

**To: Post-Offer/Pre-Employment 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 sole purpose of the form 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.

Please sign and date the acknowledgment form so indicating, and enclose the form in the envelope provided. The envelope should be delivered to \_\_\_\_\_. We appreciate your cooperation with this effort. Please see \_\_\_\_\_ for any questions.