Go to Form

Instructions for Completing the

Fatal Final 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 Number (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 # and dollar amounts. Do not use dashes or dollar signs; when you tab out of the field, it will fill in automatically. 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 "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 change the information in one field, use the backspace or delete key.

Adobe Acrobat - [Final Fatal Final Admission.pdf]

File Edit Document Tools Plug-Ins View Window Help

158%

Bookmarks | Thumbnails | Comments | Signatures | Tags

FATAL CASE - FINAL ADMISSION

Clear Entire Form

Workers' Compensation (WC) # _____ Carrier Claim # _____

Deceased's Name _____ Average Weekly Wage _____

Deceased's Social Security # _____ Date of Death _____

Date of Injury _____ Weekly Compensation Rate _____

Insurance Carrier _____ Employer _____

Third Par

"Check Box"
Click in Box

"Clear Entire Form" button
Clears all information at once

NOTICE T

This Final Admission of Liability is a l al document listing benefits that
admitted or not admitted. If you do not bject to this admission within 3
close.

If you disagree with the benefits admitted not admitted you must do the following:

1. Within 30 days, write a letter to t Division of Workers' Compensation, 1515 Arapahoe St., Denver, CO 80202-2117 with a copy to the insurance carrier or self-insured em loyer stating that you object to this admission.
2. Within the same 30 days, file an Appli ation for Hearing on any disputed issues with the Division of Administrative Hearings at 1120 Lincoln St., 14th Floor, Denver, CO 80203 (on he western slope, mail to 222 South 6th, #414, Grand Junction, CO 81501.)

See page 2 for other important notices.

Liability is admitted for the following benefits:

☐ Medical Benefits ☐ Safety Rule Violation

☐ Funeral Expenses $ _____ ☐ Offset (Attach Calculation)

1 of 2 8.5 x 11 in

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

8:33 AM Thursday 8/28/2003

Adobe Acrobat - [Final Fatal Final Admission.pdf]

File Edit Document Tools Plug-Ins View Window Help

158%

admitted or not admitted. If you do not object to this admission within 30 calendar days of the date of the final admission, this case will automatically close.

If you disagree with the benefits admitted or not admitted you must do the following:

1. Within 30 days, write a letter to the Division of Workers' Compensation, 1515 Arapahoe St., Denver, CO 80202-2117 with a copy to the insurance carrier or se
2. Within the same 30 day trative Hearings at 1120 Lincoln St., 14th Floor, Denver 81501.)

"Drop Down Menu"

Click on arrow for choices

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	Wholly or Partially Dependent (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 $	= $

1 of 2 8.5 x 11 in

start

Inbox - Microsoft Out... Document2 - Microsof... Adobe Acrobat - [Fin... QuarkXPress (tm) - [I...

8:34 AM Thursday 8/28/2003

Adobe Acrobat - [Final Fatal Final Admission.pdf]

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 $	= $

"Gray Border"

Enter information and tab to next field

The above time periods include the dates specified.

Amount of Interest Paid $

Amount of Penalties Paid $

(Attach additional pages, if needed)

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 ,

Address

Dependent(s):

Dependents' Attorney(s):

Employer:

Carrier's Attorney:

Other:

Division of Workers' Compensation, 1515 Arapahoe Street, Denver, CO 80202-2117

By

Back to Instructions

FATAL CASE - FINAL 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 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 calendar days of the date of the final admission, this case will automatically close.

If you disagree with the benefits admitted or not admitted you must do the following:

1. **Within 30 days, write a letter to the Division of Workers' Compensation, 633 17th St., Suite 400 Denver, CO 80202-3660 with a copy to the insurance carrier or self-insured employer stating that you object to this admission.**
2. **Within the same 30 days, file an Application for Hearing on any disputed issues with the Office of Administrative Courts at 633 17th St., Suite 1300, Denver, CO 80202 (on the western slope, mail to 222 South 6th, #414, Grand Junction, CO 81501.)**

See page 2 for other important notices.

Liability is admitted for the following benefits:

- ☐ Medical Benefits
- ☐ Funeral Expenses $ _____
- ☐ Safety Rule Violation
- ☐ 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 $ _____	= $_____

The above time periods include the dates specified.

Amount of Interest Paid $ _____

Amount of Penalties Paid $ _____

(Attach additional pages, if needed)

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 _____ , _____ .

Dependent(s):

Dependents' Attorney(s):

Employer:

Carrier's Attorney:

Other:

Division of Workers' Compensation, 633 17th Street, Suite 400, Denver, CO 80202-3660

By _____

Block #	Adj. Code

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

FATAL CASE - FINAL 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.

Block #	Adj. Code