



DEN

ROLLING OWNER CONTROLLED
INSURANCE PROGRAM (ROCIP)

ROCIP4

Claims Guide

Program Term: February 1, 2022 to February 1, 2027

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1. KEY CLAIM CONTACTS and GENERAL PROCEDURES

1.1 Key Claim Contacts

Claims Management is handled by the ROCIP Administrator, Marsh USA, Inc. (Marsh). Below are the key claims personnel that manage the DEN ROCIP claims.



Workers' Compensation

Dan Chilton
Claim Advisor
303.589.7063
dan.chilton@marsh.com

General Liability
Builders' Risk

Dan Killebrew
Claim Advisor
303.308.4668
daniel.killebrew@marsh.com

1.2 Incident and Accident Reporting Overview

Even with a robust safety program in place accidents can occur on a project site due to human factors, equipment failures, acts of nature, etc. To be as prepared as possible to handle these events promptly and keep the safety of all workers as our top priority, we have developed detailed claim reporting procedures to assist you if something does go wrong on your site with your workers.

Remember:

- All incidents and accidents resulting in employee injury, property damage or involving the public must be reported immediately to the General Contractor.
- General Contractor must report all incidents and accidents to DEN Safety and DEN Project Management within 24 hours.
- Never discuss any incident, accident or claim with anyone except employees from Marsh and DEN, the ROCIP Insurer(s), appointed legal counsel, or law enforcement agencies.
- Do not make statements to media. All media inquiries should be directed to DEN.
- Do not voluntarily admit liability or responsibility.
- Cooperate with DEN, Marsh, and Insurers in any investigation or requests for information.

EVENTS INVOLVING BODILY INJURY TO NON-EMPLOYEES, FATALITY OR EXTENSIVE PROPERTY DAMAGE MUST BE IMMEDIATELY REPORTED TO:

- DEN COMM CENTER 303.342.4211
- DEN RISK 303.342.2152
- MARSH 303.308.4668

1.3 Investigation Assistance

All parties will assist in the investigation of any incident, accident or occurrence involving injury to persons or property. All Contractors will cooperate with the Insurers and their representatives involved in adjusting any claim by securing and giving evidence and obtaining the participation and attendance of witnesses required for the investigation and defense of any claim or suit.

**INVESTIGATION ASSISTANCE
AND COOPERATION IS
REQUIRED FROM ALL
CONTRACTORS**

**This includes accidents and
losses that are not covered
under ROCIP such as
automobile accidents**

1.4 Joint Representation

In the event legal representation is required to defend parties insured under the DEN ROCIP, absent an actual conflict of interest between two or more insureds, the Insurer shall have the right to retain one counsel to represent all such insureds in any action or proceeding in which more than one insured is joined.

1.5 Claim Settlements

Claims, excluding Workers' Compensation and Excess Liability claims, will be managed by Marsh and the Insurer in collaboration with the General Contractor, DEN Risk, and DEN Project Management. Any final claim settlement amount will require a signed Proof of Loss Sworn Statement and Release from the General Contractor on behalf of itself and any involved subcontractor. The claim payment will be issued from DEN to the General Contractor less any applied Claim Charge Back. The General Contractor is responsible for any claim payment to involved subcontractors.

1.6 Claim Charge Backs

A claim charge-back will be assessed, regardless of fault, for any loss payable under this program except for Workers' Compensation and Excess Liability, up to a maximum of \$25,000 per loss. The claim charge-back will be deducted by DEN from the final settlement amount to be distributed to the General Contractor. General Contractor may elect to pass no more than \$5,000 of this charge, per loss, through to any involved subcontractor.

1.7 Where to Find this Claims Guide

You should have received the Claims Guide as part of the ROCIP Insurance Manual during the bid process, again as part of your contractual agreement either with DEN or a General Contractor and a final time upon successful completion of Project enrollment.

Additionally, you will be able to access the Claims Guide 24/7 via the Contractor Online Portal under the Documents Section for each Contract/Project you are enrolled in.

**CONTRACTOR
ONLINE PORTAL** 

2. WORKERS' COMPENSATION CLAIMS

2.1 DEN Responsibilities

2.1.1 Emergency Medical Response

DEN will arrange for on-site 911 emergency ambulance services for response to any serious, traumatic, or life-threatening injuries.

2.1.2 Designated Medical Providers

DEN, through its Insurer, will arrange designated medical providers for treatment of all minor and non-life-threatening injuries. A list of approved providers is detailed on the Workers' Compensation Information and Designated Medical Provider Form (CO Form WC50).



See Section 7.8 for the Workers' Compensation Information and Designated Medical Provider Form

2.2 Contractor Responsibilities

2.2.1 Immediate Medical Care

The main responsibility is first to see that any injured worker receives medical care.

2.2.2 Designated Medical Providers

- a. Contractor shall provide injured workers with the Workers' Compensation Information and Designated Medical Provider Form (CO Form WC50) (See Section 7.8). This document includes a list of the approved medical providers and requires the injured worker to indicate their choice, sign, date and return the completed form to their employer.
- b. *If the injured worker is away from their usual place of employment* at the time of the injury, the injured worker may be referred to a physician in the vicinity where the injury occurred to provide necessary care. Within seven (7) business days following the date the Contractor received notice of the injury the Contractor shall comply with the provisions of the above Section 2.2.2.a.
- c. *In emergency situations*, injured workers shall be taken to any physician or medical facility that is able to provide the necessary care. When emergency care is no longer required the Contractor shall comply with the provisions of the above Section 2.2.2.a.
- d. The injured worker or employer must complete the Workers' Compensation Medical Care Requisition and Authorization Form (See Section 7.9) upon arrival at designated medical provider location.

2.2.3 Role of Contractor Safety Representative

Enrolled Contractors must designate a Contractor Safety Representative at the Project Site. This individual is responsible for:

- Taking injured employees to an approved medical provider or emergency room, if warranted
- Retain a copy of the employee's written notice of injury, as required by the State of Colorado
- Obtaining the completed and signed Workers' Compensation Information and Designated Medical Provider Form (CO Form WC50) from the injured worker



See Section 7.8 for Workers' Compensation Information and Designated Medical Provider Form

- Completion of the First Report of Injury form



See Section 7.7 for Workers' Compensation First Report of Injury

- Reporting the claim to the Insurer and the General Contractor
- Completion of the Workers' Compensation Medical Care Requisition and Authorization Form to be provided to the approved medical provider if the injured worker needs medical treatment and/or drug screening following an incident



See Section 7.9 for Workers' Compensation Medical Care Requisition and Authorization Form

- Remaining with the injured employee at the medical center while such employee is being treated
- Obtaining a written description of whether the injured employee can return to work, a list of restrictions (if any), and the estimated length of time such employee can stay on modified duty from the treating physician
- Recording the incident even if the worker declines to receive medical treatment

