WORKERS' COMPENSATION COMMISSION

REQUEST TO IMPLEAD A PARTY

INSTRUCTIONS: This form is to be used to implead additional parties in a claim. It does not initiate a hearing. An appropriate WCC form, such as "Issues" form H24R, must be filed to request a hearing. Do not use this form to implead the the Maryland Property & Casualty Insurance Guaranty Corporation (PCIGC)

WCC CLAIM NUMBER _____

CLAIMANT'S NAME _____

EMPLOYER _____

INSURER _____

If hearing has been scheduled:

DATE _____ **LOCATION**

REQUEST TO THE COMMISSION:

The undersigned party to this Workers' Compensation Claim requests that the following party be impleaded:

◯ **Employer** ◯ **Statutory Employer** ◯ **Insurance Carrier** ◯ **SIF*** ◯ **UEF**

Name: _____

Address: _____

_____ _____ _____

*See COMAR 14.09.02.03

Carrier, Policy Number (if known)-

REQUESTED BY:

◯ **Claimant** ◯ **Claimant's Attorney** ◯ **Employer** ◯ **Employer's Attorney**

◯ **Insurer's Attorney** ◯ **SIF** ◯ **UEF**

Full Name _____

Address _____

City _____ **State** _____ **Zip Code** _____

I HEREBY CERTIFY that on this ____day of _____ _____service of the foregoing was made in accordance with COMAR 14.09.01.03.

_____ _____ _____

Signature **Date** **Telephone**

CLICK HERE TO CLEAR THE FORM