

**South Carolina Workers' Compensation Commission**

1333 Main Street, Suite 500 • Post Office Box 1715

Columbia, South Carolina 29202-1715

(803) 737-5739

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: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

Preparer's Name: \_\_\_\_\_ Law Firm: \_\_\_\_\_ Preparer's Phone #: \_\_\_\_\_

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

**Complete each information blank. Specify clearly when contentions are admitted in part and denied in part. The employer/carrier in answer to the claim, respectfully shows:**

1. It is  Admitted/  Denied the employee sustained an injury or illness on or about the date set forth in the Form 50. The reasons for denial are: \_\_\_\_\_
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. The reasons for denial are: \_\_\_\_\_
5. It is  Admitted/ Denied notice of injury was given the employer. The reasons for denial are: \_\_\_\_\_
6. It is  Admitted/ Denied the employee  Needs/ Is Entitled to Additional medical care as a result of injury or illness. The reasons for denial are: \_\_\_\_\_
7. It is  Admitted/ Denied the employee is entitled to temporary total disability for the period(s) of : \_\_\_\_\_
8. It is  Admitted/ Denied the employee is permanently disabled. The reasons for denial are: \_\_\_\_\_
9. It is  Admitted/ Denied the employee has serious disfigurement.
10. It is contended that an average weekly wage of \$ \_\_\_\_\_ applies, according to attached Form 20 as provided by law.
11. Further contentions, grounds of defense, or unusual aspects are: \_\_\_\_\_
12. Estimated time needed for hearing: \_\_\_\_\_

I certify I have served this document pursuant to R.67-212 by delivering a copy to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

on the \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ by  first class mail  personal service  certified mail.

**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. Questions about the use of this form may be directed to the Commission's Judicial Department. 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.