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Attorneys for Respondent/Insurer

IN THE WORKERS' COMPENSATION COURT OF THE STATE OF MONTANA

DEBRA STAVENJORD, Petitioner, v. MONTANA STATE FUND, Respondent.	WCC No. 2000-0207 STATE FUND'S STATUS REPORT AND MOTION FOR FINALIZATION OF SETTLEMENT

COMES NOW the Montana State Fund ("MSF") and provides its Status Report and Motion for Approval and Finalization of Settlement in the present action along with a parallel request in *Reesor v. Montana State Fund*, WCC No. 2002-0676.

1. Background

The settlement of the *Stavenjord* and *Reesor* actions and the implementation of the settlements have been handled in tandem by MSF. Parallel pleadings are filed in both actions to provide a Status Report and Motion regarding finalization of settlement and dismissal.

On September 22, 2008, the parties filed their Settlement Agreement and Settlement Stipulation in *Stavenjord* (Dkt. 137) and *Reesor* (Dkt. 481). On October 15,

2008, the Court entered an Order approving the settlement in *Stavenjord*. On October 16, 2008, the Court entered an Order approving the settlements in Reesor.[1] The settlement implementation was stayed pending a determination of the "paid in full" retroactivity issues in *Flynn v. Montana State Fund*, WCC No. 2000-0222. (*Stavenjord* Dkt. 148, 159, *Reesor* Dkt. 493, 511.)

The Montana Supreme Court decided the *Flynn* case on November 29, 2011 (2011 MT 300). In that decision this Court was affirmed in its definition of claims considered to be settled because they were "paid in full." Paid in full claims, considered to be settled and not subject to retroactive application of judicial holdings, are defined as follows:

> A claim in which all benefits to which a claimant is entitled pursuant to the statutes applicable to that claim, are paid prior to the issuance of a judicial decision. If any benefits are paid on the claim after the issuance of a judicial decision, the claim can no longer be considered "paid in full" and is subject to retroactive application of the judicial decision.

Flynn, ¶ 7.

2. Settlements

In addition to being subject to the determination of "paid in full" settlement directions from a final decision in *Flynn*, the approved *Stavenjord* and *Reesor* settlements contain identical implementation provisions:

> 2. In reviewing potential entitlement under the *Reesor* and *Stavenjord* decisions of this Court and the Montana Supreme Court, the following standards, procedures and practices shall apply to the State Fund:
>
> * * *
>
> b. In the process of implementation, the State Fund will be allowed to take credit for any advances or overpayment on claims found entitled to *Reesor* or *Stavenjord* benefits.
>
> c. Those claimants who died prior to the Supreme Court decision in each case will not be entitled to additional benefits. Those dying after the Supreme Court decision will only be entitled to benefit consideration if a claim is presented with proper documentation by an appointed and

[1] Supplemental Settlement Stipulations were filed on October 16, 2008 (*Stavenjord* Dkt. 143, *Reesor* Dkt. 487).

presently acting Personal Representative.

d. Claims which have been settled, by settlement petitions approved by the Department of Labor or Stipulations approved by the Workers' Compensation Court, will not be entitled to additional benefits under *Reesor* or *Stavenjord.*

e. Payments of prior occupational disease entitlement will be credited against any award under *Reesor* or *Stavenjord.*

f. The entitlement date for an occupational disease claim considered for additional benefits under *Reesor* or *Stavenjord* shall be the date the claimant's occupational disease was first diagnosed as work related.

g. The notification process for consideration of *Reesor* and *Stavenjord* benefits shall be by letter to the population identified in each claim as potentially entitled to additional benefits under the decisions. The letters shall generally explain the potential entitlement, provide a questionnaire for information to be utilized in the review process and invite the person receiving the letter to submit a claim requesting review of potential entitlement. Claims will be processed on the basis of signed and completed questionnaires providing claim information and making claim for further benefits. The completed and executed questionnaire/claim form must be returned and received by the State Fund within 120 days of its mailing. Those claimants not returning the completed and executed questionnaire/claim form within 120 days will be considered as having opted out from and not bound by the settlement. Having opted out, such claimants will not be entitled to have their claims reviewed for *Stavenjord* or *Reesor* entitlement pursuant to the terms and conditions hereof but may present their claims separately. Letters returned as undeliverable to the State Fund will be processed once through an appropriate address review software. In the event of a second mailing to a new address, the addressees will have 120 days from the date of re-mailing to respond with a completed and executed questionnaire/claim form. Those not returning the completed and executed questionnaire/claim form within such 120 days will be considered as having opted out from and not bound by the settlement. Having opted out, such claimants will not be entitled to have their claims reviewed for *Stavenjord* or *Reesor* entitlement pursuant to the terms and conditions hereof but may present their claim separately.

