AmTrust North America
An AmTrust Financial Company

Colorado
Worker's Compensation
Claim Kit

(p) 888.239.3909 • (f) 678.258.8399 • www.amtrustfinancial.com

AmTrust North America
An AmTrust Financial Company

Table of Contents

AmTrust INSURANCE

Workers' Compensation Claim Reporting Information

24/7 Toll Free Claim Reporting for All States

(888)239-3909

WorkersCompClaimReport@AmTrustgroup.com

www.amtrustfinancial.com

Information Required for All Claims Reported

1. Name of the insured and policy number
2. Name, social security number and contact information of injured worker
3. Date, time and place of accident
4. Description of accident or incident
5. Name, phone, and/or email of person making the report
6. Any information on the injured workers lost time

Early claim reporting is essential to a better claim outcome. Don't delay reporting if you do not have all the details.

How do I help my injured worker find a doctor?

- We offer an online physician search for all states, www.talispoint.com/amtrust/external
- For California, www-lv.talispoint.com/amtrust/campn
- For CO, GA, PA & TN, please refer to the panel provided by AmTrust via mail or email

How does my injured employee receive prescription medications related to the accident/injury?

- Refer to the claims kit for your state at www.talispoint.com/amtrust/external for a First Fill card for your injured employee to use at the pharmacy to cover the cost of approved medication.

Timely Reporting

When a work-related injury occurs, it is important to act immediately. Timely reporting of a new claim helps to provide a smooth and successful claim process for both you and your injured worker.

We're Here To Help

After your claim has been filed, we may be in touch to obtain additional information. Our goal is to offer a smooth and hassle-free experience – from your first contact to the claims conclusion. Feel free to also call us with any questions. We're here to help.

Relax And Stay Positive

You have the assurance of our knowledge, expertise, and understanding of the claim process. We're with you all the way.

877.528.7878 I www.amtrustfinancial.com

AmTrust INSURANCE

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AmTrust North America
An AmTrust Financial Company

EASY ONLINE CLAIMS REPORTING INSTRUCTIONS

By logging into AmTrust's web portal, policyholders can access a wide variety of account information including the ability to report injuries online. The following instructions will help get you started.

First Time Portal Access:

1. Go to www.amtrustnorthamerica.com
2. In the upper right corner of the home page, click "LOGIN"
3. In the subsequent AmTrust *Online* drop-down box, click the word "**Register**"
4. On the following screen, enter your policy number, zip code and the security code that appears on that screen and click "**Enter**" at the bottom right of the screen
5. Enter your email address, user name and password to complete the registration process
6. After completing the registration process, go back to www.amtrustnorthamerica.com and log in

Reporting of New Injuries:

1. Go to www.amtrustnorthamerica.com
2. Log in to "AmTrust ***Online***"
3. Click the "**Claims**" icon in the upper middle of your screen to view the screen that lists your policies
4. Click "**View**" next to the policy for which you wish to enter a claim. This brings you to the policy detail screen
5. Click on "**First Reports**" in the upper left corner
6. On the next screen, click "**Add**" to view the "**New First Report of Injury**" screen
7. Click "**Use WebForm**." This brings you to the screen where you will enter all of the detailed information about the injury/injured worker
8. When finished entering all of the data, click "**Submit**" and this report will channel into our intake center to be set up and assigned to a claims adjuster
9. Return to the "**First Reports"** screen and you will see the claim number for the report entered
10. When finished, click on "**Return to Listing**"

For ID/Password issues or if you receive error messages while using this application, please contact our help desk at help.desk@amtrustgroup.com or call 866.427.6150. Please be sure to specify that you are an AmTrust policyholder and provide your AmTrust Online ID.

AmTrust North America
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Helpful Hints:

- "**Time Employee Began Work**" and "**Time of Occurrence**" must be entered in military time
- Enter the hours in the first box and the minutes in the second box
- All dates must be entered as two-digit day, two-digit month and four-digit year, i.e.: XX/XX/XXXX
- For PEOs, in the "**Location Address**" box, please include the PEO client name and address of the applicable PEO client location. If there is a location code/number, specify in the "**Location #**" box
- If during the entry of a claim you must exit the application, first click on "S**ave as Draft**" and you may return to it later by going back into the "**First Reports"** screen and clicking on "**In Progress**"

For ID/Password issues or if you receive error messages while using this application, please contact our help desk at help.desk@amtrustgroup.com or call 866.427.6150. Please be sure to specify that you are an AmTrust policyholder and provide your AmTrust Online ID.

Thank you for your attention to this matter.

Sincerely,

AmTrust North
America Claims
Department

Workers' Compensation Posting Requirements

Thank you for placing your Workers' Compensation Coverage with AmTrust.

