CC-FORM-2A	OKLAHOMA WORKERS' COMPENSATION COMMISSION	FOR COMMISSION USE ONLY
Send original to: Workers' Compensation Commission and 1 copy to Employee or Beneficiaries, or to the attorney therefor, if any is known	1915 NORTH STILES AVENUE OKLAHOMA CITY, OKLAHOMA 73105 (405) 522-5308 or In-State Toll Free (855) 291-3612	

EMPLOYER'S INTENT TO 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?** ☐ Yes ☐ 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., or to the attorney therefor, if any is known.

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 Controvert 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) 522-5308 or In-State Toll Free (855) 291-3612.

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.