

Instructions for Completing the Workers' Claim for Compensation

Please read all pages

This form is “**fillable**.” That means you can type the information onto the form from your computer and print the form. You will not be able to save the form onto your computer's hard drive.

When you open the form, click in the “Employee's Name” box (field), and use the tab key to navigate to the next field. Do not use the Enter key; pressing the Enter key will only page down. Each field has been *limited*. This means that you cannot continue to type information into a field if it doesn't fit into the space provided.

Use numbers only to fill in the fields for Social Security Number, phone numbers and dollar amounts. Do not use dashes or parentheses; when you tab out of the field, it will fill in automatically. If a dollar amount contains cents, do type the period. To fill in a **check box**, click inside the box with your mouse. Some fields contain a **drop down menu**; click on the arrow and select one of the choices.

To clear or delete all the information you have typed onto the form, click on the red “**Clear Entire Form**” button. To change the information in one field, use the backspace or delete key.

Adobe Acrobat - [WC015 Workers' Claim for Compensation.pdf]

File Edit Document Tools View Window Help

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COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
 Division of Workers' Compensation
 1515 Arapahoe St., Denver, CO 80202-2117

READ REVERSE SIDE

WORKER'S CLAIM FOR COMPENSATION

Clear Entire Form

Employee's Name (first, middle, last) Social Security Number Sex Employee's Home Phone Number Print or Use Typewriter Answer Every Question Mail Two Signed Copies

Employee's Street Address City State Zip Code Occupation

Age Birthdate Dependence of experience at this moment? DO NOT WRITE IN SHADED AREAS

“Clear Entire Form” button
 Clears all information at once

Years of Education Completed (select one) Ethnic Area

“Check Box”
 Click in box

Address Where Injury or Disease Occurred (street address) City

Reported to Employer To whom was it reported? Accident Date

Mo Day Yr

Are you receiving pay for Average Weekly Wage at Time of Injury or Disease Hourly Wage at Time of Injury OCC

Overtime Average Weekly \$
 Commissions Average Weekly \$
 Piecework Average Weekly \$

“Drop Down Menu”
 Click on the arrow for choices

Employee's Scheduled Hrs. Per Day Days Per Week Check box if you receive Will benefit continue During disability? Average weekly Value of benefit Part of Body

start | 10:02 AM Tuesday 5/6/2003

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WORKER'S CLAIM FOR COMPENSATION

Employee's Name (first, middle, last)			Social Security Number		Sex		Employee's Home Phone Number		Print or Use Typewriter Answer Every Question Mail Two Signed Copies			
Employee's Street Address			City		State	Zip Code	Occupation					
Age	Birthdate Mo Day Yr		Dependents Yes No		Marital Status		How Long employed with this employer?		Job assigned when injured/exposed?	Length of experience at this assignment?	DO NOT WRITE IN SHADED AREAS	
Years of Education Completed (select one)						Ethnic				Accident Date		
Employer's Name at Time of Injury or Disease						Employer's Other Company Name					Area	
Employer's Mailing Address						City	State	Zip Code	Employer's Phone Number		SIC	
Address Where Injury or Disease Occurred (street address)						City	State	County		Zip Code	Accident Time	
Reported to Employer Mo Day Yr			To whom was it reported?									Sex
Are you receiving pay for			Average Weekly Wage at Time of Injury or Disease				Hourly Wage at Time of Injury			OCC		
Overtime Average Weekly \$ _____			\$ _____				\$ _____			Source		
Commissions Average Weekly \$ _____										Part of Body		
Piecework Average Weekly \$ _____												
Employee's Scheduled Work Week When Injured		Hrs. Per Day	Days Per Week	Check box if you receive		Will benefit continue During disability?		Average weekly Value of benefit		Nature		
Employee's Usual Work Schedule				Tips				\$ _____		Type		
				Meals				\$ _____		County		
				Rooms				\$ _____				
				Health Insurance *				\$ _____		AWW		
* If health insurance benefit will not continue during disability, set forth your cost of continuing employer's health insurance or employee's cost of conversion \$ _____ per week.												
Date of Injury/Disease Mo Day Yr	Injury Time		Last Day Worked Mo Day Yr		Date Returned to Work _____			Disfigurement	Scar	3 rd Party		
					Date Estimated to Return _____			Describe				Coder
					Date Left Work Again _____					Scarring		
					Date Return to Work Again _____							
Injury description (state exactly the part of the body affected, how injury or illness happened, what you were doing at the time, (include name(s) of other individuals involved, tools, machinery, objects, vapors, chemicals, radiations, unnatural motions, etc.). Please specify the items which directly injured you.										Scarring		
Do you claim to have any permanent disability?			Name of Witness				Address					
Name of Doctor						Address						
Name of Hospital						Address						
If claim is for occupational disease (silicosis, asbestosis, anthracosis, radioactivity, or poisoning by uranium, etc.) give dates and names of employers for whom you have worked during the last ten years, and give the name of the employer for whom you last worked and spent a period of 60 days or more breathing or exposed to silicon dioxide, asbestos, or coal dust. (Attach an additional sheet.)												
Date			Employer			Address						
Sign your name						Date						
FEIN			Carrier Claim Number			Policy Number			Adjuster Code		Block Number	