Colorado Required Posting Notices

Print and Post at place of employment, in a sufficient number of places on the premises to assure that the notice will reasonably be seen by all employees at all business locations and work sites (Break Room, Lunch Room or Time Clock) Employees that may not reasonably be expected to see a posted notice must receive notice of the posting in writing.

- **Notice to Employer of Injury Poster Form WC-50** Poster has already been sized to meet the requirement of 27" x 40". This form can also be accessed at: https://cdle.colorado.gov/dwc You are only required to print out the English version of the poster in black/white.

The following forms need to be completed and submitted to AmTrust when a work-related injury occurs:

- **Employer's First Report of Injury - Form WC-1.** All injuries or occupational diseases that result in lost time from work in excess of three shirts or calendar days or from permanent physical impairment must be reported to AmTrust on this form within 10 days after notice or knowledge of the injury or disease. Fatalities must be reported to AmTrust immediately. You must use this form to notify AmTrust of every work-related injury or disease suffered by an employee, regardless of severity.

- **Supplemental Report of Return to Work - Form WC-12.** This form is to provide information to AmTrust to determine the accurate payment of temporary disability benefits. This form may be completed by the employee or the employer. The form should be completed and forwarded to AmTrust each time the employee returns to work at full or reduced wages.

- **Workers' Claim for Compensation - Form WC-15.** This form should be completed by the employee. Two copies of the completed form must be sent to the Colorado Division of Workers' Compensation. The Division of Workers' Compensation will provide a copy to AmTrust. AmTrust will have 20 days from receipt of this form to advise in writing if it is accepted or denied.

- **Dependent's Notice and Claim for Compensation - Form WC-18.** This form should be completed by the dependent. Two copies of the completed form must be sent to the Colorado Division of Workers' Compensation. The Division of Workers' Compensation will provide a copy to AmTrust. AmTrust will have 20 days from receipt of this form to advise in writing if it is accepted or denied.

- **Optum First Fill Form.** Use of this form will enable quick authorization for your employee's initial medication and ensure that the initial prescription is provided at no cost to the injured employee. Immediately upon receiving notice of injury, fill in the information on this form and give this form to the employee.Your employee will need to provide this completed form along with the prescription for their work-related injury or occupational disease to the pharmacist.

- **Statement of Wages/Salary.** This form enables us to calculate the correct compensation that may be owed to an injured employee. Please complete this form and submit to AmTrust within five days after your knowledge of any accident that has caused your employee to be disabled for more than seven scheduled work calendar days

You may send an email to clientservices@amtrustgroup.com with any Claims Kit related questions. Please make sure to include your policy number along with your request.

I have a question about a claim or injured worker, who do I contact?

Customer Service can direct you to the appropriate person. Please contact them at 888-239-3909.

59 Maiden Lane, New York, NY 10038 I 877.528.7878 I www.amtrustfinancial.com

AmTrust FINANCIAL

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:

AmTrust North America
PO Box 89404, Cleveland, OH 44101
888-239-3909

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:

AmTrust North America
PO Box 89404, Cleveland, OH 44101
888-239-3909

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

See instructions on reverse side before completing form.

Back to Instructions

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 #	☐ 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 C/O AmTrust North America	Address PO Box 89404, Cleveland, OH 44101
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 * See "Average Weekly Wage Worksheet" 

- 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: _____

Clear Form

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 ○ Minor on-site ○ Emergency Room
○ Clinic/hospital ○ Hospital stay over 24 hours

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 Workers' Claim for Compensation

To ensure your claim gets processed in a 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.

Click here to open our 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 10 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.

Click here to view the Injured Worker Guide

Please review the instructions on page 3 before completing form

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Dependent's Notice and Claim for Compensation

Clear Form

Decedent's name (first, middle, last)	Social Security (SS) #	Gender	Birth date / /
Decedent's street address	City	State	ZIP code

Marital status	Dependents	Date of hire	Occupation	Employment status
○ Married ○ Separated ○ Single ○ Unknown	○ Yes ○ No	/ /		○ Full-time ○ Part-time ○ Other ○ Unknown

Decedent's employer's name (company)			
Decedent's employer's mailing address	City	State	ZIP code

Dependent's name (first, middle, last) (***person filing this form***)	Social Security (SS) #	Birth date / /	Dependent's phone #
Dependent's street 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 the decedent's injury. **Subtotal (B): $**

C. **Add subtotals of A + B** **Total Average Weekly Wage at time of injury (C): $_____**

Date of injury/disease / / **(See instructions)**	Date of death / /	Time decedent began work _____ : _____ ○ a.m. ○ p.m.	Injury time _____ : _____ ○ a.m. ○ p.m. ☐ Unknown	Last date worked / /	Date employer notified / /

Which part of the body was affected? (upper arm, lower back, etc.)	Tell us the nature of the injury/illness (laceration, head injury, etc.)

