OPTUM®

PO Box 152539
Tampa, FL 33684-2539

EMPLOYERS®
America's small business insurance specialist®

MAKING IT EASY TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured person:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacy will fill the prescription at no cost to you.

If your workers' compensation claim is accepted, you will receive a permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Employer:

Immediately upon receiving notice of injury, fill in the information below and give this form to the employee.

Finding a network pharmacy

Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

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WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Employers
CARRIER/TPA — EMPLOYER

INJURED PERSON NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER — DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	EMPLFF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

tmesys®

IMP14-2013-84

OPTUM®

PO Box 152539
Tampa, FL 33684-2539

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America's small business insurance specialist®

HACEMOS MÁS SENCILLO QUE SE LE ABASTEZCA LAS RECETAS DE SU PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Persona lesionada:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información que aparece a continuación y entregue este formulario al empleado.

Cómo encontrar una farmacia de la red

La mayoría de farmacias y todas las grandes cadenas de farmacias forman parte de la red. Para ubicar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta? ¿Necesita ayuda?

1-866-599-5426

OPTUM®

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WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Employers
PORTADORA — EMPLEADOR

NOMBRE DEL PERSONA LESIONADA

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL — FECHA DE LA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	EMPLFF		

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

tmesys®

EMPLOYERS®

America's small business insurance specialist®

Basic Accident Report

Date of Report:_____ Report Completed By:_____

Last Name of Injured Person:	First Name:	Job Title:
Date of Accident:	Time of Accident:	Location of Accident:
Supervisor's Name & Job Title:	Name of Witnesses:	
Full Description of Injuries:		
Description of accident/incident or employee's account, including sequence of events preceding the accident:		
Basic cause and contributory causes. Explain fully unsafe act, unsafe condition, personal factor, other:		
Recommended Corrective Measures:		Action By:
Names of Inspection Team Participants:		
Management Review By:	Date to be Completed By:	

America's small business insurance specialist®

Informe Básico de Accidentes

Fecha Del Informe:_____Informe Completado Por:_____

Apellido De La Persona Lesionada:	Primer Nombre:	Puesto De Trabajo:
Fecha Del Accidente:	Hora Del Accidente:	Lugar Del Accidente:
Nombre Del Supervisor Y Cargo:	Nombre De Los Testigos:	
Descripción Completa De Las Lesiones:		
Descripción del accidente / incidente o versión del empleado, incluyendo la secuencia de eventos que preceden al accidente:		
Causas básicas y causas contributivas. Explique el tipo de situación ya sea si fue una situación insegura, condición insegura, factor personal, otros:		
Medidas Correctivas Recomendadas:		Acciones Tomadas Por:
Nombres De Los Participantes Del Equipo De Inspección:		
Revisión Por Parte De La Gerencia:	Fecha Límite De Entrega:	

Clear Entire Form

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Información De Indemnización Por Accidentes Laborales De Colorado

Su empleador tiene cobertura de indemnización por accidentes laborales para empleados completamente:

La indemnización por accidentes laborales es un tipo de cobertura de seguro que los empleadores deben proveer a sus empleados. El coste del seguro de indemnización por accidentes laborales es pagado completamente por el empleador y no puede ser deducido de los sueldos de un empleado.

Si usted sufrió un accidente o mantiene una enfermedad profesional en su trabajo, usted puede calificar para los beneficios de compensación. Usted tiene la obligación de NOTIFICAR POR ESCRITO A SU EMPLEADOR DENTRO DE 4 DÍAS DEL ACCIDENTE. Si usted no informa sobre su accidente o enfermedad profesional inmediatamente sus beneficios podrían ser reducidos.

Si usted no puede trabajar por el resultado de su accidente de trabajo o la enfermedad profesional, los beneficios de compensación serán pagados sobre la base de 2/3 de su sueldo semanal hasta un máximo fijado por ley. Los primeros 3 dias no son cubiertos por la aseguranza.

Usted está autorizado para el tratamiento médico que sea razonable y necesario si usted sufrió lesiones en el trabajo o enfermedades profesionales. Si usted notifica a su empleador sobre una lesión o la enfermedad profesional y no le ofrecen atención médica adecuada, usted puede seleccionar los servicios de otro médico que tenga licencia o que sea quiropráctico.

