ROLLING OWNER CONTROLLED INSURANCE PROGRAM (ROCIP)

ROCIP5 Claims Manual

Program Term: September 1, 2025 – September 1, 2032
Version 1.0
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Accessibility Notice for ROCIP Documents

Some technical documents available on this site are provided in their original formats. Due to the highly technical and visual nature of these materials, certain documents may not be fully compatible with assistive technologies.

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Contents

The below table of contents is linked to each respective section of the manual for ease of navigation.

1. KEY CLAIM CONTACTS and GENERAL PROCEDURES

1.1 Key Claim Contacts

Claims Management is handled by the ROCIP Administrator, Marsh USA, Inc. (Marsh). Below are the key claims personnel that manage the DEN ROCIP claims.

Workers' Compensation	Dan Chilton, Claim Advisor 303.589.7063 dan.chilton@marsh.com
General Liability	Dan Killebrew, Claim Advisor 303.308.4668 daniel.killebrew@marsh.com
Builders' Risk	Jennifer Knoblauch, Claim Advisor 303.308.4513 Jennifer.knoblauch@marsh.com
All Claims	Jon Arcila, Claims Administrator 720.745.0996 jonathan.arcila@flydenver.com

1.2 Incident and Accident Reporting Overview

Even with a robust safety program in place accidents can occur on a project site due to human factors, equipment failures, acts of nature, etc. To be as prepared as possible to handle these events promptly and keep the safety of all workers as our top priority, we have developed detailed claim reporting procedures to assist you if something does go wrong on your site with your workers.

Remember:

- All incidents and accidents resulting in employee injury, property damage or involving the public must be reported immediately to the General Contractor.
- General Contractor must report all incidents and accidents to DEN Construction Safety and DEN Project Management within 24 hours.
- Never discuss any incident, accident or claim with anyone except employees from DEN, Marsh, the ROCIP Insurer(s), appointed legal counsel, or law enforcement agencies.
- Do not make statements to media. All media inquiries should be directed to DEN.
- Do not voluntarily admit liability or responsibility.
- Cooperate with DEN, Marsh, and Insurers in any investigation or requests for information.

EVENTS INVOLVING BODILY INJURY TO NON-EMPLOYEES, FATALITY OR EXTENSIVE PROPERTY DAMAGE MUST BE IMMEDIATELY REPORTED TO:

- **DEN COMM CENTER 303.342.4211**
- **DEN RISK 720.902.1307**
- **MARSH 303.308.4668**

1.2.1 Risk Management Information System (RMIS)

DEN utilizes its RMIS to intake both investigation and loss reports (excluding Workers' Compensation), and no longer uses standalone forms to streamline both the process and the information capture, dissemination, and analysis.

To access the DEN RMIS to complete a loss report to submit a claim online, contact DEN Construction Safety or DEN Risk Management for login Information. The table of data fields (see Section 7.5) is provided in this manual for information gathering only to assist with ease of completing online reports; emailed copies of the table will not be accepted. For any technical issues, please contact Jon Arcila, DEN Claims Administrator at jonathan.arcila@flydenver.com or 720.745.0996.

DEN also utilizes its RMIS to receive incident and investigation reports under the DEN ROCIP Safety Manual requirements; be advised that the data field table includes all categories not only those pertaining to claim submittals.

1.3 Investigation Assistance

All parties will assist in the investigation of any incident, accident or occurrence involving injury to persons or property. All Contractors will cooperate with DEN, the Insurers and their representatives involved in adjusting any claim by securing and giving evidence and obtaining the participation and attendance of witnesses required for the investigation and defense of any claim or suit.

INVESTIGATION ASSISTANCE AND COOPERATION IS REQUIRED FROM ALL CONTRACTORS
This includes accidents and losses that are not covered under ROCIP such as automobile accidents

If equipment is involved, DEN reserves the right to quarantine that equipment until an investigation is completed including inspection by experts, if necessary. The designated quarantine location shall be at the sole discretion of DEN.

1.4 Joint Representation

In the event legal representation is required to defend parties insured under the DEN ROCIP, absent an actual conflict of interest between two or more insureds, the Insurer shall have the right to retain one counsel to represent all such insureds in any action or proceeding in which more than one insured is joined.

1.5 Claim Settlements

Claims, excluding Workers' Compensation and Excess Liability claims, will be managed by Marsh and the Insurer in collaboration with the General Contractor, DEN Risk Management, and DEN Project Management. Any final claim settlement amount will require a signed Proof of Loss Sworn Statement and Release from the General Contractor on behalf of itself and any involved subcontractor. The claim payment will be issued from DEN to the General Contractor less any applied Claim Charge Back. The General Contractor is responsible for any claim payment to involved subcontractors.

1.6 Claim Charge Backs

A claim charge-back will be assessed, regardless of fault, for any loss payable under this program except for Workers' Compensation and Excess Liability, up to a maximum of $25,000 per loss. The claim charge-back will be deducted by DEN from the final settlement amount to be distributed to the General Contractor. General Contractor may elect to pass no more than $5,000 of this charge, per loss, through to any involved subcontractor.

1.7 Where to Find this Claims Manual

You should have received this Claims Manual, as well as the ROCIP Insurance Manual and ROCIP Safety Manual during the bid process, again as part of your contractual agreement either with DEN or a General Contractor and a third time upon successful completion of Project enrollment.

Additionally, you will be able to access the most current version of the Claims Manual 24/7 via the Contractor Online Portal under the Documents Section for each Contract/Project you are enrolled in.

2. WORKERS' COMPENSATION CLAIMS

2.1 DEN Responsibilities

2.1.1 Emergency Medical Response

DEN will arrange for on-site 911 emergency ambulance services for response to any serious, traumatic, or life-threatening injuries.

2.1.2 Designated Medical Providers

DEN, through its Insurer, will arrange designated medical providers for treatment of all minor and non-life-threatening injuries. A list of approved providers is detailed on the Workers' Compensation Medical Care Requisition and Authorization Form.

See Section 7.1 for the Workers' Compensation Medical Care Requisition and Authorization Form

2.2 Contractor Responsibilities

2.2.1 Colorado Workers' Compensation Notice of Injury Poster

The General Contractor is responsible for ensuring the Colorado Workers' Compensation Notice of Injury Poster (WC50) is displayed at each project site. Insurance carrier information to include on the poster for DEN ROCIP5 is:

Zurich American Insurance Company
800-987-3373

2.2.2 Immediate Medical Care

The main responsibility is first to see that any injured worker receives medical care.

2.2.3 Designated Medical Providers

a. Contractor shall provide injured workers with the Workers' Compensation Medical Care Requisition and Authorization Form (See Section 7.1). This document includes a list of the approved medical providers and requires the injured worker to indicate their choice, sign, date and return the completed form to their employer.

b. *If the injured worker is away from their usual place of employment* at the time of the injury, the injured worker may be referred to a physician in the vicinity where the injury occurred to provide necessary care. Within seven (7) business days following the date the Contractor received notice of the injury the Contractor shall comply with the provisions of the above Section 2.2.3.a.

c. *In emergency situations*, injured workers shall be taken to any physician or medical facility that is able to provide the necessary care. When emergency care is no longer required the Contractor shall comply with the provisions of the above Section 2.2.3.a.

d. The injured worker or employer must complete the Workers' Compensation Medical Care Requisition and Authorization Form (See Section 7.1) upon arrival at designated medical provider location.

2.2.4 Role of Contractor Safety Representative

Enrolled Contractors must designate a Contractor Safety Representative at the Project Site. This individual is responsible for:

- Taking injured employees to an approved medical provider or emergency room, if warranted
- Retain a copy of the employee's written notice of injury, as required by the State of Colorado
- Completion of the First Report of Injury form

   See Section 7.2 for Workers' Compensation First Report of Injury
- Reporting the claim to the Insurer and the General Contractor
- Completion of the Workers' Compensation Medical Care Requisition and Authorization Form to be provided to the approved medical provider if the injured worker needs medical treatment and/or drug screening following an incident

   See Section 7.1 for Workers' Compensation Medical Care Requisition and Authorization Form
- Remaining with the injured employee at the medical center while such employee is being treated
- Obtaining a written description of whether the injured employee can return to work, a list of restrictions (if any), and the estimated length of time such employee can stay on modified duty from the treating physician
- Recording the incident even if the worker declines to receive medical treatment

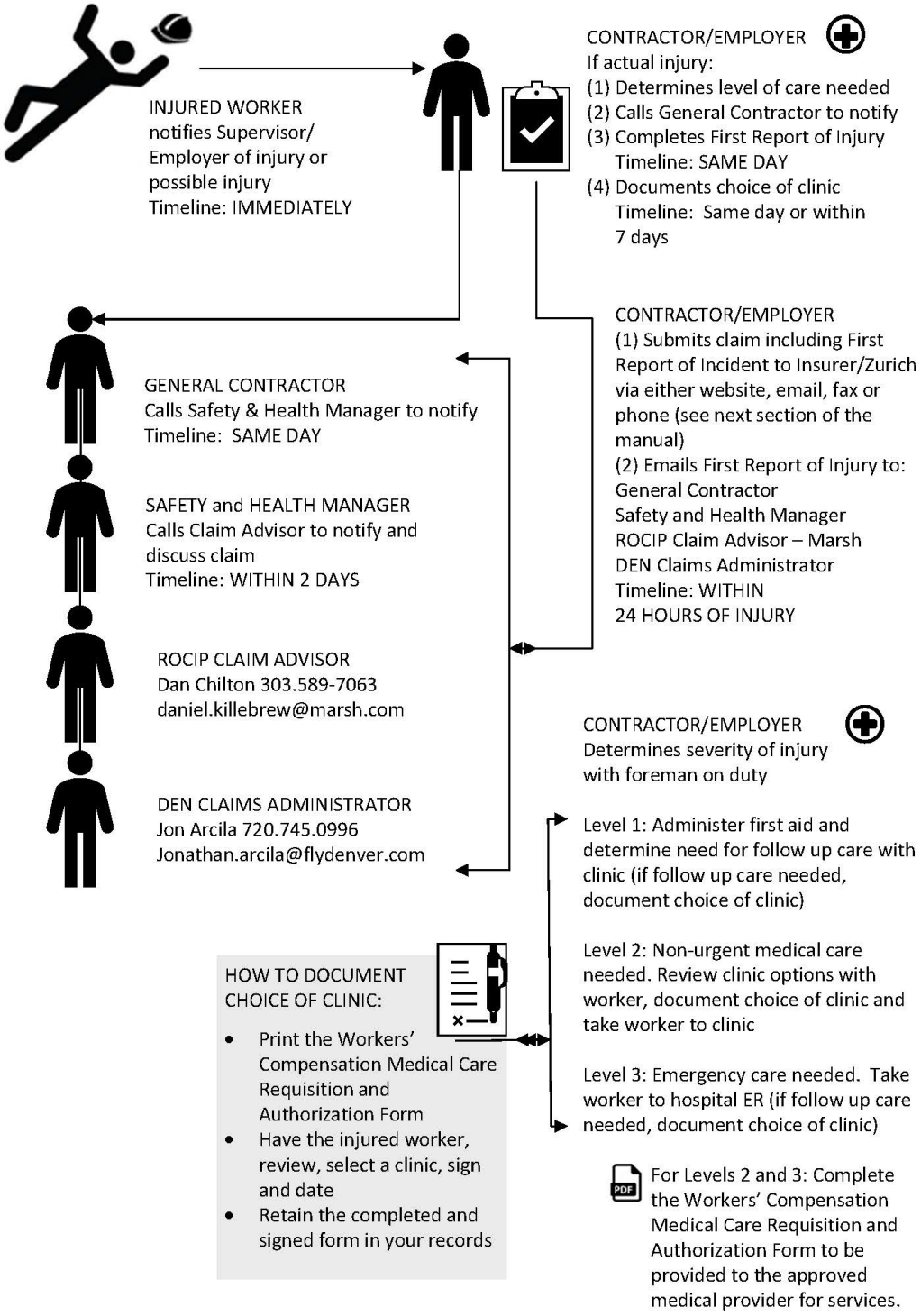
2.2.5 Role of General Contractor

Each General Contractor, and higher tier subcontractor, is expected to monitor the reporting of on-the-job injuries to ensure:

- Immediate medical care is offered and provided
- Medical care is provided by an approved facility
- Timely reporting of the claim to the Insurer
- Return to work options are thoroughly evaluated

2.3 Workers' Compensation Claims Process

Following is the general process to address an on-the-job injury or possible injury:



Provide the PROJECT NAME, PROJECT NUMBER, and your project-specific WORK COMP POLICY NUMBER on all claim documents

Additionally, please be mindful of the following:

- Do not comment on coverage for an injury, insurance will make the final determination.
- If a worker wishes to change their medical provider, they may do this one time. See Section 2.5 for more information.
- Report concerns regarding the claim, medical treatment or malingering to the Safety & Health Manager. The Safety & Health Manager will contact the ROCIP Claim Consultant to discuss concerns.

2.4 How to Report a Workers' Compensation Claim

Claims may be reported to the Insurer in several ways:

Website	Email	Fax	Phone
www.zurichna.com **PREFERRED METHOD**	USZ_CareCenter@Zurichna.com	877.962.2567	800.987.3373 **PREFERRED METHOD**

2.4.1 Website Reporting Instructions

1) Complete the First Report of Injury (Workers' Compensation First Report of Injury) to have the information captured and ready to enter.

   See Section 7.2 for Workers' Compensation First Report of Injury

2) Go to the above Zurich website.

3) Select "Claims" in the top menu.

4) Click "Report a New Claim" or "File a claim online".

5) Click "Workers Compensation" and provide detailed loss information to expedite the claim handling process. Supporting files, documentation and images can be attached at the bottom of the form. Once the claim has been submitted and assigned, a confirmation will be sent to the email provided.

24 HOURS
First Report of Injury must be submitted within 24 hours of the event

YOU WILL NEED
- **Employer Entity Name (Insured)**
- **Project Number**
- **Your Project-Specific Work Comp Policy Number**

You will receive a separate Work Comp Policy Number for EACH PROJECT. Be sure to use the correct one!

Examples of Incorrect Policy Numbers Used:
- **Policy Number from another DEN Project you are working on**
- **Policy Number for your company's regular Work Comp**

2.4.2 Email Reporting Instructions

1) Complete the First Report of Injury (Workers' Compensation Email and Telephone Reporting Worksheet).

See Section 7.2 for Workers' Compensation First Report of Injury

2) Email report to USZ_CareCenter@Zurichna.com noting the below restrictions:
   - Do not include photos, color graphics or shaded attachments
   - Do not include digitized logos, hyperlinks or other unstable formatting
   - Do not use the Colorado First Report of Injury form from the Colorado State website as it does not include fields for Location Code and Policy# that are needed for a ROCIP claim

2.4.3 Claim Documents including Medical Bills

Subsequent to submitting the First Report of Injury, submit all additional claim documents including medical bills in one of the following ways:

REMEMBER:
Always include your Claim No. with any submitted documents

By Email: usz.zurich.claims.documents@zurichna.com

By Mail or Fax: Zurich North America – Claims
PO Box 66941
Chicago, IL 60666
Fax: 847.240.8172

Inquires: Contact the assigned claims adjuster

2.4.4 Help

For questions or assistance reporting a claim please contact Marsh or Zurich's Customer Care Center.

To find an assigned claim number if misplaced, call the Zurich Medical Provider Helpline at 719.590.8719.

FOR ASSISTANCE

Dan Chilton, Marsh Claim Advisor
303.589.7063
dan.chilton@marsh.com

Zurich Customer Care
800.987.3373
Usz_CareCenter@Zurichna.com

2.5 One-Time Change of Medical Provider

Contractor/Employer will generally select medical providers under Workers' Compensation as approved by the Insurer, although injured workers do have the option to change their authorized treating physician a single time. This change must be requested within ninety (90) days following the date of injury, but before reaching maximum medical improvement (MMI). The new physician must still be on the approved list of providers.

To make this change, the injured worker must complete and sign the "Notice of One-Time Change of Physician & Authorization for Release of Medical Information" form required by the State of Colorado.

See Section 7.3 for Notice of One-Time Change of Physician & Authorization for Release of Medical Information form.

2.6 Return to Work Program

Each Contractor must have a Return-to-Work Program (also referred to as “transitional duty”, "light duty", or "modified duty") for any injured employee who is released by a medical doctor to return-to-work with restrictions, or for modified or alternative work. Restricted Duty shall be an assignment provided to an employee who, because of a job-related injury or illness, is physically or mentally unable to perform all or any part of his/her normal assignment during all or any part of the normal workday or shift for a minimum duration of 90 days. Each employer offering transitional duty to an injured worker shall comply with Rule 6 of the Colorado Workers’ Compensation Act.

- If an employee has questions about medical treatment for a job-related injury, they must contact their employer.
- Contractor employees are expected to return to work as soon as possible after a job-related injury or illness has occurred. All possible opportunities must be considered to return the employee to work.
- When an injured employee returns to work, all physical and mental limitations must be evaluated to avoid further injury.
- Safety of other employees working with the injured individual must be considered.
- The program safety manager, claims coordinator, and the insurance carrier will evaluate all injuries and illnesses on case-by-case basis.

2.6.1 Requirements and Limitations for an Injured Employee Returning to Work

- Employee’s treating physician has determined the physical restrictions.
- Contractor has modified duty that accommodates the restrictions.
- Contractor’s Project Managers, Supervisors, and Foreman are informed of the injured employee’s restrictions.
- No employee on modified duty will be allowed to work more than (40) forty-hours per week.
- The injured employee will remain on the project where the injury occurred while on transitional duty if at all possible. If not possible (project completed, contractor no longer on site, etc.) the injured employee’s Contractor is expected to accommodate Transitional Duty requirements for the employee on other jobs they currently have enrolled under the ROCIP.
- Injured employees must follow work restrictions issued by their treating physician while off duty.
- Employee must receive a full medical release from the treating physician before resuming normal work activities.
- Contractors shall discuss employee injury management protocol with the ROCIP Claims Advisor 303.589.7063 prior to any injured employee being laid-off or terminated from a Return-to-Work Program.

3. GENERAL LIABILITY CLAIMS

All incidents and accidents at a Project Site involving death, injury, or damage to property of non-employee personnel (the public, tenants, and visitors) must be reported immediately or as soon as the onsite personnel become aware of the event.

Take appropriate emergency measures to prevent additional injury or damage, including contacting police and fire authorities as required by law.

3.1 How to Report a General Liability Claim

IMMEDIATELY REPORT EVENTS INVOLVING BODILY INJURY, FATALITY, EXTENSIVE PROPERTY DAMAGE TO:

- **DEN 303.342.4211**
- **DEN Risk 720.902.1307**
- **Marsh 303.308.4668**

INVOLVING LAWSUITS

- **DEN Risk 720.902.1307**
- **Marsh 303.308.4668**

1) Contractor shall complete and submit a General Liability Loss Report via DEN's RMIS within 24 hours of the occurrence. See Section 7.5 for data that will be required and how to access the RMIS for online entry and submittal.

   The report will automatically be sent to the following parties once submitted:
   - ROCIP Marsh Claims Advisor
   - DEN Claims Administrator
   - DEN Construction Safety Manager
   - DEN Project Management Team assigned to specific project

2) An investigation will be completed as soon as possible by DEN Construction Safety with all Contractors involved in the event and in coordination with DEN Risk Management, DEN Legal, DEN Project Management and the Insurer.

3) Immediately send all subsequent inquires or correspondence about a loss or claim, including a summons or other legal documents to the General Contractor. General Contractor will be responsible for providing same to the ROCIP Claims Advisor and DEN Claims Administrator.

Contractors shall not voluntarily admit liability or responsibility and shall cooperate with DEN, Marsh, the Insurer and their respective representatives in an investigation.

3.2 Filing a Claim Against the City and County of Denver

For any party that advises a Contractor they wish to make a claim for any incident or accident involving the City and County of Denver, Contractor should provide that party with the below link to access the City Attorney's Office online portal to file a claim.

For questions of when this process versus the other claim reporting processes outlined in this guide should be followed, please contact the ROCIP Administrator or DEN Risk Management.

https://www.denvergov.org/content/denvergov/en/city-attorneys-office/file-a-claim.html

3.3 Claims Reported Directly to the City and County of Denver

In the event a claim is reported directly to the City and County of Denver, the following steps will be taken:

1) DEN Risk Management and DEN Legal will be notified by the City Attorney's Office of the received claim and will assess whether or not it is ROCIP-related.

2) If the claim is, or possibly is, ROCIP-related DEN Risk Management will forward the notice and information to the following parties within 48 hours of receipt:

General Contractor	General Contractor responsible for the specific project
ROCIP Claim Advisor	Dan Killebrew, Daniel.Killebrew@marsh.com
DEN Construction Safety Manager	Suezann Bohner, Suezann.Bohner@flydenver.com
DEN Project Management	Project Management Team assigned to the specific project

3) An accident investigation will be completed as soon as possible by DEN Construction Safety with all Contractors involved in the event and in coordination with DEN Legal, DEN Risk Management, DEN Project Management and the Insurer.

4) If Contractor receives any subsequent direct inquires or correspondence about the claim, including a summons or other legal documents, the information must be immediately forwarded to the General Contractor. General Contractor will be responsible for providing to the following parties within 48 hours of receipt:

ROCIP Claims Advisor	Dan Killebrew, Daniel.Killebrew@marsh.com
DEN Claims Administrator	Jon Arcila, Claims Administrator, Jonathan.Arcila@flydenver.com

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4. BUILDER'S RISK CLAIMS

When damage occurs on a construction site, DEN's Builder's Risk insurance can help offset the costs and get the project back on track. It can pay for damage to the project, materials awaiting installation, and for costs associated with project delays.

4.1 Contractor Responsibilities

4.1.1 All Contractors

- Report any damages to your Work or the Work of any other Contractor on a Project to the General Contractor.
- Report any injuries to non-employees that may be suffered on a Project Site to the General Contractor.
- Follow the claim reporting procedures in this guide if you are directly involved in a loss and cooperate fully and timely with any requests from the Insurer, DEN, Marsh or any of their respective representatives.

4.1.2 General Contractors

- Responsible for ensuring all subcontractors involved in a Builder's Risk loss follow the claim reporting procedures in this guide.
- Responsible for pricing and cost proposals for needed work/rework to repair the damage and obtaining approval from DEN Project Management.
- Responsible for providing updated schedule analysis and costs associated with any delay in completion.
- Responsible for oversight and management of the specific work/rework necessary to repair the damage.
- Responsible for collecting, reviewing, and compiling all claim documentation for claim adjustment and claim payment purposes.
- Responsible for ensuring rework and any associated costs related to a claim are separated and billed independent of the Contract work.

4.2 Builder's Risk Claims Process

Contractor must immediately report an event as directed in the right column

Contractor uses the Builder's Risk Claim Checklist to document and mitigate loss

Contractor completes Builder's Risk Loss Report in Riskonnect, which will notify the contacts on the right (excl. DEN COM Center)

Claim is investigated by the Adjuster in coordination with the Contractor(s), General Contractor, DEN PM, and DEN Safety

Claims Adjuster will authorize the start of repair work after initial claim investigation.

! NOTE: DEN PM has the ability to pre-approve repairs at any point during the claims process to minimize delays.

General Contractor is responsible for: (i) oversight of work, (ii) collecting and compiling all claim documentation, (iii) reporting daily on behalf of subcontractors to DEN PM on work and costs incurred, (iv) invoicing separately from Contract work, and (v) providing claim documentation to Adjuster and Claims Administrator.

Adjuster will review claim submittals with DEN to ensure they are contractually compliant (pricing, delay costs, etc.) prior to final submittal to the Insurer.

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Adjuster will advise DEN Risk and Claim Administrator of Insurer agreed settlement. DEN Risk will process claim settlement through the General Contractor.

INITIAL CONTACTS

FOR EMERGENCIES
CALL DEN COM CENTER
303.342.4211

GENERAL CONTRACTOR
Responsible for the specific project notifies all below individuals

ROCIP CLAIMS ADJUSTER
Scott Markey
303.905.6233
Scott.markey@mclarens.com

ROCIP CLAIMS ADMINISTRATOR
Jennifer Knoblauch
303.308.4513
Jennifer.knoblauch@marsh.com

DEN PROJECT MANAGER
Assigned to the specific project

DEN CONSTRUCTION SAFETY
Suezann Bohner
303.342.2132
Suezann.bohner@flydenver.com

DEN RISK MANAGEMENT
Jon Arcila
720.745.0996
Jonathan.arcila@flydenver.com

4.3 Builder's Risk Claim Checklist

Provided with this manual is a checklist to assist Contractors in capturing immediate claims information following an event, mitigating the loss and evaluating the scope of the loss. This checklist is not required to be submitted with a loss report to file a claim.

See Section 7.4 for Builder's Risk Claim Checklist.

4.4 How to Report a Builder's Risk Claim

1) Contractor shall complete and submit a Builder's Risk Loss Report via DEN's RMIS within 24 hours of the occurrence. See Section 7.5 for data that will be required and how to access the RMIS for online entry and submittal.

   The report will automatically be sent to the following parties once submitted:
   - ROCIP Marsh Claims Advisor
   - DEN Claims Administrator
   - DEN Construction Safety Manager
   - DEN Project Management Team assigned to specific project

2) An investigation will be completed as soon as possible by DEN Construction Safety with all Contractors involved in the event and in coordination with DEN Risk Management, DEN Legal, DEN Project Management and the Insurer.

3) Insurer's claims adjuster may conduct a site visit to assess the loss; these visits would be arranged by the claims adjuster with the General Contractor, DEN Project Management, DEN Risk Management, and DEN Construction Safety. DEN Project Management would assume responsibility for providing required access and escort.

4) Provide the Insurer with any requested supporting documentation for the claim to be adjusted properly and avoid further Project delay.

5. POLLUTION LIABILITY CLAIMS

5.1 How to Report a Pollution Incident or Claim

1) Contractors shall immediately notify the following parties of any known or suspected pollution incidents.

DEN COMMUNICATIONS CENTER 303.342.4200

ROCIP Claims Advisor	Dan Killebrew, Daniel.Killebrew@marsh.com
DEN Claims Administrator	Jon Arcila, Jonathan.Arcila@flydenver.com
DEN Construction Safety Manager	Suezann Bohner, Suezann.Bohner@flydenver.com
DEN Project Management	Project Management Team assigned to the specific project

2) Contractor shall complete and submit a Pollution Loss Report via DEN's RMIS within 24 hours of the occurrence. See Section 7.5 for data that will be required and how to access the RMIS for online entry and submittal.. The report will automatically be sent to the individuals referenced in this Section 5.1.

6. AUTOMOBILE AND OTHER TYPES OF INCIDENTS

6.1 Reporting to DEN

Refer to the DEN ROCIP Safety Manual for details on incident, accident and near miss reporting requirements. Please note that all incidents and accidents must be reported to DEN Construction Safety via the process outlined in the ROCIP Safety Manual regardless of whether a formal claim is being submitted to an insurance carrier.

6.2 Reporting to Your Company's Insurer and CORA Requests

Insurance coverages outside those provided under the DEN ROCIP, such as automobile liability, professional liability, or physical damage to Contractor's or their employees' property, should be reported by the impacted Contractor to its Insurer. It is the sole responsibility of each Contractor to report claims covered by non-ROCIP insurance policies to their own Insurers and directly manage the claims process.

DEN will provide supporting documentation when available and when requested, such as video footage. Documentation from DEN related to an incident or accident occurring on DEN premises may be requested through the Colorado Open Records Act, Colorado Revised Statutes §24-72-201 to 206 (CORA). You may request public records of the airport via the following online portal link:
https://flydenver.govqa.us/WEBAPP/_rs/(S(lnxwnqethmgjf0ostyotlmgy))/supporthome.aspx

NOTE: e-mail messages are vulnerable to non-delivery or rejection by the airport's computer security systems. If you do not receive a reply e-mail acknowledging receipt of your e-mail request within 24 hours, please contact the City Attorney's Office at CAO.CORAREQUEST@denvergov.org.

For complete information specific to DEN, please read the rules for Open Records Act requests, which can be accessed online via the below link.
Part 220 of the Airport Rules & Regulations

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7. FORMS and RESOURCES

The following forms and resources provided in this section are also available as single files for your ease of download and use in the Documents Section of the Contractor Online Portal excluding the Investigation and Claim Form RMISFields.

7.1 Workers' Compensation Medical Care Requisition and Authorization Form with List of Approved Medical Providers

DEN ROCIP4/ROCIP5

MEDICAL CARE

REQUISITION and AUTHORIZATION FORM

INSTRUCTIONS: This form is to be completed in its entirety by the Employer/Contractor's Safety Representative or an authorized Requesting Party (Lead Contractor's Safety Representative or DEN Safety) and email or fax to the desired clinic.

Date: _____

DEN Project Name:

Employee Name: _____

Employer/Contractor Name: _____

DEN Project No.

Employer/Contractor Address: _____

Authorizing Representative Information: Name/Title: _____

Company/Entity Name

Email _____ Tel. No. _____

BILLING INSTRUCTIONS

BILL REQUESTED MEDICAL SERVICES TO: ZURICH

BILL REQUSTED DRUG and/or ALCOHOL SCREENS TO: EMPLOYER/CONTRACTOR LISTED ABOVE

Indicate requested treatment and screening request(s) below:

- ☐ Medical treatment for injury
- ☐ 11 Panel Rapid Drug Screen
- ☐ Alcohol Screen
- ☐ Other: _____

Date of Injury: _____

Body Part(s) Injured: _____

DOT Reportable Injury: ○ Yes ◉ No

Comments: _____

DESIGNATED LOCATIONS

EMPLOYEE MUST SELECT AN OPTION, SIGN THE FORM, AND TAKE COMPLETED FORM TO BE PRESENTED AT THE DESIRED LOCATION. Contractor must keep a signed copy for their records.

☐ Concentra

AURORA
3449 Chambers Road Suite B
Aurora, CO 80011
Colorado_ccdia@concentra.com
720.859.6139 tel
720.859.3294 fax
Hours: 8am-5pm M-F

☐ Concentra

AURORA
15235 E. 38th Ave
Aurora, CO 80229
Colorado_ccdia@concentra.com
303.340.3053 tel
303.342.3862 fax
Hours: 8am-8pm M-F
8am-4pm Sat

☐ MIDTOWN OCCUPATIONAL HEALTH SERVICES

DOWNTOWN
2420 W. 26th Ave, Bldg D
Suite 200
Denver, CO 80211
303.831.9393 tel
303.831.6335 fax
Hours: 7am-5:30pm M-F

☐ MEDICINE-BUSINESS-INDUSTRY

AURORA
3350 Peoria St, Ste 190
Aurora, CO 80010
dneclinic@workwellworks.com
303.365.4646 tel
303.365.4644 fax
Hours: 8am-5pm M-F

☐ Front Range Occupational Medicine

GOLDEN
770 Simms St, Ste 100
Golden, CO 80401
frontdesk@frontrangemed.com
303.635.6337 tel
303.862.7953 fax
Hours: 8am-5pm M-F

☐ I do not wish to seek medical treatment at this time. At a later time, I understand that I may request a medical evaluation for my reported injury. By signing this form, I acknowledge any future claims regarding this incident will require a medical evaluation through an approved Worker's Compensation medical provider listed above.

Employee Signature:_____ Date:_____

EMERGENCY CARE

UCHealth

AURORA 1635 Aurora Ct. Aurora, CO 80045 720.848.8650 tel 720.848.7374 fax
Hours: 24/7/365

For assistance contact ROCIP4/5 Claims Advisor Dan Chilton at dan.chilton@marsh.com or 303.589.7063

Revised JUL 2025

ROCIP4/ROCIP5
LIST OF APPROVED MEDICAL CARE PROVIDERS

Pre-employment Drug Screens*	Medical Treatment	Provider Type	Approved Provider	Location and Contact Information	Hours
✓	✓	Clinic	Concentra	3449 Chambers Road, Ste B, Aurora, CO 80011 Colorado_ccdia@concentra.com 720.859.6139 tel / 303.859.3294 fax	8am – 5pm M-F
	✓	Clinic	Concentra	15235 E 38th Ave, Aurora, CO 80011 Colorado_ccdia@concentra.com 303.340.3053 tel / 303.342.3862 fax	8am – 8pm M-F 8am – 4pm Sat
✓		Clinic	Concentra	550 E Thornton Pkwy, Ste 110, Thornton, CO 80229 Colorado_ccdia@concentra.com 720.872.0399 tel / 720.872.0421 fax	8am – 5pm M-F
✓		Clinic	Concentra	1730 Blake St, Ste 100, Denver, CO 80202 Colorado_ccdia@concentra.com 303.293.2273 tel / 303.296.8330 fax	8am – 6pm M-F
✓		Clinic	Concentra	11185 W 6th Ave, Lakewood, CO 80215 Colorado_ccdia@concentra.com 303.239.6060 tel / 303.239.6046 fax	8am – 6pm M-F
✓		Clinic	Concentra	9330 S University Blvd, Ste 100/120, Highlands Ranch, CO 80216 Colorado_ccdia@concentra.com 303.346.3627 tel / 303.683.9392 fax	8am – 5pm M-F
	✓	Clinic	Midtown Occupational Health Services	2420 W 26th Ave, Bldg A, Ste 300, Denver, CO 80211 frontdesk1@mdtwn.com 303.831.9393 tel / 303.831.6335 fax	7am – 4:30pm M-F
✓		Clinic **ONSITE AT DEN**	Secure Health Partners	8500 Pena Blvd, Concourse A, Room 3284, Denver, CO 80249 den@securehealthpartners.com 720.556.9791 tel	7am – 12pm M-F
✓		Mobile	Secure Health Partners	Mobile Services Available by Appointment – must have restroom avail den@securehealthpartners.com 720.556.9791 tel	24/7/365 by appointment
✓		Clinic	Secure Health Partners	2175 S Jasmine St, Ste 117, Denver, CO 80222 den@securehealthpartners.com 303.963.5554 tel	7am – 5pm M-F
✓	✓	Clinic	MBI	3350 Peoria St, Ste 190, Aurora, CO 80010 dneclinic@workwellworks.com 303.365.4646 tel / 303.365.4644 fax	8am – 5pm M-F
✓		Clinic	MBI	2550 S Parker Rd, Ste 150, Aurora, CO 80014 aseclinic@workwellworks.com 720.512.4408 tel / 720.512.5978 fax	8am – 5pm M-F
	✓	Clinic	Front Range Occupational Medicine	770 Simms St, Ste 100, Golden, CO 80401 frontdesk@frontrangemed.com 303.635.6337 tel / 303.862.7953 fax	8am – 5pm M-F
	✓	**EMERGENCY ONLY**	UC Health Hospital	1635 Aurora Ct, Aurora, CO 80045 720.848.8650 tel / 720.848.7374 fax	24/7/365

*Post Accident and Reasonable Suspicion Drug Screens are paid for by the Contractor and may be obtained at the facility of their choice.

Revised July 2025

7.2 Workers' Compensation First Report of Injury Form

WORKERS' COMPENSATION FIRST REPORT OF INJURY

INSTRUCTIONS: This First Report of Injury may be reported to the DEN ROCIP 4 Workers' Compensation Insurer via online website submission, email, fax or telephone. The Insurer will produce the necessary ~~state required~~ forms on your behalf following receipt of the claim. **DO NOT DELAY SUBMITTING THIS REPORT EVEN IF YOU DO NOT HAVE ANSWERS TO ALL THE QUESTIONS.**

WAYS TO SUBMIT THIS REPORT →	BY ONLINE WEBSITE: www.zurichna.com	BY EMAIL: USZ CareCenter@Zurichna.com	BY FAX: 877.962.2567	BY TELEPHONE: 800.987.3373

ACCOUNT / ACCIDENT INFORMATION

CALLER'S PHONE NUMBER / EXTENSION	CALLER'S TITLE	CALLER'S NAME	REPORTING STATE
( )			CO

CONTRACTOR/EMPLOYER NAME	CONTRACTOR/EMPLOYER ADDRESS (STREET, CITY, STATE & ZIP)	CONTRACTOR/EMPLOYER MAILING ADDRESS (STREET, CITY, STATE & ZIP) ☐ SAME

DID THE ACCIDENT OCCUR AT THE LOCATION ADDRESS? ☐ YES ☐ NO IF NO, ADDRESS WHERE ACCIDENT OCCURRED

CONTRACTOR DEN PROJECT NO.

PARENT COMPANY / INSURED'S NAME

City and County of Denver, Department of Aviation, DEN ROCIP5 [Account # 0000047842]

LOCATION CODE	POLICY SYMBOL AND NUMBER	NATURE OF BUSINESS

DATE OF INJURY	TIME OF INJURY

ACCIDENT DESCRIPTION

EMPLOYEE INFORMATION

INJURED EMPLOYEE'S SOCIAL SECURITY NUMBER:			EMPLOYEE'S NAME (FIRST, MI, LAST)	GENDER ☐ MALE ☐ FEMALE

DATE OF BIRTH	EMPLOYEE'S MAILING ADDRESS

EMPLOYEE'S HOME PHONE NUMBER	EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING)
( )	

EMPLOYEE JOB INFORMATION

EMPLOYMENT STATUS CODE ☐ FULL-TIME ☐ PART-TIME ☐ OTHER_____	INJURED WORKER TYPE	REGULAR OCCUPATION

OCCUPATION WHEN INJURED			
EMPLOYEE'S WORK SCHEDULE REGULAR WORK HOURS		HOURS/DAY	DAYS/WEEK
EMPLOYEE'S WAGE INFORMATION:			
$_____/ HOUR OR $_____/ ANNUAL	OR $_____/ WEEKLY	OVERTIME: $ _____	ADDITIONAL BENEFITS: $_____
DATE OF HIRE OR LENGTH OF EMPLOYMENT			

SUPERVISOR'S NAME:	SUPERVISOR'S PHONE NUMBER: ( )	BEST HOURS TO CONTACT

ACCIDENT INFORMATION

DATE CLAIM REPORTED TO EMPLOYER?	DID EMPLOYEE LOSE ANY TIME FROM WORK? ☐ YES ☐ NO	IS THE EMPLOYEE BACK AT WORK? ☐ YES ☐ NO IF YES, DATE RETURNED TO WORK?

RETURN TO WORK STATUS ☐ LIGHT ☐ MODIFIED ☐ REGULAR	DATE EMPLOYEE LAST WORKED	WAS INJURY FATAL? IF YES, DATE OF DEATH ☐ YES ☐ NO

CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)

EQUIPMENT, MATERIAL OR SUBSTANCE INVOLVED

DO YOU QUESTION THE VALIDITY OF THE CLAIM? ☐ YES ☐ NO

WITNESS INFORMATION/OTHERS INVOLVED

NAME (FIRST, MI, LAST)	ADDRESS	PHONE NUMBER

CONTINUED ON REVERSE SIDE

Revised Feb 2022

INJURY INFORMATION

PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG)

NATURE OF INJURY (E.G., FRACTURE, SPRAIN, LACERATION

PRIOR INJURY OR PRE-EXISTING CONDITION(S) (IF YES, DESCRIBE)

☐ YES ☐ NO

TREATMENT ("X" ALL THAT APPLY	
☐ FIRST AID —	TREATMENT AND DATE OF 1ST TREATMENT
☐ HOSPITAL/ CLINIC —	NAME, ADDRESS, PHONE NUMBER, PHYSICIAN NAME, TREATMENT, DATE OF 1ST TREATMENT, LENGTH OF STAY, AMBULANCE USED? WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT'? ☐ YES ☐ NO
☐ PHYSICIAN —	

SEE WORKERS' COMPENSATION - FIRST REPORT OF INJURY - STATE SPECIFIC QUESTIONS FOR YOUR INDIVIDUAL STATE.

CUSTOMER SPECIFIC INFORMATION

ADDITIONAL COMMENTS & INFORMATION

7.3 One-Time Change of Physician (CO Form WC003)

Clear Entire Form | Clear This Page

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

NOTICE OF ONE-TIME CHANGE OF PHYSICIAN &
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Claimant TBD
Date of Injury TBD
Claimant's Telephone # TBD
Insurance Carrier TBD
Employer
Insurance Carrier Claim #
WC# (if applicable)

Instructions:

Most employers are required to give an employee a choice of physicians following notification that the employee has been injured on the job. However, some employers are exempt from this requirement. Unless you work for an employer that is exempt from this requirement, you should have been given a written designated provider list containing a list of at least four physicians or corporate medical providers or a combination of both, where available. The designated provider list should also contain the name and contact information of the respondents' representative(s), as well as the name of the insurer or if the employer is self-insured. Unless you work for an employer that is exempt, you are allowed a one-time change of physician, subject to the following requirements:

1. You must complete and sign this form. The form should be filled out as fully as possible with all known information.
2. This form must be provided to the respondents' representative(s) within ninety days after the date of the injury, and before the treating physician has determined maximum medical improvement.
3. The requested new physician is on the designated provider list or provides medical services for a designated corporate medical provider on the list given to you following your injury.
4. You are **not** required to provide this form to the physicians, but may do so.

Current Authorized Treating Physician:

Physician Name _____ Phone # (_____) _____

Address _____
Street Address/PO Box City State Zip Code

Requested Authorized Treating Physician:

Physician Name _____ Phone # (_____) _____

Address _____
Street Address/PO Box City State Zip Code

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Clear This Page

By signing this form I acknowledge that I wish to make a one-time change of physician pursuant to §8-43-404(5)(a)(III) and certify that the information provided in this form is, to the best of my knowledge and belief, true, correct and complete.

I hereby authorize _____ to release medical
(Name and address of current treating physician)

information relating to _____ , _____ on-the-job injury
(Claimant's name) (Date of Injury)

to _____ for purposes of providing medical care under the
(Name and address of requested new treating physician)

Workers' Compensation Act.

I understand that this information may be given to my employer and also may be given to other persons necessary to resolve my claim. All written communications to any physician or health care provider shall be simultaneously provided to me or, if represented, to my attorney.

Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified: _____

Signed: _____ Dated: _____

Print Name: _____

CERTIFICATE OF SERVICE: Copies of this document were placed in the U.S. mail or hand-delivered to the following parties this _____ day of _____ , _____ .
Day Month Year

List the names and addresses of all persons copied:

Respondents' Representative(s): _____

While you are not required to send this form to the physicians, see Instruction No. 4., doing so may result in a smoother transition.

Current Authorized Treating Physician: _____

Requested Authorized Treating Physician: _____

By: _____
Signature

WC003 Rev. 06/15 Page 2 of 2

7.4 Builder's Risk Claim Checklist

BUILDER'S RISK CLAIM CHECKLIST

For Contractor informational use only. This form is not part of an official loss report.

PROJECT INFORMATION	
DEN Project Name:	
Lead Contractor:	
Date of Event:	
Time/Date Project Delays Began (approx.):	
Time/Date Project Resumed (approx.):	

CHECKLIST	
Immediate Actions	
☐	Take ample photographs and videos to document ALL damage (however small), especially before mitigation efforts have begun. Show the full loss in its initial state. Photos and Videos • Focus in on specific damages, especially to porous materials where the visible damage can dry overtime • Take photos from multiple angles • Time stamp photos and videos • Retain copies of the photos and videos for your records
☐	Mitigate the loss. Take immediate steps to protect property (damaged and undamaged) from further loss, including securing boarding-up, security or other services as necessary.
☐	Secure and save all damaged property, equipment and parts to be inspected by the Insurer in their investigation to determine cause of loss and possible subrogation proceeding. DO NOT discard anything unless directed by the Insurer.
☐	Take detailed notes: • Description of the event and resulting damage suffered • Date, Time, Specific Location • Other involved Contractors (companies and individual worker names) • Other involved parties and witnesses (capture names and contact information) • Description of any injuries that resulted (name, contact info and description of injury) • Description of any resultant damage to existing property
☐	List all property and items damaged or stolen.
☐	Call the Police, if appropriate. This step is required if the loss involves theft or vandalism.
☐	Witnesses: If there were any witnesses to the incident, have them give you a written statement on what happened. Make sure the statements are detailed and have each witness sign their statement.
☐	Third Party Responsibility: If a third party is thought to be responsible for the damage, capture name and contact information as well as vehicle information if a vehicle was involved (Make/Model and License Plate No.).
Estimating and Documentation Actions	
☐	Develop a Rough Order of Magnitude (ROM) that outlines all areas of anticipated loss amounts by category with estimated labor and materials separately shown: Debris Removal, Permanent Works, Temporary Works, Pollutant Cleanup and Removal, Preservation of Property, Valuable Papers, Trees/Shrubs/Plants, Engineering Assessments and Professional Fees, Site Preparation, Inspections, Other Round Numbers and "TBDs" are sufficient at this time.
☐	Analyze any schedule impacts and quantify associated costs, if any
☐	Keep detailed records and documentation for all expenses (labor and materials) incurred related to the loss.
☐	If original purchase invoices are available for damaged property be prepared to provide copies to the Insurer.
☐	Identify any Expediting Expenses—costs incurred to speed up repair of damaged property, such as overtime wages and express transportation charges.
☐	Identify Extra Expenses and costs above normal related to the event. Any cost or expense incurred, that would not have been incurred "but for" the event, should be tracked.
☐	Identify costs related to ingress/egress delays, enforcement of laws or ordinances regulating repair, demolition, and reconstruction of damaged buildings.

Issued: Feb 2022

7.5 Investigation and Claim Report Form RMIS Fields

DEN utilizes its Risk Management Information System (RMIS) to intake a loss report to submit a claim under the program (excluding Workers' Compensation), and no longer uses standalone forms to streamline both the process and the information capture, dissemination, and analysis.

To access the DEN RMIS to complete a loss report to submit a claim online, contact DEN Construction Safety or DEN Risk Management for login Information. The below table of data fields is provided for information gathering only to assist with ease of completing online reports; emailed copies of this table will not be accepted. For any technical issues, please contact Jon Arcila, DEN Claims Administrator at jonathan.arcila@flydenver.com or 720.745.0996.

This is the same tool DEN utilizes to receive incident and investigation reports under the DEN ROCIP Safety Manual requirements; be advised that the below table includes all categories not only those pertaining to claim submittals.

