Instructions for Completing the

General Admission of Liability

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'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 number and dollar amounts. Do not use dashes, parentheses, 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.

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 - [WC002 General Admission.pdf]

File Edit Document Tools Plug-Ins View Window Help

DIVISION OF WORKERS' COMPENSATION

GENERAL ADMISSION OF LIABILITY

Clear Entire Form

WC # ______

Carrier # ______

TO: ______ Soc. Sec. # ______

Claimant's Name

Employer ______

"Clear Entire Form" button
Clears all information at once

Claimant's Address

Date first payment paid TTD ______

and

Date first payment PPD ______

"Check Box"
Click in box

COMPENSATION

Date of MMI ______

Y... D that the insurance carrier or self-insured employer (named below) admits that the injury or oc... 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 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.

Liability is admitted for the following benefits: See Reverse Side for Codes

Safety Rule Violation ☐

☐ medical benefits Offset ☐ Attach Calculation

☐ temporary total disability Amount of Interest Paid $ ______

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2:20 PM Tuesday 5/20/2003

COLORADO DEPARTMENT OF LABOR & EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

GENERAL ADMISSION OF LIABILITY

TO: ______________________
Claimant's Name

____
Claimant's Address

____

and

DIVISION OF WORKERS' COMPENSATION

WC # ______________________
Carrier # ______________________
Soc. Sec. # ______________________
Employer ______________________
Date of Injury ______________________
Average Weekly Wage ______________________
Date first payment paid TTD ______________________
Date first payment PPD ______________________
Date of MMI ______________________

YOU ARE HEREBY NOTIFIED that the insurance carrier or self-insured employer (named below) admits that the injury or occupational disease 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 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.

Liability is admitted for the following benefits:

See Reverse Side for Codes

Safety Rule Violation

- medical benefits
- temporary total disability
- temporary partial disability
- rehabilitation maintenance benefits
- disfigurement
- permanent partial disability

Offset Attach Calculation
Amount of Interest Paid $ ______________________
Amount of Penalties Paid $ ______________________
Working unit __________ % Disability __________ Age
1. Schedule Injury __________ % __________ (part of body)
2. Schedule Injury __________ % __________ (part of body)

Complete the following if admitting for disability

Type of Benefit	Time Periods					Rate per Week	Totals
	thru		=		wks	$	$
	thru		=		wks	$	$
	thru		=		wks	$	$
	thru		=		wks	$	$
	thru		=		wks	$	$
	thru		=		wks	$	$
	thru		=		wks	$	$

The above time periods represent inclusive dates.

Remarks: ______________________

____
Carrier or Self-Insured

____
Address

____

____
Telephone No.

NOTICE TO CLAIMANT: 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 WORKERS' COMPENSATION, 633 17TH ST., SUITE 400, DENVER, CO 80202-3660, STATING THAT YOU OBJECT TO THIS ADMISSION OF LIABILITY.

By: ______________________
Adjuster or Claims Representative

Copies of this admission were mailed this __________ day of __________ , __________ to:

Claimant's Attorney | Employer | Division of Workers' Compensation | Respondent's Attorney | Claimant

Block #	Adj. Code

PLEASE READ REVERSE SIDE

BENEFITS

Compensation benefits are paid by insurance carriers for compensable injuries. Temporary disability benefits are paid every 2 weeks.

Temporary Total Disability - Total disability of more than 3 working days. If disability lasts for more than 14 calendar days, compensation shall be paid from the day left work. Compensation is payable at the rate of 66 2/3% average weekly wage in effect at the time the injury/exposure not to exceed the statutory maximum. A loss of fringe benefits specifically enumerated in the statute should be included in the calculation of the average weekly wage.

Permanent Partial Disability - Payable where there is residual impairment, based upon the part of the body affected, or on the extent of medical impairment.

Facial or Bodily Disfigurement – Payable for serious, permanent disfigurement about the head, face, or parts of the body normally exposed to public view. The maximum benefit is established each year for injuries that occur during that year. In addition, for injuries that occurred on or after July 1, 2007, it is possible to receive a larger amount for extensive disfigurement. Information regarding the maximum benefit for your date of injury is located on the Division's website, or you may contact the Customer Service Unit at (303) 318-8700.

Medical Benefits - Current medical benefits for medical, hospital and surgical supplies, prescriptions, crutches, apparatus and vocational rehabilitation.

Temporary Partial Disability - Temporary partial disability of more than 3 working days. Compensation is payable at the rate of 66 2/3% of the difference between the employee's average weekly wage at the time of injury and said employee's average weekly wage during the continuance of the temporary partial disability not to exceed a maximum of 91% of the state average weekly wage per week.

MMI - Maximum Medical Improvement means a point in time where any medically determinable physical or mental impairment as a result of injury has become stable and when no further treatment is reasonably expected to improve the condition.

Codes for scheduled ratings:

01 Arm @ Shoulder
03 Hand @ Wrist
04 Thumb @Metacarpal
05 Thumb @ Proximal
06 Thumb @ Distal
07 Index @ Metacarpal
08 Index @ Proximal
09 Index @ Second
10 Index @ Distal
11 Middle @ Metacarpal
12 Middle @ Proximal
13 Middle @ Second
14 Middle @ Distal
15 Ring @ Metacarpal
16 Ring @ Proximal
17 Ring @ Second
18 Ring @ Distal
19 Little @ Metacarpal
20 Little @ Proximal
21 Little @ Second
22 Little @ Distal
23 Leg @ Hip
25 Leg @ Foot, Heel, Ankle
26 Great Toe @ Metatarsal
27 Great Toe @ Proximal
28 Great Toe @ Distal
29 Other Toe @ Metatarsal
30 Other Toe @ Proximal
31 Other Toe @ Distal
32 Eye Enucleation
33 Blindness One Eye
34 Deafness Both Ears
35 Deafness One Ear
36 Total Hearing 2nd Ear