WC50 Notice to Employer of Injury

The poster in this document is a sample of the text only.

It does not meet the size requirements.

This poster must be a minimum of:

14 inches high
11 inches wide

Each letter must measure 1/2" high

The text for the poster is attached.

A Spanish translation of this WC50 poster is available upon request. It is not required to post a Spanish translation.

WARNING

IF YOU ARE INJURED ON THE JOB, WRITTEN NOTICE OF YOUR INJURY MUST BE GIVEN TO YOUR EMPLOYER WITHIN FOUR WORKING DAYS AFTER THE ACCIDENT, PURSUANT TO SECTION 8-43-102(1) AND (1.5), COLORADO REVISED STATUTES.

IF THE INJURY RESULTS FROM YOUR USE OF ALCOHOL OR CONTROLLED SUBSTANCES, YOUR WORKERS' COMPENSATION DISABILITY BENEFITS MAY BE REDUCED BY ONE-HALF IN ACCORDANCE WITH SECTION 8-42-112.5, COLORADO REVISED STATUTES.

Translation of : Notice to Employer of Injury Poster

AVISO

SI SE LASTIMA EN EL TRABAJO, DEBE DARLE UN AVISO POR ESCRITO A SU EMPLEADOR DENTRO DE CUATRO DÍAS LABORABLES DEL ACCIDENTE, SEGÚN A LA SECCIÓN DE LOS ESTATUOS REVISADOS DE COLORADO 8-43-102(1) Y (1.5).

SI EL ACCIDENTE RESULTA DEBIDO AL USO DE ALCOHOL O UNA SUSTANCIA CONTROLADA, SUS BENEFICIOS DE LA INCAPACIDAD DE LA COMPENSACIÓN DE LOS TRABAJADORES PUEDEN SER REDUCIDOS POR UN MEDIO EN ACUERDO DE LA SECCIÓN DE LOS ESTATUOS REVISADOS DE COLORADO 8-42-112.5.

AVERAGE WEEKLY WAGE WORKSHEET WC# _____

The definition of wages can be found in 8-40-201(19), C.R.S. Calculation of average weekly wage can be found in 8-42-102(2), C.R.S. Use earnings immediately prior to the date of injury.

Employee Name _____ SS# _____ Carrier # _____

Time Period used for calculations: From___/___/___ TO ___/___/___

If completed by the adjuster: Information received from: _____ _____ _____
Name Title On Date

WAGES (**Choose one** from lines 1 through 7, then add other wages from lines 8 - 10, if applicable) TOTALS

1.	Hourly (exclude overtime)	Hourly wage $_____ x average hours/week _____ =.....	
2.	Daily (per diem).....	Daily rate $_____x # of days (and fractions of days) in a week that employee worked (or would have worked, but for the injury) _____ =.....	
3.	Weekly.....	Weekly wage $_____ =.....	
4.	Bi-Weekly.....	Bi-Weekly wage (every other week) $_____÷ 2 = ...	
5.	Semi-Monthly	Semi-Monthly wage $_____ x 24 ÷ 52 =.....	
6.	Monthly.....	Monthly wage $_____ x 12 ÷ 52 =.....	
7.	Yearly	Yearly wage $_____ ÷ 52 = ...	
8.	Piecework or Commission	Average weekly value = Total amount earned with this employer in the 12 months immediately preceding injury $_____ ÷ # of weeks (and fractions of weeks) worked _____ = ……..	
9.	Mileage (only if mileage is a form of salary)	Rate per mile $_____x average # of miles per day driven in service of the employer 60 days preceding the injury _____ = daily rate $_____ x days (and fractions of days) per week worked _____ = ...	
10.	Other (wages not addressed above)	(Attach explanation) Average weekly value $_____ = ...	
11.	Total Wages.....	Enter amounts from 1 - 7, plus any amounts in 8 - 10	

ADDITIONS TO WAGES (Use the same time period as stated above)

12.	Overtime	Overtime rate $_____ x # of overtime hours per week _____ = ...	
13.	Tips.....	Weekly amount reported to IRS $_____ =.....	
14.	Total Additions	Enter total of lines 12 + 13……..	