Usted puede reportar su propio reclamo si su empleador no lo ha hecho. Para obtener formularios o información acerca de accidentes laborales usted puede puede llamar al servicio de asistencia al numero 303-318-8700 o sin costo a 1-888-390-7936 o visitar nuestro sitio web en www.colorado.gov/cdle/dwc.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
633 17th St. Suite 400, Denver, CO 80202-3660

Cualquier información proveída abajo viene directamente de su empleador y es exclusivo de este lugar del empleo:

Instructions for Completing the

Dependent's Notice and Claim for Compensation

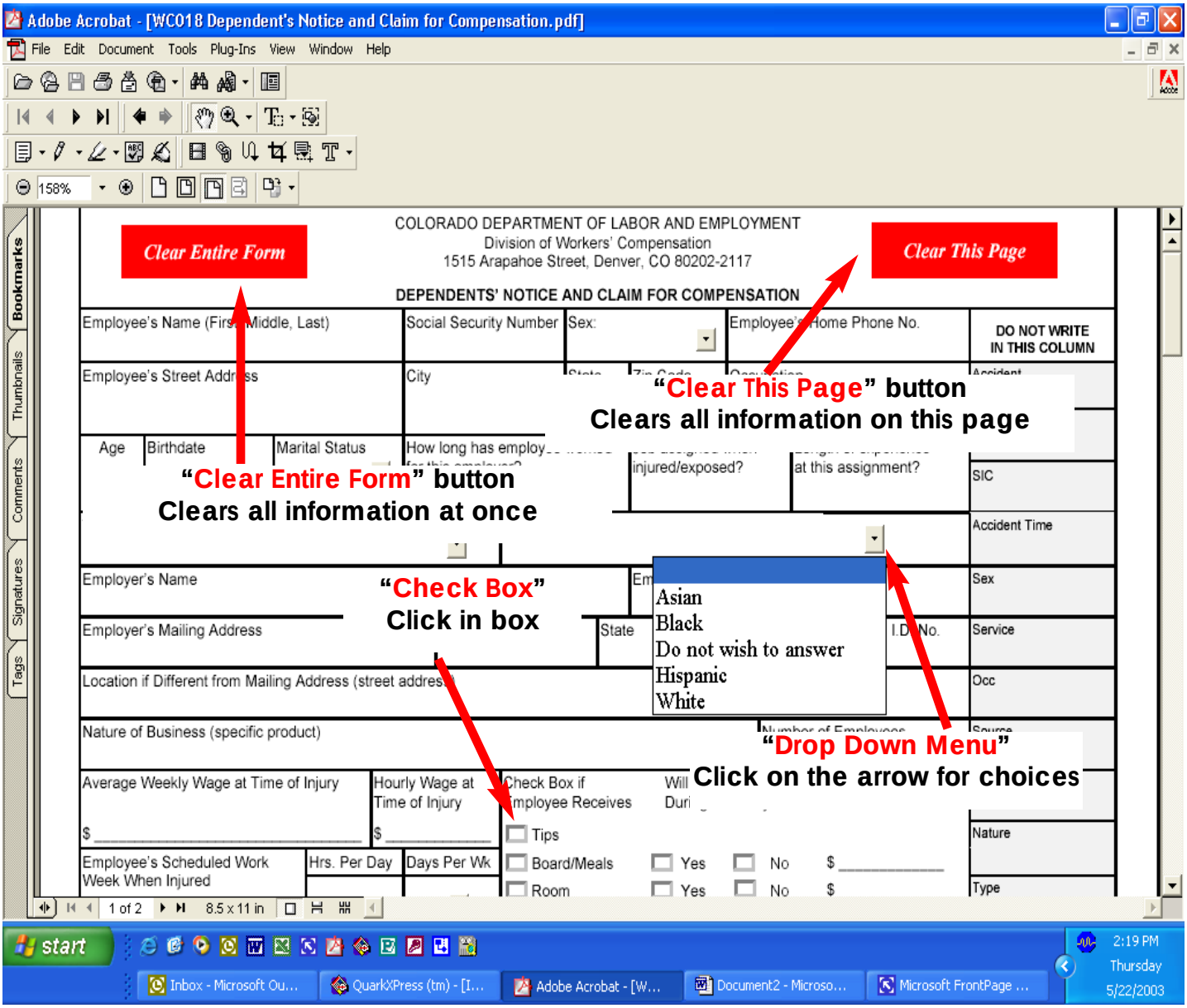
Please read all pages

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.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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
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
Age
Birthdate
Marital Status
How long has employ
injured/exposed?
at this assignment?
SIC
Accident Time
Employer's Name
Sex
Employer's Mailing Address
State
I.D. No.
Service
Location if Different from Mailing Address (street address
Occ
Nature of Business (specific product)
Asian
Black
Do not wish to answer
Hispanic
White
Average Weekly Wage at Time of Injury
Hourly Wage at Time of Injury
Check Box if Employee Receives
Will
Tips
Nature
Employee's Scheduled Work Week When Injured
