

COLORADO DEPARTMENT OF LABOR & EMPLOYMENT  
 DIVISION OF WORKERS' COMPENSATION  
**FINAL ADMISSION OF LIABILITY**

TO: \_\_\_\_\_  
 Claimant's Name  
 \_\_\_\_\_  
 Claimant's Address  
 \_\_\_\_\_  
 \_\_\_\_\_  
 and  
 DIVISION OF WORKERS' COMPENSATION

WC # \_\_\_\_\_  
 Carrier # \_\_\_\_\_  
 Soc. Sec. # \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Date of Injury \_\_\_\_\_  
 Average Weekly Wage \_\_\_\_\_  
 Date first payment paid TTD \_\_\_\_\_  
 Date first payment PPD \_\_\_\_\_  
 Date of MMI \_\_\_\_\_

**YOU ARE HEREBY NOTIFIED that the insurance carrier or self-insured employer (named below) admits that the injury or occupational disease reported herein is compensable. YOU ARE ALSO 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.**

Liability is admitted for the following benefits:

See Reverse Side for Codes

† medical benefits † temporary total disability † temporary partial disability † rehabilitation maintenance benefits † disfigurement † permanent partial disability	Safety Rule Violation † Offset † Amount of Interest Paid \$ _____ Amount of Penalties Paid \$ _____ † Working unit _____ % Disability _____ Age _____ 1. † Schedule Injury _____ % _____ (part of body) 2. † Schedule Injury _____ % _____ (part of body)	† Attach Calculation
--	---	----------------------

Complete the following if admitting for disability

Type of Benefit	Time Periods			Rate per Week	Totals
_____	_____ thru _____	=	_____ wks	\$ _____	\$ _____
_____	_____ thru _____	=	_____ wks	\$ _____	\$ _____
_____	_____ thru _____	=	_____ wks	\$ _____	\$ _____
_____	_____ thru _____	=	_____ wks	\$ _____	\$ _____
_____	_____ thru _____	=	_____ wks	\$ _____	\$ _____
_____	_____ thru _____	=	_____ wks	\$ _____	\$ _____

The above time periods represent inclusive dates.

Remarks: \_\_\_\_\_  
 \_\_\_\_\_

Carrier or Self-Insured \_\_\_\_\_  
 Address \_\_\_\_\_  
 Telephone No. \_\_\_\_\_

By: \_\_\_\_\_  
 Adjuster or Claims Representative

Copies of this admission were mailed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ to:  
 † Claimant's Attorney † Employer † Division of Workers' Compensation † Respondent's Attorney † Claimant

Block #	Adj. Code
---------	-----------

## **BENEFITS**

Compensation benefits are paid by insurance carriers for compensable injuries. Temporary 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 calendar days, compensation shall be paid from the day left work. Compensation is payable at the rate of 66 2/3% average weekly wage in effect at the time the injury/exposure not to exceed the statutory maximum. A loss of fringe benefits specifically enumerated in the statute should be included in the calculation of the average weekly wage.

*Permanent Partial Disability* - Payable where there is residual impairment, based upon the part of the body affected, or on the extent of medical impairment.

*Facial or Bodily Disfigurement* - Serious, permanent disfigurement about the head, face or parts of the body normally exposed to public view. Benefits are not to exceed \$2000.

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

*Temporary Partial Disability* - Temporary partial disability of more than 3 working days. Compensation is payable at the rate of 66 2/3% of the difference between the employee's average weekly wage at the time of injury and said employee's average weekly wage during the continuance of the temporary partial disability not to exceed a maximum of 91% of the state average weekly wage per week.

*MMI* - Maximum Medical Improvement means a point in time where any medically determinable physical or mental impairment as a result of injury has become stable and when no further treatment is reasonably expected to improve the condition.

---

### **Codes for scheduled ratings:**

01 Arm @ Shoulder	19 Little @ Metacarpal
03 Hand @ Wrist	20 Little @ Proximal
04 Thumb @ Metacarpal	21 Little @ Second
05 Thumb @ Proximal	22 Little @ Distal
06 Thumb @ Distal	23 Leg @ Hip
07 Index @ Metacarpal	25 Leg @ Foot, Heel, Ankle
08 Index @ Proximal	26 Great Toe @ Metatarsal
09 Index @ Second	27 Great Toe @ Proximal
10 Index @ Distal	28 Great Toe @ Distal
11 Middle @ Metacarpal	29 Other Toe @ Metatarsal
12 Middle @ Proximal	30 Other Toe @ Proximal
13 Middle @ Second	31 Other Toe @ Distal
14 Middle @ Distal	32 Eye Enucleation
15 Ring @ Metacarpal	33 Blindness One Eye
16 Ring @ Proximal	34 Deafness Both Ears
17 Ring @ Second	35 Deafness One Ear
18 Ring @ Distal	36 Total Hearing 2nd Ear

Filename: wc002\_general\_admission  
Directory: C:  
Template: C:\Documents and Settings\Cheryl Spencer\Application  
Data\Microsoft\Templates\Normal.dot  
Title: COLORADO DEPARTMENT OF LABOR &  
EMPLOYMENT  
Subject:  
Author: NTUSER  
Keywords:  
Comments:  
Creation Date: 1/30/2006 9:40 AM  
Change Number: 3  
Last Saved On: 1/30/2006 9:48 AM  
Last Saved By: Cheryl Spencer  
Total Editing Time: 10 Minutes  
Last Printed On: 1/30/2006 9:51 AM  
As of Last Complete Printing  
Number of Pages: 2  
Number of Words: 734 (approx.)  
Number of Characters: 4,189 (approx.)