# COLORADO WORKERS' COMPENSATION INFORMATION

**Your employer has workers' compensation coverage for employees through:**

Berkley Industrial Comp

P.O. BOX 660847, Birmingham, AL 35266

(855) 425-5800

Workers' compensation is a type of insurance coverage that employers must provide to their employees. The cost of workers' compensation insurance is paid entirely by the employer and may not be deducted from an employee's wages.

If you are injured or sustain an occupational disease while at work, you may be entitled to compensation benefits as provided by law. WRITTEN NOTICE MUST BE GIVEN TO YOUR EMPLOYER WITHIN 4 WORKING DAYS OF THE ACCIDENT. If you don't report your injury or occupational disease promptly your benefits may be reduced.

If you are unable to work as the result of a work-related injury or occupational disease, compensation (wage replacement) benefits will be based on 2/3 of your average weekly wage up to a maximum set by law. No compensation is payable for the first 3 days' disability unless the period of disability exceeds two weeks.

You are entitled to reasonable and necessary medical treatment of compensable injuries or occupational diseases. If you notify your employer of an injury or occupational disease and are not offered medical care, you may select the services of a licensed physician or chiropractor.

You may file a Worker's Claim for Compensation with the Division of Workers' Compensation. To obtain forms or information regarding the workers' compensation system, you may call Customer Service at 303.318.8700, or visit our website at: www.coworkforce.com/dwc/.

**COLORADO DIVISION OF WORKERS' COMPENSATION**
**633 17TH Street, Suite 400, Denver, CO 80202-3626**

**Any information provided below comes from your employer and is specific to this place of employment:**

# COLORADO WORK INJURY REPORTING PROCEDURES

This Claim Packet is provided for your use in reporting employee work related injuries. Copy the enclosed forms as needed.

## Employer's First Report of Injury (WC 1)

This form must be completed at the time of the injury and/or immediately upon the employer's knowledge of the injury. The original form should be immediately mailed, faxed or e-mailed to us. As an alternative, Employer's First Reports of Injury (FROI's) may be submitted to us online at: **https://berkindcomp.com**. Online Reporting Instructions are enclosed. Maintain a copy of the FROI for your records. Keep a separate file for each workers' compensation claim.

## Supervisor's Report

The supervisor should fill out this form as soon as the accident is reported. The original should be submitted with the FROI. If the FROI is reported online, then please mail, fax or e-mail the Supervisor's Report to us. Maintain a copy for your records. If you utilize another version of a supervisor's report, it may be substituted for the enclosed report.

## Average Weekly Wage Worksheet (DK 1)

The Average Weekly Wage Worksheet must be completed on claims involving lost time from work.

Please contact our claims department if you have questions about completing the Average Weekly Wage Worksheet.

**Do not delay reporting the Employer's First Report of Injury for completion of the Average Weekly Wage Worksheet.**

## Work Status

You must immediately notify Berkley Industrial Comp if an employee begins to lose time from work. You must immediately notify us of the date the employee is scheduled to return to any type work (full duty, modified duty, light duty).

See instructions on reverse side before completing form.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

# EMPLOYER'S FIRST REPORT OF INJURY

Employee's name (first, middle, last) | Social Security # | ☐ Male ☐ Female | Employee's home phone # ( ) | OSHA Log #

Employee's street address | City | State | Zip code

Birth date / / | Marital status ☐ Married ☐ Separated ☐ Single ☐ Unknown | Date of hire / / | Occupation | Employment status ☐ Full time ☐ Part time ☐ Other ☐ Unknown

For Division use only: SOI | POB | NOI | Coder

Employer's name | Employer's Federal ID # | Employer's phone # ( )

Employer's mailing address | City | State | Zip code

Average weekly wage at time of injury $______________ (see instructions on reverse side)

Check box if employee receives ☐ Tips ☐ Meals ☐ Room ☐ Health insurance

Check if these benefits are included in AWW ☐ Tips ☐ Meals ☐ Room ☐ Health insurance

Is the employer self-insured? ☐ Yes ☐ No | Were full wages paid for the DOI? ☐ Yes ☐ No | Are wages continued per C.R.S. 8-42-124?[1] ☐ Yes ☐ No

Injury/Illness date / / (See instructions on reverse side) | Time employee began work ____ ___ ☐ a.m. ____ ___ ☐ p.m. | Injury time ____ ___☐ a.m. ____ ___ ☐ p.m. ☐ unknown | Last day worked / / | Date employer notified / / | Date disability began / / | Date returned to work / /

Did injury cause death? ☐ Yes ☐ No | If so, date of death / / | Name, relationship, and address of closest dependent if injury caused death | Injury occurred because of ☐ Intoxication ☐ Safety violation ☐ Not applicable

Tell us the part of body that was affected | Tell us the nature of the injury/illness[2]

What was the employee doing just before the accident occurred?[3]