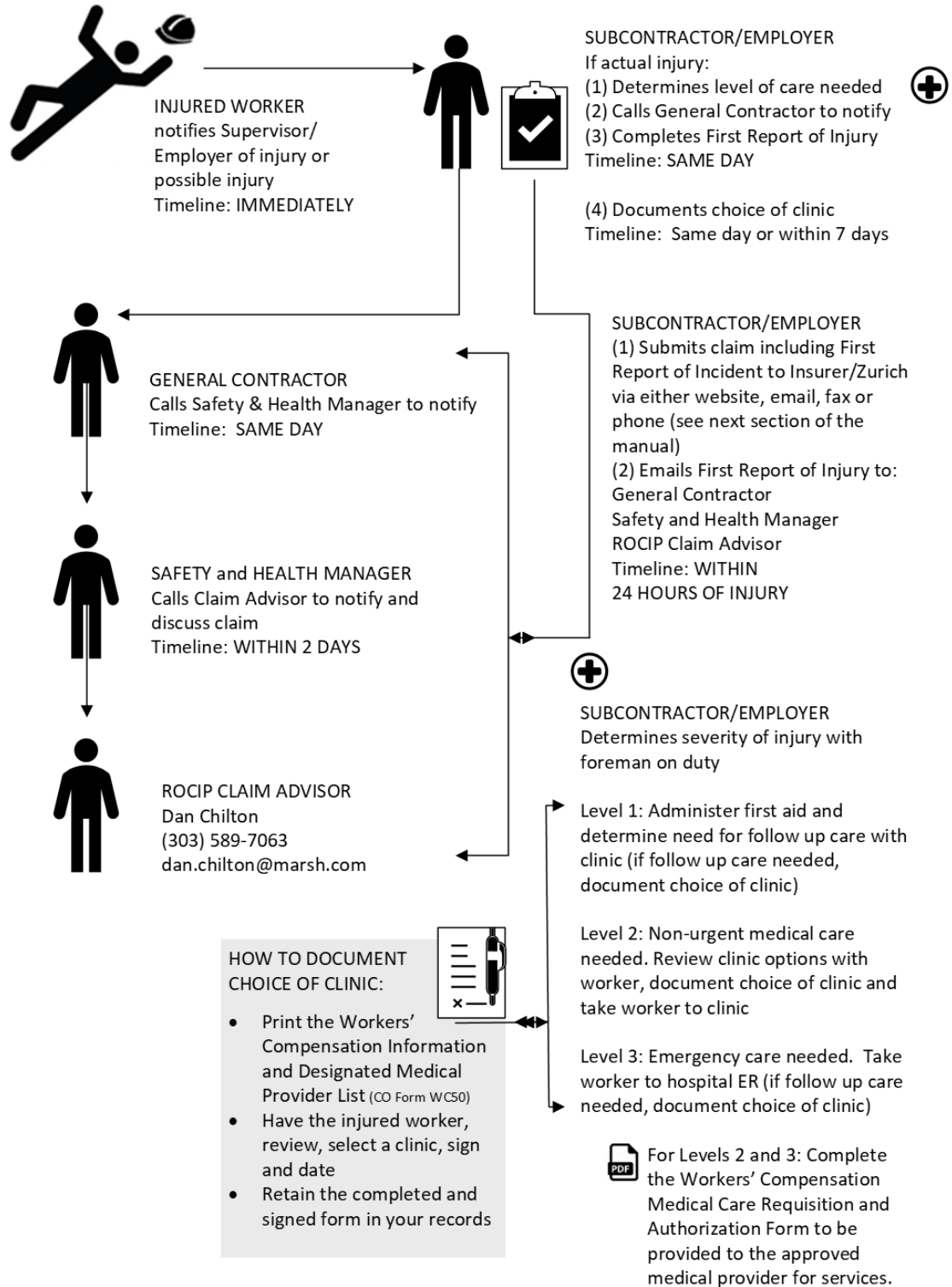
2.2.4 Role of General Contractor

Each General Contractor, and higher tier subcontractor, is expected to monitor the reporting of on-the-job injuries to ensure:

- immediate medical care is offered and provided
- medical care is provided by an approved facility
- timely reporting of the claim to the Insurer
- return to work options are thoroughly evaluated

2.3 Workers' Compensation Claims Process

Following is the general process to address an on-the-job injury or possible injury:



Provide the **PROJECT NAME, PROJECT NUMBER, and your project-specific WORK COMP POLICY NUMBER** on all claim documents

Additionally, please be mindful of the following:

- Do not comment on coverage for an injury, insurance will make the final determination
- If a worker wishes to change their medical provider, they may do this one time. See Section 2.5 for more information.
- Report concerns regarding the claim, medical treatment or malingering to the Safety & Health Manager. The Safety & Health Manager will contact the ROCIP Claim Consultant to discuss concerns.

2.4 How to Report a Workers' Compensation Claim

Claims may be reported to the Insurer in several ways:

Website 
www.zurichna.com
PREFERRED METHOD

Email 
USZ_CareCenter@Zurichna.com

Fax 
877.962.2567

Phone 
800.987.3373
PREFERRED METHOD

2.4.1 Website Reporting Instructions

- 1) Complete the First Report of Injury (Workers' Compensation First Report of Injury) to have the information captured and ready to enter.



See Section 7.7 for Workers' Compensation First Report of Injury

- 2) Go to the above Zurich website.
- 3) Select "Claims" in the top menu.
- 4) Click "Report a New Claim" or "File a claim online".
- 5) Click "Workers Compensation" and provide detailed loss information to expedite the claim handling process. Supporting files, documentation and images can be attached at the bottom of the form. Once the claim has been submitted and assigned, a confirmation will be sent to the email provided.

24 HOURS

First Report of Injury must be submitted within 24 hours of the event

YOU WILL NEED

- Employer Entity Name (Insured)
- Project Number
- Your Project-Specific Work Comp Policy Number

Your will receive a separate Work Comp Policy Number for EACH PROJECT. Be sure to use the correct one!



Examples of Incorrect Policy Numbers Used:

- Policy Number from another DEN Project you are working on
- Policy Number for your company's regular Work Comp

2.4.2 Email Reporting Instructions

- 1) Complete the First Report of Injury (Workers' Compensation Email and Telephone Reporting Worksheet).



