Go to Form

Instructions for Completing the

Fatal General Admission

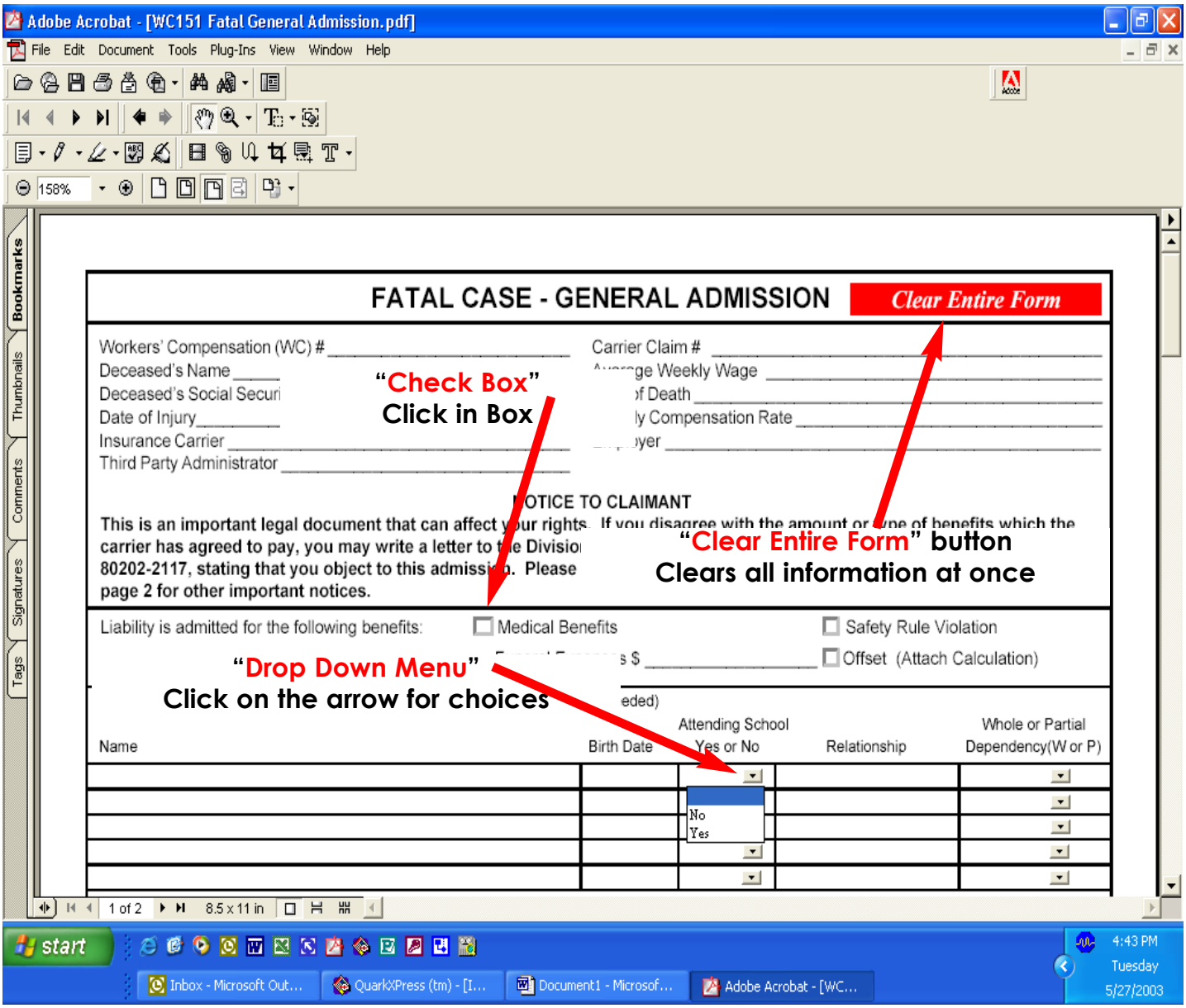
Please read all pages

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 # and dollar amounts. Do not use dashes 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. Some fields contain a drop down menu; click on the arrow and select one of the choices. The "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 change the information in one field, use the backspace or delete key.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File Edit Document Tools Plug-Ins View Window Help
FATAL CASE - GENERAL ADMISSION
Clear Entire Form
Workers' Compensation (WC) #
Carrier Claim #
Deceased's Name
Deceased's Social Securi
Date of Injury
Insurance Carrier
Third Party Administrator
Average Weekly Wage
of Death
ly Compensation Rate
yer
"Check Box"
Click in Box
NOTICE TO CLAIMANT
This is an important legal document that can affect your rights. 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 80202-2117, stating that you object to this admission. Please page 2 for other important notices.
"Clear Entire Form" button
