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|  **South Carolina Workers’ Compensation Commission** 1333 Main Street, Suite 500 P.O. BOX 1715 Columbia, SC 29202-1715 (803) 737-5700 [www.wcc.sc.gov](http://www.wcc.sc.gov)  | SCSealBWjpg |

|  |  |
| --- | --- |
| WCC File #: |  |
|  |  |
| Carrier File #: |  |
|  |  |
| Carrier Code #: |  |
|  |  |
| Employer FEIN #: |  |
|  |  |

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|

|  |  |  |  |
| --- | --- | --- | --- |
| Decedent’s Name: |       | SSN: |    -  -     |

|  |  |  |  |
| --- | --- | --- | --- |
| Claimant's Name: |       | SSN: |  |
|  |  |
| Address: |       |
|  |  |  |  |  |  |
| City: |       | State: |    | Zip: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Home Phone: |  | Work Phone: |  |

 |

|  |  |
| --- | --- |
| Employer's Name: |       |
|  |  |
| Address: |       |
|  |  |  |  |  |  |
| City: |       | State: |    | Zip: |       |

|  |  |
| --- | --- |
| Insurance Carrier: |       |

  |
|  Preparer’s Name: |       |  Law Firm: |       |  Preparer’s Phone #:  |  |
|  |  |  |  |  |  |

 **Date of Injury or Illness:\_\_\_\_\_\_\_\_\_\_\_**

**Complete each information blank. Clearly specify when contentions are admitted in part or denied in part.**

**The Employer-insurance Carrier in answer to the claim due to the death of**       (employee’s name)

**respectfully shows:**

|  |  |
| --- | --- |
|  1. | It is [ ]  admitted [ ]  denied the employee sustained an injury on or about the date set forth in the application. |
|  2. | It is [ ]  admitted [ ]  denied both the employer and employee were subject to the Workers’ Compensation Act at the time in question. The reasons for denial are:      |
|  3. | It is [ ]  admitted [ ]  denied the relationship of employer and employee existed at the time in question. The reasons for denial are:      |
|  4. | It is [ ]  admitted [ ]  denied at the time in question the employee was performing services arising out of and in the course of employment. |
|  5. | It is [ ]  admitted [ ]  denied notice of injury was given the employer as specified in the application. |
|  6. | It is [ ]  admitted [ ]  denied the employee was entitled to medical care as a result of the injury. |
|  7. | It is [ ]  admitted [ ]  denied the employee lost compensable time from work and wages for period(s) of:      |
|  8. | It is admitted denied the employee’s death resulted proximately from accidental injury arising out of and in the course of employment on\_\_\_\_\_\_\_\_\_\_\_\_(m/d/yyyy). |
|  9. | It is contended that an average weekly wage of $\_\_\_\_\_\_\_\_\_\_ applies, according to the attached accounting of employee’s earnings, as provided by law. |
| 10. | Further grounds of claim:  |

 **Mediation**

 a. Mediation is required to be ordered pursuant to Reg. 67-1801 B.

 b. Mediation is required pursuant to Reg. 67-1802.

 c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.

 d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Questions regarding mediation may be submitted to **mediation@wcc.sc.gov**.

**I certify I have served this document pursuant to Reg. 67-211. See attached certificate of service.**

**I verify the contents of the form are accurate and true to the best of my knowledge.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preparer’s Signature Title Email Date