See Section 7.7 for Workers' Compensation First Report of Injury

- 2) Email report to USZ_CareCenter@Zurichna.com noting the below restrictions:
 - Do not include photos, color graphics or shaded attachments
 - Do not include digitized logos, hyperlinks or other unstable formatting
 - Do not use the Colorado First Report of Injury form from the Colorado State website as it does not include fields for Location Code and Policy# that are needed for a ROCIP claim

2.4.3 Claim Documents including Medical Bills

Subsequent to submitting the First Report of Injury, submit all additional claim documents including medical bills in one of the following ways:

REMEMBER:

Always include your Claim No. with any submitted documents

By Email: usz.zurich.claims.documents@zurichna.com

By Mail or Fax: Zurich North America – Claims
PO Box 66941
Chicago, IL 60666
Fax: 847.240.8172

Inquires: Contact the assigned claims adjuster

2.4.4 Help

For questions or assistance reporting a claim please contact Marsh or Zurich's Customer Care Center.

To find an assigned claim number if misplaced, call the Zurich Medical Provider Helpline at 719.590.8719.

FOR ASSISTANCE



Dan Killebrew at Marsh
303.308.4668
daniel.killebrew@marsh.com

Zurich Customer Care
800.987.3373
Usz_CareCenter@Zurichna.com

2.5 One-Time Change of Medical Provider

Contractor/Employer will generally select medical providers under Workers' Compensation as approved by the Insurer, although injured workers do have the option to change their authorized treating physician a single time. This change must be requested within ninety (90) days following the date of injury, but before reaching maximum medical improvement (MMI). The new physician must still be on the approved list of providers.

To make this change, the injured worker must complete and sign the "Notice of One-Time Change of Physician & Authorization for Release of Medical Information" form required by the State of Colorado



See Section 7.4 for Notice of One-Time Change of Physician & Authorization for Release of Medical Information form.

2.6 Return to Work Program

Each Contractor must have a Return-to-Work Program (also referred to as “transitional duty”, “light duty”, or “modified duty”) for any injured employee who is released by a medical doctor to return-to-work with restrictions, or for modified or alternative work. Restricted Duty shall be an assignment provided to an employee who, because of a job-related injury or illness, is physically or mentally unable to perform all or any part of his/her normal assignment during all or any part of the normal workday or shift for a minimum duration of 90 days. Each employer offering transitional duty to an injured worker shall comply with Rule 6 of the Colorado Workers’ Compensation Act.

- If an employee has questions about medical treatment for a job-related injury, they must contact their employer.
- Contractor employees are expected to return to work as soon as possible after a job-related injury or illness has occurred. All possible opportunities must be considered to return the employee to work.
- When an injured employee returns to work, all physical and mental limitations must be evaluated to avoid further injury.
- Safety of other employees working with the injured individual must be considered
- The program safety manager, claims coordinator, and the insurance carrier will evaluate all injuries and illnesses on case-by-case basis.

2.6.1 Requirements and Limitations for an Injured Employee Returning to Work

- Employee’s treating physician has determined the physical restrictions.
- Contractor has modified duty that accommodates the restrictions.
- Contractor’s Project Managers, Supervisors, and Foreman are informed of the injured employee’s restrictions.
- No employee on modified duty will be allowed to work more than (40) forty-hours per week.
- The injured employee will remain on the project where the injury occurred while on transitional duty if at all possible. If not possible (project completed, contractor no longer on site, etc.) the injured employee’s Contractor is expected to accommodate Transitional Duty requirements for the employee on other jobs they currently have enrolled under the ROCIP.
- Injured employees must follow work restrictions issued by their treating physician while off duty.
- Employee must receive a full medical release from the treating physician before resuming normal work activities.
- Contractors shall discuss employee injury management protocol with the ROCIP Claims Advisor 303.589.7063 prior to any injured employee being laid-off or terminated from a Return-to-Work Program.

3. GENERAL LIABILITY CLAIMS

All incidents and accidents at a Project Site involving death, injury, or damage to property of non-employee personnel (the public, tenants, and visitors) must be reported immediately or as soon as the onsite personnel become aware of the event.

Take appropriate emergency measures to prevent additional injury or damage, including contacting police and fire authorities as required by law.

3.1 How to Report a General Liability Claim

- 1) Complete and submit a General Liability Loss Report to the General Contractor within 24 hours of the event.



See Section 7.3 for General Liability Loss Report form.

- 2) General Contractor will email the completed General Liability Loss Report to the following parties within 48 hours of the event:

ROCIP Claims Consultant	Dan Killebrew Daniel.Killebrew@marsh.com
DEN Risk Management	Hope Olthuis, Insurance Manager Hope.Olthuis@flydenver.com Jon Arcila, Risk Administrator Jonathan.Arcila@flydenver.com
DEN Safety	Suezann Bohner, Safety Supervisor Suezann.Bohner@flydenver.com
DEN Project Management	Project Management Team assigned to the specific project

- 3) An accident investigation will be completed as soon as possible by DEN Safety with all Contractors involved in the event and in coordination with DEN Risk Management, DEN Legal, DEN Project Management and the Insurer.
- 4) Immediately send all subsequent inquires or correspondence about an insured loss or claim, including a summons or other legal documents to the General Contractor. General Contractor will be responsible for providing to the ROCIP Claims Consultant and DEN Risk Management.

Contractors shall not voluntarily admit liability or responsibility and shall cooperate with DEN, Marsh, the Insurer and their respective representatives in the accident investigation.

IMMEDIATELY REPORT EVENTS INVOLVING BODILY INJURY, FATALITY, EXTENSIVE PROPERTY DAMAGE TO:

- DEN 303.342.4211
- DEN Risk 303.342.2152
- Marsh 303.308.4668

INVOLVING LAWSUITS

- DEN Risk 303.342.2152
- Marsh 303.308.4668

3.2 Filing a Claim Against the City and County of Denver

For any party that advises a Contractor they wish to make a claim for any incident or accident involving the City and County of Denver, Contractor should provide that party with the “Procedure for Filing a Notice of Claim Against the City and County of Denver”. This can be provided via the below link to the online instructions or via the attached document.

For questions of when this process versus the other claim reporting processes outlined in this guide should be followed, please contact the ROCIP Administrator or DEN Risk Management.

<https://www.denvergov.org/content/denvergov/en/city-attorneys-office/file-a-claim.html>



See Section 7.6 for Procedure for Filing a Notice of Claim Against the City and County of Denver.

