Go to Form

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

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 Mo Day Yr | Depende Yes

"Clear Entire Form" button
Clears all information at once

of experience at this ment?

DO NOT WRITE IN SHADED AREAS

Accident Date

Years of Education Completed (select one)

"Check Box"
Click in box

Ethnic

Asian
Black
Do Not Wish to Answer
Hispanic
White

Employer's O

City

Area

SIC

Accident Time

Address Where Injury or Disease Occurred (street address) | City

Reported to Employer Mo Day Yr | To whom was it reported?

Are you receiving pay for

- [x] Overtime Average Weekly $_____
- [ ] Commissions Average Weekly $_____
- [ ] Piecework Average Weekly $_____

Average Weekly Wage at Time of Injury or Disease | Hourly Wage at Time of Injury

$

"Drop Down Menu"
Click on the arrow for choices

OCC

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

1 of 2 8.5 x 11 in

start | Inbox - Microsoft Out... | Adobe Acrobat - [WC... | QuarkXPress (tm) - [I...

10:02 AM Tuesday 5/6/2003

See instructions on reverse side before completing form

← *Back to Instructions*

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

WORKER'S CLAIM FOR COMPENSATION

Clear Entire Form

Employee's name (first, middle, last)	Social Security #	☐ Male ☐ Female	Employee's home phone #	Division Use Only
Employee's street address	City	State	Zip code	SOI

Birth date	Marital status	Dependents	Date of hire	Occupation	Employment status	POB
/ /	☐ Married ☐ Separated ☐ Single ☐ Unknown	☐ Yes ☐ No	/ /		☐ Full time ☐ Part time ☐ Other ☐ Unknown	

Employer's name (Company)	Employer's phone #	NOI
Employer's mailing address	City	State	Zip code	Coder

Average Weekly Wage

A. Calculate the *average weekly wage.* Multiply the average number of hours worked per week, excluding overtime, times the hourly wage—see instructions **Subtotal (A)** $ _____

B. Check box if employee receives

	Will benefit continue during disability?		If benefit will not continue, provide the average weekly value of the benefit
☐ Overtime	☐ Yes	☐ No	$ _____
☐ Tips (amount reported to IRS)	☐ Yes	☐ No	$ _____
☐ Commissions	☐ Yes	☐ No	$ _____
☐ Piecework	☐ Yes	☐ No	$ _____
☐ Mileage (if a form of salary)	☐ Yes	☐ No	$ _____
☐ Other (room, board, etc.)	☐ Yes	☐ No	$ _____
☐ Health Insurance (see instructions)	☐ Yes	☐ No	$ _____
		Subtotal (B)	$ _____

C. Add subtotals A & B = **Average weekly wage at time of injury (C)** $ _____

Date of injury/disease	Time employee began work	Injury time	Last date worked	Date employer notified	Date you returned to work	Do you claim to have a permanent disability?
/ / (See instructions)	____ ____ ☐ a.m ____ ____ ☐ p.m	____ ____ ☐ a.m. ____ ____ ☐ p.m ☐ Unknown	/ /	/ /	/ /	☐ Yes ☐ No ☐ Unknown

Which part of body was affected? (specify *upper* or *lower* for arms, legs and back injuries)	Tell us the nature of the injury/illness (sprain, strain, laceration, contusion, fracture, etc.) [1]

What were you doing just before the accident occurred?[2]

How did the injury occur?[3]

What object or substance directly harmed you?[4]	Name and phone number of witness

Where did the accident occur? (street address, city, state, and county)	To whom was it reported?

Initial treatment (check one)	Do you claim to have a disfigurement or scar?
☐ None ☐ Emergency room ☐ Hospital stay over 24 hrs ☐ Minor on-site ☐ Clinic/Hospital	☐ Yes ☐ No

Name and address of treating doctor or other health care professional	Name and address of facility where treated

If claim is for an occupational disease (i.e., asbestos related, repetitive motion, hearing loss), give names of employers where the exposure occurred and dates of employment (attach additional sheet if needed).

