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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **South Carolina Workers’ Compensation Commission**  1333 Main Street, Suite 500 ● Post Office Box 1715  Columbia, South Carolina 29202-1715  (803) 737-5675 [www.wcc.sc.gov](http://www.wcc.sc.gov) | | | SCSealBWjpg | | | |  |  | | --- | --- | | WCC File #: |  | | Carrier File #: |  | | Carrier Code #: |  | | Employer FEIN #: |  | | |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Claimant's Name: | | |  | | | SSN: | | -  - | | |  | |  | | | | | | | | | Address: | |  | | | | | | | | |  |  | | |  |  | |  | |  | | City: |  | | | State: |  | | Zip: | |  |  |  |  |  |  | | --- | --- | --- | --- | | Home Phone: | (     )    - | Work Phone: | (     )    - | | Date of Injury: |  |  |  | | | | | | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Employer's Name: | | |  | | | | | |  | | |  | | | | | | Address: | |  | | | | | | |  |  | | |  |  |  |  | | City: |  | | | State: |  | Zip: |  |  |  |  |  |  | | --- | --- | --- | --- | | Insurance Carrier: |  |  |  | | | |
| Preparer’s Name: |  | Law Firm: | |  | | Preparer’s Phone #: | (     )    - |
|  |  |  | |  | |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Injury or Illness:** |  |  | **Estimated time for hearing:** |

**Complete each information blank. Clearly specify when contentions are admitted in part and denied in part. The Employer/Carrier in answer to the claim, respectfully shows:**

1. It is  the employee sustained an injury or illness on or about the date set forth in the Form 50. The reasons for denial are:

|  |
| --- |
|  |

1. It is  both the employer and employee were subject to the Workers’ Compensation Act at the time in question. The reasons for denial are:

|  |
| --- |
|  |

1. It is  the relationship of employer and employee existed at the time in question. The reasons for denial are:

|  |
| --- |
|  |

1. It is at the time in question the employee was performing services arising out of and in the course of employment. The reasons for denial are:

|  |
| --- |
|  |

1. It is notice of injury was given the employer.  The reasons for denial are:

|  |
| --- |
|  |

1. It is the employee  medical care as a result of injury or illness. The reasons for denial are:

|  |
| --- |
|  |

1. It is the employee is entitled to temporary total disability for the period(s) of :

|  |
| --- |
|  |

1. It is  the employee is permanently disabled. The reasons for denial are:

|  |
| --- |
|  |

1. It is the employee has serious disfigurement.
2. It is contended that an average weekly wage of **$**  applies, according to attached Form 20 as provided by law.
3. Further contentions, grounds of defense, or unusual aspects are:

|  |
| --- |
|  |
|  |

**Mediation**

a. Mediation is requested 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**](mailto:mediation@wcc.sc.gov).

**I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to**

**Address on the** **day of** **20****, by:**

**first class postage**  **certified mail**  **personal service  electronic service**

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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
| Preparer’s Signature |  | Title |  | Email |  | Date |

|  |  |  |  |
| --- | --- | --- | --- |
| Refer to R.67-204 through R.67-210 and R.67-601 through R.67-615. Refer to R. 67-1801 for mediation. Questions about the use of this form may be directed to the Commission’s Judicial Department at 803-737-5675 or [**judicial@wcc.sc.gov**](mailto:judicial@wcc.sc.gov) or [**mediation@wcc.sc.gov**](mailto:mediation@wcc.sc.gov). Pursuant to R.67-606, a Form 20 must be filed with the Claims Department at least 30 days from the date of filing this form.   |  |  |  | | --- | --- | --- | | **WCC Form # 51**  Revised 07/15 | 51 | Employer’s Answer to Request for Hearing | |