Briefly describe the accident (what decedent was doing, how the accident occurred, object that harmed decedent, etc.) (please limit the description to **200 characters**)	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 ○ Minor on-site ○ Emergency Room ○ Clinic/hospital ○ Hospital stay over 24 hours

Name of treating medical provider and name of medical facility	Address of facility where treated

If death resulted from an occupational disease (i.e.,silicosis, asbestosis, etc.) 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 #**

Please review the instructions on page 3 before completing form

Clear Form

1. Name of mortuary _____ Address _____
2. Amount of funeral expenses _____ Has some been paid? _____ If so, by whom? _____
3. Was decedent married on the date of injury? ○ Yes ○ No
4. If married, provide
   a. Name of surviving spouse _____
   b. Current address and phone # of surviving spouse _____
   c. Social Security # of spouse _____
   d. Birth date of spouse _____/_____/_____
5. Provide name, date of birth, SS #, and present address of any child of the decedent under the age of twenty-one (21), and check the included box if the child is a **full-time** student at an accredited school. If you need more space, please attach an additional sheet to this filing.

Name	Date of birth	SS #	Address	Full-time student?
	/ /			☐
	/ /			☐
	/ /			☐
	/ /			☐
	/ /			☐
	/ /			☐

6. Provide name, date of birth, SS #, present occupation, relationship to the decedent and present address of any other person who was wholly or partially supported by the decedent at the time of decedent's death. If you need more space, please attach an additional sheet to this filing.

Name	Date of birth	SS #	Relationship to decedent	Address	Is this person disabled?
	/ /				☐
	/ /				☐

7. Other than amounts received from the decedent, what income did each of the dependents listed in #6 received, during the year immediately preceding the death of the decedent? _____
8. For the dependents listed in #6, please list for what period of time the dependent was disabled or incapable of earning their own income. _____

Attach a copy of decedent's marriage certificate(s), death certificate, and children's birth certificates.

I swear/affirm under oath that I have read the foregoing Dependent's Notice and Claim for Compensation and that the statements set forth herein are true and correct to the best of my knowledge.

_____ _____ _____
Printed name | Dependent's signature | Date

_____
Mailing address

_____
Email address

Instructions for the Dependent's Notice and Claim for Compensation

To ensure your claim gets processed in a timely manner, please enter all available information on pages 1 & 2.

Average Weekly Wage

To determine the weekly wage, do the following:

1. Take the decedent's 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 the decedent's Average Weekly Wage for the job where the injury occurred.
3. **Repeat this process for any concurrent employment the decedent had at the time of the decedent's injury.** The Average Weekly Wage from concurrent employment should be entered on line B.
4. Add lines A and B to determine the decedent's 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.

Click here to open our calculator

Date of Injury/Disease

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

Injury Description

Be as specific as possible when describing the decedent's injury.

Examples of good descriptions:

- "chemical exposure"
- "climbing a ladder while carrying roofing materials"
- "spraying chlorine from hand sprayer"
- "When ladder slipped on wet floor, decedent fell 20 feet."
- "Decedent was sprayed with chlorine when gasket broke during replacement."

Examples of incomplete descriptions:

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

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 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 your claim form is received by the Division of Workers' Compensation, a copy will be sent to the employer's insurance carrier (carrier). The carrier 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 carrier 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 reimbursement for at least some funeral costs, up to a maximum adjusted annually by the Director of the Division of Workers' Compensation.

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.

Click here to view the Injured Worker Guide

OPTUM®

AmTrust North America
An AmTrust Financial Company

Optum
PO Box 152539
Tampa, FL 33684-2539

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 Employee:

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 pharmacist will fill your prescription at low or no cost to you.

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

Most pharmacies, including Walgreens, our preferred provider, 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

OPTUM®

AmTrust North America
An AmTrust Financial Company

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
CARRIER/TPA

EMPLOYER

INJURED WORKER 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	FF		

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

Employer:

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

tmesys®

IMP14-1614-109-FFWG

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL 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 su 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.

Empleado lesionado:

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 bajo costo o 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.