3.3 Claims Reported Directly to the City and County of Denver

In the event a claim is reported directly to the City and County of Denver, the following steps will be taken:

- 1) DEN Risk Management and DEN Legal will be notified by the City Attorney’s Office of the received claim and will assess whether or not it is ROCIP-related.
- 2) If the claim is, or possibly is, ROCIP-related DEN Risk Management will forward the notice and information to the following parties within 48 hours of receipt:

General Contractor	General Contractor responsible for the specific project
ROCIP Claim Advisor	Dan Killebrew Daniel.Killebrew@marsh.com
DEN Safety	Suezann Bohner, Safety Supervisor Suezann.Bohner@flydenver.com
DEN Project Management	Project Management Team assigned to the specific project

- 3) An accident investigation will be completed as soon as possible by DEN Safety with all Contractors involved in the event and in coordination with DEN Legal, DEN Project Management and the Insurer.
- 4) If Contractor receives any subsequent direct inquires or correspondence about the claim, including a summons or other legal documents, the information must be immediately forwarded to the General Contractor. General Contractor will be responsible for providing to the following parties within 48 hours of receipt:

ROCIP Claims Consultant	Dan Killebrew Daniel.Killebrew@marsh.com	
DEN Risk Management	Hope Olthuis, Insurance Manager Hope.Olthuis@flydenver.com	Jon Arcila, Risk Administrator Jonathan.Arcila@flydenver.com

4. BUILDER'S RISK CLAIMS

When damage occurs on a construction site, our builder's risk insurance can help offset the costs and get the project back on track. It can pay for damage to the project, materials awaiting installation, and for costs associated with project delays.

4.1 Contractor Responsibilities

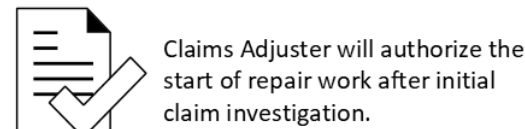
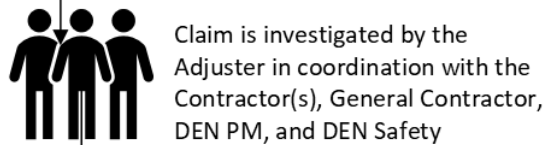
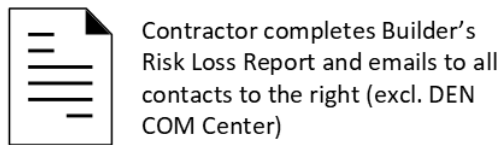
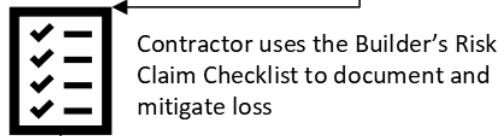
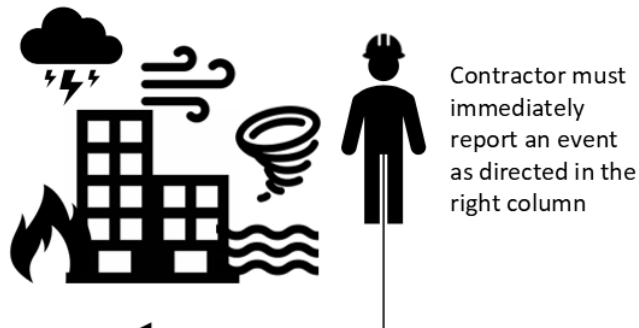
4.1.1 All Contractors

- Report any damages to your Work or the Work of any other Contractor on a Project to the General Contractor.
- Report any injuries to non-employees that may be suffered on a Project Site to the General Contractor.
- Follow the claim reporting procedures in this guide if you are directly involved in a loss and cooperate fully and timely with any requests from the Insurer, DEN, Marsh or any of their respective representatives.

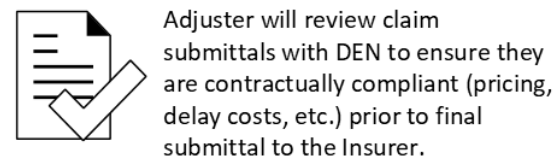
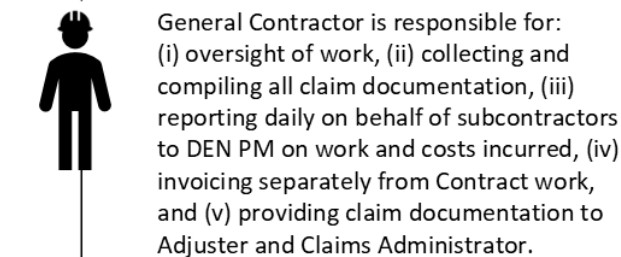
4.1.2 General Contractors

- Responsible for ensuring all subcontractors involved in a Builder's Risk loss follow the claim reporting procedures in this guide.
- Responsible for pricing and cost proposals for needed work/rework to repair the damage and obtaining approval from DEN Project Management.
- Responsible for providing updated schedule analysis and costs associated with any delay in completion.
- Responsible for oversight and management of the specific work/rework necessary to repair the damage.
- Responsible for collecting, reviewing, and compiling all claim documentation for claim adjustment and claim payment purposes.
- Responsible for ensuring rework and any associated costs related to a claim are separated and billed independent of the Contract work.

4.2 Builder's Risk Claims Process



! NOTE: DEN PM has the ability to pre-approve repairs at any point during the claims process to minimize delays.



INITIAL CONTACTS



FOR EMERGENCIES
CALL DEN COM CENTER
303.342.4211



GENERAL CONTRACTOR
Responsible for the specific project notifies all below individuals



ROCIP CLAIMS ADJUSTER
Scott Markey
303.905.6233
Scott.markey@mclarens.com



ROCIP CLAIMS ADMINISTRATOR
Dan Killebrew
303.308.4668
Daniel.killebrew@marsh.com



DEN PROJECT MANAGER
Assigned to the specific project



DEN SAFETY
Suezann Bohner
303.342.2132
Suezann.bohner@flydenver.com



DEN RISK MANAGEMENT
Hope Verro
303.342.2137
Hope.verro@flydenver.com

+

Adjuster will advise DEN Risk and Claim Administrator of Insurer agreed settlement. DEN Risk will process claim settlement through the General Contractor.

4.3 Builder’s Risk Claim Checklist

Provided with this manual is a checklist to assist Contractors’ in capturing immediate claims information following an event, mitigating the loss and evaluating the scope of the loss.



See Section 7.1 for Builder’s Risk Claim Checklist.

4.4 How to Report a Builder’s Risk Claim

- 1) Complete and submit a Builder’s Risk Loss Report to the following parties within 24 hours of the event:

General Contractor	General Contractor responsible for the specific project	
ROCIP Claims Advisor	Dan Killebrew Daniel.Killebrew@marsh.com	
DEN Risk Management	Hope Olthuis, Insurance Manager hope.olthuis@flydenver.com	Jon Arcila, Risk Administrator Jonathan.Arcila@flydenver.com
DEN Safety	Suezann Bohner, Safety Supervisor Suezann.Bohner@flydenver.com	
DEN Project Management	Project Management Team assigned to the specific project	



See Section 7.2 for Builder’s Risk Loss Report form.