Tell us how the injury occurred[4] | What object or substance directly harmed the employee?[5]

Did injury occur on premises? ☐ Yes ☐ No | Injury site address/ 9-digit zip code | Initial treatment (check one) ☐ None ☐ Emergency room ☐ Minor on-site ☐ Hospital >24 hrs ☐ Clinic/hospital | Was the employee hospitalized overnight as an in-patient? ☐ Yes ☐ No

Names of witnesses | Name of employer representative notified

Name and address of treating doctor or other health care professional | Name and address of facility where treated

Completed by (name) | Title | Phone # ( ) | Date completed / /

**The following is to be completed by the insurer prior to filing with the Division of Workers' Compensation.**

Name of insurance company | Address

Name of third party administrator (if applicable) | Address

Adjuster name | Adjuster phone #

Policy # | Carrier claim # | Date insurer received first report / / | Block # | Adj. Code

## INSTRUCTIONS

### This form contains all items requested on OSHA Form No. 301, "Injuries & Illnesses Incident Report"

### General

- All injuries no matter how trivial must be reported to your insurance company.
- All injuries or occupational diseases which result in lost time from work in excess of three shifts or calendar days, or in permanent physical impairment, must be reported to your insurance carrier on this form within ten days after notice or knowledge of the injury or disease. Fatalities must be reported to your insurance carrier immediately.
- Forms should be typed or printed legibly.
- All questions must be answered completely to meet requirements of the Colorado Workers' Compensation Act and to conform to the OSHA requirements for Form No. 301.
- The employer has the right in the first instance, to select the physician who attends the injured employee.

### Calculation of Average Weekly Wage

- Determine the weekly wage rate.
- Add the average weekly amount of any overtime wages, tips or commissions.
- Add the average weekly value of any board, rent, housing, or lodging provided by the employer *if the employer will not be paying such benefit during the period of disability.*
- If the employee is covered by group health insurance *and* the employer does not continue the employee's health insurance coverage during the period of disability, add the employee's cost of conversion to a similar or lesser insurance plan and include this cost in the average weekly wage computation.
- Compute the total from the above categories and insert in the *Average weekly wage at time of injury* field.

### Injury Date Information

In the case of an occupational disease, use the date of the last injurious exposure.

### Notes

Are Wages continued per C.R.S. 8-42-124?[1]
(Subject to application with and approval of the Director of the Colorado Division of Workers' Compensation)

**1** Any employer who, by separate agreement, working agreement, contract of hire, or any other procedure, continues to pay a sum in excess of the temporary total disability benefits to an employee temporarily disabled as a result of a work related injury or disease, and has not charged the employee with any earned vacation leave, sick leave, or other similar benefits, shall be reimbursed if insured by an insurance carrier or shall take credit if self-insured, to the extent of all moneys that such employee may be eligible to receive as compensation for temporary partial or temporary total disability subject to the approval of the Director of the Colorado Division of Workers' Compensation.

Injury Description (Tell us the part of body that was affected. Tell us the nature of the injury/illness [2]; What was the employee doing just before the accident occurred? [3]; What happened? [4]; What object or substance directly harmed the employee?[5])

**2** Be more specific than ""hurt", "pain", or "sore." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
**3** Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; or "daily computer key-entry."
**4** Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
**5** Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank

### Notices

**You are hereby 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.**

**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 purposes 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."**

## AVERAGE WEEKLY WAGE WORKSHEET WC# ____________________

The definition of wages can be found in 8-40-201(19), C.R.S. Calculation of average weekly wage can be found in 8-42-102(2), C.R.S. Use earnings immediately prior to the date of injury.

Employee Name ______________________ SS# __________ Carrier # __________

Time Period used for calculations: From___/___/___ TO ___/___/___

If completed by the adjuster: Information received from: ______________ Name ______________ Title ______________ On Date

WAGES (**Choose one** from lines 1 through 7, then add other wages from lines 8 - 10, if applicable) TOTALS

| | | | TOTALS |
|---|---|---|---|
| 1. | Hourly (exclude overtime) | Hourly wage $_______ x average hours/week _____ =........................................... | |
| 2. | Daily (per diem).................... | Daily rate $_________x # of days (and fractions of days) in a week that employee worked (or would have worked, but for the injury) ______ =................................ | |
| 3. | Weekly................................. | Weekly wage $________ =...................................................................................... | |
| 4 . | Bi-Weekly............................. | Bi-Weekly wage (every other week) $_________÷ 2 = ........................................ | |
| 5. | Semi-Monthly ....................... | Semi-Monthly wage $_______ x 24 ÷ 52 =.......................................................... | |
| 6. | Monthly................................ | Monthly wage $_______ x 12 ÷ 52 = ........................................................... | |
| 7. | Yearly .................................. | Yearly wage $_________ ÷ 52 = ................................................................. | |
| 8. | Piecework or Commission ..... | Average weekly value = Total amount earned with this employer in the 12 months immediately preceding injury $_____________ ÷ # of weeks (and fractions of weeks) worked ________ = ……………………………………………………... | |
| 9. | Mileage (only if mileage is a form of salary) ...................... | Rate per mile $_______x average # of miles per day driven in service of the employer 60 days preceding the injury __________ = daily rate $__________ x days (and fractions of days) per week worked ______ = ........................................ | |
| 10. | Other (wages not addressed above) .................................. | (Attach explanation) Average weekly value $__________ = ....................................................... | |
| 11. | Total Wages .......................... | Enter amounts from 1 - 7, plus any amounts in 8 - 10 ............................................. | |