Hrs. Per Day
Days Per Wk
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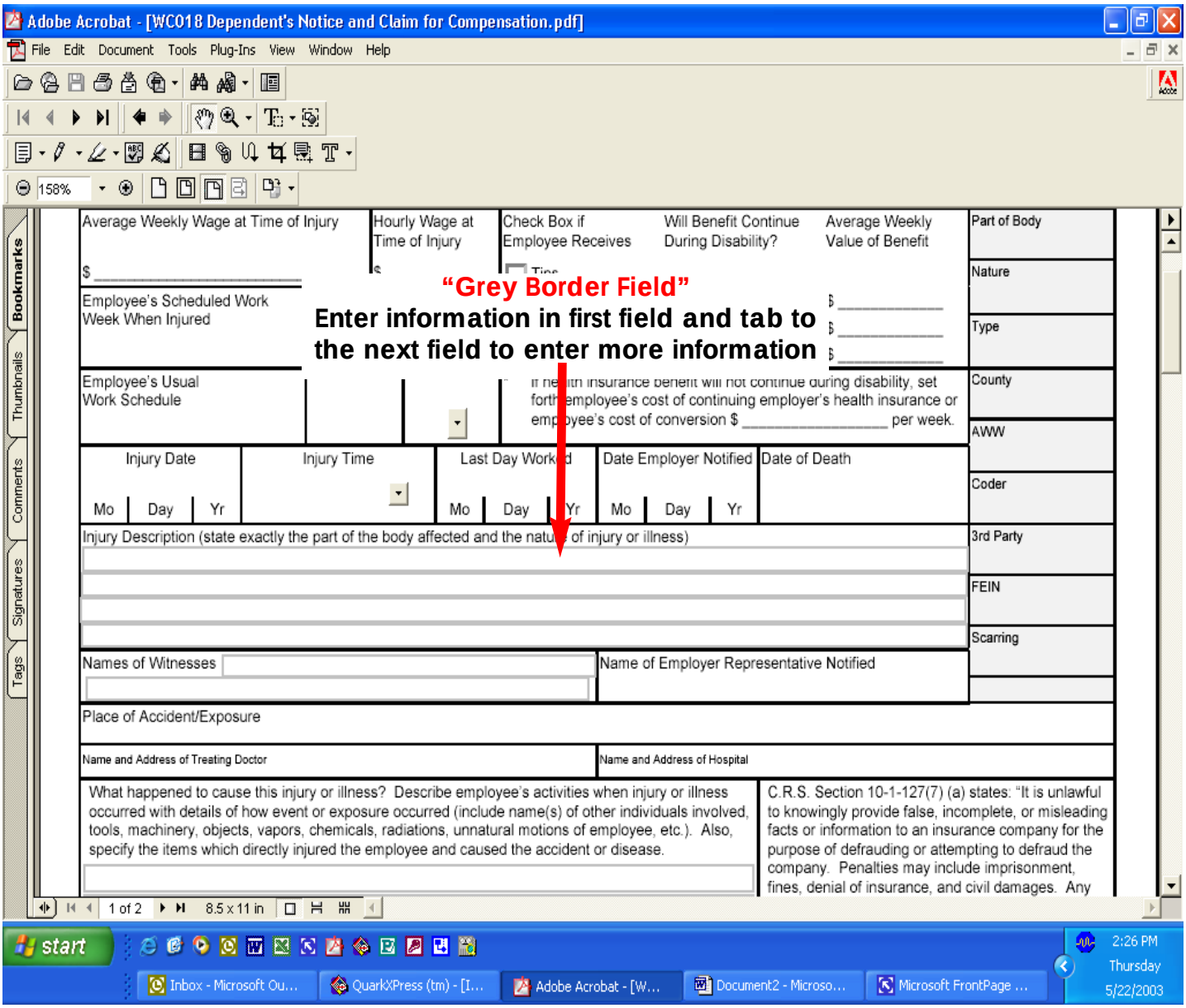
Adobe Acrobat - [WC018 Dependent's Notice and Claim for Compensation.pdf]
File Edit Document Tools Plug-Ins View Window Help
"Grey Border Field"
Enter information in first field and tab to the next field to enter more information
Average Weekly Wage at Time of Injury
Hourly Wage at Time of Injury
Check Box if Employee Receives
Will Benefit Continue During Disability?
Average Weekly Value of Benefit
Part of Body
Nature
Type
Employee's Scheduled Work Week When Injured
Employee's Usual Work Schedule
County
AWW
Coder
Injury Date
Injury Time
Last Day Worked
Date Employer Notified
Date of Death
Mo Day Yr
Injury Description (state exactly the part of the body affected and the nature of injury or illness)
3rd Party
FEIN
Scarring
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
Bookmarks
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Signatures
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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	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 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 / /
Employer	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 80202-3626**. 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."

