

# 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 STE 231  
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? <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., 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.