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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 #: |  |
|  |  |  | |  | | |  |  |

**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**](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.**

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

Preparer’s Signature Title Email Date