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 visit our website at: www.coworkforce.com/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:

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 está lastimado o mantiene una enfermedad profesional mientras su curso de trabajo, usted puede estar autorizado para los beneficios de compensación como proveer por ley. LA NOTIFICACIÓN ESCRITA DEBE SER DADO A SU EMPLEADOR DENTRO DE 4 DÍAS HÁBILES DEL ACCIDENTE. Si usted no informa sobre su lastimasion o enfermedad profesional inmediatamente sus beneficios podrían ser reducidos.

Si usted no puede trabajar por el resultado de una lastimasion de trabajo o la enfermedad profesional, los beneficios de compensación (la sustitución de sueldo) serán sobre la base de 2/3 de su sueldo semanal medio iguales a un máximo fijado por ley. Ninguna remuneración es pagadera para la incapacidad de los primeros 3 días a menos que el período de la incapacidad sobrepasa dos semanas.

Usted está autorizado para el tratamiento médico razonable y necesario de lesiones compensables o enfermedades profesionales. Si usted notifica a su empleador sobre una lesión o la enfermedad profesional y no ser ofrecidos la atención médica, usted puede seleccionar los servicios de un médico dado licencia o quiropráctico.

Usted puede archivar el Reclamo de un Trabajador para la Compensación con la División de la Indemnización por Accidentes Laborales. Para obtener formularios o información tratar del sistema de indemnización por accidentes laborales, en los que usted puede llamar al servicio de asistencia al numero 303.318.8700, o visitar nuestro sitio web en: www.coworkforce.com/dwc/.

División de Colorado de la Indemnización por Accidentes Laborales
633 17th St. Suite 400, Denver, CO 80202-3660