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
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 toll-free at 1-888-390-7936 or visit our website at www.colorado.gov/cdle/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:

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

NOTICE

IF YOU ARE INJURED ON THE JOB, YOU HAVE RIGHTS UNDER THE COLORADO WORKERS' COMPENSATION ACT. YOUR EMPLOYER IS REQUIRED BY LAW TO HAVE WORKERS' COMPENSATION INSURANCE. THE COST OF THE INSURANCE IS PAID ENTIRELY BY YOUR EMPLOYER. IF YOUR EMPLOYER DOES NOT HAVE WORKERS' COMPENSATION INSURANCE, YOU STILL HAVE RIGHTS UNDER THE LAW.

IT IS AGAINST THE LAW FOR YOUR EMPLOYER TO HAVE A POLICY CONTRARY TO THE REPORTING REQUIREMENTS SET FORTH IN THE COLORADO WORKERS' COMPENSATION ACT. YOUR EMPLOYER IS INSURED THROUGH:

IF YOU ARE INJURED ON THE JOB, NOTIFY YOUR EMPLOYER AS SOON AS YOU ARE ABLE, AND REPORT YOUR INJURY TO YOUR EMPLOYER IN WRITING WITHIN 10 DAYS AFTER THE INJURY. IF YOU DO NOT REPORT YOUR INJURY PROMPTLY, YOU MAY STILL PURSUE A CLAIM.

ADVISE YOUR EMPLOYER IF YOU NEED MEDICAL TREATMENT. IF YOU OBTAIN MEDICAL CARE, BE SURE TO REPORT TO YOUR EMPLOYER AND HEALTH-CARE PROVIDER HOW, WHEN, AND WHERE THE INJURY OCCURRED.

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,THE CUSTOMER SERVICE CONTACT INFORMATION FOR THE DIVISION OF WORKERS' COMPENSATION IS:

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

303-318-8700
1-888-390-7936 (Toll-Free)
cdle.colorado.gov/dwc

WC50 Rev 08/22

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

AVISO

SI SE LESIONA EN EL TRABAJO, TIENE DERECHOS BAJO LA LEY DE COMPENSACIÓN DE TRABAJADORES DE COLORADO. SU EMPLEADOR ESTÁ OBLIGADO POR LEY A TENER UN SEGURO DE COMPENSACIÓN PARA TRABAJADORES. EL COSTO DEL SEGURO ES PAGADO EN SU TOTALIDAD POR SU EMPLEADOR. SI SU EMPLEADOR NO TIENE SEGURO DE COMPENSACIÓN PARA TRABAJADORES, USTED TODAVÍA TIENE DERECHOS BAJO LA LEY.

ES CONTRA LA LEY QUE SU EMPLEADOR TENGA UNA PÓLIZA CONTRARIA A LOS REQUISITOS DE INFORMES ESTABLECIDOS EN LA LEY DE COMPENSACIÓN DE TRABAJADORES DE COLORADO. SU EMPLEADOR ESTÁ ASEGURADO A TRAVÉS DE:

SI SE LESIONA EN EL TRABAJO, NOTIFIQUE A SU EMPLEADOR TAN PRONTO COMO PUEDA E INFORME SU LESIÓN A SU EMPLEADOR POR ESCRITO DENTRO DE LOS 10 DÍAS POSTERIORES A LA LESIÓN. SI NO INFORMA SU LESIÓN CON PRONTITUD, AÚN PUEDE PRESENTAR UN RECLAMO.

