COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
Division of Workers' Compensation
633 17th Street, Suite 400, Claims Section
Denver, CO 80202-3626

Clear Entire Form

PETITION TO MODIFY, TERMINATE, OR SUSPEND COMPENSATION

(Insurance representative must complete all fields below)

Claimant	Workers' Compensation Number
Employer	Social Security Number
Insurer	Carrier Number

The insurance carrier or self-insured employer declares that the claimant is presently receiving compensation for _____ disability at the rate of $ _____ per week. Compensation is presently paid to _____ in the amount totaling $ _____ .
(date)

The petitioner requests permission to ☐ modify ☐ terminate, or ☐ suspend compensation for the period from _____ to _____ .
(date) (date)

The facts upon which the petitioner relies are as follows:

The rule and statute upon which the petitioner relies: _____

NOTICE TO CLAIMANT: Rule 6-4(C) of the Workers' Compensation Rules of Procedure provides that if written objection to the petition is not filed with the Division of Workers' Compensation within 20 days from the date of mailing of the petition, the Director of the Division of Workers' Compensation may grant the insurance carrier or self-insured employer permission to modify, terminate, or suspend compensation <u>as of the date of petition</u>. In the event that a written objection is filed, this matter will be heard within 40 days of the date of the mailing or delivery of an Application for Expedited Hearing.

_____
Insurance Carrier or Self Insured

_____
Address

By _____

Certificate of Mailing (must be completed)

Copies of this Petition and Objection to Petition were mailed this _____ day of _____ , _____ to all of the following parties:

☐ Division of Workers' Compensation, 633 17th Street, Suite 400, Claims Section, CO 80202-3626
☐ Claimant: _____
(name) (address)
☐ Claimant's Attorney: _____
(name) (address)

By _____

Block #	Adj. Code

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COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
Division of Workers' Compensation
633 17th Street, Suite 400, Claims Section
Denver, CO 80202-3626

OBJECTION TO PETITION TO MODIFY, TERMINATE, OR SUSPEND COMPENSATION

(Insurance representative must complete top half of this page)

Claimant	Workers' Compensation Number
Employer	Social Security Number
Insurer	Carrier Number

Enclosed is a copy of the Petition to Modify, Terminate, or Suspend Compensation filed by the insurance carrier or self-insured employer in your workers' compensation case.

IN THE EVENT THAT YOU WISH TO OBJECT TO THIS PETITION, YOU MUST FILE A WRITTEN OBJECTION WITH THE DIVISION OF WORKERS' COMPENSATION, 633 17TH ST., SUITE 400, CLAIMS SECTION, DENVER, CO 80202-3626, WITHIN 20 DAYS FROM THE DATE THE PETITION WAS MAILED. **YOUR OBJECTION MUST BE FILED ON THIS FORM**. A copy must be sent to the insurance carrier or the self-insured employer at the address shown on the petition.

In the event that you do not file a written objection to the petition within the required 20 days, the Director of the Division of Workers' Compensation will grant the insurance carrier or self-insured employer permission to modify, terminate or suspend compensation as of the date of the petition.

In the event that you do object to the petition, a hearing will be held on the petition within 40 days of the date of mailing or delivery of an Application for Expedited Hearing. The only matter which will be considered at this hearing will be the request to modify, terminate, or suspend compensation.

CLAIMANT'S OBJECTION TO PETITION

(Claimant or claimant representative must complete all fields below)

☐ I object to the Petition to Modify, Terminate or Suspend Compensation filed by the insurance carrier or self-insured employer. The reasons for my objections are:

Signature

Address

Certificate of Mailing (must be completed)

Copies of this Objection to Petition were mailed this _____ day of _____ , _____ to all of the following parties:

☐ Division of Workers' Compensation, 633 17th Street, Suite 400, Denver, CO 80202-3626

☐ Insurance Carrier or
Self-Insured Employer: _____
(name) (address)

By _____

If you have any questions concerning this form, please contact the Claims Management Section at (303) 318-8600.

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