

Instructions for Completing the Fatal General Admission

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 “Workers’ Compensation WC #” 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 # 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. Some fields contain a **drop down menu**; click on the arrow and select one of the choices. The “Certificate of Mailing” fields are surrounded by a **gray border**. 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 - [WC151 Fatal General Admission.pdf]

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FATAL CASE - GENERAL ADMISSION

Clear Entire Form

Workers' Compensation (WC) # _____ Carrier Claim # _____
Deceased's Name _____ Average Weekly Wage _____
Deceased's Social Security _____ of Death _____
Date of Injury _____ Compensation Rate _____
Insurance Carrier _____ Employer _____
Third Party Administrator _____

**“Check Box”
Click in Box**

NOTICE TO CLAIMANT
This is an important legal document that can affect your rights. If you disagree with the amount or type of benefits which the carrier has agreed to pay, you may write a letter to the Division of Industrial Accidents, 80202-2117, stating that you object to this admission. Please refer to page 2 for other important notices.

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

Liability is admitted for the following benefits: Medical Benefits Safety Rule Violation
 _____ s \$ _____ Offset (Attach Calculation)

**“Drop Down Menu”
Click on the arrow for choices**

Name	Birth Date	Attending School Yes or No	Relationship	Whole or Partial Dependency(W or P)
		<input type="button" value="v"/>		<input type="button" value="v"/>
		No		<input type="button" value="v"/>
		Yes		<input type="button" value="v"/>
		<input type="button" value="v"/>		<input type="button" value="v"/>
		<input type="button" value="v"/>		<input type="button" value="v"/>

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through _____ = _____ x \$ _____ = \$ _____

The above time periods include the dates specified _____ Amount of Interest Paid _____

(Attach additional pages, if needed) **Enter Information and tab to next field** _____ (See Remarks)

Claims Representative _____ Phone# _____ Toll-Free Phone # _____
 Address: _____

CERTIFICATE OF MAILING: Copies of this document were placed in the _____ S. mail or delivered to the following parties
 this _____ day of _____

List names and addresses of all persons copied:	Name	Address
Dependent(s):	_____	_____
Dependents' Attorney(s):	_____	_____
Employer:	_____	_____
Carrier's Attorney:	_____	_____
Other:	_____	_____

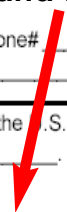
Division of Workers' Compensation, 1515 Arapahoe Street, Denver, CO 80202-2117

By: _____

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"Gray Border"

Enter Information and tab to next field



(The top portion of this side may be used for mailing address)

FATAL CASE - GENERAL ADMISSION

IMPORTANT: SEE NOTICE TO CLAIMANT SECTION ON THE OTHER SIDE OF THIS FORM

OTHER NOTICES TO CLAIMANT:

YOU ARE HEREBY NOTIFIED that the insurance carrier or self-insured employer admits that the fatality reported herein is compensable. **YOU ARE ALSO 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 C.R.S. section 8-42-124 and C.R.S. section 26-13-122(4). **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 C.R.S. section 8-42-113.5.