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

Go to Form

Instructions for Completing the

First Report of Injury

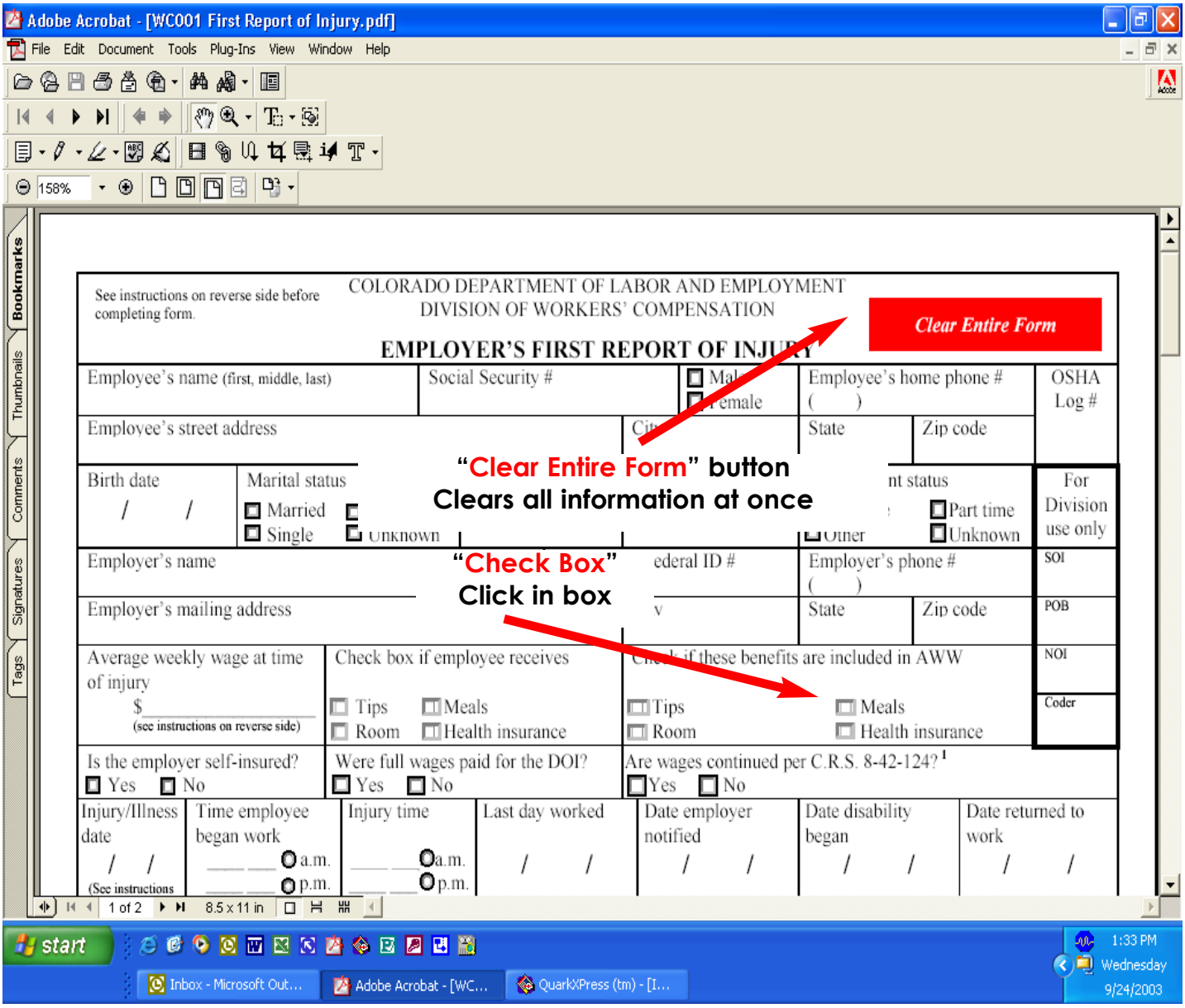
Please read all pages

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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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 #
Male
Female
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
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
(See instructions
Time employee began work
a.m.
p.m.
Injury time
a.m.
p.m.
Last day worked
Date employer notified
Date disability began
Date returned to work
1 of 2
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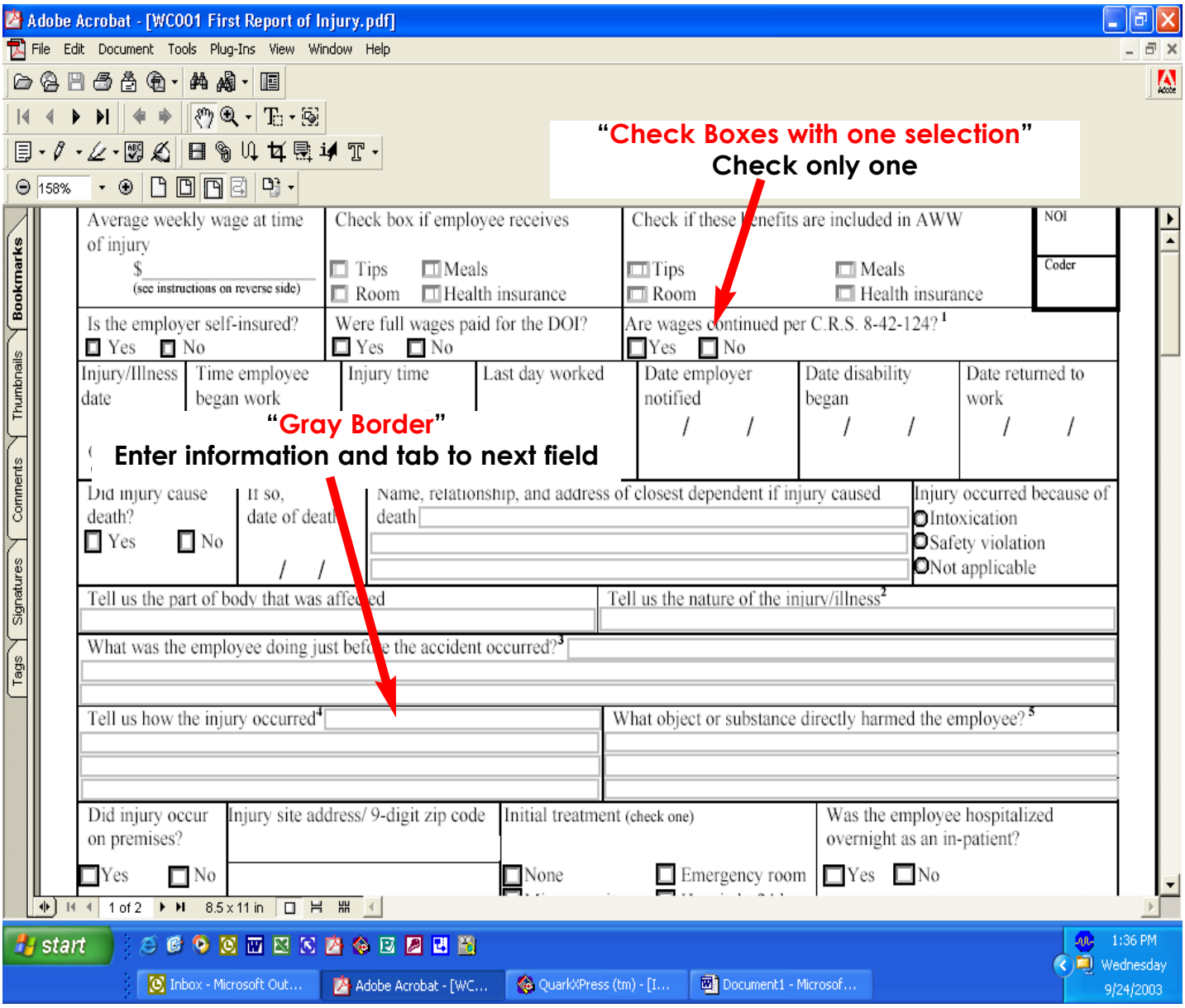
9/24/2003