GENERAL INFORMATION

When your claim forms are received by the Division of Workers' Compensation, a copy will be sent to your employer's worker's compensation insurance carrier for their position. If they fail to admit liability within the prescribed time limit, you will be advised by the Division how to proceed further.

REPORTING INJURY

Seek medical aid as soon as possible. The employer in the first instance has the right to select a physician to attend the injury. Failure on the part of an injured employee to report and remain under the care of a doctor tendered by an employer or its insurance carrier can result in the injured employee being responsible for unauthorized medical expenses. If services are not tendered at the time of the injury, the employee shall have the right to select his own physician.

If an injured employee desires to obtain the services of a physician of his choice, he must first request *in writing* to his insurance carrier permission to change doctors, and receive written permission from the compensation carrier authorizing a change of physician. If such permission is neither granted nor refused within twenty days, the insurance carrier shall be deemed to have waived any objection.

Notify employer of injury. Failure to report injury to employer in writing within 4 days could result in loss of one day's compensation for each day's failure to do so.

Failure to attend medical appointments may be reason for the insurance carrier to suspend benefits.

BENEFITS

YOU ARE HEREBY NOTIFIED that if a child support obligation is owed, compensation benefits may be attached and payment of the child support obligation may be withheld and forwarded to the obligee pursuant to sections 8-42-124 and 26-13-122(4), C.R.S. YOU ARE FURTHER NOTIFIED that you must provide written notice of any award for social security, pension, disability or other source of income that might reduce your compensation benefits. This notice must be sent to the insurance carrier or self-insured employer within 20 days after learning of the payment or award. Failure to report may result in suspension of your benefits pursuant to section 8-42-113.5, C.R.S.

Compensation benefits are paid by insurance carriers for compensable injuries. Disability benefits are paid every 2 weeks.

Temporary Total Disability - Total disability of more than 3 working days. If disability lasts for more than 14 days, compensation shall be paid from the day left work. Compensation is payable at the rate of 66 2/3% of one's weekly wage, not to exceed the statutory maximum.

Temporary Partial Disability - Partially disabled, but able to resume work in a different capacity or on a part-time basis at a reduced wage. Compensation is payable at the rate of 66 2/3 % of the impairment of one's earning capacity during the continuance thereof, not to exceed the statutory maximum.

Permanent Partial Disability - Where full recovery is not possible; i.e. loss of arm, or its use. Scheduled group of awards, ranging from 4 weeks to 208 weeks, depending on severity of loss may be awarded. Non-scheduled group--percent of rating based on the body as a working unit may be awarded if a scheduled award is not suitable.

Facial or Body Disfigurement - Serious permanent disfigurement about the head, face or parts of the body normally exposed to public view. Benefits are not to exceed \$2000.00.

Medical Benefits - Current medical benefits for medical, hospital and surgical supplies, prescriptions, crutches, and apparatus.

USE YOUR WORKER'S COMPENSATION NUMBER ON ALL CORRESPONDENCE WITH THE DIVISION OF WORKERS' COMPENSATION.

C.R.S. 10-1-127(7) (a) states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies."