

Instructions for Completing the Final 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 “Workers’ Compensation WC #” 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 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. “Remarks” and “Certificate of Mailing” fields are surrounded by a **gray border**. Type the information in the first field and tab to the next to enter more information.

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

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Clear Entire Form **FINAL ADMISSION OF LIABILITY** **Clear This Page**

Workers' Compensation (WC) # _____	Average Weekly Wage _____
Claimant's Name _____	Date First Payment of TTD _____
Social Security # _____	Date of MMI _____
Date of Injury _____	Date First Payment of PPD _____
Carrier Claim # _____	Employer _____
Insurance Carrier _____	Third Party Administrator _____

NOTICE TO CLAIMANT:
 This Final Admission of Liability is a legal document listing benefits that have been or will be paid. You have the right to disagree or object to benefits admitted or not admitted. If you do not object to this admission within 30 calendardays of the date of the final admission, your file will

"Clear Entire Form" button **"Clear This Page" button**
Clears all information at once **Clears all information on this page**

1. Within 30 days, complete the attached objection form or write a letter to the Division of Workers' Compensation, 1515 Arapahoe St., Denver, CO 80202-2117 with a copy to the insurance carrier or self-insured employer stating that you object to this admission. You must also file an application for hearing with the Division of Administrative Hearings on any disputed issues.
2. Within the same 30 days, if you disagree with the date of MMI or whole person impairment rating, complete the attached Notice and Proposal to Select an Independent Medical Examiner form and send it to the insurance carrier or self-insured employer and the Division.
3. If an IME is requested, you are not required to file an application for hearing until after the IME is completed.
4. If your date of injury is prior to July 1, 1991, the provisions regarding an Independent Medical Examination do not apply.

See page 2 for codes, definitions and other important notices.

BENEFIT SUMMARY (Check box & list amount for admitted benefits)

Medical to Date (total) \$ _____

Permanent Partial Disability (PPD): _____

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2. If you have any disputed issues, mail or deliver an Application for Hearing, within 30 days, to the Division of Administrative Hearings, 1120 Lincoln St., 14th Floor, Denver, CO 80203 (on the western slope, mail to 222 South 6th, #414, Grand Junction, CO 81501); AND/OR

3. If you disagree with either the date of MMI or whole person impairment determinations, complete the Notice and Proposal to Select an Independent Medical Examiner form, within 30 days, and send it to the insurance carrier. You must propose the name of one or more doctors, to co already deter a Division IME pursuant to C.R.S. section 8-42-107.2 C.R.S. has not

“Check Box”
Click in Box

If you do not object to th as to the issues admitted in the final admission. Objection information is attached. See page 2 for

“Gray Border”
Enter Information and tab to next field

BENEFIT SUMMARY (Check box & list amount for admitted benef

Medical to Date (total) \$ _____

Disfigurement (total) \$ _____

Vocational Rehabilitation Services (total) \$ _____

Temporary Total Disability (TTD) (total) \$ _____

Temporary Partial Disability (TPD) (total) \$ _____

Stipulation \$ _____

Permanent Total Disability (PTD) _____

Safety Rule Violation Offset (Attach Calculation)

Scheduled Impairment _____ % Part of Body Code _____

or

Scheduled Impairment _____ % Part of Body Code _____

(See page 2 for Part of Body Codes)

Position on Medical Benefits after Maximum Medical Improvement (MMI): _____

Remarks and basis for permanent disability award: _____

(Attach additional pages, if needed)

BENEFIT HISTORY

Type of Benefits	Time Periods	Weeks	Rate per Week	Totals
_____	through _____	= _____ x \$ _____	= \$ _____	_____
_____	through _____	= _____ x \$ _____	= \$ _____	_____
_____	through _____	= _____ x \$ _____	= \$ _____	_____
_____	through _____	= _____ x \$ _____	= \$ _____	_____
_____	through _____	= _____ x \$ _____	= \$ _____	_____

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NOTICE TO CLAIMANT:

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 C.R.S. section 8-42-124 and C.R.S. section 26-13-122(4). **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 C.R.S. section 8-42-113.5.

BENEFITS:

Compensation benefits are paid by insurance carriers for compensable injuries. Temporary disability benefits are paid every two weeks.