BENEFITS (If Discontinued During Disability)

15.	Health Insurance	Effective date benefit discontinued:_____ Employee's monthly cost of continuing the employer's group plan or conversion to a similar or lesser plan = $_____ x 12 ÷ 52 =	
16.	Meals / Board	Effective date benefit discontinued:_____ Weekly value $_____ =.....	
17.	Rent / Housing	Effective date benefit discontinued: _____ Monthly value $_____ x 12 ÷ 52	
18.	Total Benefits.....	Enter total of lines 15 - 18	
19.	TOTAL AVERAGE WEEKLY WAGE	Enter total of lines 11 + 14 + 18	

Enter the number in line 19 on the Employer's First Report of Injury in the "Average Weekly Wage at Time of Injury" Box

Completed by: _____Date_____

Division of Workers' Compensation
633 17th Street, Suite 400
Denver, Colorado 80202-3660
303.318.8700

- The Average Weekly Wage worksheet may be reproduced as needed -

The Average Weekly Wage worksheet is provided by the Division of Workers' Compensation as a guideline in computing the Average Weekly Wage. It is intended as a desk aid worksheet and is not a required document. It may be used to document wage information received verbally.

If the worksheet is completed by the employer, the final Average Weekly Wage amount on Line 19 of the worksheet should be inserted in the box, "Average Weekly Wage at Time of Injury," on the Employer's First Report of Injury form.

Notice to Employer:

The worksheet should be attached to the Employer's First Report of Injury form when submitted to your workers' compensation insurance administrator.

If you have questions on completing this worksheet, contact your workers' compensation insurance administrator.

Notice to Insurance Carrier or Self-Insured Employer:

If you complete the worksheet with information provided by either the claimant or the employer, attach the worksheet to your position statement when filing with the Division. Also, state on the worksheet the name and title of the person providing wage information and the date the information was provided.

If you receive the worksheet from the employer and only "the Average Weekly Wage at Time of Injury" box is completed in the wage information section of the Employer's First Report of Injury, attach the worksheet to the Employer's First Report of Injury form that is submitted to the Division of Workers' Compensation.

COLORADO WORKERS' COMPENSATION INFORMATION

Your employer has workers' compensation coverage for employees through:

Workers' compensation is a type of insurance coverage that employers must provide to their employees. The cost of workers' compensation insurance is paid entirely by the employer and may not be deducted from an employee's wages.

If you are injured or sustain an occupational disease while at work, you may be entitled to compensation benefits as provided by law. WRITTEN NOTICE MUST BE GIVEN TO YOUR EMPLOYER WITHIN 4 WORKING DAYS OF THE ACCIDENT. If you don't report your injury or occupational disease promptly your benefits may be reduced.

If you are unable to work as the result of a work-related injury or occupational disease, compensation (wage replacement) benefits will be based on 2/3 of your average weekly wage up to a maximum set by law. No compensation is payable for the first 3 days' disability unless the period of disability exceeds two weeks.

You are entitled to reasonable and necessary medical treatment of compensable injuries or occupational diseases. If you notify your employer of an injury or occupational disease and are not offered medical care, you may select the services of a licensed physician or chiropractor.

You may file a Worker's Claim for Compensation with the Division of Workers' Compensation. To obtain forms or information regarding the workers' compensation system, you may call Customer Service at 303.318.8700, or visit our website at: www.coworkforce.com/dwc/.

COLORADO DIVISION OF WORKERS' COMPENSATION
633 17TH Street, Suite 400, Denver, CO 80202-3626

Any information provided below comes from your employer and is specific to this place of employment:

Instructions for Completing the

Workers' Claim for Compensation

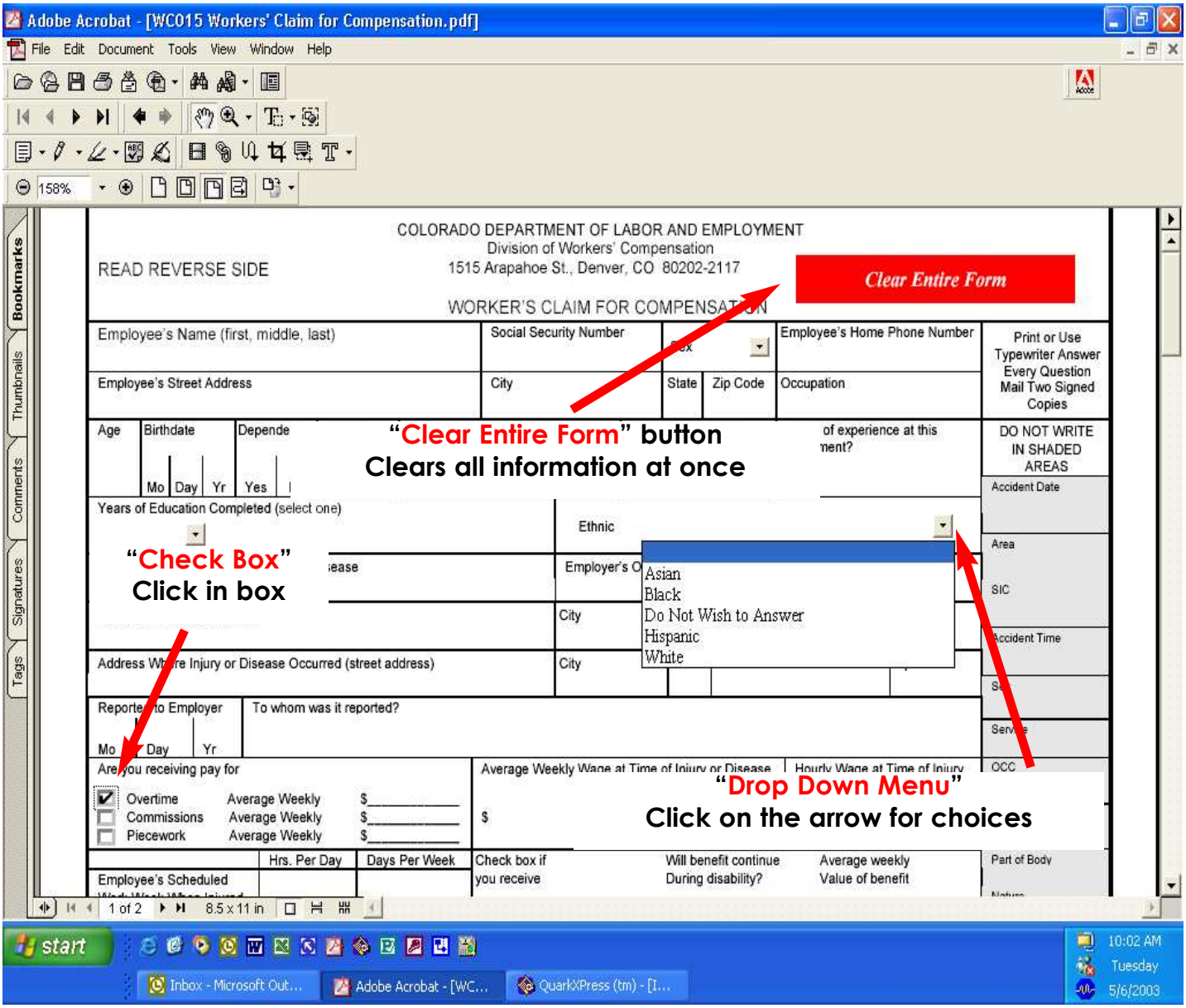
Please read all pages

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 "Employee's Name"box (field), 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 Number, phone numbers and dollar amounts. Do not use dashes or parentheses; 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.

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 - [WC015 Workers' Claim for Compensation.pdf]
File Edit Document Tools View Window Help
COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
Division of Workers' Compensation
1515 Arapahoe St., Denver, CO 80202-2117
READ REVERSE SIDE
Clear Entire Form
WORKER'S CLAIM FOR COMPENSATION
Employee's Name (first, middle, last)
Social Security Number
Employee's Home Phone Number
Employee's Street Address
City
State
Zip Code
Occupation
Print or Use Typewriter Answer Every Question Mail Two Signed Copies
DO NOT WRITE IN SHADED AREAS
Accident Date
Area
SIC
Accident Time
"Clear Entire Form" button
Clears all information at once
"Check Box"
Click in box
"Drop Down Menu"
Click on the arrow for choices
Asian
Black
Do Not Wish to Answer
Hispanic
White
Years of Education Completed (select one)
Ethnic
Address Where Injury or Disease Occurred (street address)
To whom was it reported?
Are you receiving pay for
Overtime Average Weekly
Commissions Average Weekly
Piecework Average Weekly
Hrs. Per Day
Days Per Week
Employee's Scheduled
Check box if you receive
Will benefit continue During disability?
Average weekly Value of benefit
Part of Body
1 of 2
8.5 x 11 in
start
Inbox - Microsoft Out...
Adobe Acrobat - [WC...
QuarkXPress (tm) - [I...
10:02 AM
Tuesday
5/6/2003