ADDITIONS TO WAGES (Use the same time period as stated above)

| | | | |
|---|---|---|---|
| 12. | Overtime ............................... | Overtime rate $________ x # of overtime hours per week ________ = .................. | |
| 13. | Tips ...................................... | Weekly amount reported to IRS $___________ =.................................................. | |
| 14. | Total Additions ..................... | Enter total of lines 12 + 13……………………………………………………….. | |

BENEFITS (If Discontinued During Disability)

| | | | |
|---|---|---|---|
| 15. | Health Insurance | Effective date benefit discontinued:_____________ Employee's monthly cost of continuing the employer's group plan or conversion to a similar or lesser plan = $_________ x 12 ÷ 52 = | |
| 16. | Meals / Board | Effective date benefit discontinued:______________ Weekly value $___________ =................................................................................ | |
| 17. | Rent / Housing | Effective date benefit discontinued: ______________ Monthly value $__________ x 12 ÷ 52 ............................................................. | |
| 18. | Total Benefits........................ | Enter total of lines 15 - 18 ........................................................................ | |
| 19. | TOTAL AVERAGE WEEKLY WAGE | Enter total of lines 11 + 14 + 18 ............................................................... | |

Enter the number in line 19 on the Employer's First Report of Injury in the "Average Weekly Wage at Time of Injury" Box

Completed by: ________________________________________Date_____________________

**Division of Workers' Compensation**
633 17th Street, Suite 400
Denver, Colorado 80202-3626
303.318.8700

- The Average Weekly Wage worksheet may be reproduced as needed -

The Average Weekly Wage worksheet is provided by the Division of Workers' Compensation as a guideline in computing the Average Weekly Wage. It is intended as a desk aid worksheet and is not a required document. It may be used to document wage information received verbally.

If the worksheet is completed by the employer, the final Average Weekly Wage amount on Line 19 of the worksheet should be inserted in the box, "Average Weekly Wage at Time of Injury," on the Employer's First Report of Injury form.

**Notice to Employer:**

The worksheet should be attached to the Employer's First Report of Injury form when submitted to your workers' compensation insurance administrator.

If you have questions on completing this worksheet, contact your workers' compensation insurance administrator.

**Notice to Insurance Carrier or Self-Insured Employer:**

If you complete the worksheet with information provided by either the claimant or the employer, attach the worksheet to your position statement when filing with the Division. Also, state on the worksheet the name and title of the person providing wage information and the date the information was provided.

If you receive the worksheet from the employer and only "the Average Weekly Wage at Time of Injury" box is completed in the wage information section of the Employer's First Report of Injury, attach the worksheet to the Employer's First Report of Injury form that is submitted to the Division of Workers' Compensation.

# WARNING

IF YOU ARE INJURED ON THE JOB, WRITTEN NOTICE OF YOUR INJURY MUST BE GIVEN TO YOUR EMPLOYER WITHIN FOUR WORKING DAYS AFTER THE ACCIDENT, PURSUANT TO SECTION 8-43-102(1) AND (1.5), COLORADO REVISED STATUTES.

IF THE INJURY RESULTS FROM YOUR USE OF ALCOHOL OR CONTROLLED SUBSTANCES, YOUR WORKERS' COMPENSATION DISABILITY BENEFITS MAY BE REDUCED BY ONE-HALF IN ACCORDANCE WITH SECTION 8-42-112.5, COLORADO REVISED STATUTES.

# AVISO

SI SE LASTIMA EN EL TRABAJO, DEBE DARLE UN AVISO POR ESCRITO A SU EMPLEADOR DENTRO DE CUATRO DÍAS LABORABLES DEL ACCIDENTE, SEGÚN A LA SECCIÓN DE LOS ESTATUOS REVISADOS DE COLORADO 8-43-102(1) Y (1.5).

SI EL ACCIDENTE RESULTA DEBIDO AL USO DE ALCOHOL O UNA SUSTANCIA CONTROLADA, SUS BENEFICIOS DE LA INCAPACIDAD DE LA COMPENSACIÓN DE LOS TRABAJADORES PUEDEN SER REDUCIDOS POR UN MEDIO EN ACUERDO DE LA SECCIÓN DE LOS ESTATUOS REVISADOS DE COLORADO 8-42-112.5.