

Instructions for Completing the Request for Offset of Liability to Subsequent Injury Fund

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 “Claimant” 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 #. Do not use dashes; when you tab out of the field, it will fill in automatically. “Prior Industrial Disability” and “Occupational Disease” information 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 - [WC063 Request for Offset of Liability to SIF.pdf]

File Edit Document Tools Plug-Ins View Window Help

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COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
Division of Workers' Compensation
Special Funds Section

Clear Entire Form

REQUEST FOR OFFSET OF LIABILITY TO SUBSEQUENT INJURY FUND

Claimant _____ W.C. # _____
Employer _____ Social Security # _____
Insurance Carrier _____ Carrier Claim # _____

**"Clear Entire Form" button
Clears all information at once**

The _____ he/
(claimant, employer, insurance carrier)
Compensation be named as an interested party herein on behalf of the Subsequent Injury Fund. In support of this request,
p
"Gray Border"

Enter information and tab to next field complete section A, and if offset is claimed pursuant to
§ _____, C.R.S., complete section B.

A. Prior Industrial Disability (Section 8-46-101, C.R.S.)
List prior workers' compensation cases below by employer, number, brief description of injury(ies) and award:

	Employer	W. C. Number	Description of Injuries	Award
1.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>			
2.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
Division of Workers' Compensation
Special Funds Section

REQUEST FOR OFFSET OF LIABILITY TO SUBSEQUENT INJURY FUND

Claimant _____ W.C. # _____
Employer _____ Social Security # _____
Insurance Carrier _____ Carrier Claim # _____
Date of Injury _____

The _____ hereby requests that the Director of the Division of Workers' Compensation be named as an interested party herein on behalf of the Subsequent Injury Fund. In support of this request, petitioner submits the following information:
(claimant, employer, insurance carrier)

If an offset is claimed pursuant to Section 8-46-101, C.R.S., complete section A, and if offset is claimed pursuant to Section 8-41-304, C.R.S., complete section B.

A. Prior Industrial Disability (Section 8-46-101, C.R.S.)

List prior workers' compensation cases below by employer, number, brief description of injury(ies) and award:

	Employer	W. C. Number	Description of Injuries	Award
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

B. Covered Occupational Disease (Section 8-41-304(2), C.R.S.)

Indicate the type(s) of exposure(s) alleged, the approximate dates of each, and the name and location of the employer in whose employ the exposure(s) allegedly occurred.

	Type of Exposure	Approximate Date of Exposure	Employer	Address of Employer
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____

(attach additional sheet(s) if necessary)

Date of Request _____ Signature of Requestor _____

NOTE:

A copy of this request and all pleadings, notices, reports and documents thereafter filed must be served upon the Director of the Division of Workers' Compensation. Submit these with this form to the Division of Workers' Compensation, Special Funds Section, P.O. Box 300009, Denver, CO 80203-0009. Where an assistant attorney general has entered an appearance for the Director in a case, such service shall be made upon that attorney.

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 purpose 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."