La mayoría de farmacias, incluyendo Walgreens, nuestro proveedor preferido, y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar 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

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
PORTADORA — EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL — FECHA DE ALA 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	FF		

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

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-1614-109-FFWG

STATEMENT OF WAGES/SALARY

IMPORTANT: PLEASE COMPLETE ALL INFORMATION REQUESTED

Employee: Employer: Claim Number:
Social Security Number: Date of Hire: Position/Job Title

EMPLOYMENT TYPE: Full Time ☐ Part Time ☐ Seasonal ☐ Temp ☐
If Temporary or Seasonal worker, last day of season or job end date _____
WAGE TYPE: Hourly ☐ Salary ☐ Commission ☐
WAGE INFORMATION:
$_____ per hour ; Monthly Wage $_____ ; Does monthly wage include commission ☐ Yes ☐ No
Hours per Week _____ ; Overtime Rate $_____ per hour ; Overtime Hours Regularly Worked per week ____
Tips reported: $_____ per week

If employees' compensation package includes an allowance for any of the following, please indicate the actual or estimated value:
Meals: $_____ per week Auto: $_____ Rent/Lodging: $_____ per week Bonus $_____ per ☐ wk ☐ mth ☐ yr

PLEASE COMPLETE THE BELOW FOR THE PERIOD _____ TO _____

WK	Pay Rate	Hrs Worked	Begin Date	End Date	Gross Salary	WK	Pay Rate	Hrs Worked	Begin Date	End Date	Gross Salary
1						27					
2						28					
3						29					
4						30					
5						31					
6						32					
7						33					
8						34					
9						35					
10						36					
11						37					
12						38					
13						39					
14						40					
15						41					
16						42					
17						43					
18						44					
19						45					
20						46					
21						47					
22						48					
23						49					
24						50					
25						51					
26						52					

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 # AmTrust North America

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.

RETURN-TO-WORK; A **GREAT** IDEA

We at the AmTrust Group, are convinced that an employer who provides light, or restricted work for injured employees, enjoys numerous benefits. This is not just an opinion, it's something we see day in and day out. Consider:

- Unless an injured worker returns to the workplace within 60 days, chances of him/her ever returning drop dramatically. (resulting in a very expensive permanent disability situation.)
- After 6 months away from the workplace, only 50% chance of return.
- After 12 months, only a 10% chance of return.

Some Return-to Work Benefits Include:

- "Test" of malingering potential. Injured employees who refuse light duty are more prone to being malingerers.
- Opportunity for employer to demonstrate true concern for workers' well-being.
- Promotion of rehabilitation and recovery.
- Lower medical and rehabilitation costs.
- Productivity.
- Morale improvement for the injured worker.
- Ability for the employer to monitor the injured employee's recovery progress.
- Decrease of WC claims costs, with resultant downstream WC premium savings.

(Notice we're not just talking about 'feel-good' issues, but also hard dollars !)

Some common misconceptions (and truths) about Return-to-Work / Light Duty:

Misconception: *We've already got too many "programs" around here, and don't need any more paper*.

Truth: While it is true a written, planned program works best, in many cases a Light Duty "program" can be nothing more than a management understanding of the benefits and principles of Return-to-Work, how it works, and the commitment to 'just do it', when light-duty recommendations are made by WC physicians.

Misconception: *It will get me into an Americans With Disabilities (ADA) "situation".*

Truth: Light-duty and ADA "reasonable accommodation" are two entirely separate issues. Generally, light duty is a temporary assignment, for a relatively short period. ADA accommodations are made for serious, permanent disabilities that impair major life activities.

Misconception*: I'll have to devise a whole new job each time an employee needs light duty.*

Truth: The vast majority of light-duty restrictions require accommodating only one or two factors, such as "no lifting over 10 pounds", or the like. In many cases, if you break the jobs down into individual **tasks**, you'll see that only one or two tasks within the employee's normal job are affected, and can be handled in some other way.

Misconception: *Once an employee gets into a "cushy" light-duty job, s/he'll never leave it, and I'll be stuck with it.*

Truth: Light duty is always defined by, and monitored by the attending physician. An employee on light duty is periodically monitored by the physician for improvement, and is released for full-duty as soon as medically indicated.

Misconception: *We're a union company. Our union won't allow us to pay lower rates, or move employees between classifications, or between bargaining groups.*

Truth: Any Local that objects to a Return-to-Work program should be referred to its national body for guidance. Return to Work is universally recognized as a very positive influence on an injured worker (as well as benefiting the employer). Labor unions, whose major purpose for existence is the benefit of the workers they represent, should not only "tolerate" Return-to-Work programs, but enthusiastically promote, and assist in such programs' implementation and operation. It is strongly suggested that management approach labor representatives to solicit their input, and assistance in making Return to Work a positive force in your workplace.

Misconception: *I might be willing to place a worker in a light-duty position, but I can't afford pay them their full pay, for the decreased productivity.*

Truth: Talk to your WC insuror's claims professional. In many cases, states' WC plans provide for "make-up" pay to replace some, or all of the injured employees' decreased earnings. The goal of getting them back to the workplace, and doing some productive work is that important!