

Instructions for Completing the

# Application for Admission to the Colorado Major Medical Insurance Fund

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 “W.C. Number” 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.

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.

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COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT  
Division of Workers' Compensation

**APPLICATION FOR ADMISSION TO THE COLORADO  
MAJOR MEDICAL INSURANCE FUND**

**Clear Entire Form**

W.C. Number \_\_\_\_\_ Insurance Carrier \_\_\_\_\_  
Claimant Name \_\_\_\_\_ Carrier Claim Number \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Date of Accident/Injury \_\_\_\_\_  
Claimant's Mailing Address \_\_\_\_\_  
Street Address or P.O. Box \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_

On behalf of the above named claimant, we hereby apply for  
In support of the application, we submit that:

The insurance carrier or self-insured employer has expended at least \$20,000 in medical benefits as defined in Section 8-42-101(1) C.R.S., as amended, as follows:

a. Treating physician expenses (including dental) \$ \_\_\_\_\_  
b. Hospital and nursing expenses \$ \_\_\_\_\_  
c. Other (drugs, apparatus, etc.) \$ \_\_\_\_\_  
d. Vocational rehabilitation services \$ \_\_\_\_\_

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If there is need for further medical benefits please explain briefly and include name(s) of present treating physician(s) or primary care physician. (Attach additional pages, if needed)

**“Check Box”**  
**Click in Box**

II. Are you aware of any third party activity on this claim?  Yes  No

If any such action is initiated, claimant agrees to provide prompt and reasonable notice to the Director of the Division of Workers' Compensation.

Date: \_\_\_\_\_ Claimant's Signature \_\_\_\_\_

Date: \_\_\_\_\_ Insurance Carrier Representative's Signature \_\_\_\_\_

Insurance Carrier Representative's Phone Number \_\_\_\_\_

**Mail the completed form to: Division of Workers' Compensation, Special Funds Section,  
P.O. Box 300009, Denver, CO., 80203-0009**

C.R.S. Section 10-1-127(7)(a) states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies."

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**APPLICATION FOR ADMISSION TO THE COLORADO  
MAJOR MEDICAL INSURANCE FUND**

W.C. Number \_\_\_\_\_ Insurance Carrier \_\_\_\_\_  
Claimant Name \_\_\_\_\_ Carrier Claim Number \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Date of Accident/Injury \_\_\_\_\_  
Claimant's Mailing Address \_\_\_\_\_  
Street Address or P.O. Box \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_

On behalf of the above named claimant, we hereby apply for admission to the Colorado Major Medical Insurance Fund. In support of the application, we submit that:

The insurance carrier or self-insured employer has expended at least \$20,000 in medical benefits as defined in Section 8-42-101(1) C.R.S., as amended, as follows:

- |   |                |
|---|----------------|
| a. Treating physician expenses (including dental) | \$ _____       |
| b. Hospital and nursing expenses                  | \$ _____       |
| c. Other (drugs, apparatus, etc.)                 | \$ _____       |
| d. Vocational rehabilitation services             | \$ _____       |
| e. Rehabilitation maintenance benefits            | \$ _____       |
| Number of weeks of RMBs _____                     |                |
|   | Total \$ _____ |

In each category list on a separate sheet, or by inclusion of evidence of payment, actual amounts paid and payee. Do not include attorney fees, penalties, interest, investigative costs or administrative costs. Please submit a complete copy of the carrier's file.

If there is need for further medical benefits please explain briefly and include name(s) of present treating physician(s) Include the name of the authorized primary care physician. (Attach additional pages, if needed)

- II. Are you aware of any third party activity on this claim?      Yes      No  
If any such action is initiated, claimant agrees to provide prompt and reasonable notice to the Director of the Division of Workers' Compensation.

Date: \_\_\_\_\_  
Date: \_\_\_\_\_  
Claimant's Signature \_\_\_\_\_  
Insurance Carrier Representative's Signature \_\_\_\_\_  
Insurance Carrier Representative's Phone Number \_\_\_\_\_

**Mail the completed form to:      Division of Workers' Compensation, Special Funds Section,  
P.O. Box 300009, CO 80203-0009**

C.R.S. Section 10-1-128(6)(a) states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."