

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.