MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
3315 West Truman Blvd., P.O. Box 58
Jefferson City, MO 65102-0058

ANSWER TO CLAIM FOR COMPENSATION

INJURY NUMBER

+ ☐☐ - ☐☐☐☐☐☐☐

☐ Original ☐ Amended

Item Number(s) Amended

NOTE: Pursuant to 8 CSR 50-2.010 (8), 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.
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. Telephone Number of the Insurance Carrier	Telephone 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.

DIVISION USE ONLY

DATE STAMP

INJURY NUMBER

		-							

10. Employer's Signature	Date	11. Insurer's Signature	Date

12. Attorney Signature	12.A. Attorney Name *(Type or Print)*	12.B. Bar Number

13. Attorney Phone Number	13.A. Attorney Fax Number	13.B. Attorney E-Mail Address *(Optional)*

14. Attorney Mailing Address	14.A. City	14.B. State	14.C. ZIP Code

Missouri Division of Workers' Compensation

Answer To Claim For Compensation
Instructions

1) Amended Answer to Claim: If the Answer is being amended, the item number amended must be indicated in the box "ITEM 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, please 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 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 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 Programs & Support Section at 573-526-4948 or you may call the Division toll free at 800-775-2667.

Missouri Division of Workers' Compensation is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. TDD/TTY: 800-735-2966 Relay Missouri: 711