INFORME A SU EMPLEADOR SI NECESITA TRATAMIENTO MÉDICO. SI OBTIENE ATENCIÓN MÉDICA, ASEGÚRESE DE INFORMAR A SU EMPLEADOR Y PROVEEDOR DE ATENCIÓN MÉDICA CÓMO, CUÁNDO Y DÓNDE OCURRIÓ LA LESIÓN.

PUEDE PRESENTAR UN RECLAMO DE COMPENSACIÓN DEL TRABAJADOR ANTE LA DIVISIÓN DE COMPENSACIÓN DE LOS TRABAJADORES. PARA OBTENER FORMULARIOS O INFORMACIÓN SOBRE EL SISTEMA DE COMPENSACIÓN DE TRABAJADORES, LA INFORMACIÓN DE CONTACTO DE SERVICIO AL CLIENTE PARA LA DIVISIÓN DE COMPENSACIÓN DE LOS TRABAJADORES ES:

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

303-318-8700
1-888-390-7936 (Llame Gratis)
cdle.colorado.gov/dwc

WC50 Rev 08/22

EIG Services, Inc.
In California, dba
EIG Insurance Services

SAMPLE

DESIGNATED PROVIDER LIST

Healthone Occupational Medical Center
14000 E Arapahoe Rd Ste 110
Centennial, CO 80112
Arapahoe County
(303) 806-5500

Occupational Medicine and Injury Clinic
6870 W 52nd Ave Ste 201
Arvada, CO 80002
Jefferson County
(303) 463-8900

Employer Representative:
TO BE ENTERED BY EMPLOYER WITH NAME OF INDIVIDUAL, NAME OF COMPANY, COMPANY ADDRESS AND TELEPHONE NUMBER

Insurance Company Claims Examiners:
Carla Micolo-Zisman
E-Mail: cservices@employers.com

EMPLOYERS
P.O. Box 539004
Henderson, NV 89053
Toll Free Telephone: (888) 682-6671

I acknowledge that I have received this Designated Provider List from my employer this ____ day of __(month)___, (year).

Injured Employee Signature

Injured employee provider selection:

Name of Selected Provider

Instructions for Completing the

First Report of Injury

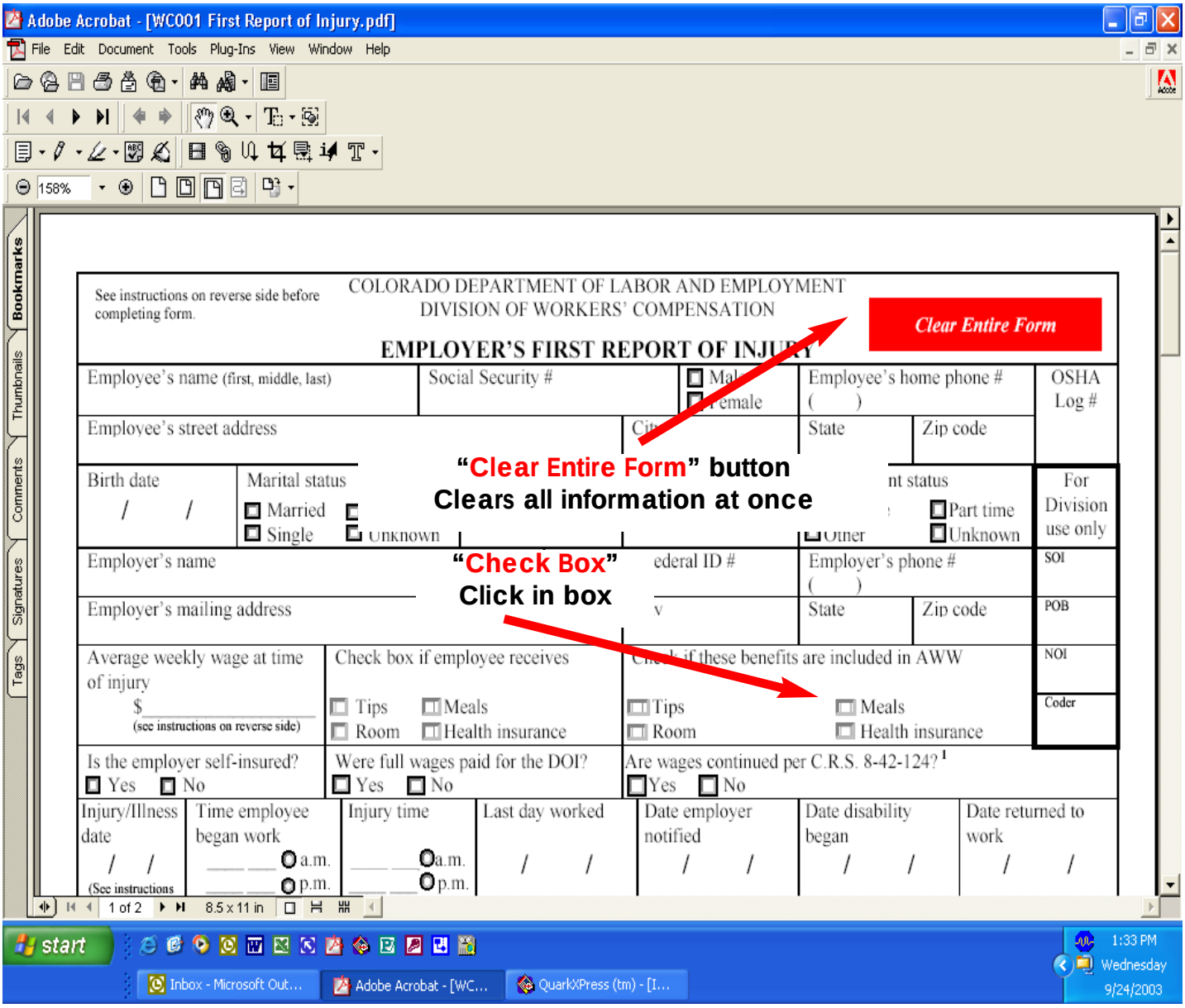
Please read all pages

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 #, phone numbers and dollar amounts. If a dollar amount contains cents, *do* type the period. To fill in a check box, click inside the box with your mouse. Some check boxes require you to select only one answer; you cannot check both. The "Injury Description", "Name of Witness", and "Name of Doctor" fields have a gray border to indicate how many lines you have to type in. Use the tab key to navigate to the next field.

