

**CC-FORM-2A****OKLAHOMA WORKERS' COMPENSATION COMMISSION**

FOR COMMISSION USE ONLY

Send original to:

Workers' Compensation Commission  
and 1 copy to Employee or  
Beneficiaries1915 NORTH STILES AVENUE  
OKLAHOMA CITY, OKLAHOMA 73105  
(405) 522-8600 or In-State Toll Free (800) 522-8210**EMPLOYER'S INTENT TO ACCEPT OR CONTROVERT CLAIM** **Initial Filing**       **Amended Filing**

Commission File No. if any	Carrier Claim No.	Full Employee Name (Last, First, MI)	Employee Social Security No. (Last 4 digits only)	
			XXX-XX-_____	
Employer Name			Federal Employer ID No.	
Address			City	State      Zip Code
Carrier or Self-Insured Name		Claims Office Name, Address, and Phone		

Is this a medical only claim?

 Yes     No

Is this a PPD-Only Claim?

 Yes     No

COMPENSATION (if not applicable, skip to next section)

Date of First Comp. Check	Dates Covered by First Check	Body Part Injured	First Day of Disability
Average Weekly Wage	Weekly TTD Comp. Rate	Was Disability Continuous During the First 4 Days? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Indemnity Triggered

**STATEMENT OF POSITION**Date of injury or death: \_\_\_\_\_ City, State of Injury: \_\_\_\_\_ Parts of the body injured or affected \_\_\_\_\_  
Nature of the Injury or Illness \_\_\_\_\_State your position. If controverting, state the grounds therefor (attach additional pages if needed): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_**DEATH CASE DATA**

List all Dependents below: (If more space is needed, attach supplemental sheet)

If no Dependents, check here: 

Attach Death Certificate of Deceased Employee and Birth Certificates for Dependent Children

Name of Dependent	Date of Birth	Relationship to Deceased	Weekly Benefit Amount

**CERTIFICATION**

I certify under PENALTY OF PERJURY that the foregoing is a complete and accurate report according to the records of the insurer pertaining to first payment, controversion and beneficiary information. I further certify that a copy of this report has been provided to the employee or beneficiaries.

Signature	Printed or Typewritten Name	Title: _____	Date
		Phone: _____	
If the employer/insurer is represented by an attorney, that legal representative must sign below pursuant to 85A O.S., § 83.			
Name and Address of Attorney, including OBA #		Signature	
OBA #			

## CC-Form-2A

### (Employer's Intent to Accept or Controvert Claim)

A form used to accept a case and report payment or to controvert. The CC-Form-2A also is used to amend positions taken earlier.

#### Help With CC-Form-2A:

1. The first payment of compensation is due by the 15th day after the employer has notice of the injury or death. (See Workers' Compensation Commission Rule 810:10-1-5)
2. The Commission is notified "upon making the first payment." (85A O.S., §92)
3. A controversion notice is due on or before the 15th day after notice of the death or alleged injury. (85A O.S., §86)
4. Therefore, the CC-Form-2A is required in all cases by the 15th day from: (a) the day of disability, or (b) the day the employer is aware of the alleged incident, whichever date is later.

#### The following are required fields on the CC-Form-2A:

5. A mark in either the Initial Filing Box or Amended Filing Box.
6. The Commission File Number, if any; your company's file number for this case; the employee's full name; the employee's Social Security Number (last 4 digits only); the employer's name; the carrier or self-insured's name; date of injury or death; city, state of injury; parts of body injured or affected; nature of injury or illness; and statement of position (e.g. that you are "paying all medical and TTD benefits due", that you have "accepted the claim as compensable and are paying all appropriate benefits"; that you are "controverting the claim because [state your reason(s)]", etc.)

#### Be sure to bear in mind:

7. If respondents need additional time for investigation, an extension request must be sent to the Commission before the CC-Form-2A deadline. Using the CC-Form-2A to report that the respondent needs more time is invalid.
8. If a claim file is opened at the Commission based on the filing of a claim for compensation (CC-Form-3, CC-Form-3A, CC-Form-3B), a CC-Form-2A is required, even if the case upon investigation is determined to be a medical only claim.

**Questions about the CC-Form-2A, or general information or assistance on completing or filing a CC-Form-2A, may be directed to the Workers' Compensation Commission Counselor Division, (405) 522-8760 or In-State Toll Free (800) 522-8210.**

**Administrative Workers' Compensation Act, 85A O.S., §6(A)(1)(a):** "Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for the purpose of: (1) obtaining any benefit or payment ... shall be guilty of a felony."

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.