Instructions for Completing the

Dependent's Notice and Claim for Compensation

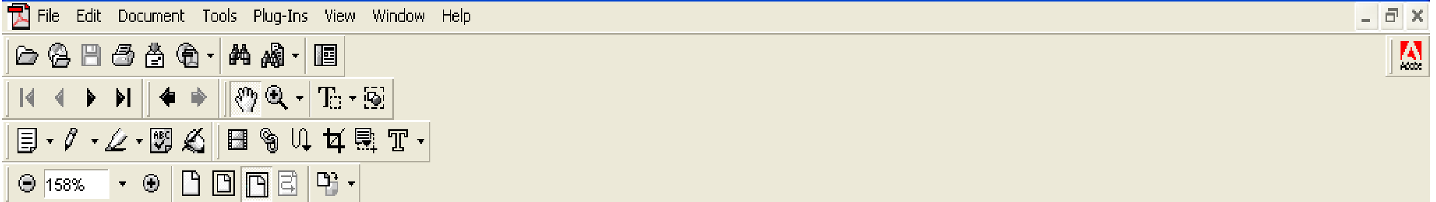
Please read all pages

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), 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 Number, phone number and dollar amounts. Do not use dashes, parentheses or dollar signs; 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. The injury description, witness information, incident description and dependent information fields are surrounded by a grey 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 clear all information on a single page, click on the red "Clear This Page" button. To change the information in one field, use the backspace or delete key.



Clear Entire Form

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
Division of Workers' Compensation
1515 Arapahoe Street, Denver, CO 80202-2117

Clear This Page

DEPENDENTS' NOTICE AND CLAIM FOR COMPENSATION

"**Clear This Page**" button
Clears all information on this page

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

"**Check Box**"
Click in box

"**Drop Down Menu**"
Click on the arrow for choices

Employee's Name (First, Middle, Last)	Social Security Number	Sex:	Employee's Home Phone No.	DO NOT WRITE IN THIS COLUMN
Employee's Street Address	City	State / Zip Code	Occupation	Accident
Age / Birthdate / Marital Status	How long has employee worked for this employer?	Job assigned when injured/exposed?	Length of experience at this assignment?	SIC
				Accident Time
Employer's Name		Em...		Sex
Employer's Mailing Address		State	I.D. No.	Service
Location if Different from Mailing Address (street address)				Occ
Nature of Business (specific product)		Number of Employees		Source
Average Weekly Wage at Time of Injury $	Hourly Wage at Time of Injury $	Check Box if Employee Receives: Tips; Board/Meals; Room	Will ... Duri... Yes / No $	Nature
Employee's Scheduled Work Week When Injured	Hrs. Per Day / Days Per Wk			Type

Asian
Black
Do not wish to answer
Hispanic
White

Adobe Acrobat - [WC018 Dependent's Notice and Claim for Compensation.pdf]

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Average Weekly Wage at Time of Injury

$ ____________________

Hourly Wage at Time of Injury

Check Box if Employee Receives

Will Benefit Continue During Disability?

Average Weekly Value of Benefit

$ ____________

$ ____________

$ ____________

"Grey Border Field"

Enter information in first field and tab to the next field to enter more information

Employee's Scheduled Work Week When Injured

Employee's Usual Work Schedule

If health insurance benefit will not continue during disability, set forth employee's cost of continuing employer's health insurance or employee's cost of conversion $ ______________ per week.

Injury Date			Injury Time	Last Day Worked			Date Employer Notified			Date of Death
Mo	Day	Yr		Mo	Day	Yr	Mo	Day	Yr	

Injury Description (state exactly the part of the body affected and the nature of injury or illness)

Names of Witnesses

Name of Employer Representative Notified

Place of Accident/Exposure

Name and Address of Treating Doctor

Name and Address of Hospital

What happened to cause this injury or illness? Describe employee's activities when injury or illness occurred with details of how event or exposure occurred (include name(s) of other individuals involved, tools, machinery, objects, vapors, chemicals, radiations, unnatural motions of employee, etc.). Also, specify the items which directly injured the employee and caused the accident or disease.

C.R.S. Section 10-1-127(7) (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

Part of Body

Nature

Type

County

AWW

Coder

3rd Party

FEIN

Scarring

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2:26 PM Thursday 5/22/2003

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

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

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 80202-3626**. 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 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."