- 2) An incident investigation will be completed as soon as possible by DEN Safety with all Contractors involved in the event and in coordination with DEN Risk Management, DEN Legal, DEN Project Management and the Insurer.
- 3) Insurer’s claims adjuster may conduct a site visit to assess the loss; these visits would be arranged by the claims adjuster with the General Contractor, DEN Project Management, and DEN Safety. DEN Project Management would assume responsibility for providing required access and escort.
- 4) Provide the Insurer with any requested supporting documentation for the claim to be adjusted properly and avoid further Project delay.

5. POLLUTION LIABILITY CLAIMS

5.1 How to Report a Pollution Incident or Claim

- 1) Contractors shall immediately notify the following parties of any known or suspected pollution incidents.

DEN COMMUNICATIONS CENTER 303.342.4200

ROCIP Claims Consultant	Dan Killebrew Daniel.Killebrew@marsh.com
DEN Risk Management	Hope Olthuis, Insurance Manager Jon Arcila, Risk Administrator Hope.Olthuis@flydenver.com Jonathan.Arcila@flydenver.com
DEN Safety	Suezann Bohner, Safety Supervisor Suezann.Bohner@flydenver.com
DEN Project Management	Project Management Team assigned to the specific project

- 2) Complete and submit a Pollution Incident Report to the captioned individuals and the General Contractor within 24 hours of the event.



See Section 7.5 for Pollution Incident Report.

6. AUTOMOBILE AND OTHER TYPES OF INCIDENTS

6.1 Reporting to DEN

Refer to the DEN ROCIP Safety Manual for details on incident, accident and near miss reporting requirements. Please note that all incidents and accidents must be reported to DEN Safety via the process outlined in the ROCIP Safety Manual regardless of whether a formal claim is being submitted to an insurance carrier.

6.2 Reporting to Your Company's Insurer and CORA Requests

Insurance covers outside those provided under the DEN ROCIP, such as automobile liability or physical damage, should be reported by the impacted Contractor to its Insurer. It is the sole responsibility of each Contractor to report claims covered by non-ROCIP insurance policies to their own Insurers and directly manage the claims process.

DEN will provide supporting documentation when available and when requested, such as video footage. Documentation from DEN related to an incident or accident occurring on DEN premises may be requested through the Colorado Open Records Act, Colorado Revised Statutes §24-72-201 to 206 (CORA).

You may request public records of the airport via the following online portal link:

[https://flydenver.govqa.us/WEBAPP/rs/\(S\(Inxwnqethmgjf0ostyotlmgy\)\)/supporthome.aspx](https://flydenver.govqa.us/WEBAPP/rs/(S(Inxwnqethmgjf0ostyotlmgy))/supporthome.aspx)

NOTE: e-mail messages are vulnerable to non-delivery or rejection by the airport's computer security systems. If you do not receive a reply e-mail acknowledging receipt of your e-mail request within 24 hours, you should mail or fax your request to the airport.

For complete information, please read the rules for Open Records Act requests, which can be accessed online via the below link.

[Part 220 of the Airport Rules & Regulations](#)

7. FORMS and RESOURCES

The following forms and resources provided in this section are also available as single files for your ease of download and use in the Documents Section of the Contractor Online Portal.

- 7.1 [Builder's Risk Claim Checklist](#)
- 7.2 [Builder's Risk Loss Report](#)
- 7.3 [General Liability Loss Report](#)
- 7.4 [One-Time Change of Physician \(CO Form WC003\)](#)
- 7.5 [Pollution Incident Report](#)
- 7.6 [Procedure for Filing a Claim Against the City and County of Denver](#)
- 7.7 [Worker's Compensation First Report of Injury Form](#)
- 7.8 [Workers' Compensation Information and Designated Medical Provider Form \(CO Form WC49\)](#)
- 7.9 [Workers' Compensation Medical Care Requisition and Authorization Form](#)

7.1 Builder’s Risk Claim Checklist



BUILDER’S RISK CLAIM CHECKLIST

For Contractor informational use only. This form is not part of an official loss report.

PROJECT INFORMATION	
DEN Project Name:	
Lead Contractor:	
Date of Event:	
Time/Date Project Delays Began (approx.):	
Time/Date Project Resumed (approx.):	

CHECKLIST	
Immediate Actions	
<input type="checkbox"/>	Take ample photographs and videos to document ALL damage (however small), especially before mitigation efforts have begun. Show the full loss in its initial state. Photos and Videos <ul style="list-style-type: none"> Focus in on specific damages, especially to porous materials where the visible damage can dry overtime Take photos from multiple angles Time stamp photos and videos Retain copies of the photos and videos for your records
	Mitigate the loss. Take immediate steps to protect property {damaged and undamaged} from further loss, including securing boarding-up, security or other services as necessary.
<input type="checkbox"/>	Secure and save all damaged property, equipment and parts to be inspected by the Insurer in their investigation to determine cause of loss and possible subrogation proceeding. DO NOT discard anything unless directed by the Insurer.
	Take detailed notes: <ul style="list-style-type: none"> Description of the event and resulting damage suffered Date, Time, Specific Location Other involved Contractors (companies and individual worker names) Other involved parties and witnesses (capture names and contact information) Description of any injuries that resulted (name, contact info and description of injury) Description of any resultant damage to existing property
	List all property and items damaged or stolen.
<input type="checkbox"/>	Call the Police, if appropriate. This step is required if the loss involves theft or vandalism.
<input type="checkbox"/>	Witnesses: If there were any witnesses to the incident, have them give you a written statement on what happened. Make sure the statements are detailed and have each witness sign their statement.
	Third Party Responsibility: If a third party is thought to be responsible for the damage, capture name and contact information as well as vehicle information if a vehicle was involved (Make/Model and License Plate No.).
Estimating and Documentation Actions	
<input type="checkbox"/>	Develop a Rough Order of Magnitude (ROM) that outlines all areas of anticipated loss amounts by category with estimated labor and materials separately shown: Debris Removal, Permanent Works, Temporary Works, Pollutant Cleanup and Removal, Preservation of Property, Valuable Papers, Trees/Shrubs/Plants, Engineering Assessments and Professional Fees, Site Preparation, Inspections, Other Round Numbers and “TBDs” are sufficient at this time.
	Analyze any schedule impacts and quantify associated costs, if any
	Keep detailed records and documentation for all expenses (labor and materials) incurred related to the loss.
<input type="checkbox"/>	If original purchase invoices are available for damaged property be prepared to provide copies to the Insurer.
<input type="checkbox"/>	Identify any Expediting Expenses—costs incurred to speed up repair of damaged property, such as overtime wages and express transportation charges.
	Identify Extra Expenses and costs above normal related to the event. Any cost or expense incurred, that would not have been incurred “but for” the event, should be tracked.
<input type="checkbox"/>	Identify costs related to ingress/egress delays, enforcement of laws or ordinances regulating repair, demolition, and reconstruction of damaged buildings.

Issued: Feb 2022

7.2 Builder's Risk Loss Report

DEN ROCIP 4
BUILDER'S RISK LOSS REPORT



INSTRUCTIONS: Complete form in its entirety and submit to the following individuals within 24 hours of event. Use the Builder's Risk Claim Checklist on the reserve side of this form to assist you in addressing the situation and gathering critical information.

ROCIP Claims Advisor: Dan Killebrew daniel.killebrew@marsh.com
DEN Risk Management: Hope Olthuis hope.olthuis@flydenver.com
Jon Arcila jonathan.arcila@flydenver.com

PROJECT INFORMATION

DEN Project Name:
DEN Project No:
Contractor Company Reporting Claim:
Lead Contractor Company:

LOSS INFORMATION

Date of Loss: Time of Loss:
Address/Location of Loss:
Type of Loss: Fire Flood Hail Lightning Water Wind Theft Vandalism Other

Describe what happened:

Describe the property damage suffered:

ATTACH PHOTOGRAPHS AND PROVIDE VIDEO IF AVAILABLE

Estimated Dollar Value of Property Damaged: Estimated Value of Entire Loss:

If loss was the result of theft or vandalism was the event reported to the Police? Yes No

If Yes, please provide: Officer Name and Tel No. Case No.

If loss was the result of fire, please provide contact information for the responding Fire Dept.:

ADDITIONAL INFORMATION

Was any existing property damaged? Yes No Estimated Dollar Value of Property Damage:

Describe the property damage suffered:

Any injuries resulting from the event? Yes No Estimated Dollar Value of Project Delay Costs:

List Injured Parties and any Witnesses: (list names and contact information)

INFORMATION FOR PERSON COMPLETING THIS FORM

Name and Title:
Tel No. Email:
Date:

Revised Feb 2022

7.3 General Liability Loss Report

DEN ROCIP 4
GENERAL LIABILITY LOSS REPORT



INSTRUCTIONS: Complete form in its entirety and submit to the following individuals within 24 hours of event.

ROCIP Claims Advisor: Dan Killebrew daniel.killebrew@marsh.com
DEN Risk Management: Hope Verro hope.verro@flydenver.com
Janet Bressler janet.bressler@flydenver.com

IMMEDIATELY REPORT LOSSES INVOLVING BODILY INJURY, FATALITY, EXTENSIVE PROPERTY DAMAGE OR LAWSUIT TO: 303.308.4500

PROJECT INFORMATION

DEN Project Name:
DEN Project No:
Contractor Company Reporting Claim:
General Contractor:

LOSS INFORMATION

Date of Loss: Time of Loss: am pm

Address/Location of Loss:

Describe what happened:
(include identified cause of loss)

ATTACH PHOTOGRAPHS AND PROVIDE VIDEO IF AVAILABLE

Was accident caused by subcontractor employee? Yes No
If Yes, provide the following: Name of Subcontractor Company:
Name of Employee:

INJURED PERSONS (please provide a supplement to this report if more than one person was injured)

Name Address City/State/Zip Tel No. Email Age
Description of Injuries: Fatality
What was the Person doing at the time of injury?
Where was the Person taken for medical care?

DAMAGE TO PROPERTY OF OTHERS

Was any property damaged? Yes No Estimated Dollar Value of Property Damage:
Describe the property and the damage:
Property Owner's Name and Contact Information:

WITNESSES (please provide a supplement to this report with additional witnesses)

Name Address City/State/Zip Tel No. Email

INFORMATION FOR PERSON COMPLETING THIS FORM

Name and Title:
Tel No. Email:
Date:

Revised Feb 2022

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Clear This Page

By signing this form I acknowledge that I wish to make a one-time change of physician pursuant to §8-43-404(5)(a)(III) and certify that the information provided in this form is, to the best of my knowledge and belief, true, correct and complete.

I hereby authorize _____ to release medical information relating to _____ on-the-job injury to _____ for purposes of providing medical care under the Workers' Compensation Act.
(Name and address of current treating physician) (Claimant's name) (Date of Injury) (Name and address of requested new treating physician)

I understand that this information may be given to my employer and also may be given to other persons necessary to resolve my claim. All written communications to any physician or health care provider shall be simultaneously provided to me or, if represented, to my attorney.

Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified: _____

Signed: _____ Dated: _____
Print Name: _____

CERTIFICATE OF SERVICE: Copies of this document were placed in the U.S. mail or hand-delivered to the following parties this _____ day of _____, _____ Year.
Day Month Year

List the names and addresses of all persons copied:
Respondents' Representative(s): _____

While you are not required to send this form to the physicians, see Instruction No. 4., doing so may result in a smoother transition.

Current Authorized Treating Physician: _____

Requested Authorized Treating Physician: _____

By: _____
Signature

7.5 Pollution Incident Report

DEN ROCIP 4 POLLUTION INCIDENT REPORT



INSTRUCTIONS: Complete form in its entirety and submit to the following individuals within 24 hours of event.

ROCIP Claims Advisor: Dan Killebrew daniel.killebrew@marsh.com
DEN Risk Management: Hope Verro hope.verro@flydenver.com
Janet Bressler janet.bressler@flydenver.com

ALL POLLUTION INCIDENTS SHOULD BE IMMEDIATELY REPORTED TO DEN COMMUNICATIONS CENTER 303.342.4200

PROJECT INFORMATION

DEN Project Name: _____

DEN Project No: _____

Contractor Company Reporting Claim: _____

Lead Contractor Company: _____

LOSS INFORMATION

Date of Loss: _____ Time of Loss: _____ am pm Incident Date/Time Unknown

Description of Location: _____

Description of Incident:

Is incident still active?
 Yes No

ATTACH PHOTOGRAPHS AND PROVIDE VIDEO IF AVAILABLE

Were other agencies notified? Yes No

If yes, list agencies:

Is a water source threatened? Yes No

If yes, provide details: _____

ADDITIONAL INFORMATION

Was any property damaged? Yes No Estimated Dollar Value of Property Damage: _____

Describe the property damage suffered:

Any injuries resulting from the event? Yes No

List Injured Parties and any Witnesses:
(list names and contact information)

INFORMATION FOR PERSON COMPLETING THIS FORM

Name and Title: _____

Tel No. _____ Email: _____

Date: _____

Revised Feb 2022



Michael B. Hancock
Mayor

CITY AND COUNTY OF DENVER

PROCEDURE FOR FILING A NOTICE OF CLAIM AGAINST THE CITY AND COUNTY OF DENVER

(For any party who may want to make a claim for any accident or incident involving the City and County of Denver)

1. Write and file a Notice of Claim (letter) that complies with the provisions of the Colorado Governmental Immunity Act notice requirements found in §24-10-109, 7B (2003), as amended and may be further amended by the legislature.
2. Mail or deliver your Notice of Claim to:

Mayor Michael Hancock
1437 Bannock Street, Room 350
Denver, CO 80202
3. The Mayor's Office will forward your Notice of Claim to the Denver City Attorney's Office. You will receive a letter, which will provide Denver's claim number and the investigator's name and phone number.
4. If you have any questions about your claim contact the Denver International Airport Risk Management Department at 303.342-2151.

§ 24-10-109. Notice required--contents--to whom given--limitations

(1) Any person claiming to have suffered an injury by a public entity or by an employee thereof while in the course of such employment, whether or not by a willful and wanton act or omission, shall file a written notice as provided in this section within one hundred eighty-two days after the date of the discovery of the injury, regardless of whether the person then knew all of the elements of a claim or of a cause of action for such injury. Compliance with the provisions of this section shall be a jurisdictional prerequisite to any action brought under the provisions of this article, and failure of compliance shall forever bar any such action.

(2) The notice shall contain the following:

- (a) The name and address of the claimant and the name and address of his attorney, if any;
- (b) A concise statement of the factual basis of the claim, including the date, time, place, and circumstances of the act, omission, or event complained of;
- (c) The name and address of any public employee involved, if known;
- (d) A concise statement of the nature and the extent of the injury claimed to have been suffered;
- (e) A statement of the amount of monetary damages that is being requested.

(3) (a) If the claim is against the state or an employee thereof, the notice shall be filed with the attorney general. If the claim is against any other public entity or an employee thereof, the notice shall be filed with the governing body of the public entity or the attorney representing the public entity. Such notice shall be effective upon mailing by registered or certified mail, return receipt requested, or upon personal service.

(4) When the claim is one for death by wrongful act or omission, the notice may be presented by the personal representative, surviving spouse, or next of kin of the deceased.

(5) Any action brought pursuant to this article shall be commenced within the time period provided for that type of action in articles 80 and 81 of title 13, C.R.S., relating to limitation of actions, or it shall be forever barred, except that, if compliance with the provisions of subsection (6) of this section would otherwise result in the barring of an action, such time period shall be extended by the time period required for compliance with the provisions of subsection (6) of this section.

(6) No action brought pursuant to this article shall be commenced until after the claimant who has filed timely notice pursuant to subsection (1) of this section has received notice from the public entity that the public entity has denied the claim or until after ninety days has passed following the filing of the notice of claim required by this section, whichever occurs first.

Amended by Laws 1979, S.B.101, § 2; Laws 1986, H.B.1196, § 9; Laws 1992, H.B.92-1291, § 4, eff. July 1, 1992; Laws 2009, Ch. 252, § 21, eff. May 14, 2009; Laws 2012, Ch. 172, § 1, eff. Aug. 8, 2012; Laws 2012, Ch. 208, § 145, eff. July 1, 2012.

7.7 Worker's Compensation First Report of Injury Form

WORKERS' COMPENSATION FIRST REPORT OF INJURY

INSTRUCTIONS: This First Report of Injury may be reported to the DEN ROCIP 4 Workers' Compensation Insurer via online website submission, email, fax or telephone. The Insurer will produce the necessary state required forms on your behalf following receipt of the claim. **DO NOT DELAY SUBMITTING THIS REPORT EVEN IF YOU DO NOT HAVE AN ANSWER TO ALL THE QUESTIONS.**

WAYS TO SUBMIT THIS REPORT
BY ONLINE WEB SITE: www.zurlohna.com
BY EMAIL: [U\\$Z_CareCenter@Zurlohna.com](mailto:U$Z_CareCenter@Zurlohna.com)
BY FAX: 877.882.2687
BY TELEPHONE: 800.887.3373

ACCOUNT / ACCIDENT INFORMATION

CALLER'S PHONE NUMBER / EXTENSION { }	CALLER'S TITLE	CALLER'S NAME	REPORTING STATE CO
CONTRACTOR/EMPLOYER NAME		CONTRACTOR/EMPLOYER ADDRESS (STREET, CITY, STATE & ZIP)	CONTRACTOR/EMPLOYER MAILING ADDRESS (STREET, CITY, STATE & ZIP) <input type="checkbox"/> SAME
DID THE ACCIDENT OCCUR AT THE LOCATION ADDRESS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, ADDRESS WHERE ACCIDENT OCCURRED		CONTRACTOR DEN PROJECT NO.	
PARENT COMPANY / INSURED'S NAME City and County of Denver, Department of Aviation, DEN ROCIP 4 [Account # 0000047842]			
LOCATION CODE	POLICY SYMBOL AND NUMBER	NATURE OF BUSINESS	
DATE OF INJURY		TIME OF INJURY	
ACCIDENT DESCRIPTION			

EMPLOYEE INFORMATION

INJURED EMPLOYEE'S SOCIAL SECURITY NUMBER:	EMPLOYEE'S NAME (FIRST, MI, LAST)	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
DATE OF BIRTH	EMPLOYEE'S MAILING ADDRESS	
EMPLOYEE'S HOME PHONE NUMBER { }	EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING)	

EMPLOYEE JOB INFORMATION

EMPLOYMENT STATUS CODE <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> OTHER _____	INJURED WORKER TYPE	REGULAR OCCUPATION
OCCUPATION WHEN INJURED		
EMPLOYEE'S WORK SCHEDULE		
REGULAR WORK HOURS	HOURS/DAY	DAYS/WEEK
EMPLOYEE'S WAGE INFORMATION: \$ _____ / HOUR OR \$ _____ / ANNUAL OR \$ _____ / WEEKLY OVERTIME: \$ _____ ADDITIONAL BENEFITS: \$ _____		
DATE OF HIRE OR LENGTH OF EMPLOYMENT		
SUPERVISOR'S NAME:	SUPERVISOR'S PHONE NUMBER: { }	BEST HOURS TO CONTACT

ACCIDENT INFORMATION

DATE CLAIM REPORTED TO EMPLOYER?	DID EMPLOYEE LOSE ANY TIME FROM WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS THE EMPLOYEE BACK AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE RETURNED TO WORK?
RETURN TO WORK STATUS <input type="checkbox"/> LIGHT <input type="checkbox"/> MODIFIED <input type="checkbox"/> REGULAR	DATE EMPLOYEE LAST WORKED	WAS INJURY FATAL? IF YES, DATE OF DEATH <input type="checkbox"/> YES <input type="checkbox"/> NO
CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)		
EQUIPMENT, MATERIAL OR SUBSTANCE INVOLVED		
DO YOU QUESTION THE VALIDITY OF THE CLAIM? <input type="checkbox"/> YES <input type="checkbox"/> NO		
WITNESS INFORMATION/OTHERS INVOLVED NAME (FIRST, MI, LAST)	ADDRESS	PHONE NUMBER

Continued on reverse side

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INJURY INFORMATION

PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG)

NATURE OF INJURY (E.G., FRACTURE, SPRAIN, LACERATION)

PRIOR INJURY OR PRE-EXISTING CONDITION(S) (IF YES, DESCRIBE)

YES NO

TREATMENT (X ALL THAT APPLY)

<input type="checkbox"/> FIRST AID —	TREATMENT AND DATE OF 1 ST TREATMENT
<input type="checkbox"/> HOSPITAL/ CLINIC —	NAME, ADDRESS, PHONE NUMBER, PHYSICIAN NAME, TREATMENT, DATE OF 1 ST TREATMENT, LENGTH OF STAY, AMBULANCE USED? WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? <input type="checkbox"/> YES <input type="checkbox"/> NO WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> PHYSICIAN —	

SEE WORKERS' COMPENSATION - FIRST REPORT OF INJURY - STATE SPECIFIC QUESTIONS FOR YOUR INDIVIDUAL STATE.

CUSTOMER SPECIFIC INFORMATION

ADDITIONAL COMMENTS & INFORMATION



7.8 Worker's Compensation Information and Designated Medical Provider Form (CO Form WC49)

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

**Colorado Workers' Compensation Information
and Designated Medical Provider List**

for this DEN ROCIP PROJECT your employer has workers' compensation coverage for employees through:

AMERICAN ZURICH INSURANCE COMPANY

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 of 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 toll-free at 1-888-390-7936 or visit our website at www.colorado.gov/cdle/dwc.

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

TO BE COMPLETED BY INJURED WORKER: Review this form in its entirety. Select your desired designated medical provider by checking the appropriate box below, sign, date and return this form to your employer.

Designated Medical Provider List for DEN ROCIP 3/ROCIP 4. Check the box above your desired medical provider.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentra Medical Center 3449 Chambers Road Ste B Aurora, CO 80111 720.859.6139	Concentra Medical Center 15235 E 38th Avenue Aurora, CO 80111 303.340.3053	Midtown Occupational Health 2420 W 26th Ave., Bldg D Ste 200 Denver, CO 80211 303.831.9393	MBI 3350 Peoria St Ste 190 Aurora, CO 80010 303.365.4646

Pursuant to section 8-42-404 (5) (III), if a request for a change of physician is made, the insurance carrier representative is: American Zurich Ins. Co., PO Box 968023, Schaumburg, IL, 60196. Phone: 1-800-777-9005, Fax 1-214-866-1676.

I acknowledge that I have reviewed this form, received the Designated Medical Provider List and have selected the medical provider I wish to use above.

Signature

Print Name

Date

DEN ROCIP 3/ROCIP 4 MEDICAL CARE REQUISITION and AUTHORIZATION FORM



INSTRUCTIONS: This form is to be completed in its entirety by the Employer/Contractor's Safety Representative or an authorized Requesting Party (Lead Contractor's Safety Representative or DEN Safety) and email or fax to the desired clinic.

Date: _____ DEN Project Name: _____

Employee Name: _____

Employer/Contractor Name: _____ DEN Project No. _____

Employer/Contractor Address: _____

Authorizing Representative Information: Name/Title _____
 Company/Entity Name _____
 Email _____ Tel. No. _____

INSTRUCTIONS BILL REQUESTED MEDICAL SERVICES TO: ZURICH
 BILL REQUESTED DRUG and/or ALCOHOL SCREENS TO: EMPLOYER/CONTRACTOR LISTED ABOVE

Indicate requested treatment and screening request(s) below:

Medical treatment for injury

11 Panel Rapid Drug Screen

Alcohol Screen

Other: _____

Date of Injury: _____

Body Part(s) Injured: _____

DOT Reportable Injury: Yes No

Comments: _____

DESIGNATED LOCATIONS

EMPLOYEE MUST SELECT AN OPTION, SIGN THE FORM, AND TAKE COMPLETED FORM TO BE PRESENTED AT THE DESIRED LOCATION. Contractor must keep a signed copy for their records.



AURORA
 3449 Chambers Road Suite B
 Aurora, CO 80011
 colorado_ccdia@concentra.com
 720.859.6139 tel
 720.859.3294 fax
 Hours: 8am-5pm M-F



AURORA
 15235 E. 38th Ave.
 Aurora, CO 80229
 colorado_ccdia@concentra.com
 303.340.3053 tel
 303.342.3862 fax
 Hours: 8am-8pm M-F
 8am - 4pm Sat



DOWNTOWN
 2420 W. 26th Ave. Bldg. D.
 Suite 200
 Denver, CO 80211
 303.831.9393 tel
 303.831.6335 fax
 Hours: 7am-5:30pm M-F



AURORA
 3350 Peoria St, Ste 190
 Aurora, CO 80010
 dneclinic@workwellworks.com
 303.365.4646 tel
 303.365.4644 fax
 Hours: 8am-5pm M-F

I do not wish to seek medical treatment at this time. At a later time, I understand that I may request a medical evaluation for my reported injury. By signing this form, I acknowledge any future claims regarding this incident will require a medical evaluation through an approved Worker's Compensation medical provider listed above.

Employee Signature: _____ Date: _____



AURORA 1635 Aurora Ct. Aurora, CO 80045 720.848.8650 tel 720.848.7374 fax
 Hours: 24/7/365



For assistance contact ROCIP3 Claims Advisor Calvin Carroll at calvin_carroll@marsh.com or 214.228.8933
 For assistance contact ROCIP4 Claims Advisor Dan Chilton at dan.chilton@marsh.com or 303.308.4594

Revised Feb 2022

8. SUMMARY OF REVISIONS:

Version 1.2 – August 2022				
Section	Page	Original	Revision	Explanation
2.2.3	7		Added “Retain a copy of the employee’s written notice of injury, as required by the State of Colorado”	Colorado HB22-1112 – Workers’ Compensation Injury Notice: new requirement
7.8	30	“3 working days”	“10 working days”	Updated form to reflect legislative update on number of days to provide employer with written notice of injury – HB22-1112
Version 1.3 – August 2023				
			Workwell Clinics to MBI for name change	Workwell is now MBI
			Updated Hope’s last name	Hope Verro is now Hope Olthuis
Version 1.4 – April 2024				
3.1	12		Jon Arcila	Added Jon as a DEN Risk Management contact
3.3	13		Jon Arcila	Added Jon as a DEN Risk Management contact

4.4	16		Jon Arcila	Added Jon as a DEN Risk Management contact
5.1	17		Jon Arcila	Added Jon as a DEN Risk Management contact