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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **South Carolina Workers’ Compensation Commission**  1333 Main Street, Suite 500  P.O. BOX 1715  Columbia, SC 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: | (     )     - | | | | | | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Employer's Name: | | |  | | | | | |  | | |  | | | | | | Address: | |  | | | | | | |  |  | | |  |  |  |  | | City: |  | | | State: |  | Zip: |  |  |  |  | | --- | --- | | Insurance Carrier: |  | | | | |
| Preparer’s Name: |  | Law Firm: | |  | | Preparer’s Phone #: | | (     )     - |
|  |  |  | |  | |  | |  |

The South Carolina Second Injury, in answer to the claim, respectfully shows:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | It is  acknowledged  denied the employee sustained a compensable accident; | | | | |  |
|  |  | | | | | |
|  | It is  acknowledged  denied the notice was given to the Second Injury Fund; | | | |  | |
|  |  | | | | | |
|  | It is  acknowledged  denied the disability claim has been concluded. | | | | | |
|  | It is  acknowledged  denied the impairment is: | | |  | | |
|  | a. It is  admitted  denied the impairment pre-existed. | | | | | |
|  | b. It is  admitted  denied the impairment was permanent. | | | | | |
|  | c. It is  admitted  denied the impairment is physical. | | | | | |
|  | It is  admitted  denied the impairment combined with or was aggravated by the subsequent injury. | | | | | |
|  | It is  admitted  denied the combination/aggravation substantially increased the carrier’s liability for | | | | | |
|  | disability  medical or  both: | |  | | | |
|  |  | | | | | |
|  | It is  admitted  denied the impairment was a hindrance or obstacle to employment or re-employment. | | | | | |
|  | a. It is  admitted  denied the employer had knowledge of the impairment. | | | | | |
|  | b. It is  admitted  denied the impairment was unknown to the employee and employer. | | | | | |
|  | c. It is  admitted  denied the employee concealed the impairment. | | | | | |
|  | It is  admitted  denied the subsequent injury would not have occurred “but for” the prior impairment. | | | | | |
|  | It is  admitted  denied the claim qualifies for reimbursement under S.C. Code Section 42-9-410; | | | | | |
|  |  | | | | | |
|  | The Carrier’s claim is barred by the Statute of Limitations pursuant to S.C. Code Section 42-15-40; | | | | | |
|  |  | | | | | |
|  | Other grounds for denial: |  | | | | |
|  |  | | | | | |

**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)**.**

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Preparer’s Signature Title Email Date

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature on behalf of the Second Injury Fund |  | Date (m/d/yyyy) |