See instructions on reverse side before completing form

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

WORKER'S CLAIM FOR COMPENSATION

Employee's name (first, middle, last)	Social Security #	☐ Male ☐ Female	Employee's home phone #	Division Use Only

Employee's street address	City	State	Zip code	SOI

Birth date	Marital status	Dependents	Date of hire	Occupation	Employment status	POB
/ /	☐ Married ☐ Separated ☐ Single ☐ Unknown	☐ Yes ☐ No	/ /		☐ Full time ☐ Part time ☐ Other ☐ Unknown	

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 receives

	Will benefit continue during disability?		If benefit will not continue, provide the average weekly value of the benefit
☐ Overtime	☐ Yes	☐ No	$ _____
☐ Tips (amount reported to IRS)	☐ Yes	☐ No	$ _____
☐ Commissions	☐ Yes	☐ No	$ _____
☐ Piecework	☐ Yes	☐ No	$ _____
☐ Mileage (if a form of salary)	☐ Yes	☐ No	$ _____
☐ Other (room, board, etc.)	☐ Yes	☐ No	$ _____
☐ Health Insurance (see instructions)	☐ Yes	☐ No	$ _____
			Subtotal (B) $ _____

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

Date of injury/disease	Time employee began work	Injury time	Last date worked	Date employer notified	Date you returned to work	Do you claim to have a permanent disability?
/ / (See instructions)	____ ____ ☐ a.m ____ ____ ☐ p.m ☐ Unknown	____ ____ ☐ a.m. ____ ____ ☐ p.m ☐ Unknown	/ /	/ /	/ /	☐ Yes ☐ No ☐ Unknown

Which part of body was affected? (specify *upper* or *lower* for arms, legs and back injuries)	Tell us the nature of the injury/illness (sprain, strain, laceration, contusion, fracture, etc.) [1]

What were you doing just before the accident occurred?[2]

How did the injury occur?[3]

What object or substance directly harmed you?[4]	Name and phone number of witness

Where did the accident occur? (street address, city, state, and county)	To whom was it reported?

Initial treatment (check one)
☐ None ☐ Emergency room ☐ Hospital stay over 24 hrs
☐ Minor on-site ☐ Clinic/Hospital

Do you claim to have a disfigurement or scar? ☐ Yes ☐ No

Name and address of treating doctor or other health care professional	Name and address of facility where treated

If claim is for an occupational disease (i.e., asbestos related, repetitive motion, hearing loss), give names of employers where the exposure occurred and dates of employment (attach additional sheet if needed).

Employer	Dates of employment / / to / /
Employer	Dates of employment / / to / /
Employer	Dates of employment

Completed by **Date completed** / /

For Division Use Only

FEIN	Carrier claim #	
Policy #	Adjuster Code	Block #

CALCULATION OF AVERAGE WEEKLY WAGE

To determine the weekly wage calculate the following:

- First, calculate your average weekly wage. Multiply the average number of hours worked per week (excluding overtime) times your hourly wage. If you are paid by the month, multiply your monthly salary times 12 (months) and divide by 52 (weeks). If you are paid bi-weekly (every other week), take your bi-weekly salary and divide by 2. If you are paid on a per diem basis, multiply the daily wage times the number of days and fractions of days in the week you 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 is 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 the employer will not be paying such benefit during the period of disability.*
- If you are covered by group health insurance *and* your employer does not continue your health insurance coverage during the period of disability, 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 your 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 you were last exposed to the hazard.

