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

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: _____ SSN: _____ Employer's Name: _____
Address: _____ Address: _____
City: _____ State: ____ Zip: _____ City: _____ State: ____ Zip: _____
Home Phone: _____ Work Phone: _____ Insurance Carrier: _____
Preparer's Name: _____ Law Firm: _____ Preparer's Phone #: _____

Date of Injury or Illness: _____

Complete each information blank. Clearly specify when contention are admitted in part and denied in part. The Claimant's answer to the claim respectfully shows:

I. ☐ **Stop payment of compensation.**
It is ☐ admitted ☐ denied the Claimant has reached maximum medical improvement and continues to receive temporary compensation payments.
It is ☐ admitted ☐ denied the Claimant's temporary total payments are current.
It is ☐ admitted ☐ denied the Claimant's temporary total payments have been properly stopped as of _____ (m/d/yyyy) pursuant to Reg. 67-505.

II. ☐ **Address suspension, termination, or reduction of temporary disability payments for any cause.**
☐ a. At any time pursuant to § 42-9-260(E).
☐ b. After the one-hundred-fifty day period has expired pursuant to § 42-9-260(F), R.67-505 and R.67-506.
☐ c. Temporary total compensation was suspended, terminated, or reduced without proper order of the Commission.
☐ d. Additional compensation and penalties are requested pursuant to Reg. 67-510.
The basis for additional compensation and penalty is _____

III. ☐ **Determine if compensation is due** pursuant to § 42-9-10, § 42-9-20 or § 42-9-30 and, if so, in what amount, based on the following grounds:

_____

Claimant reached maximum medical improvement on _____ (m/d/yyyy) (copy of medical report must be attached).
It is admitted/denied the Claimant has reached maximum medical improvement.
Claimant ☐ has ☐ has not returned to work. Claimant ☐ has ☐ has not returned to light duty.
☐ a. Permanency is premature at this time.
☐ b. Claimant is in need of additional medical care and treatment
☐ c. Claimant is entitled to permanent partial disability pursuant to 42-9-30.
☐ d. Claimant is entitled to wage loss pursuant to 42-9-20.
☐ e. Claimant is entitled to total and permanent disability pursuant to 42-9-10 or 42-9-30(21) and Reg. 67-1802.

IV. ☐ **Request Credit for Overpayment of temporary compensation pursuant to § 42-9-210.**
It is ☐ admitted ☐ denied that the Employer/Carrier is due a credit for overpayment.

V. ☐ **Determine amount of compensation for claims involving a fatality.**
☐ a. Payment of unpaid balance of compensation when employee dies pursuant to § 42-9-280.
☐ b. Amount of compensation for death of employee due to accident pursuant to § 42-9-290.

VI. ☐ **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.

Failure to respond pursuant to Reg. 67-208 B in writing or by submission of a Form 22 may result in ordered mediation pursuant to Reg. 67-1801 B. Questions regarding mediation may be submitted to **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.

_____ _____ _____ _____
Preparer's Signature Title Email Date

Questions about the use of this form should be directed to the Judicial Department at 803-737-5675, or **judicial@wcc.sc.gov** or **mediation@wcc.sc.gov**
Refer to Regulations 67-211, 67-504, 67-505, 67-506, 67-510; and 67-1801.