ☐ Employer has not filed WC-1 ☐ Reopening of old claim ☐ Insurance carrier has not paid benefits ☐ Others (explain)		

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(Rev. 10/05)

FORM WC-5 EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

Witness

Name	Work Phone ( )	Home Phone ( )
Address		

Name	Work Phone ( )	Home Phone ( )
Address		

Notice

Did you notify the employer of the injury? ☐ Yes ☐ No If so, when:
How: ☐ Oral ☐ Written To whom:

Attending Physician

Name	Telephone No. ( )
Address	

I hereby present my claim for compensation for disability resulting from the foregoing injury arising out of and in the course of my employment and not caused by my intoxication nor by my willful intention to injure myself or another individual.

I hereby authorize any physician and/or hospital to release any information related to any treatment rendered to me.

Represented by _____ _____

ATTORNEY/UNION AGENT SIGNATURE OF CLAIMANT

Address_____ Date _____

_____

_____

Auxiliary aids and services are available upon request. Please call: (808) 586-9174; TTY (808) 586-8847; and for neighbor islands, TTY 1-888-569-6859. A request for reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

It is the policy of the Department of Labor and Industrial Relations that no person shall, on the basis of race, color, sex, marital status, religion, creed, ethnic origin, national origin, age, disability, ancestry, arrest/court record, sexual orientation, and National Guard participation, be subjected to discrimination, excluded from participation in, or denied the benefits of the Department's services, programs, activities, or employment.