Adobe Acrobat - [WC001 First Report of Injury.pdf]
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
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Comments
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Tags
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Wednesday
9/24/2003

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
Employer's name	Employer's Federal ID #	Employer's phone # ( )		For Division use only
Employer's mailing address	City	State	Zip code	SOI
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		POB
				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."

WARNING

IF YOU ARE INJURED ON THE JOB, WRITTEN NOTICE OF YOUR INJURY MUST BE GIVEN TO YOUR EMPLOYER WITHIN FOUR WORKING DAYS AFTER THE ACCIDENT, PURSUANT TO SECTION 8-43-102(1) AND (1.5), COLORADO REVISED STATUTES.

IF THE INJURY RESULTS FROM YOUR USE OF ALCOHOL OR CONTROLLED SUBSTANCES, YOUR WORKERS' COMPENSATION DISABILITY BENEFITS MAY BE REDUCED BY ONE-HALF IN ACCORDANCE WITH SECTION 8-42-112.5, COLORADO REVISED STATUTES.

AVISO

SI SE LASTIMA EN EL TRABAJO, DEBE DARLE UN AVISO POR ESCRITO A SU EMPLEADOR DENTRO DE CUATRO DÍAS LABORABLES DEL ACCIDENTE, SEGÚN A LA SECCIÓN DE LOS ESTATUOS REVISADOS DE COLORADO 8-43-102(1) Y (1.5).

SI EL ACCIDENTE RESULTA DEBIDO AL USO DE ALCOHOL O UNA SUSTANCIA CONTROLADA, SUS BENEFICIOS DE LA INCAPACIDAD DE LA COMPENSACIÓN DE LOS TRABAJADORES PUEDEN SER REDUCIDOS POR UN MEDIO EN ACUERDO DE LA SECCIÓN DE LOS ESTATUOS REVISADOS DE COLORADO 8-42-112.5.