

# Instructions for Completing the General Admission of Liability

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 “Claimant’s Name” box (field), complete the information, 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 #, phone number and dollar amounts. Do not use dashes, parentheses, or dollar signs; 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.

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 - [WC002 General Admission.pdf]

File Edit Document Tools Plug-Ins View Window Help

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DIVISION OF WORKERS' COMPENSATION  
**GENERAL ADMISSION OF LIABILITY**

**Clear Entire Form**

WC # \_\_\_\_\_  
Carrier # \_\_\_\_\_  
Soc. Sec. # \_\_\_\_\_  
Employer \_\_\_\_\_

TO: \_\_\_\_\_  
Claimant's Name \_\_\_\_\_  
\_\_\_\_\_ Claimant's Address \_\_\_\_\_  
\_\_\_\_\_ and \_\_\_\_\_

**“Clear Entire Form” button  
Clears all information at once**

Date first payment paid TTD \_\_\_\_\_  
Date first payment PPD \_\_\_\_\_  
Date of MMI \_\_\_\_\_

**“Check Box”  
Click in box**

COMPENSATION

YOU ADMIT 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  Safety Rule Violation   
 temporary total disability  Offset  Attach Calculation  
Amount of Interest Paid \$ \_\_\_\_\_

start | 2:20 PM Tuesday 5/20/2003

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COLORADO DEPARTMENT OF LABOR & EMPLOYMENT  
DIVISION OF WORKERS' COMPENSATION

**GENERAL 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 Attach Calculation  
 Amount of Interest Paid \$ \_\_\_\_\_  
 Amount of Penalties Paid \$ \_\_\_\_\_  
 Working unit \_\_\_\_\_ % Disability \_\_\_\_\_ Age \_\_\_\_\_  
 1. Schedule Injury \_\_\_\_\_ % \_\_\_\_\_ (part of body)  
 2. Schedule Injury \_\_\_\_\_ % \_\_\_\_\_ (part of body)

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. \_\_\_\_\_

**NOTICE TO CLAIMANT: IF YOU DISAGREE WITH THE AMOUNT OR TYPE OF BENEFITS WHICH THE CARRIER HAS AGREED TO PAY, YOU MAY WRITE A LETTER TO THE DIVISION OF WORKERS' COMPENSATION, 633 17TH ST., SUITE 400, DENVER, CO 80202-3660, STATING THAT YOU OBJECT TO THIS ADMISSION OF LIABILITY.**

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

## **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* – Payable for serious, permanent disfigurement about the head, face, or parts of the body normally exposed to public view. The maximum benefit is established each year for injuries that occur during that year. In addition, for injuries that occurred on or after July 1, 2007, it is possible to receive a larger amount for extensive disfigurement. Information regarding the maximum benefit for your date of injury is located on the Division's website, or you may contact the Customer Service Unit at (303) 318-8700.

*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.

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

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