KANSAS DEPARTMENT OF LABOR

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ABLE AND AVAILABLE STATEMENT: MEDICAL CONDITION OR WORKERS COMPENSATION

K-BEN 31-M Web (10-17)

MAIL: Unemployment Contact Center
P.O. Box 3539
Topeka, KS 66601-3539

FAX: (785) 296-3249

EMAIL: **Submit**

Claimant Name: ____ Social Security number: ____________________

The Employment Security Law requires that in order to receive unemployment benefits, you must be able and immediately available for employment with no undue restrictions. You have indicated that you have the following restriction that may prevent you from accepting employment or limit your availability to work: **Medical.**

Complete this form and return it within **seven days** of the date you filed your claim. **Failure to reply by this date may result in a denial of benefits or possible overpayment.**

IMPORTANT: Health care information is required to determine if you are eligible for unemployment insurance benefits. If you're under a doctor's care, a *Health Care Provider's Certification, K-BEN 312,* must be completed by your physician. Your signature is required on the certification and the Claimant's Release.

Were/are you able to work? ☐ YES ☐ NO If NO, date you became unable to work (mm/dd/yyyy): ___________________

Date of injury (mm/dd/yyyy): ________________

Describe illness or injury: ____

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____

Were/are you currently under a doctor's care?

☐ YES Explain: ____

☐ NO Date you were released to return to work (mm/dd/yyyy): _______________

Do you have medical restrictions? ☐ YES ☐ NO

If YES, explain: ____

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Were you injured at work? ☐ YES ☐ NO

If YES, name of employer you were working for when you were injured: ____

Date you applied for workers compensation (mm/dd/yyyy): _____________________

Are you currently receiving, or have you received, workers compensation since your last day of work? ☐ YES ☐ NO

If YES, provide the insurance company's information:

Agent name: ____

Company name: ____

Company address: ____

Company phone: ____

Able and Available Statement: Medical Condition or Workers Compensation

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Claimant name: ____ Social Security number: __________________________

Date you received your last workers compensation benefits (mm/dd/yyyy): _______________________

Did you receive a weekly payment from Workers Compensation? ☐ YES ☐ NO

If YES, the weekly amount: $ ____________________

Date you began receiving payment (mm/dd/yyyy): __________________

Type of workers compensation benefits received:

☐ Temporary Total Disability ☐ Temporary Partial Disability ☐ Permanent Total Disability ☐ Permanent Partial Disability

Your normal work duties: ____

Have you contacted your employer since your injury? ☐ YES ☐ NO

Will you return to your job after you are released to go to work? ☐ YES ☐ NO

If NO, explain: ____

Is there other work you are able and qualified to do within your medical restrictions, experience and training? ☐ YES ☐ NO

If NO, explain: ____

____

If YES, type of work you are looking for: ____

Do you have experience or training in this type of work? ☐ YES ☐ NO

If YES, amount of experience: No. of years: ________ No. of months: ________ No. of weeks: ________

Number of days per week you are willing to work: ________

Shifts you are willing to work (check all that apply): ☐ 1st ☐ 2nd ☐ 3rd

If you are only willing to work one specific shift, explain why: ____

Miles you are willing to travel to your next job: _________

The least wage per hour you will accept on your next job: $ _____________.______

List your efforts to seek work in the past seven days:

Date of Contact	Name of Employer	Method of Contact	Results of Contact

If no contacts were made, explain: ____

CERTIFICATION: I certify that the information I have provided is correct and complete, and I understand the willful or intentional misrepresentation or failure to disclose a material fact is punishable under the Kansas Employment Security Law.

Signature: ____

Phone: (______)____________________________________ Date (mm/dd/yyyy): ____

*NOTE: Protecting claimants' identity is important to us. Please be advised that: (1) email communication is not a secure method of communication; (2) any email that is sent between you and this agency may be copied and held by various computers it passes through as it is transmitted; (3) persons not participating in the communication between you and KDOL may intercept the communication by improperly accessing your computer or this agency's computer or even some computer unconnected to either of us that this email passes through. If you do not want to communicate with KDOL through email, please call KDOL or mail your communication to KDOL, instead of using email.