

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
Division of Workers' Compensation
633 17th St., Suite 400, Denver, CO 80202-3660

READ REVERSE SIDE

WORKER'S CLAIM FOR COMPENSATION

Employee's Name (first, middle, last)				Social Security Number		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		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		Dependents		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
	Mo	Day	Yr	Yes	No					Accident Date	
Years of Education Completed (circle one)						Ethnic <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Do not wish to answer					Area
6 7 8 9 10 11 12 13 14 15 16 17 18 19 20											SIC
Employer's Name at Time of Injury or Disease						Employer's Other Company Name					Accident Time
Employer's Mailing Address						City	State	Zip Code	Employer's Phone Number ()		Sex
Address Where Injury or Disease Occurred (street address)						City	State	County		Zip Code	Service
Reported to Employer			To whom was it reported?								
Mo	Day	Yr									
Are you receiving pay for				Average Weekly Wage at Time of Injury or Disease			Hourly Wage at Time of Injury			OCC	
<input type="checkbox"/> Overtime Average Weekly \$ _____				\$ _____			\$ _____			Source	
<input type="checkbox"/> Commissions Average Weekly \$ _____										Part of Body	
<input type="checkbox"/> Piecework Average Weekly \$ _____										Nature	
		Hrs. Per Day	Days Per Week	Check box if you receive		Will benefit continue During disability?		Average weekly Value of benefit		Type	
Employee's Scheduled Work Week When Injured				<input type="checkbox"/> Tips		<input type="checkbox"/> Yes <input type="checkbox"/> No		\$ _____		County	
Employee's Usual Work Schedule				<input type="checkbox"/> Meals		<input type="checkbox"/> Yes <input type="checkbox"/> No		\$ _____			
				<input type="checkbox"/> Rooms		<input type="checkbox"/> Yes <input type="checkbox"/> No		\$ _____			
				<input type="checkbox"/> Health Insurance *		<input type="checkbox"/> Yes <input type="checkbox"/> No		\$ _____			
* 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		Injury Time		Last Day Worked		Date Returned to Work		Disfigurement <input type="checkbox"/> Scar <input type="checkbox"/>		AWW	
Mo Day Yr		<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Mo Day Yr		Date Estimated to Return		Describe		Coder	
						Date Left Work Again					
						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.										3 rd Party	
										Scarring	
Do you claim to have any permanent disability? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Presently				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."