h. It is reasonable to establish appropriate time tables for the adjustment of claims potentially entitled to further benefits. Therefore, the State Fund may issue denial letters relative to further entitlement under the Supreme Court decision in this matter to those claimants who opt out of the

settlement. Such claimants would nevertheless retain the right to present their claims, subject to the applicable provisions of the Workers' Compensation Act.

i. The periods for returning properly completed and executed questionnaires/claim forms may be extended for good cause. For purposes of this agreement, "good cause" shall mean that the claimant to whom the notification letter was sent was unable to receive the letter because of being in the military on active duty, out of the country or was subject to a disability that made it impossible to understand the contents of the notification letter. The extension of the period for response to the notification letter with a completed and executed questionnaire and claim form shall be limited to the period of unavailability or mental disability defined above.

j. The notification letters, questionnaire/claim forms, and denial letters, referenced in the preceding two paragraphs, shall be presented to the Court and subject to Court approval before being sent to the claimants.

Dkt. 142 at 2-3. The Court also approved the process for identification and notification of persons potentially entitled to increased benefits under both the *Stavenjord* and *Reesor* decisions described during the hearing on April 26, 2007, in this action. (Transcr. & Exs. at Dkt. 111.)

3. Settlement Implementation

A. Identification

The mailing list for potentially entitled claimants assembled by the methods approved in the April 26, 2007, hearing has been updated by MSF following the *Flynn* decision, as noted above.

The master mailing lists of claimants potentially entitled to benefits under the decisions were known to be overinclusive. Additional review has determined that some claims identified involved claimants who had returned to their time of injury positions and had a 0% impairment rating, partial benefits were paid or the claims were settled. From that revised list those claims paid in full under *Flynn* were removed. (*Stavenjord* claims with no payments made of any kind after the date of the original Supreme Court benefit decision, May 21, 2001, were considered paid in full. The decision date for *Reesor* was December 22, 2004.)

The updated "final mailing list" for *Stavenjord* contains 543 claims. The updated "final mailing list" for *Reesor* list contains 602 claims. These claims will be included in the notice/questionnaire mailing.

B. Notice

MSF will mail approved letters to all claimants on the revised mailing list within 30 days of the Court approving the finalization process. Copies of such letters are attached as Exhibits 1 and 2.[2] Each letter will contain a questionnaire, attached as Exhibits 3 and 4. Deceased claimant letters are attached as Exhibits 5 and 6. Deceased claimant questionnaires are attached as Exhibits 7 and 8.

C. Review

All questionnaires timely received by MSF will be reviewed pursuant to the terms and conditions of the approved settlements and entitlement decisions. Every claimant will be notified of the determination of entitlement made after the review. Copies of letters to be sent on each claim after review are attached as Exhibit 9 (award notice) and Exhibit 10 (no entitlement notice).

D. Opt Out

Those claimants who do not return questionnaires will receive a denial letter. *See* Ex. 11.

E. Returned Letters

Letters returned as undeliverable to the State Fund will be processed once through appropriate address review software. The software to be utilized is Lexis/Nexis and/or Merlin Information Services. Second letters will be sent upon securing a new address through the software.

F. Payment

Claimants entitled to additional benefits shall be paid within 30 days of MSF's calculation of further entitlement.

G. Final Report

MSF will provide the Court a Final Report upon completion of the settlement implementation process.

[2] The letters and questionnaires are the same as reviewed at and approved following the 2007 hearing in *Stavenjord* with a few minor, non substantive edits.

4. Motions

MSF moves the Court for the entry of an Order approving the described identification and notice process and the settlement implementation process. MSF further moves the Court for an Order finalizing the list of those entitled to review and potential payment under the approved settlements to those claimants on the final mailing list for each case.

DATED this 6th day of March, 2012.

Attorneys for Respondent/Insurer:

MONTANA STATE FUND
P.O. Box 4759
Helena, MT 59604-4759

GARLINGTON, LOHN & ROBINSON, PLLP
350 Ryman• P.O. Box 7909
Missoula, MT 59807-7909

By Bradley J. Luck
Bradley J. Luck

Stavenjord · PO Box 6698 · Helena MT 59604-6698
Customer Service: 1-800-332-6102 or 406-495-5000
Fraud Hotline: 1-888-682-7463 (888-MT-CRIME)

December 1, 2011

RE: Injured Employee:
Claim #:

Dear Sir or Madam:

A Montana Supreme Court decision, *Stavenjord v. Montana State Fund*, has determined that workers suffering from an occupational disease are entitled to the same permanent partial disability benefits as workers suffering from an injury.

Montana State Fund (MSF) is reviewing its workers' compensation claims to determine eligibility for additional permanent partial disability benefits which may be due under *Stavenjord*.

The above noted claim has been identified as potentially entitled to additional permanent partial disability benefits under *Stavenjord*.

In order to determine potential eligibility for additional permanent partial disability benefits, further information is necessary. To expedite our review, we have enclosed a questionnaire to be completed and returned in the enclosed return envelope. Your prompt attention to this matter will expedite our review of this file.

PLEASE DO NOT CALL. Completion and return of the enclosed questionnaire will assist us in reviewing the claim for entitlement. If further information is needed, we will contact you.

PLEASE NOTE: This letter is not notification of entitlement to Stavenjord permanent partial disability benefits. Rather, we have identified this claim as potentially being due additional permanent partial disability benefits. Further review of the claim is necessary and we will notify you in writing of our determination upon assessment of the necessary information.

MONTANA STATE FUND

c:

Stavenjord FY88-91 – Rev 02/2008

Exhibit 1

Stavenjord · PO Box 6698 · Helena MT 59604-6698
Customer Service: 1-800-332-6102 or 406-495-5000
Fraud Hotline: 1-888-682-7463 (888-MT-CRIME)

December 1, 2011

RE: Injured Employee:
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Dear Sir or Madam:

A Montana Supreme Court decision, *Stavenjord v. Montana State Fund*, has determined that workers suffering from an occupational disease are entitled to the same permanent partial disability benefits as workers suffering from an injury.

Montana State Fund (MSF) is reviewing its workers' compensation claims to determine eligibility for additional permanent partial disability benefits which may be due under *Stavenjord.*

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In order to determine potential eligibility for additional permanent partial disability benefits, further information is necessary. To expedite our review, we have enclosed a questionnaire to be completed and returned in the enclosed return envelope. Your prompt attention to this matter will expedite our review of this file.

PLEASE DO NOT CALL. Completion and return of the enclosed questionnaire will assist us in reviewing the claim for entitlement. If further information is needed, we will contact you.

PLEASE NOTE: This letter is not notification of entitlement to Stavenjord permanent partial disability benefits. Rather, we have identified this claim as potentially being due additional permanent partial disability benefits. Further review of the claim is necessary and we will notify you in writing of our determination upon assessment of the necessary information.

MONTANA STATE FUND

c:

Stavenjord FY92+ - Rev 02/2008

Exhibit 2

MONTANA STATEFUND

Stavenjord · PO Box 6698 · Helena MT 59604-6698
Customer Service: 1-800-332-6102 or 406-495-5000
Fraud Hotline: 1-888-682-7463 (888-MT-CRIME)

STAVENJORD QUESTIONNAIRE

NAME: **CLAIM NUMBER:**

PHYSICAL IMPAIRMENT (a purely medical determination provided by a physician based upon the Guides to Evaluation of Permanent Impairment published by the American Medical Association.)

A. I received an impairment rating from my physician of _____ %.

B. I was not notified of an impairment rating but do ~~think/know~~ believe that I did suffer a permanent restriction or physical limitation as a result of my occupational disease _____ Yes _____ No

If "Yes", please explain what limitations you feel you have suffered as a result of your occupationally related condition: _____

_____

_____

WAGE LOSS

A. I did suffer a wage loss as a result of my occupationally related condition when I returned to my time of injury job _____ Yes _____ No

B. I did suffer a wage loss as a result of my occupationally related condition when I returned to alternative employment _____ Yes _____ No

If "Yes" to either of the above, please provide three (3) years of employment history from your release to return to work. **Please note, we may later request documentation to support this information.** Please utilize a separate sheet if needed.

FROM	TO	EMPLOYER	OCCUPATION	HOURLY WAGE

SUBSEQUENT INJURY / OCCUPATIONAL DISEASE

Have you suffered a subsequent injury and/or disease that have affected your above noted occupational disease?

O No
O Yes

88-91

Exhibit 3

Stavenjord · PO Box 6698 · Helena MT 59604-6698
Customer Service: 1-800-332-6102 or 406-495-5000
Fraud Hotline: 1-888-682-7463 (888-MT-CRIME)

STAVENJORD QUESTIONNAIRE – PG 2

NAME:	CLAIM NUMBER:

CONTACT INFORMATION

Please note your address below if such is different than the address to which this information was mailed:

Mailing address: _____

_____

_____

Phone: _____

In submitting this information, I understand if I obtain workers' compensation benefits that I am not entitled to I may be subject to civil or criminal penalties as provided in Section 39-71-316 of the Montana Code Annotated.

Signed: _____ Date: _____

Stavenjord FY88-91Questionnaire

Exhibit 3

MONTANA STATEFUND

Stavenjord · PO Box 6698 · Helena MT 59604-6698
Customer Service: 1-800-332-6102 or 406-495-5000
Fraud Hotline: 1-888-682-7463 (888-MT-CRIME)

STAVENJORD QUESTIONNAIRE

NAME: **CLAIM NUMBER:**

PHYSICAL IMPAIRMENT (a purely medical determination provided by a physician based upon the Guides to Evaluation of Permanent Impairment published by the American Medical Association.)

A. I received an impairment rating from my physician of _____ %.

B. I was not notified of an impairment rating but do ~~know/think~~ believe that I did suffer a permanent restriction or physical limitation as a result of my occupational disease _____ Yes _____ No

If "Yes", please explain what limitations you feel you have suffered as a result of your occupationally related condition: _____

_____

_____

WAGE LOSS

A. I did suffer a wage loss as a result of my occupationally related condition when I returned to my time of injury job _____ Yes _____ No

B. I did suffer a wage loss as a result of my occupationally related condition when I returned to alternative employment _____ Yes _____ No

If "Yes" to either of the above, please provide three (3) years of employment history from your release to return to work. **Please note, we may later request documentation to support this information.** Please utilize a separate sheet if needed.

FROM	TO	EMPLOYER	OCCUPATION	HOURLY WAGE

EDUCATION LEVEL

At the time of the onset of my occupational disease (as indicated on your claim form) my level of education was:

O Less than 9 years
O 9 through 12 years
O More than 12 years

Exhibit 4

Stavenjord · PO Box 6698 · Helena MT 59604-6698
Customer Service: 1-800-332-6102 or 406-495-5000
Fraud Hotline: 1-888-682-7463 (888-MT-CRIME)

STAVENJORD QUESTIONNAIRE – PG 2

NAME: **CLAIM NUMBER:**

LABOR LEVEL

At my time of injury job, I was required to do:

O **Heavy labor activity** (lift over 50# occasionally or up to 50# frequently)
O **Medium labor activity** (lift up to 50# occasionally or up to 25# frequently)
O **Light labor activity** (lift up to 25# occasionally or up to 10# frequently)
O **Sedentary labor activity** (lift up to 10# occasionally or up to 5# frequently)

As a result of my occupational disease, my physician permanently limited me to:
O Medium labor activity
O Light or sedentary labor activity
O There was no change in my work abilities as a result of my occupational disease

SUBSEQUENT INJURY / OCCUPATIONAL DISEASE

Have you suffered a subsequent injury and/or disease that have affected your above noted occupational disease?

O No
O Yes

CONTACT INFORMATION

Please note your current address below if such is different than the address to which this information was mailed:

Mailing address: _____

_____

_____

Phone: _____

In submitting this information, I understand if I obtain workers' compensation benefits that I am not entitled to, I may be subject to civil or criminal penalties as provided in Section 39-71-316 of the Montana Code Annotated.

Signed: _____ Date: _____

Exhibit 4

Stavenjord · PO Box 5598 · Helena MT 59604-6698
Customer Service: 1-800-332-6102 or 406-444-6500
Fraud Hotline: 1-888-682-7463 (888-MT-CRIME)

MONTANA STATE FUND

Date

Estate of XXXXXXXXX
Address
City State Zip

RE: WORKER:
CLAIM NUMBER:

Dear Sir or Madam:

Montana State Fund managed a workers' compensation claim for XXXXXX regarding an occupational disease dated XX/XX/XX.

In the case of *Stavenjord v. Montana State Fund*, the Montana Supreme Court determined that workers suffering from an occupational disease are entitled to the same permanent partial disability benefits as workers suffering from an injury.

Montana State Fund (MSF) and the attorney representing Stavenjord have reached a settlement in the case. As a component of the settlement, MSF will review claims in which it receives a completed and signed questionnaire regarding potential eligibility for permanent partial disability benefits which may be due under *Stavenjord*.

The above noted claim has been identified as being potentially entitled to additional permanent partial disability benefits under *Stavenjord*.

We recognize Ms. Doe passed away XX/XX/XX. However, heirs to the estate may be eligible for any *Stavenjord* benefits due. To determine potential eligibility for additional permanent partial disability benefits, we require additional information. We have enclosed a questionnaire for a representative of the deceased's estate to complete and returne in the enclosed return envelope. We recognize given the circumstances you may not be able to provide responses to all questions. However, any responses you can provide will assist us in determining entitlement to further benefits. **You must return the completed questionnaire to Montana State Fund within 120 days from the date of this letter.** The questionnaire must be completed and submitted by an appointed and presently acting personal representative of the deceased worker's estate. Please provide a copy of the representation documentation with submission of the completed questionnaire.

If the completed and signed questionnaire is not returned and received by MSF within 120 days from the date of this letter, we will consider that you have opted out of the settlement and you will not be bound by its terms. However, you may choose to pursue this claim independently.

Exhibit 5

PLEASE NOTE: This letter is not notification of entitlement to Stavenjord permanent partial disability benefits. Rather, we have identified this claim as potentially being due additional permanent partial disability benefits. Further review of the claim is necessary and we will notify you in writing of our determination upon assessment of the necessary information.

If you have any questions, please contact:

Kathy Strobel
Claims Project Specialist
(406) XXX-XXXX

Stavenjord · PO Box 5598 · Helena MT 59604-6698
Customer Service: 1-800-332-6102 or 406-444-6500
Fraud Hotline: 1-888-682-7463 (888-MT-CRIME)

Date

Estate of XXXXXXXXX
Address
City State Zip

RE: WORKER:
CLAIM NUMBER:

Dear Sir or Madam:

Montana State Fund managed a workers' compensation claim for XXXXXX regarding an occupational disease dated XX/XX/XX.

In the case of *Stavenjord v. Montana State Fund*, the Montana Supreme Court determined that workers suffering from an occupational disease are entitled to the same permanent partial disability benefits as workers suffering from an injury.

Montana State Fund (MSF) and the attorney representing Stavenjord have reached a settlement in the case. As a component of the settlement, MSF will review claims in which it receives a completed and signed questionnaire regarding potential eligibility for permanent partial disability benefits which may be due under *Stavenjord*.

The above noted claim has been identified as being potentially entitled to additional permanent partial disability benefits under *Stavenjord*.

We recognize Ms. Doe passed away XX/XX/XX. However, heirs to the estate may be eligible for any *Stavenjord* benefits due. To determine potential eligibility for additional permanent partial disability benefits, we require additional information. We have enclosed a questionnaire for a representative of the deceased's estate to complete and returne in the enclosed return envelope. We recognize given the circumstances you may not be able to provide responses to all questions. However, any responses you can provide will assist us in determining entitlement to further benefits. **You must return the completed questionnaire to Montana State Fund within 120 days from the date of this letter**. The questionnaire must be completed and submitted by an appointed and presently acting personal representative of the deceased worker's estate. Please provide a copy of the representation documentation with submission of the completed questionnaire.

If the completed and signed questionnaire is not returned and received by MSF within 120 days from the date of this letter, we will consider that you have opted out of the settlement and you will not be bound by its terms. However, you may choose to pursue this claim independently.

Exhibit 6

PLEASE NOTE: This letter is not notification of entitlement to Stavenjord permanent partial disability benefits. Rather, we have identified this claim as potentially being due additional permanent partial disability benefits. Further review of the claim is necessary and we will notify you in writing of our determination upon assessment of the necessary information.

If you have any questions, please contact:

Kathy Strobel
Claims Project Specialist
(406) XXX-XXXX

STAVENJORD QUESTIONNAIRE

WORKER NAME: **CLAIM NUMBER:**

PHYSICAL IMPAIRMENT (a purely medical determination provided by a physician based upon the Guides to Evaluation of Permanent Impairment published by the American Medical Association.)

A. An impairment rating from the physician of ____ % was rendered prior to death.

B. Unknown if a physical impairment was rated prior to death ____

WAGE LOSS

A. The worker was released to or returned to their time of injury position: O Yes O No O Don't know (If "yes" skip to the Contact Information)

B. The worker returned to and/or was released to work in a modified or alternative work position: O Yes O No O Don't know

C. The worker suffered a wage loss as a result of the occupationally related condition when the worker returned to alternative employment:: O Yes O No O Don't know

If "Yes" to B & C, please provide three (3) years of employment history from the release to return to work. **Please note, we may later request documentation to support this information.** Please utilize a separate sheet if needed.

FROM	TO	EMPLOYER	OCCUPATION	HOURLY WAGE

SUBSEQUENT INJURY / OCCUPATIONAL DISEASE

Did the worker suffer any other known subsequent work-related injuries and/or conditions that may have affected the worker's above noted occupational disease?

O Don't know
O No
O Yes Please explain: _____

STAVENJORD QUESTIONNAIRE – PG 2

WORKER NAME:	CLAIM NUMBER:

CONTACT INFORMATION

Please note the name/address of the heir responsible for the worker's estate:

Name & Mailing address: _____

_____

Phone: _____

(Please provide a copy of documentation noting personal representation of the estate)

In submitting this information, I understand if I provide false information and consequently obtain workers' compensation benefits that I am not entitled to, I may be subject to civil or criminal penalties as provided in Section 39-71-316 of the Montana Code Annotated.

Signed: _____ Print:: _____ Date: _____

Exhibit 7

STAVENJORD QUESTIONNAIRE

WORKER NAME: **CLAIM NUMBER:**

PHYSICAL IMPAIRMENT (a purely medical determination provided by a physician based upon the Guides to Evaluation of Permanent Impairment published by the American Medical Association.)

A. An impairment rating from the physician of ____ % was rendered prior to death.

B. Unknown if a physical impairment rating was determined prior to death ____

WAGE LOSS

A. The worker was released to or returned to their time of injury position: O Yes O No O Don't know (If "yes" skip to the Contact Information)

B. The worker returned to and/or was released to work in a modified or alternative work position: O Yes O No O Don't know

C. The worker suffered a wage loss as a result of the occupationally related condition when the worker returned to alternative employment: O Yes O No O Don't know

If "Yes" to B & C, please provide three (3) years of employment history from the release to return to work. **Please note, we may later request documentation to support this information.** Please utilize a separate sheet if needed.

FROM	TO	EMPLOYER	OCCUPATION	HOURLY WAGE

EDUCATION LEVEL

A. At the time the claim was filed, what was the highest level of education the worker had attained? _____

B. At the time the claim was filed, had the worker attained either a high school diploma or GED? O Yes O No O Don't know

Exhibit 8

STAVENJORD QUESTIONNAIRE – PG 2

WORKER NAME: **CLAIM NUMBER:**

LABOR LEVEL

At the time of injury job, the worker was required to do:

O **Heavy labor activity** (lift over 50# occasionally or up to 50# frequently)
O **Medium labor activity** (lift up to 50# occasionally or up to 25# frequently)
O **Light labor activity** (lift up to 25# occasionally or up to 10# frequently)
O **Sedentary labor activity** (lift up to 10# occasionally or up to 5# frequently)
O Don't know

As a result of the occupational disease, the physician permanently limited the worker to:
O Medium labor activity
O Light or sedentary labor activity
O There was no change in my work abilities as a result of my occupational disease
O Don't know

SUBSEQUENT INJURY / OCCUPATIONAL DISEASE

Did the worker suffer any known subsequent work-related injuries and/or diseases that have affected the above noted occupational disease?

