



Minnesota Pollution Control Agency

520 Lafayette Road
St. Paul, MN 55155-4194

Harmful Substance Compensation Program

Application for Compensation for Personal Injury

Return form to: Superfund Program
Minnesota Pollution Control Agency
520 Lafayette Road North
St. Paul, Minnesota 55155-4194

Instructions: Please print and use ink for your answers and attached extra sheets as needed.

Applicant

Last name: _____ First name: _____ Social Security No. _____

Current Address: _____

City: _____ State: _____ Zip code: _____

Birthdate: _____ Sex: Male Female Telephone Number: _____

Address at time of personal injury: Same as above County: _____

Street: _____

City: _____ State: _____ Zip code: _____

Claimant's Representative

Name: _____ Telephone Number: _____

Address: _____

City: _____ State: _____ Zip code: _____

Relationship to claimant (e.g., lawyer, guardian, etc.): _____

Employer

Name: _____ Telephone Number: _____

Address: _____

City: _____ State: _____ Zip code: _____

Exposure to Harmful Substances

List harmful substances to which you were exposed: _____

What was the source? (name facility or site) _____

Who told you about the presence of harmful substances? _____

What government agency did you contact about the harmful substances? _____

When did you find out about the exposure? _____ How long were you exposed? _____

Where were you exposed? (location, e.g. home) _____

How were you exposed to the harmful substance? (e.g., via drinking water, air, etc.) _____

What is the disease, illness, or disability that resulted from exposure to the harmful substance?

Who diagnosed the condition? _____ Date diagnosed: _____

Address: _____

City: _____ State: _____ Zip code: _____

What other doctors have examined you concerning the condition? _____

Address: _____

City: _____ State: _____ Zip code: _____

When were you hospitalized for the condition? _____ Name of hospital: _____

Why do you believe the exposure to the harmful substance caused or contributed to the condition? _____

When was the connection between the exposure and the illness discovered? _____

Who discovered the connection: _____

What unreimbursed medial expenses have you incurred because of this condition? (submit bills) _____

What wages have you lost due to this condition? (list amount) _____

Have you received compensation from any of the following for your losses? If yes, attach additional sheets describing the amount.

- | | | |
|--|------------------------------|-----------------------------|
| a) the party responsible for the release of the harmful substances | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) insurance | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) federal, state, or local government programs | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d) other compensation source (specify) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Certification

I certify that all statements in this application are true and complete to the best of my knowledge:

Signature of applicant

Date

Signature of Notary Public

Date

State: _____ County: _____

Commission expires: _____

Consent Form

If you are applying for compensation for personal injury, this form must be signed and returned with your claim form.

Pursuant to Minnesota Statutes 115B.25 to 115B.37, I hereby voluntarily consent and authorize the Minnesota Pollution Control Agency (MPCA) or its representatives to examine medical records, including records in existence on the date of signature and after this date. I authorize any hospital, physician, medical practitioner, supplier, facility, insurance company, or employer to release to the MPCA any information concerning medical care, advice, treatment or supplies. I also give the MPCA or its representatives permission to discuss with health care providers, any information or opinion which may be relevant to the claim.

I agree to undergo medical examination or testing which may reasonably be required by the MPCA.

I further authorize the examination of employment records, records of unemployment or disability benefits, insurance benefits, and other information concerning my financial status or the status of my spouse and/or dependents, including all governmental or private benefits received, and waive all legal privileges pertaining to such as would otherwise apply. I agree to supply federal tax data when requested.

I understand this information will be used solely by the MPCA and its staff to determine compensation. This authorization is granted until the MPCA issues a final determination of the claim. A photocopy of this authorization shall be as valid as the original.

Signature of claimant
(parent or guardian if claimant is a minor)

Printed name of claimant

Date