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.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Bookmarks
Thumbnails
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See instructions on reverse side before completing form.
COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION
Clear Entire Form
EMPLOYER'S FIRST REPORT OF INJURY
Employee's name (first, middle, last)
Social Security #
Employee's home phone #
OSHA Log #
Employee's street address
State
Zip code
Birth date
Marital status
Married
Single
Unknown
Part time
Unknown
For Division use only
Employer's name
Employer's phone #
SOI
Employer's mailing address
State
Zip code
POB
NOI
Coder
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
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?
Yes
No
Injury/Illness date
Time employee began work
Injury time
Last day worked
Date employer notified
Date disability began
Date returned to work
a.m.
p.m.
(See instructions
1 of 2
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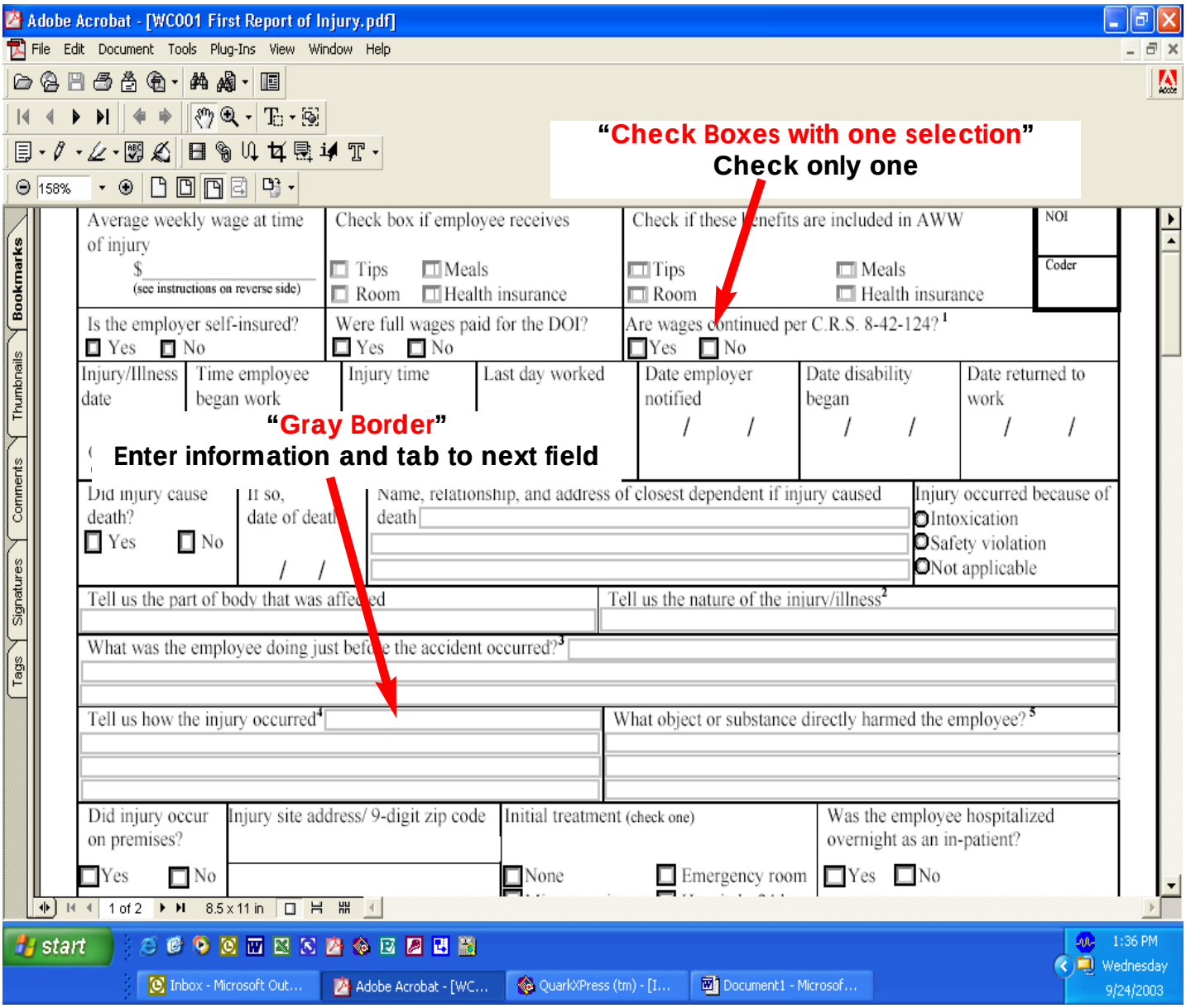
Wednesday
9/24/2003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File Edit Document Tools Plug-Ins View Window Help
"Check Boxes with one selection"
Check only one
"Gray Border"
Enter information and tab to next field
Average weekly wage at time of injury
$
(see instructions on reverse side)
Check 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
Time employee began work
Injury time
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
Was the employee hospitalized overnight as an in-patient?
Yes No
Bookmarks
Thumbnails
Comments
Signatures
Tags
1 of 2
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9/24/2003

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 ☐ Minor on-site ☐ Clinic/hospital ☐ Emergency room ☐ Hospital >24 hrs	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."

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Supplemental Report of Return to Work

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

Employee Name:_____ Carrier Claim #: _____

Social Security #: _____-_____-_____ Employer: _____

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 and/or hours.**
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/full hours

☐ Reduced wages and/or hours

(Please provide wage information to the claims adjuster every two weeks during periods of wage loss)

Additional information:

_____

_____

_____

_____

Completed by (Check the box that applies): ☐ Employee ☐ Employer

_____ _____

Name Date
(Cannot be dated prior to the return to work date)

Address: _____

Phone #: _____ Email: _____

Please review the instructions on page 2 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 #	Gender	Employee's Phone #

Employee's Street Address	City	State	Zip Code

Employee's Email Address

Birth Date	Marital Status	Dependents	Date of Hire	Occupation	Employment Status
/ /	☐ Married ☐ Separated ☐ Single ☐ Unknown	☐ Yes ☐ No	/ /		☐ Full Time ☐ Part Time ☐ Other ☐ Unknown

Employer's Name (Company)	Employer's Phone #

Employer's Mailing Address	City	State	Zip Code

Average Weekly Wage (See page 2 for instructions)

A. Average Weekly Wage from the job where the injury occurred. **Subtotal (A): $**_____

B. Average Weekly Wage from any other job held concurrently at the time of your injury. **Subtotal (B): $**_____

C. **Add subtotals of A + B** **Total 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.	____ ____ ☐ a.m. ____ ____ ☐ p.m. ☐ Unknown	/ /	/ /	/ /	☐ Yes ☐ No ☐ Unknown

Which part of the 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.)

