FORM WC-02

CLAIM AGAINST A THIRD-PARTY [A.S.C.A. §32.0669]

Pursuant to A.S.C.A. §32.0669(a), the employee is entitled to compensation against a third-party if some individual other than the employer are liable in damages. An employee needs not to elect whether to receive such compensation or to recover damages against such a third person. However, the acceptance of compensation under an award in a compensation order operates as an assignment to the employer of all rights of the individual entitled to compensation to recover damage against such third person, unless such individual commences an action against such third person within 6 months after the award is made. To file a claim in recovering damages against a third-party, this form must be filed with the Commission's Office.

1. Name of Applicant:	2. Specify Applicant Filing Third Party Claim: ☐ Employer | ☐ Injured Employee	3. WCC Case No.:
4. Name of the Third-Party Entity or Person:	5. Specify the Third-Party's Type of Business or Industry:	

6. Third Part's Mailing Address:	7. Telephone Number:	8. Email Address:
	9. Specify the Relation of the Employee's to the Third-Party Entity or Person (if any):	

10. REQUIRED – Specify Total Payment(s) or Damages the Applicant is Claiming for Recovery:

Medical Expenses:	Reimbursements:	TTD (Temporary Loss Wages):	TPD (Temporary Loss in Wage-Earning):
Disfigurement:	Permanent Impairment Disability (Partial):	Permanent Impairment Disability (Total):	
Other Payments (specify):			

11. Are the payments claimed for recovery have already settled and paid by the employer / carrier to the injured employee? ☐ Yes ☐ Only a Few	12. Name the payments not yet paid to the employee:
13. Name of Authorized Person Signing this Claim Form:	14. Title or Position of Person Signing this Form:
15. **Authorization:** *I hereby verify and acknowledge as the Applicant, or the Petitioner or Attorney representing on behalf of the Applicant, filing this third-party claim before the Commission. I affirmed that all information, records, and documentation disclosed within and enclosed together with this form are both true and not fraudulent.* (Sign): _____. SIGNATURE DATE: _____.	FILED *** AUTHORIZED OWCC PERONNEL ONLY *** WORKMEN'S COMPENSATION COMMISSION AMERICAN SAMOA GOVERNMENT

FORM DISTRIBUTION:

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