Clears all information at once
Liability is admitted for the following benefits:
Medical Benefits
Safety Rule Violation
Offset (Attach Calculation)
"Drop Down Menu"
Click on the arrow for choices
Name
Birth Date
Attending School Yes or No
Relationship
Whole or Partial Dependency(W or P)
No
Yes
1 of 2
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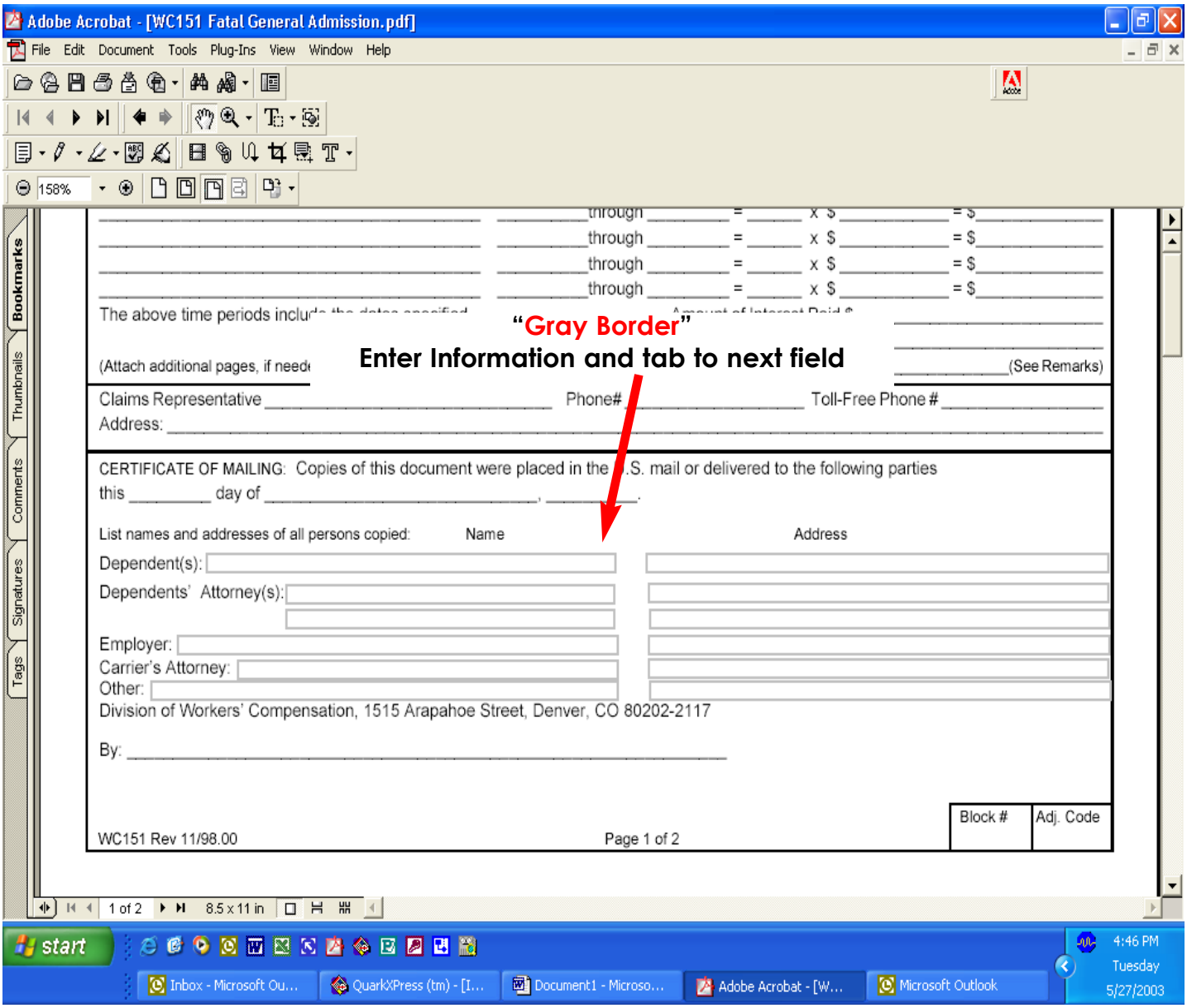
Adobe Acrobat - [WC151 Fatal General Admission.pdf]
File Edit Document Tools Plug-Ins View Window Help
"Gray Border"
Enter Information and tab to next field
Bookmarks
Thumbnails
Comments
Signatures
Tags
through = x $ = $
The above time periods inclu
(Attach additional pages, if need
(See Remarks)
Claims Representative
Phone#
Toll-Free Phone #
Address:
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
Dependent(s):
Dependents' Attorney(s):
Employer:
Carrier's Attorney:
Other:
Division of Workers' Compensation, 1515 Arapahoe Street, Denver, CO 80202-2117
By:
Block #
Adj. Code
WC151 Rev 11/98.00
Page 1 of 2
1 of 2
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Microsoft Outlook
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Tuesday
5/27/2003

