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COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

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REQUEST FOR LUMP SUM PAYMENT
(Permanent Partial, Permanent Total and Dependents' Benefits)

Claimant _____ W.C. # _____

Date of Injury _____ Employer _____

Insurance Carrier _____ Insurance Carrier Claim # _____

Insurance Carrier/TPA Address _____
Street City State Zip Code

CHECK THE APPROPRIATE BOX:

☐ I am represented and request a lump sum payment*
☐ I am not represented and request a lump sum payment (to be calculated and ordered by the Division of Workers' Compensation.)

* the lump sum, less discount, will be calculated and paid by the insurance carrier

FAILURE TO SIGN THE APPLICATION MAY DELAY PROCESSING OF YOUR REQUEST.

NOTE: A lump sum payment cannot be granted until **SIX (6) MONTHS** have elapsed from the date of injury or death, and there has been a final award of permanent benefits.

1. Name of applicant: _____ Phone #: (_____) _____
   Address _____
   Street City State Zip Code
2. Date of applicant's birth: _____
3. If applicant is other than claimant, state family relationship: _____
4. The disability or death benefit award is the result of a: ☐ Final Admission ☐ Final Order
5. Date of disability or death benefit award: _____
   month day year
6. Amount requested $ _____
7. Applicant is presently:
   ☐ Receiving Social Security Benefits: Monthly Amount $ _____
   ☐ Receiving pension benefits or other income: Monthly Amount $ _____

Check the box that applies:

☐ **I accept the amount of permanent partial or permanent total disability benefits if so awarded. I understand that in accordance with section 8-43-406 of the Colorado Workers' Compensation Act, a four percent per annum discount is subtracted from the total award.**

☐ **I accept the award of death benefits. I understand that in accordance with section 8-43-406 of the Colorado Workers' Compensation Act, a four percent per annum discount is subtracted from the total award.**

Dated this _____ day of _____ , _____ .
day month year

_____
Applicant's Signature

COMPLETE, SIGN AND DELIVER OR MAIL ONE COPY OF THIS FORM TO THE INSURANCE CARRIER HANDLING YOUR CLAIM AND ONE COPY TO THE DIVISION OF WORKERS' COMPENSATION

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

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LUMP SUM CALCULATION AND PROOF OF PAYMENT FOR PERMANENT PARTIAL DISABILITY CLAIMS

Claimant: _____ WC#: _____

Insurance Adjuster: Please complete this form within 10 business days of the mailing date of the claimant's request for a lump sum payment. A copy should be sent to the claimant attorney if represented. **Check the applicable box:**

☐ The insurance carrier has calculated and paid a lump sum and is confirming payment (Complete entire form)
☐ The insurance carrier is submitting figures to the Division to calculate a lump sum (Complete Parts A, C & D)
☐ **OBJECTION TO LUMP SUM:** The insurance carrier objects to the payment of a lump sum based on the following:

_____

Part A: Calculation (REQUIRED)

1.	**Total award for permanent partial disability (PPD), if applicable:**	#1	$
2.	Has a previous lump sum been paid? ☐ No ☐ Yes • If so, what is the aggregate of all lump sums paid? • Provide the date of the last PPD payment: ___/___/___	#2	$
3.	Is there an overpayment to be credited? ☐ No ☐ Yes If so, what is the amount?	#3	$
4.	Amount of permanent partial disability payments made to date:	#4	$
5.	**Total of the amounts paid from #2 + #3 + #4 = Amount of #5**	#5	$
6.	**PPD balance due: (#1 minus #5)**	#6	$ 0

Part B: Confirmation of Payment (forward the completed form to all parties within 10 business days from date of the request)

1. Date of Payment: ___/___/___ Amount of payment: $ _____
2. Lump sum discount applied (attach the discount calculation) $ _____
3. Is there a PPD balance remaining? ☐ No ☐ Yes If yes, amount: $ _____

Part C: Adjuster Information (REQUIRED)

Adjuster: _____ Phone: ( ) _____

Insurance Carrier or 3rd Party Administrator _____ Fax #: ( ) _____

Address: _____

Part D: Certificate of Mailing (REQUIRED): Copies of this document were placed in U.S. mail or delivered to the following parties this

_____ day of _____ , _____ by: _____
day month year Insurance Adjuster or Representative

List names and addresses of all persons copied:

Claimant: _____

Claimant Attorney: _____

Respondent Attorney: _____

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

Notice to Applicant: If you object to this response, notify the Division of Workers' Compensation in writing of your objection within 10 (ten) business days from the certificate of mailing date. Mail this objection to the Division of Workers' Compensation, 633 17th St., Suite 400, Denver, CO 80202-3626.

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COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

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LUMP SUM CALCULATION AND PROOF OF PAYMENT FOR PERMANENT TOTAL AND FATAL CLAIMS

Claimant: _____ WC#: _____

Insurance Adjuster: Please complete this form within 10 business days of the mailing date of the claimant's request for a lump sum payment. A copy should be sent to the claimant attorney if represented. **Check the applicable box:**

☐ The insurance carrier has calculated and paid a lump sum and is confirming payment (Complete entire form)
☐ The insurance carrier is submitting figures to the Division to calculate a lump sum (Complete Parts A, C & D)
☐ **OBJECTION TO LUMP SUM:** The insurance carrier objects to the payment of a lump sum based on the following:

_____

TYPE OF AWARD – CHECK ONE: ☐ **PTD** (permanent total disability) ☐ **Fatal** (dependent's benefits)

Part A: Calculation (REQUIRED)

1. **Lump Sum amount requested:** $
   - Birthdate of the claimant and (for fatal claims) dependent(s): ___/___/___
     (if additional space is needed, please attach a separate page) ___/___/___
   - For fatal benefits, identify any dependents currently in school: _____
     (if additional space is needed, please attach a separate page) _____
     _____
2. Have any previous lump sums been paid? ☐ No ☐ Yes
   - If so, what is the total of all lump sums paid for this claimant? $
3. What is the weekly benefit rate? $

Part B: Confirmation of Payment (forward the completed form to all parties within 10 business days from date of the request)
All Permanent Total and Fatal claims must have a new admission when the weekly benefit rate changes. Attach discount calculations.

1. Date of Payment ___/___/___ Amount of payment: $ _____
2. Cost of the Lump Sum per week (to be recovered over the life of the claim) $ _____
3. New weekly payout rate: $ _____

Part C: Adjuster Information (REQUIRED)

Adjuster: _____ Phone: (___) _____
Insurance Carrier or 3rd Party Administrator _____ Fax #: (___) _____
Address: _____

Part D: Certificate of Mailing (REQUIRED): Copies of this document were placed in U.S. mail or delivered to the following parties this

_____ day of _____ , _____ by: _____
day month year Insurance Adjuster or Representative

List names and addresses of all persons copied:

Claimant: _____

Claimant Attorney: _____

Respondent Attorney: _____

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