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

Maximum Medical Improvement (MMI) - The date when any medically determinable physical or mental condition as a result of injury has become stable and when no further treatment is reasonably expected to improve the condition.

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.

Temporary Total Disability (TTD) - Total disability of more than 3 working days. If disability lasts for more than 14 calendar days, compensation shall be paid from the day the claimant left work. Compensation is payable at the rate of 66 2/3% of the average weekly wage in effect at the time of the injury 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.

Temporary Partial Disability (TPD) - Temporary partial disability of more than three 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 the employee's average weekly wage during the continuance of the temporary partial disability not to exceed the statutory maximum.

Permanent Partial Disability (PPD) - For dates of injury on or after July 1, 1991, an award for PPD is based on permanent impairment as defined by the authorized treating physician and is limited to the part of the body that is affected.

Whole Person Impairment - Loss of function affecting body parts, including mental, not listed under the schedule below.

Scheduled Impairment - Loss of function affecting the toes, feet, legs, fingers, hands, arms, eyes, vision and deafness. Codes for scheduled impairment ratings used by insurance carriers are listed below:

Part of body codes for scheduled ratings:

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

If you have any questions or need forms, contact the Division of Workers' Compensation, Customer Service Unit at 303.318.8700 or toll-free at 888.390.7936.

OBJECTION TO FINAL ADMISSION OF LIABILITY

If you disagree with the Final Admission, **WITHIN 30 CALENDAR DAYS** of the date of the Final Admission you must complete the attached objection form or write a letter to the Division of Workers' Compensation, 633 17th St., Suite 400, Denver, CO 80202-3626, with a copy to the insurance carrier or self-insured employer, stating your objection. Within the same 30 days, if you disagree with the date of Maximum Medical Improvement (MMI), and/or Whole Person Permanent Impairment*, you must complete the attached Notice and Proposal form and send it to the insurance carrier or self-insured employer. If a Division Independent Medical Examination has already determined MMI and/or Whole Person Impairment, you must request a hearing on any disputed issues. Otherwise, your claim will be closed as to issues admitted in the Final Admission of Liability.

Please complete Sections I and II of this form. Complete page 4, if applicable. If you need an Application for Hearing form and/or Application for Independent Medical Examination (IME) form, please access the Division of Workers' Compensation web site. You may contact the Customer Service Unit at 303.318.8700 or toll-free at 888.390.7936 if you have questions or need any forms.

SECTION I - OBJECTION TO FINAL ADMISSION

Name of Claimant: _____ Social Security #: _____

Workers' Compensation (WC) #: _____ Date of Injury: _____

Insurance Carrier Claim #: _____ Date of Final Admission: _____

I contest this admission. Check the boxes that apply:

- I am proposing the name(s) of an Independent Medical Examiner and requesting an Independent Medical Examination (IME). I have not previously undergone a Division IME that resolved a dispute over maximum medical improvement (MMI), or a whole person permanent impairment determination*. I am completing the Notice and Proposal to Select an Independent Medical Examiner on page 4 of this form. Additional instructions are on page 4. **I understand that I will be responsible for the cost of the IME, and I must complete an Application for Independent Medical Examination (IME) form. If an IME is requested, I am not required to file an application for hearing on any disputed issues that are ripe for hearing until after completion of the IME.**

*** Note: If you believe that a scheduled rating should be a whole person rating, you may request an IME. If you disagree with a scheduled rating, you may proceed directly to hearing without an IME.** (See definition of scheduled impairment rating and codes on page 2.)

- I will mail or deliver an Application for Hearing form on disputed issues to the Office of Administrative Courts within 30 calendar days of the date of the Final Admission. Disputes about MMI and/or whole person impairment ratings are not ready for hearing until an IME has been completed.

SECTION II - CERTIFICATE OF MAILING

Copies of this document were placed in the U.S. mail or delivered to the following parties this _____ day of _____, _____.

List names and addresses of all persons copied: Name Address

Employer:

Carrier:

Carrier's Attorney:

Division of Workers' Compensation, 633 17th St., Suite 400, Denver, CO 80202-3626

By: _____
Signature