INJURY DESCRIPTION

1 Be more specific than "hurt", "pain", or "sore." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
2 Describe the activity, as well as the tools, equipment or material you were using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; or "daily computer key-entry."
3 Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, I fell 20 feet"; "I was sprayed with chlorine when gasket broke during replacement"; "I developed soreness in my wrist over time."
4 Examples: "concrete floor"; "chlorine"; "radial arm saw", "beryllium."

FILING AND BENEFIT INFORMATION

Upon completion, mail or deliver two (2) copies of the *Worker's Claim for Compensation* to: **The Colorado Division of Workers' Compensation, Customer Service Unit, 633 17th St., Suite 400, Denver, CO 80202-3626**. 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 your 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 and/or lost wage benefits. If the insurer fails to admit liability within the prescribed time limit, you will receive information from the Division on the options that are available to you.

Always notify your employer of an injury. Failure to report an injury to the employer in writing within 4 days could result in loss of one day's compensation for each day's failure to notify.

Seek medical assistance as soon as possible. The employer has the right to select the physician who attends you. If you fail to remain under the care of a physician designated by the employer or its insurer, you may be responsible for payment of any unauthorized medical expenses. If the employer fails to designate a physician, you have the right to select a treating physician.

If you would like to change physicians, you must first request in writing, from the insurer, permission to change physicians and receive authorization to do so. If such permission is neither granted nor refused within twenty days, the insurer shall be deemed to have waived any objection to the change.

Failure to attend medical appointments may result in the suspension of benefits by the insurer.

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."

See instructions on reverse side before completing form.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY

Employee's name (first, middle, last)	Social Security #	☐ Male ☐ Female	Employee's home phone # ( )	OSHA Log #
Employee's street address	City	State	Zip code	

Birth date / /	Marital status ☐ Married ☐ Separated ☐ Single ☐ Unknown	Date of hire / /	Occupation	Employment status ☐ Full time ☐ Part time ☐ Other ☐ Unknown	For Division use only

Employer's name	Employer's Federal ID #	Employer's phone # ( )	SOI
Employer's mailing address	City	State / Zip code	POB

Average weekly wage at time of injury $_____ (see instructions on reverse side)	Check box if employee receives ☐ Tips ☐ Meals ☐ Room ☐ Health insurance	Check if these benefits are included in AWW ☐ Tips ☐ Meals ☐ Room ☐ Health insurance	NOI / Coder

Is the employer self-insured? ☐ Yes ☐ No	Were full wages paid for the DOI? ☐ Yes ☐ No	Are wages continued per C.R.S. 8-42-124? [1] ☐ Yes ☐ No

Injury/Illness date / / (See instructions on reverse side)	Time employee began work ____ ___ ☐ a.m. ____ ___ ☐ p.m.	Injury time ____ ___ ☐ a.m. ____ ___ ☐ p.m. ☐ unknown	Last day worked / /	Date employer notified / /	Date disability began / /	Date returned to work / /

Did injury cause death? ☐ Yes ☐ No	If so, date of death / /	Name, relationship, and address of closest dependent if injury caused death	Injury occurred because of ☐ Intoxication ☐ Safety violation ☐ Not applicable

Tell us the part of body that was affected	Tell us the nature of the injury/illness[2]

What was the employee doing just before the accident occurred?[3]

Tell us how the injury occurred[4]	What object or substance directly harmed the employee? [5]

Did injury occur on premises? ☐ Yes ☐ No	Injury site address/ 9-digit zip code	Initial treatment (check one) ☐ None ☐ Emergency room ☐ Minor on-site ☐ Hospital >24 hrs ☐ Clinic/hospital	Was the employee hospitalized overnight as an in-patient? ☐ Yes ☐ No

Names of witnesses	Name of employer representative notified
Name and address of treating doctor or other health care professional	Name and address of facility where treated

Completed by (name)	Title	Phone # ( )	Date completed / /

The following is to be completed by the insurer prior to filing with the Division of Workers' Compensation.

