



NOTICE: COLORADO WORKERS COMPENSATION

This business operates under Colorado Workers Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, OR AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR OR FOREMAN OF THE EMPLOYER.

Workers Compensation insurance benefits are provided through:

BerkleyNet

To report a claim, contact us at:

Website: berkleynet.com

Email: claimops@berkleynet.com

Address: 9301 Innovation Drive, Suite 200, Manassas, VA 20110

Phone: 877.497.2637

Fax: 866.275.6320

COLORADO WORKERS' COMPENSATION INFORMATION

Your employer has workers' compensation coverage for employees through:

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:

INFORMACIÓN DE INDEMNIZACIÓN POR ACCIDENTES LABORALES DE COLORADO

Su empleador tiene cobertura de indemnización por accidentes laborales para empleados completamente:

La indemnización por accidentes laborales es un tipo de cobertura de seguro que los empleadores deben proveer a sus empleados. El coste del seguro de indemnización por accidentes laborales es pagado completamente por el empleador y no puede ser deducido de los sueldos de un empleado.

Si usted está lastimado o mantiene una enfermedad profesional mientras su curso de trabajo, usted puede estar autorizado para los beneficios de compensación como proveer por ley. **LA NOTIFICACIÓN ESCRITA DEBE SER DADO A SU EMPLEADOR DENTRO DE 4 DÍAS HÁBILES DEL ACCIDENTE.** Si usted no informa sobre su lastimación o enfermedad profesional inmediatamente sus beneficios podrían ser reducidos.

Si usted no puede trabajar por el resultado de una lastimación de trabajo o la enfermedad profesional, los beneficios de compensación (la sustitución de sueldo) serán sobre la base de 2/3 de su sueldo semanal medio iguales a un máximo fijado por ley. Ninguna remuneración es pagadera para la incapacidad de los primeros 3 días a menos que el período de la incapacidad sobrepasa dos semanas.

Usted está autorizado para el tratamiento médico razonable y necesario de lesiones compensables o enfermedades profesionales. Si usted notifica a su empleador sobre una lesión o la enfermedad profesional y no ser ofrecidos la atención médica, usted puede seleccionar los servicios de un médico dado licencia o quiropráctico.

Usted puede archivar el Reclamo de un Trabajador para la Compensación con la División de la Indemnización por Accidentes Laborales. Para obtener formularios o información tratar del sistema de indemnización por accidentes laborales, en los que usted puede llamar al servicio de asistencia al numero 303.318.8700, o visitar nuestro sitio web en: www.coworkforce.com/dwc/.

**División de Colorado de la Indemnización por Accidentes Laborales
633 17th St. Suite 400, Denver, CO 80202-3660**

Cualquier información proveída abajo viene de su empleador y es propio de este lugar del empleo:

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.

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 #		<input type="checkbox"/> Male <input type="checkbox"/> Female	Employee's home phone # ()		OSHA Log #		
Employee's street address				City		State		Zip code	
Birth date / /	Marital status <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Unknown		Date of hire / /		Occupation		Employment status <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Other <input type="checkbox"/> Unknown	For Division use only	
Employer's name			Employer's Federal ID #		Employer's phone # ()		SOI		
Employer's mailing address				City		State	Zip code	POB	
Average weekly wage at time of injury \$ _____ <small>(see instructions on reverse side)</small>		Check box if employee receives <input type="checkbox"/> Tips <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Health insurance		Check if these benefits are included in AWW <input type="checkbox"/> Tips <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Health insurance			NOI	Coder	
Is the employer self-insured? <input type="checkbox"/> Yes <input type="checkbox"/> No		Were full wages paid for the DOI? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are wages continued per C.R.S. 8-42-124? ¹ <input type="checkbox"/> Yes <input type="checkbox"/> No					
Injury/Illness date / / <small>(See instructions on reverse side)</small>	Time employee began work ____ a.m. ____ p.m.	Injury time ____ a.m. ____ p.m. <input type="checkbox"/> unknown	Last day worked / /		Date employer notified / /	Date disability began / /	Date returned to work / /		
Did injury cause death? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, date of death / /	Name, relationship, and address of closest dependent if injury caused death				Injury occurred because of <input type="checkbox"/> Intoxication <input type="checkbox"/> Safety violation <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Injury site address/ 9-digit zip code		Initial treatment (check one) <input type="checkbox"/> None <input type="checkbox"/> Emergency room <input type="checkbox"/> Minor on-site <input type="checkbox"/> Hospital >24 hrs <input type="checkbox"/> Clinic/hospital			Was the employee hospitalized overnight as an in-patient? <input type="checkbox"/> Yes <input type="checkbox"/> 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/illness²; 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.”