

Instructions for Completing the

Objection to Petition to Modify, Terminate, or Suspend 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 “Claimant” box (field), complete the information, and use the tab key to navigate to the next field. Do not use the Enter key; pressing the Enter key will only page down. Each field has been *limited*. This means that you cannot continue to type information into a field if it doesn’t fit into the space provided.

Use numbers only to fill in the fields for Social Security Number. Do not use dashes; when you tab out of the field, it will fill in automatically. To fill in a **check box**, click inside the box with your mouse.

To clear or delete all the information you have typed onto the form, click on the red “**Clear Entire Form**” button. To change the information in one field, use the backspace or delete key.

Adobe Acrobat - [WC055 Objection to Petition to Modify.pdf]

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

Clear Entire Form

OBJECTION TO PETITION TO MODIFY, TERMINATE, OR SUSPEND COMPENSATION

Claimant _____ Workers' Compensation Number _____
Employer _____ Social Security Number _____
Insurer _____

**“Clear Entire Form” button
Clears all information at once**

Enclosed is a copy of the Petition to Modify, Terminate, or Suspend Compensation filed by the insurance carrier or self-insured employer in your worker's compensation case.

IN THE EVENT THAT YOU WISH TO OBJECT TO THIS PETITION, YOU MUST FILE A WRITTEN OBJECTION WITH THE DIVISION OF WORKERS' COMPENSATION, 1515 ARAPAHOE STREET, CLAIMS SECTION, DENVER, CO 80202-2117, WITHIN 20 DAYS FROM THE DATE THE PETITION WAS MAILED. **YOUR OBJECTION MUST BE FILED ON THIS FORM.** A copy must be sent to the insurance carrier or the self-insured employer at the address shown on the petition.

In the event that you do not file a written objection to the petition within the required 20 days, the Director of the Division of Workers' Compensation will grant the insurance carrier or self-insured employer permission to modify, terminate or suspend

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start 9:43 AM Tuesday 5/27/2003

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I will call the following witnesses at the hearing on this issue:

_____ **“Check Box”** _____
Click in box _____
Signature _____
Address _____

CERTIFICATE OF MAILING

Copies of this Objection to Petition were mailed this _____ day of _____, _____ to the following:

Division of Workers' Compensation, 1515 Arapahoe Street, Claims Section, Denver, CO 80202-2117

Insurance Carrier or _____
Self-Insured Employer (name) (address)

By _____
Claimant

If you have any questions concerning this form, please contact the Division of Workers' Compensation, Claims Management Section 303.318.8600.

Please use your worker's compensation number on all correspondence to the Division of Workers' Compensation.

WC55 Rev 1/93.00

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COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
Division of Workers' Compensation
633 17th Street, Suite 400
Denver, CO 80202-3626

OBJECTION TO PETITION TO MODIFY, TERMINATE, OR SUSPEND COMPENSATION

Claimant

Workers' Compensation Number

Employer

Social Security Number

Insurer

Carrier Number

Enclosed is a copy of the Petition to Modify, Terminate, or Suspend Compensation filed by the insurance carrier or self-insured employer in your worker's compensation case.

IN THE EVENT THAT YOU WISH TO OBJECT TO THIS PETITION, YOU MUST FILE A WRITTEN OBJECTION WITH THE DIVISION OF WORKERS' COMPENSATION, 633 17TH STREET, SUITE 400, DENVER, CO 80202-3626, WITHIN 20 DAYS FROM THE DATE THE PETITION WAS MAILED. **YOUR OBJECTION MUST BE FILED ON THIS FORM.** A copy must be sent to the insurance carrier or the self-insured employer at the address shown on the petition.

In the event that you do not file a written objection to the petition within the required 20 days, the Director of the Division of Workers' Compensation will grant the insurance carrier or self-insured employer permission to modify, terminate or suspend compensation as of the date of the petition.

In the event that you do object to the petition, a hearing will be held on the petition within 40 days of the date of the setting. The only matter which will be considered at this hearing will be the request to modify, terminate, or suspend compensation.

CLAIMANT'S OBJECTION TO PETITION

I object to the Petition to Modify, Terminate, or Suspend Compensation filed by the insurance carrier or self-insured employer. I request that this matter be set for hearing on this issue. The reasons for my objections are:

I will call the following witnesses at the hearing on this issue:

Signature

Address

CERTIFICATE OF MAILING

Copies of this Objection to Petition were mailed this _____ day of _____, _____ to the following:

_____ Division of Workers' Compensation, 633 17th Street, Suite 400, Denver, CO 80202-3626

_____ Insurance Carrier or _____
Self-Insured Employer (name) (address)

By _____
Claimant

If you have any questions concerning this form, please contact the Division of Workers' Compensation, Claims Management Section 303.318.8600.

Please use your worker's compensation number on all correspondence to the Division of Workers' Compensation.