Back to Instructions

FATAL CASE - GENERAL ADMISSION

Clear Entire Form

Workers' Compensation (WC) # _____
Deceased's Name _____
Deceased's Social Security # _____
Date of Injury _____
Insurance Carrier _____
Third Party Administrator _____

Carrier Claim # _____
Average Weekly Wage _____
Date of Death _____
Weekly Compensation Rate _____
Employer _____

NOTICE TO CLAIMANT

This is an important legal document that can affect your rights. 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 Street, Suite 400, Denver, CO 80202-3660, stating that you object to this admission. Please send a copy to the insurance carrier or self-insured employer. See page 2 for other important notices.

Liability is admitted for the following benefits: ☐ Medical Benefits ☐ Safety Rule Violation

Funeral Expenses $ _____ ☐ Offset (Attach Calculation)

Complete the following for each known dependent: (Attach additional pages, if needed)

Name	Birth Date	Attending School Yes or No	Relationship	Whole or Partial Dependency(W or P)

If no dependents, has payment been made to the Subsequent Injury Fund (SIF)? ☐ Yes ☐ No

Remarks: (Attach additional pages, if needed)

BENEFIT HISTORY - Dependents= benefits (past and present) are admitted for the following:

Name	Time Periods		Weeks	Rate per Week	Totals
_____	_____	through _____	_____	x $ _____	= $_____
_____	_____	through _____	_____	x $ _____	= $_____
_____	_____	through _____	_____	x $ _____	= $_____
_____	_____	through _____	_____	x $ _____	= $_____
_____	_____	through _____	_____	x $ _____	= $_____
_____	_____	through _____	_____	x $ _____	= $_____

The above time periods include the dates specified.

(Attach additional pages, if needed)

Amount of Interest Paid $ _____
Amount of Penalties Paid $ _____
Amount Overpaid $ _____ (See Remarks)

Claims Representative _____ Phone# _____ Toll-Free Phone # _____
Address: _____

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
Dependent(s):		
Dependents' Attorney(s):		
Employer:		
Carrier's Attorney:		
Other:		

Division of Workers' Compensation, 633 17th Street, Denver, CO 80202-3660

By: _____

Block #	Adj. Code

(The top portion of this side may be used for mailing address)

FATAL CASE - GENERAL ADMISSION

IMPORTANT: SEE NOTICE TO CLAIMANT SECTION ON THE OTHER SIDE OF THIS FORM

OTHER NOTICES TO CLAIMANT:

YOU ARE HEREBY NOTIFIED that the insurance carrier or self-insured employer admits that the fatality 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 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.