Employer	/ / to / / Dates of employment
Employer	/ / to / / Dates of employment

Completed by	**Date completed** / /

For Division Use Only

FEIN	Carrier claim #	
Policy #	Adjuster Code	Block #

CALCULATION OF AVERAGE WEEKLY WAGE

To determine the weekly wage calculate the following:

- First, calculate your average weekly wage. Multiply the average number of hours worked per week (excluding overtime) times your hourly wage. If you are paid by the month, multiply your monthly salary times 12 (months) and divide by 52 (weeks). If you are paid bi-weekly (every other week), take your bi-weekly salary and divide by 2. If you are paid on a per diem basis, multiply the daily wage times the number of days and fractions of days in the week you would have worked under the contract of hire if the injury had not occurred
- Next, determine the average weekly amount of any overtime, tips (as reported to the IRS), commissions, piecework (average weekly value can be calculated by taking the total amount earned with the employer in the 12 months immediately preceding the injury and dividing that amount by the number of weeks, and fractions of weeks worked). If mileage is a form of salary, take the average earned per week in the 60 days immediately preceding the injury.
- Add the average weekly value of any board, rent, housing or lodging, etc., provided by the employer *if the employer will not be paying such benefit during the period of disability.*
- If you are covered by group health insurance *and* your employer does not continue your health insurance coverage during the period of disability, add your cost of converting to a similar or lesser insurance plan and include this cost in the average weekly wage computation.
- Add the totals from each of the above categories to obtain your average weekly wage and insert in *Average weekly wage at time of injury* field.

DATE OF INJURY/DISEASE

Always include a date of injury. In the case of an occupational disease, use the date you were last exposed to the hazard.

INJURY DESCRIPTION

1. Be more specific than "hurt", "pain", or "sore." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
2. Describe the activity, as well as the tools, equipment or material you were using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; or "daily computer key-entry."
3. Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, I fell 20 feet"; "I was sprayed with chlorine when gasket broke during replacement"; "I developed soreness in my wrist over time."
4. Examples: "concrete floor"; "chlorine"; "radial arm saw", "beryllium."

FILING AND BENEFIT INFORMATION

Upon completion, mail or deliver two (2) copies of the *Worker's Claim for Compensation* to: **The Colorado Division of Workers' Compensation, Customer Service Unit, 633 17th St., Suite 400, Denver, CO 80202-3626**. In order to obtain information on benefits and dispute resolution options, or to request a copy of the *Employee's Guide*, please contact our Customer Service Unit at (303) 318.8700 or toll free at (888) 390.7936 for English, or (800) 685.0891 for Spanish. You may also visit our website at www.coworkforce.com/DWC/

GENERAL INFORMATION

When your claim form is received by the Division of Workers' Compensation, a copy will be sent to your employer's insurance carrier (insurer). The insurer has 20 days from receipt of this information to advise, in writing, whether liability will be admitted or denied, that is, whether it accepts responsibility for payment of related medical and/or lost wage benefits. If the insurer fails to admit liability within the prescribed time limit, you will receive information from the Division on the options that are available to you.

Always notify your employer of an injury. Failure to report an injury to the employer in writing within 4 days could result in loss of one day's compensation for each day's failure to notify.

Seek medical assistance as soon as possible. The employer has the right to select the physician who attends you. If you fail to remain under the care of a physician designated by the employer or its insurer, you may be responsible for payment of any unauthorized medical expenses. If the employer fails to designate a physician, you have the right to select a treating physician.

If you would like to change physicians, you must first request in writing, from the insurer, permission to change physicians and receive authorization to do so. If such permission is neither granted nor refused within twenty days, the insurer shall be deemed to have waived any objection to the change.

Failure to attend medical appointments may result in the suspension of benefits by the insurer.

For additional information on the provisions of the Colorado workers' compensation system, you may contact the Customer Service Unit of the Colorado Division of Workers' Compensation at (303) 318.8700, or toll free at (888) 390.7936.

NOTICES

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.

C.R.S. Section 10-1-128(6) (a) states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purposes 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."