Describe the accident in detail (what you were doing, how the accident occurred, object that harmed you, etc.)	Name(s) and phone number(s) of witness(es), if applicable

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 hours
☐ Minor on-site ☐ Clinic/hospital

Do you claim to have a scar or disfigurement?
☐ 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).

_____ ____/____/____ to ____/____/____
Employer Dates of employment

_____ ____/____/____ to ____/____/____
Employer Dates of employment

Completed by _____ **Date completed** ____/____/____

For Division Use Only

SOI	POB	NOI	Coder	Adjuster code

FEIN	Policy #	Block #

Instructions for the Worker's Claim for Compensation

To ensure your claim gets processed in timely manner, please enter all available information on page 1.

Average Weekly Wage

To determine the weekly wage, do the following:

1. Take your total gross income (before taxes) over a period of weeks and divide it by the number of weeks included.

   Total gross (before taxes) includes: any wages which were reported as income to the IRS including: regular wages; overtime; vacation; sick leave; tips; commissions; piecework; mileage; employer provided board, rent, or housing.

   Alternatively, the average weekly wage can be calculated by taking one's yearly gross income and dividing it by 52 (or the number of weeks worked), or taking one's monthly income and multiplying it by 12 and dividing it by 52.

2. On line A, enter your Average Weekly Wage for the job where the injury occurred.

3. **Repeat this process for any concurrent employment you had at the time of your injury.** The Average Weekly Wage from concurrent employment should be entered on line B.

4. Add lines A and B to determine your total Average Weekly Wage and enter that number on line C.

You may also visit dowc.cdle.state.co.us/benefits/ to use an online Average Weekly Wage calculator.

Date of Injury/Disease

Always include the date of injury. In the case of an occupational disease, use the date you were last exposed to the hazard.

Injury Description

Be as specific as possible when describing your injury.

Examples of good descriptions:

- "climbing a ladder while carrying roofing materials"
- "spraying chlorine from hand sprayer"
- "daily computer key-entry"
- "When ladder slipped on the wet floor, I fell 20 feet."
- "I was sprayed with chlorine when gasket broke during replacement."
- "I developed soreness in my wrist over time."

Examples of incomplete descriptions:

- "hurt"
- "pain"
- "sore"
- "fell"

Filing and Benefit Information

Upon completion, send the Worker's Claim for Compensation to The Colorado Division of Workers' Compensation, Data Entry Unit, 633 17th St., Suite 400, Denver, CO 80202-3626 or via email to cdle_workers_compensation@state.co.us. If you need assistance filling out this form, to obtain information on benefits and dispute resolution options, or to receive a copy of the Injured Worker Guide, please contact our Customer Service Unit at 303-318-8700 or toll-free at 1-888-390-7936.

General Information

When the Division of Workers' Compensation receives your claim form, a copy will be sent to your employer's insurance carrier (carrier). The carrier has 20 days from receipt to advise, in writing, whether liability will be admitted or denied, that is, whether it accepts or denies responsibility for payment of related medical and/or lost wage benefits. If the carrier fails to admit liability within the allowed 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 four days could result in the loss of one day's compensation for each day's failure to notify.

Notices

You are further notified that you must provide written notice of any award for social security, pension, disability, or other sources of income that might reduce your compensation benefits to the insurance carrier or self-insured employer within 20 days after learning of the payment or award. Failure to report may result in the suspension of your benefits. "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."

Contact Us

Division of Workers' Compensation
633 17th Street, Suite 400
Denver, CO 80202
303-318-8700
1-888-390-7936 (Toll-Free)
cdle.colorado.gov/dwc

For more information, view our Injured Worker Guide at cdle.colorado.gov/injured-workers.