Name of insurance company	Address
Name of third party administrator (if applicable)	Address
Adjuster name	Adjuster phone #

Policy #	Carrier claim #	Date insurer received first report / /	Block #	Adj. Code

INSTRUCTIONS
This form contains all items requested on OSHA Form No. 301,
"Injuries & Illnesses Incident Report"

General

- All injuries no matter how trivial must be reported to your insurance company.
- All injuries or occupational diseases which result in lost time from work in excess of three shifts or calendar days, or in permanent physical impairment, must be reported to your insurance carrier on this form within ten days after notice or knowledge of the injury or disease. Fatalities must be reported to your insurance carrier immediately.
- Forms should be typed or printed legibly.
- All questions must be answered completely to meet requirements of the Colorado Workers' Compensation Act and to conform to the OSHA requirements for Form No. 301.
- The employer has the right in the first instance, to select the physician who attends the injured employee.

Calculation of Average Weekly Wage

- Determine the weekly wage rate.
- Add the average weekly amount of any overtime wages, tips or commissions.
- Add the average weekly value of any board, rent, housing, or lodging provided by the employer *if the employer will not be paying such benefit during the period of disability.*
- If the employee is covered by group health insurance *and* the employer does not continue the employee's health insurance coverage during the period of disability, add the employee's cost of conversion to a similar or lesser insurance plan and include this cost in the average weekly wage computation.
- Compute the total from the above categories and insert in the *Average weekly wage at time of injury* field.

Injury Date Information

In the case of an occupational disease, use the date of the last injurious exposure.

Notes

Are Wages continued per C.R.S. 8-42-124?[1]
(Subject to application with and approval of the Director of the Colorado Division of Workers' Compensation)

1 Any employer who, by separate agreement, working agreement, contract of hire, or any other procedure, continues to pay a sum in excess of the temporary total disability benefits to an employee temporarily disabled as a result of a work related injury or disease**,** and has not charged the employee with any earned vacation leave, sick leave, or other similar benefits, shall be reimbursed if insured by an insurance carrier or shall take credit if self-insured, to the extent of all moneys that such employee may be eligible to receive as compensation for temporary partial or temporary total disability subject to the approval of the Director of the Colorado Division of Workers' Compensation.

Injury Description (Tell us the part of body that was affected. Tell us the nature of the injury/illness[2]; What was the employee doing just before the accident occurred?[3]; What happened?[4]; What object or substance directly harmed the employee?[5])

2 Be more specific than ""hurt", "pain", or "sore." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
3 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"; or "daily computer key-entry."
4 Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
5 Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank

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."

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 #	□ Male □ Female	Employee's home phone # ( )	Division Use Only
Employee's street address	City	State	Zip code	SOI

Birth date / /	Marital status □ Married □ Separated □ Single □ Unknown	Dependents □ Yes □ No	Date of hire / /	Occupation	Employment status □ Full time □ Part time □ Other □ 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

□ Overtime	$ _____
□ Tips (amount reported to IRS)	$ _____
□ Commissions	$ _____
□ Piecework	$ _____
□ Mileage (if a form of salary)	$ _____
□ Other (room, board, etc.)	$ _____
□ Health Insurance (see instructions)	$ _____
Subtotal (B)	$ _____

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

Date of injury/disease / / (See instructions)	Date of death / /	Time employee began work ____ ____ □ a.m. ____ ____ □ p.m.	Injury time ____ ____ □ a.m. ____ ____ □ p.m. □ Unknown	Last date worked / /	Date employer notified / /

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	( )
Where did the accident occur? (street address, city, state, and county)	To whom was it reported?	

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

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	/ / to / / Dates of employment
Employer	/ / to / / Dates of employment

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."

Colorado Workers' Compensation
Supplemental Report of Return To Work

Workers' Compensation (WC) # _____ Date of Injury _____

Employee Name _____ Carrier Claim # _____

Social Security # _____ Employer _____

Purpose:
The purpose of this form is to provide information to determine the accurate payment of temporary disability benefits.

Instructions:
1. **This form may be completed by the employee or employer.**
2. **This form should be completed each time the employee returns to work at full or reduced wages.**
3. **This form should be forwarded to your workers' compensation carrier.**

1. Last day employee worked _____

2. Date employee returned to work _____

3. Employee's return-to-work-wages (Check the box that applies)

- □ Full Wages
- □ Reduced Wages (Provide wage information to the claims adjuster every 2 weeks during periods of wage loss)

Additional Information _____

_____

_____

Completed by (Check the box that applies) □ Employee □ Employer

_____ _____
Name Date

Address _____

_____

Phone # ( ) _____

Fax # ( ) _____