

See instructions on reverse side before completing form

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION
DEPENDENT'S NOTICE AND CLAIM FOR COMPENSATION

Employee's name (first, middle, last)		Social Security #	<input type="checkbox"/> Male <input type="checkbox"/> Female	Employee's home phone # ()	Division Use Only
Employee's street address			City	State	Zip code SOI
Birth date / /	Marital status <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Unknown	Dependents <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of hire / /	Occupation	Employment status <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Other <input type="checkbox"/> Unknown POB
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 received Provide the average weekly value of the benefit

<input type="checkbox"/> Overtime	\$ _____
<input type="checkbox"/> Tips (amount reported to IRS)	\$ _____
<input type="checkbox"/> Commissions	\$ _____
<input type="checkbox"/> Piecework	\$ _____
<input type="checkbox"/> Mileage (if a form of salary)	\$ _____
<input type="checkbox"/> Other (room, board, etc.)	\$ _____
<input type="checkbox"/> Health Insurance (see instructions)	\$ _____
	Subtotal (B) \$ _____

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

Date of injury/disease / / <small>(See instructions)</small>	Date of death / /	Time employee began work ____ ____ <input type="checkbox"/> a.m. ____ ____ <input type="checkbox"/> p.m.	Injury time ____ ____ <input type="checkbox"/> a.m. ____ ____ <input type="checkbox"/> p.m. <input type="checkbox"/> Unknown	Last date worked / /	Date employer notified / /
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Which part of body was affected? _____ What type of injury did the employee receive?¹ _____

What was the employee doing just before the accident occurred?² _____

How did the injury occur?³ _____

What object or substance directly harmed the employee? ⁴ _____	Name and phone # of witness ()
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Where did the accident occur? (street address, city, state, and county)	To whom was it reported?
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Initial treatment (check one)
 None Emergency room Hospital stay over 24 hrs Minor on-site Clinic/Hospital

Name and address of treating doctor or other health care professional	Name and address of facility where treated
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If death resulted from an occupational disease (i.e., silicosis, asbestosis, anthracosis, etc.) give names of employers where the exposure occurred and dates of employment (attach additional sheet if needed).

Employer _____	Dates of employment _____ to _____
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Employer _____	Dates of employment _____ to _____
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For Division Use Only		
FEIN	Carrier claim #	
Policy #	Adjuster Code	Block #

1. Name of Mortuary _____ Address _____

2. Amount of funeral expenses _____ Has same been paid? _____ If so, by whom? _____

3. Was employee married on the date of the injury? Yes No

4. If married, provide:

a. Full name of surviving spouse _____

b. Present address and phone # of surviving spouse _____ ()

c. Was surviving spouse living with employee at the time of death? Yes No

d. Social Security # of spouse _____

e. Birth date of spouse _____ / _____ / _____

5. Was employee previously married? Yes No If so, provide name and address of former spouse(s)

6. Provide name, date of birth, SS #, and present address of all children of the employee under the age of eighteen (18) years:

Name	Date of Birth	SS #	Address
	/ /		
	/ /		
	/ /		
	/ /		

7. Provide name, date of birth, SS #, and present address of any child of the employee over the age of eighteen (18) and under the age of twenty-one (21) who was dependent upon the employee for support and was a full-time student at an accredited school at the time of employee's death:

Name	Date of Birth	SS #	Address
	/ /		
	/ /		

8. Provide name, date of birth, SS #, present occupation, relationship to the employee and present address of any other person who was wholly or partially supported by the employee at the time of employee's death:

Name	Date of Birth	SS #	Occupation	Relationship to Employee	Present Address
	/ /				
	/ /				

9. Other than amounts received from the employee, what income did each of the dependents listed in #8 receive, during the year immediately preceding the death of the employee? _____

10. Indicate whether each of the dependents listed in #8 was incapable or actually disabled from earning his/her own living, and if so, for what period of time. _____

Attach a copy of employee's marriage certificate(s), death certificate, and children's birth certificates.

State of Colorado, { ss.
 County of _____

Affidavit of Claimant

_____ being first duly sworn upon oath deposes and says, that the statements made in the foregoing notice and claim are true.

(Signature of claimant or person making claim in his, her or their behalf)

Subscribed and sworn to before me this _____ day of _____, _____.

My commission expires _____, _____

(Notary Public in and for said County and State aforesaid.)

CALCULATION OF AVERAGE WEEKLY WAGE

To determine the weekly wage, calculate the following:

- First, calculate the employee's average weekly wage. Multiply the average number of hours worked per week (excluding overtime) times the hourly wage. If the employee was paid by the month, multiply the monthly salary times 12 (months) and divide by 52 (weeks). If the employee was paid bi-weekly (every other week), take the bi-weekly salary and divide by 2. If the employee was paid on a per diem basis, multiply the daily wage times the number of days and fractions of days in the week s/he 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 was 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 you, the dependent, were covered by group health insurance through this employment, 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 the 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 the employee was last exposed to the hazard.

INJURY DESCRIPTION

- 1 Be specific. Examples: "heart attack"; "chemical exposure", etc.
- 2 Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer," etc.
- 3 Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, employee fell 20 feet"; "Employee was sprayed with chlorine when gasket broke during replacement," etc.
- 4 Examples: "concrete floor"; "chlorine"; "radial arm saw", "beryllium."

FILING AND BENEFIT INFORMATION

Upon completion, mail or deliver two (2) copies of the *Dependent's Notice and Claim for Compensation* to: **The Colorado Division of Workers' Compensation, Customer Service Unit, 633 17th St., Suite 400, Denver, CO 80202-3660**. 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 the 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, funeral and/or dependent's benefits. If the insurer denies liability or fails to respond within the prescribed time frame, you have the right to request a formal hearing and have the issue decided by an Administrative Law Judge at the Division of Administrative Hearings.

When a person is fatally injured on the job, workers' compensation provides weekly payments to the surviving dependent(s) and up to \$7,000 for funeral expenses. The weekly amount of dependent's benefits is calculated at two thirds of the employee's average weekly wage at the time of injury and is subject to maximum and minimum benefit rates. Payments are made for the lifetime of a dependent spouse, or until remarriage. If a surviving spouse remarries and there are no dependent children, a lump sum equal to two years of benefits will be paid (less any previous lump sum payments or overpayments). If there are dependent children, the spouse's benefits are reapportioned among the remaining dependents. Any dependent child (including one to whom child support was paid or owed) may be eligible for payments until age eighteen (18), or until age twenty-one (21) if the child is a full-time student. If there is no spouse or dependent child, other relatives such as a parent, grandparent, sister or brother, may be eligible for partial benefits. These partial benefits are paid for six years. And finally, if the deceased is under the age of twenty-one (21) with no dependants, payment of \$15,000 is payable to the parents of the deceased. All of these benefits are reduced by 50 percent of the death benefits received by the dependents through social security.

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."