

Instructions for Completing the 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 and dollar amounts. Do not use dashes 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. 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 change the information in one field, use the backspace or delete key.

Adobe Acrobat - [WC054 Petition to Modify Terminate or Suspend.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

PETITION TO MODIFY, TERMINATE, OR SUSPEND COMPENSATION

**“Check Box”
Click in box**

Worker's Compensation Number

Employer

Insurer

The insurance carrier or self-insured employer declares that the claimant is presently receiving compensation for _____ disability at the rate of \$ _____ per week. Compensation is presently being paid to _____ in the amount totaling \$ _____.
(date)

The petitioner requests permission to modify terminate, or suspend compensation for the period from _____ (date) to _____ (date).

The facts upon which the petitioner relies are as follows:

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

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Tuesday
5/27/2003

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

PETITION TO MODIFY, TERMINATE, OR SUSPEND COMPENSATION

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

The insurance carrier or self-insured employer declares that the claimant is presently receiving compensation for _____ disability at the rate of \$_____ per week. Compensation is presently being paid to _____ in the amount totaling \$_____.
(date)

The petitioner requests permission to modify terminate, or suspend compensation for the period from _____ to _____.
(date) (date)

The facts upon which the petitioner relies are as follows:

If this matter is set for hearing, the petitioner will call the following witnesses:

The rule and statute upon which the petitioner relies: _____

NOTICE TO CLAIMANT: Rule 6-4(C) of the Workers' Compensation Rules of Procedure, provides that if written objection to the petition is not filed with the Division of Workers' Compensation within 20 days from the date of mailing of the petition, the Director of the Division of Workers' Compensation shall 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 a written objection is filed, this matter will then be heard within 40 days of the date of the setting.

Insurance Carrier or Self Insured

Address

By _____

Certificate of Mailing (must be completed)

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

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

_____ Claimant _____
(name) (address)
_____ Claimant's Attorney _____
(name) (address)

By _____

Block #	Adj. Code
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INSTRUCTIONS

The Objection to Petition to Modify, Terminate or Suspend Compensation form must be sent to the injured worker with the Petition to Suspend.

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

Please use the workers' compensation number on all correspondence to the Division of Workers' Compensation.