

Mississippi Workers' Compensation Commission

ANSWER

PRINT OR TYPE

MWCC#

*If Employer or Carrier Utilizes a Third Party Administrator, Provide Name and Address

GENERAL

CLAIMANT

VS

EMPLOYER

INSURANCE CARRIER

NAME

ADDRESS

CITY, STATE, ZIP

EMPLOYER AND/OR CARRIER RESPONSE

The Employer and/or Carrier above named, for answer to the Petition to Controvert herein, respectfully states:

1. It is *admitted* ___ *denied* ___ that claimant sustained an injury or occupational disease on or about the date set forth in the Petition to Controvert.
2. It is *admitted* ___ *denied* ___ that the relationship of employer and employee existed at the time of the alleged injury or occupational disease.
3. It is *admitted* ___ *denied* ___ that the parties were subject to the Mississippi Workers' Compensation Act at the time of alleged injury or occupational disease. If denied, state reason: _____
4. It is *admitted* ___ *denied* ___ that at the time of the alleged injury or occupational disease the employee was performing service growing out of and in the course of employment.
5. It is *admitted* ___ *denied* ___ that the accident causing the disability for which compensation is claimed arose out of the alleged employment.
6. It is *admitted* ___ *denied* ___ that notice of injury or occupational disease complained of in the Petition to Controvert was received.
7. It is *admitted* ___ *denied* ___ that the employer was insured under the Mississippi Workers' Compensation Act at the time of alleged injury or occupational disease, or was a Self-Insurer under the Mississippi Workers' Compensation Act.
8. It is *admitted* ___ *denied* ___ that the average weekly wage as set forth in the Petition to Controvert is correct. If denied then state the average weekly wage, attach hereto a wage statement or state reason not furnished: _____
9. It is *admitted* ___ *denied* ___ that claimant was temporarily disabled for the period stated in the Petition to Controvert. If denied, state temporary disability admitted: _____
10. It is *admitted* ___ *denied* ___ the claimant is permanently disabled to the extent and for the period stated in the Petition to Controvert. If denied, state permanent disability admitted: _____
11. It is *admitted* ___ *denied* ___ that claimant sustained the loss of wage earning capacity stated in the Petition to Controvert. If denied, state loss of wage earning capacity admitted: _____
12. YES ___ NO ___ All medical reports that have come into (my) (our) possession have been filed or are being filed herewith. If no, list reports not filed and state reason for not filing. _____
13. Affirmative defenses, special pleadings or matters in dispute (use additional sheet if necessary) _____
14. Has any compensation been paid to date? YES ___ NO ___ If yes, state amount and give inclusive dates: _____

DATE

This the _____ day of _____, _____.

Name

Title

Phone