State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

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43

WCC File #

Date filed in District

(for WCC use only)

Notice to Compensation Commissioner and Employee of Intention to Contest Employee's Right to Compensation Benefits

EMPLOYEE

Name _____

D.O.B. *(required)* _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

ATTORNEY OR REPRESENTATIVE OF EMPLOYEE

Name _____

Name of Firm _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

EMPLOYER

Name _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

INSURER

Claim Number _____

Name _____

Address _____

City/Town _____ State _____

Zip Code _____

Contact Person _____

Tel.# _____

INJURY

Date of Injury _____

Date of Death _____

City/Town of Injury _____

State _____ Zip Code _____

Body Part(s) _____

Nature of Injury _____

☐ Check, if an Occupational Disease or a Repetitive Trauma

REASON(S) FOR CONTEST — SIGNATURE

You are hereby notified that the employer/insurer will contest liability to pay compensation benefits to the employee named on this form for the following reason(s) — SPECIFIC EXPLANATION REQUIRED:

Signature _____

Date _____

Name *(type or print)* _____

Title _____

This notice must be served upon the Commissioner and Employee *(or representative, if applicable)* by personal presentation or by registered or certified mail. When medical care is the issue for contest, send a copy of this form to the medical provider also. For the protection of both parties, the claimant should note the date when this notice was received and the employer/insurer should keep a copy of this notice with the date it was served.