

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 #	<input type="checkbox"/> Male <input type="checkbox"/> Female	Employee's home phone # ( )	Division Use Only
Employee's street address			City	State	Zip code
Birth date / /	Marital status <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Unknown	Dependents <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of hire / /	Occupation	Employment status <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Employer's name (Company)				Employer's phone # ( )	NOI
Employer's mailing address			City	State	Zip code

**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

<input type="checkbox"/> Overtime	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
<input type="checkbox"/> Tips (amount reported to IRS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
<input type="checkbox"/> Commissions	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
<input type="checkbox"/> Piecework	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
<input type="checkbox"/> Mileage (if a form of salary)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
<input type="checkbox"/> Other (room, board, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
<input type="checkbox"/> Health Insurance (see instructions)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____

**Subtotal (B)** \$ \_\_\_\_\_

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

Date of injury/disease / / (See instructions)	Time employee began work ____ a.m. ____ p.m.	Injury time ____ a.m. ____ p.m. <input type="checkbox"/> Unknown	Last date worked / /	Date employer notified / /	Date you returned to work / /	Do you claim to have a permanent disability? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)<sup>1</sup>

What were you doing just before the accident occurred?<sup>2</sup>

How did the injury occur?<sup>3</sup>

What object or substance directly harmed you?<sup>4</sup> 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) Do you claim to have a disfigurement or scar?  
 None  Emergency room  Hospital stay over 24 hrs  
 Minor on-site  Clinic/Hospital  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 _____

**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 17<sup>th</sup> 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/](http://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.”**