MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

ANSWER TO CLAIM FOR COMPENSATION INSTRUCTIONS

P.O. Box 58
Jefferson City, MO 65102-0058
labor.mo.gov/DWC

This Answer form is to be used for injuries occurring on or after January 1, 2014.

1) Amended Answer to Claim: If the Answer is being amended, the box number amended must be indicated in the box "BOX NUMBER(S) AMENDED" in order for the Division to process the amendments to the Answer.

2) If the employer is a corporation or limited liability company, it must file the Answer by and through an attorney who is admitted to the practice of law in the state of Missouri. If applicable, refer to Missouri Supreme Court Rules, Rule 9, that governs the practice of law by non-resident attorneys. Insurance companies are usually corporations and must file an Answer by and through an attorney who is admitted to the practice of law in the state of Missouri.

3) File a separate Answer on behalf of each employer against whom the original/amended Claim for Compensation has been filed. Provide complete information in Boxes 2, 3, and 4 regarding the employer, insurer, and/or third-party administrator on whose behalf the Answer is being filed.

4) If the Answer is filed on behalf of an employer who has purchased a large deductible policy pursuant to §287.310, RSMo, you MUST provide the name and address of the insurance carrier in order for the Division to accept and process the Answer. **The self-insured employer or group/trust must have been granted self-insurance authority by the Missouri Division of Workers' Compensation.**

5) If you do not know the name and address of the insurance carrier and you believe that the insurance carrier information will not be available within thirty (30) days for the Answer to be timely filed pursuant to 8 CSR 50-2.010(8), include on your letterhead a statement that the insurance carrier information will be provided to the Division as soon as it becomes available. You may indicate on your letterhead that you would like the Division to enter your appearance on behalf of the employer in order for you to receive the notices on the docket settings.

6) It is the employer's responsibility to ensure that the workers' compensation insurance carrier is authorized to insure such liability in the state of Missouri by the Missouri Department of Commerce and Insurance, Financial Institutions and Professional Registration. *See* §287.280, RSMo. Similarly, the third-party administrator must have a valid certificate of authority issued by the Missouri Department of Commerce and Insurance, *see* §376.1092, RSMo, or otherwise fall within the provisions of §376.1075 (1), RSMo.

NOTE 1: If the First Report of Injury has been filed with the Division, the insurance carrier name that appears on the First Report of Injury will be entered by the Division as the carrier that issued the workers' compensation insurance policy for the time period that covers the date of injury. If your Answer indicates a different insurance carrier from the insurance carrier appearing on the First Report of Injury, the Division will add the insurance carrier that appears on the Answer as a party to the underlying case.

NOTE 2: If the First Report of Injury is not filed with the Division and the proof of coverage filed with the Division indicates the name and address of the insurance carrier that issued the workers' compensation insurance policy for the time period that covers the date of injury, the Division will add this insurance carrier as a party to the case. If your Answer indicates a different insurance carrier from the insurance carrier appearing on the proof of coverage, the Division will add the insurance carrier that appears on the Answer as a party to the underlying case.

If you have any questions, contact the Division's CARE Unit at 573-526-4948 or you may call the Division toll free at 800-775-2667.

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
P.O. Box 58
Jefferson City, MO 65102-0058

ANSWER TO CLAIM FOR COMPENSATION

INJURY NUMBER

+ ☐☐ - ☐☐☐☐☐☐☐

☐ Original ☐ Amended

Box Number(s) Amended

NOTE: Pursuant to 8 CSR 50-2.010 (8) (A), the Answer must be filed within thirty (30) days from the date the Division acknowledges receipt of the claim. Submit one original for the Division, one copy for the claimant, and one copy for claimant's attorney.

Read instructions before completing this form.

1. Injured Employee/Claimant's Name			1.A. Social Security No. XXX-XX- _____
1.B. Mailing Address	1.C. City	1.D. State	1.E. ZIP Code
2. Name of Employer or Self-Insured Employer			
2.A. Mailing Address	2.B. City	2.C. State	2.D. ZIP Code
3. Name of Insurance Carrier or Self-Insured Group/Trust			
3.A. Mailing Address	3.B. City	3.C. State	3.D. ZIP Code
4. Name of Claims Administrator or Third-Party Administrator			
4.A. Mailing Address	4.B. City	4.C. State	4.D. ZIP Code

5. Phone Number of the Insurance Carrier	Phone Number of Claims Administrator or Third Party Administrator
6. Date of accident/occupational disease.	7. Has the employer/insurer obtained a rating of permanent disability? ☐ Yes ☐ No

8. Name all authorized providers of medical aid:

_____

9. All of the statements or allegations in the claim for compensation are admitted except the following:
Describe below each statement or allegation in the claim for compensation that is being disputed, the reason why it is being disputed, and the facts in regard thereto. List all affirmative defenses.

If needed, attach sheet with additional information or additional statements.

DIVISION USE ONLY

DATE STAMP

INJURY NUMBER

		-						

Claim For Compensation alleges occupational disease due to toxic exposure that includes the following: asbestosis, berylliosis, coal worker's pneumoconiosis, bronchiolitis obliterans, silicosis, silicotuberculosis, manganism, acute myelogenous leukemia, and myelodysplastic syndrome.

COMPLETE THE FOLLOWING BOXES IF THE INSURANCE CARRIER OR SELF-INSURED GROUP TRUST IS DIFFERENT THAN THAT INDICATED IN BOXES 3 THROUGH 5 ABOVE.

10. Name of Insurance Carrier or Self-Insured Group/Trust			
10.A. Mailing Address	10.B. City	10.C. State	10.D. ZIP Code
11. Name of Claims Administrator or Third-Party Administrator			
11.A. Mailing Address	11.B. City	11.C. State	11.D. ZIP Code

12. Phone Number of the Insurance Carrier	Phone Number of Claims Administrator or Third Party Administrator

13. If the Claim for Compensation alleges an Occupational Disease due to **toxic exposure resulting in a diagnosis of mesothelioma**, check one of the following boxes that describes how the EMPLOYER has INSURED his/her LIABILITY:

- ☐ AN INSURANCE CARRIER
- ☐ GROUP INSURANCE POOL UNDER §287.223
- ☐ SELF-INSURANCE APPROVED BY THE DIVISION OF WORKERS' COMPENSATION
- ☐ REJECTED MESOTHELIOMA LIABILITY

COMPLETE THE FOLLOWING BOXES IF THE INSURANCE CARRIER OR SELF-INSURED GROUP TRUST IS DIFFERENT THAN THAT INDICATED IN BOXES 3 THROUGH 5 ABOVE.

14. Name of Insurance Carrier or Self-Insured Group/Trust or MO RISK MESOLTHELIOMA RISK MANAGEMENT FUND			
14.A. Mailing Address	14.B. City	14.C. State	14.D. ZIP Code
15. Name of Claims Administrator or Third-Party Administrator			
15.A. Mailing Address	15.B. City	15.C. State	15.D. ZIP Code

16. Phone Number of the Insurance Carrier	Phone Number of Claims Administrator or Third Party Administrator

17. Employer's Signature	Date	18. Insurer's Signature	Date
19. Attorney Signature	19.A. Attorney Name *(Type or Print)*		19.B. Bar Number

20. Attorney Phone Number	20.A. Attorney Fax Number	20.B. Attorney Email Address

21. Attorney Mailing Address	21.A. City	21.B. State	21.C. ZIP Code