

To: All Employees

Re: South Carolina Second Injury Fund Form

Attached, please find a Medical Inquiry Form that our insurance carrier has requested we have you complete. The form asks you to disclose whether you have or have had certain illnesses and permanent conditions. Your answers will not be used in making employment decisions. The form's sole purpose is to allow the (employer's) workers' compensation insurer to seek reimbursement from the State, if you are injured in a work-related accident that affects or is affected by a pre-existing condition. To qualify for reimbursement, the employee must have told the (employer) of the pre-existing condition, or the employee must have concealed the pre-existing condition from the employer. The attached form is designed to meet one of those two requirements. The form will remain with and only be reviewed by (human resources/risk management/personnel) and the (employer's) workers' compensation insurance carrier.

We understand that you may not feel comfortable filling out the form. Accordingly, you may elect not to fill out the form. If you elect not to fill out the form, we ask that you sign and date the acknowledgement form so indicating and enclose the form in the envelope provided. Your election not to fill out the form will **not** be held against you or considered in employment actions. Similarly, if you elect to fill out the form, please enclose the completed form and acknowledgement in the envelope provided. The envelope should be delivered to _____.

We appreciate your cooperation with this effort. Please see _____ for any questions.