O No
O Yes
O Don't know

CONTACT INFORMATION

Please note the name and mailing address of the heir responsible for the worker's estate:

Name & Mailing address: _____

_____

Phone: _____

(Please provide a copy of documentation noting personal representation of the estate)

In submitting this information, I understand if I provide false information and consequently obtain workers' compensation benefits that I am not entitled to, I may be subject to civil or criminal penalties as provided in Section 39-71-316 of the Montana Code Annotated.

Signed: _____ Date: _____

Exhibit 8

Stavenjord · PO Box 6698 · Helena MT 59604-6698
Customer Service: 1-800-332-6102 or 406-444-6500
Fraud Hotline: 1-888-682-7463 (888-MT-CRIME)

Date

Addressee
Address
City State Zip

RE: WORKER:
CLAIM NUMBER:

Dear:

We have received your completed and signed questionnaire regarding potential entitlement to permanent partial disability benefits under *Stavenjord.*

After we reviewed the information in our possession, we calculated your benefits per 39-71-703 of the XXXX Montana Workers' Compensation Act. Enclosed please find a copy of our calculations. We will issue a check for this amount under separate cover.

If you disagree with this decision concerning your claim, please notify Montana State Fund in writing. Montana State Fund will respond within 15 days. If you are not satisfied with Montana State Fund's response, you may request a non-binding mediation conference. You may obtain a mediation request form from the Employment Relations Division of the Department of Labor and Industry by calling 406-444-6534 or by writing to PO Box 1728, Helena MT 59624. Mediation request forms area also available at local Job Service offices.

If you have any questions regarding this matter, please contact me at the below number.

Sincerely,

XXXXXX
Claims Project Specialist
(406) 444-XXXX

Enclosure

Exhibit 9

Stavenjord · PO Box 6698 · Helena MT 59604-6698
Customer Service: 1-800-332-6102 or 406-444-6500
Fraud Hotline: 1-888-682-7463 (888-MT-CRIME)

Date

Addressee
Address
City State Zip

RE: WORKER
CLAIM NUMBER:

Dear:

We are in receipt of your signed and completed questionnaire regarding potential entitlement to permanent partial disability benefits under Stavenjord. After review of all information in our possession, we find that you are not entitled to permanent partial disability benefits under Stavenjord due to the following:

( ) Released to time of injury job
( ) Claim settled
( ) Worker deceased prior to 4/1/03
( ) Worker permanently and totally disabled
( ) Permanent partial disability benefits previously paid
( ) Other:

If you disagree with this decision concerning your claim, please notify Montana State Fund in writing. A response will be provided within 15 days. If you are not satisfied with Montana State Fund's response, you must request a non-binding mediation conference. You may obtain a mediation request form from the Employment Relations Division of the Department of Labor and Industry by calling 406-444-6534 or by writing to PO Box 1728, Helena MT 59624. Mediation request forms are also available at local Job Service offices.

If you have any questions regarding the above, please contact me at the below number.

Sincerely,

XXXXX
Claims Project Specialist
(406) 444-XXXX

Exhibit 10

Stavenjord · PO Box 6698 · Helena MT 59604-6698
Customer Service: 1-800-332-6102 or 406-444-6500
Fraud Hotline: 1-888-682-7463 (888-MT-CRIME)

MONTANA STATEFUND

Date

Addressee
Address
City State Zip

RE: WORKER:
CLAIM NUMBER:

Dear:

We previously sent you notice of your potential entitlement to permanent partial disability benefits per a Montana Supreme Court decision Stavenjord v. Montana State Fund.

You were given 120 days from the mailing date of our notice to provide a completed and signed questionnaire. We did not receive your questionnaire by the necessary deadline and therefore, as authorized by the October 16, 2008 Order from the Montana Workers' Compensation Court, we are denying liability for Stavenjord benefits.

If you disagree with this decision concerning your claim, please notify Montana State Fund in writing. Montana State Fund will provide a response within 15 days. If you are not satisfied with Montana State Fund's response, you may request a non-binding mediation conference. You may obtain a mediation request form from the Employment Relations Division of the Department of Labor and Industry by calling 406-444-6534 or by writing to PO Box 1728, Helena MT 59624. Mediation request forms are also available at local Job Service offices.

Sincerely,

XXXXXXX
Claims Project Specialist
(406) 444-XXXX

Exhibit 11