COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
Division of Workers' Compensation

# FATAL CASE - FINAL ADMISSION

WC #: _____ Carrier Claim #: _____

Deceased's SS#: _____ Average Weekly Wage: _____

Deceased's Name: _____ Date of Death: _____

Date of Injury: _____ Weekly Comp. Rate: _____

Insurance Carrier: _____ Employer: _____

**NOTICE TO DEPENDANT:**

**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 80202-3626 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 80202-3626 (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) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Effective 7/1/2017:** If no dependents, has payment been made to the Colorado Uninsured Employer Fund?

☐ Yes ☐ No

**For DOI prior to 7/1/2017:** 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.

(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 _____, _____.

Dependent(s):

Dependents' Attorney(s):

Employer:

Carrier's Attorney:

Other:

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

By: _____

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## OTHER NOTICES TO DEPENDENT:

**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.**