		REPORT TYPES *(x indicates the field is required)*				
DEN CONTRACTOR REPORT TYPE(S)	**Entry Field**	**Incident Report**	**Near Miss/ Lessons Learned**	**Vehicle / Equip. Incident**	**Builder's Risk/ Property Damage**	**GL and Pollution**
Please select the type of report(s) you are completing:	*Single-Select:* □ Incident Report (Includes Injuries, First Aid, and Denial of First Aid) □ Near Miss □ Lessons Learned □ Vehicle Incident □ Equipment Incident □ Builder's Risk/Property Damage □ General Liability □ Pollution	x	x	x	x	x
Does Contractor Intend to File a Claim with ROCIP or is this a Notification Only?	*Single-select:* □ Have Filed a Claim □ Intend to File a Claim □ Notice of Potential Claim Only at this time □ Not Planning to File	x	x	x	x	x
PROJECT INFORMATION						
Project Name	free form text	x	x	x	x	x
DEN Contract Number	free form text	x	x	x	x	x
General Contractor	free form text	x	x	x	x	x
Contractor Company Reporting Claim	free form text	x	x	x	x	x
Email of DEN Project Manager	free form text	x	x	x	x	x
Email of General Contractor Safety Representative Lead	free form text	x	x	x	x	x
Email of General Contractor Project Manager	free form text	x	x	x	x	x

		REPORT TYPES *(x indicates the field is required)*				
DEN CONTRACTOR REPORT TYPE(S)	**Entry Field**	**Incident Report**	**Near Miss/ Lessons Learned**	**Vehicle / Equip. Incident**	**Builder's Risk/ Property Damage**	**GL and Pollution**
Incident Location Type	*Single-select:* □ Airside- Movement □ Airside- Non-Movement Area □ Building- Public Area □ Building- Tunnels/Basement □ Building- Within Contained Project Limits (e.g. inside McCain walls) □ Landside- Roadway □ Landside-Parking Area □ Other Facility Area □ Other	x	x	x	x	x
If Other, describe:	free form text					
YOUR INFORMATION						
Name of Individual Completing this Report (First & Last)	free form text	x	x	x	x	x
Email of Individual Completing this Form	free form text	x	x	x	x	x
Telephone of Individual Completing this Form	###-###-####	x	x	x	x	x
INCIDENT INFORMATION						
Today's Date (Date of Report)	mm/dd/yyyy	x	x	x	x	x
Date Incident was reported to Supervisor	mm/dd/yyyy	x	x	x	x	x
Date Incident was reported to General Contractor Rep.	mm/dd/yyyy	x	x	x	x	x
Date of Incident	mm/dd/yyyy	x	x	x	x	x
Time of Incident (approximate)	hh:mm – military time	x	x	x	x	x
Location or Address of Loss	free form text			x	x	x
GC's Superintendent overseeing operation where incident/loss occurred (First & Last)	free form text	x	x	x	x	x
Superintendent's DEN Badge Number (enter NA if no badge)	free form text	x	x	x	x	x
Direct Supervisor/Foreman of Operation (First & Last)	free form text	x	x	x	x	x
Supervisor's DEN Badge Number (enter NA if no badge)	free form text	x	x	x	x	x
Supervisor's Email	free form text	x	x	x	x	x
Supervisor's Phone Number	free form text	x	x	x	x	x
Was the incident/injury caused by a Contractor employee (other than the injured worker if this is an incident report)?	Yes, No	x	x	x	x	x

		REPORT TYPES *(x indicates the field is required)*				
DEN CONTRACTOR REPORT TYPE(S)	**Entry Field**	**Incident Report**	**Near Miss/ Lessons Learned**	**Vehicle / Equip. Incident**	**Builder's Risk/ Property Damage**	**GL and Pollution**
If Yes		x	x	x	x	x
Name of Company Employee works for:	free form text	x	x	x	x	x
Name of Employee (First Last)	free form text	x	x	x	x	x
Employee's DEN Badge Number (enter NA if no badge)	free form text	x	x	x	x	x
Trade Association	*Single-select*: □ Pre-Apprentice □ Apprentice □ Journeyman □ Master □ No Association	x	x	x	x	x
Trade Association Name	free form text	x	x	x	x	x
Union Association	Yes, No	x	x	x	x	x
Union Association Name	free form text	x	x	x	x	x
Employee Position Type	*Single Select:* □ Non-Supervisor Trade Employee □ Lead □ Foreman □ Superintendent □ Non-Supervisory Project Personnel (i.e. Field Engineer) □ Supervisory Project Personnel (i.e. Project Manager) □ Other	x	x	x	x	x
If Other, please describe:	free form text	x	x	x	x	x
Employee Tenure on Project	*Single-select:* □ 0-6 Months □ 6-12 Months □ 1-2 Years □ 2-5 Years □ 5+ Years	x	x	x	x	x
Employee Tenure with Company	*Single-select:* □ 0-6 Months □ 6-12 Months □ 1-2 Years □ 2-5 Years □ 5-10 Years □ 10-20 Years □ 20+ Years	x	x	x	x	x

		REPORT TYPES *(x indicates the field is required)*				
DEN CONTRACTOR REPORT TYPE(S)	**Entry Field**	**Incident Report**	**Near Miss/ Lessons Learned**	**Vehicle / Equip. Incident**	**Builder's Risk/ Property Damage**	**GL and Pollution**
Employee Tenure in Trade	*Single-select:* □ 0-6 Months □ 6-12 Months □ 1-2 Years □ 2-5 Years □ 5-10 Years □ 10-20 Years □ 20+ Years	x	x	x	x	x
Short Description of Incident	free form text	x	x	x	x	x
Short Description of Incident continued…	free form text	x	x	x	x	x
Describe the job duties being performed when incident occurred.	free form text	x	x	x	x	x
List the causal factors	free form text	x	x	x	x	x
List the corrective actions	free form text	x	x	x	x	x
Has a similar incident occurred before?	Yes, No	x	x	x	x	x
Were injuries associated with this event?	Yes, No	x		x	x	x
Were mulitple injuries associated with this incident?	Yes, No	x		x	x	x
Did incident/event have SIF potential?	Yes, No	x	x	x	x	x
Will this claim exceed $2,500 for injuries or $25,000 for all other claims?	Yes, No	x	x	x	x	x
INJURED PERSON INFORMATION						
Select Injured Person Type (note if multiple people are injured, multiple/individual reports must be submitted)	*Single-select:* □ Contractor Employee □ DEN Employee □ Stakeholder Employee □ Public/3rd Party □ No Injury Associated with Claim	x		x	x	x
Name of Injured Person (First & Last)	free form text	x		x	x	x
Address of Injured Person	free form text	x		x	x	x
Email of Injured Person	free form text	x		x	x	x
Phone Number of Injured Person	free form text	x		x	x	x
Injured Person's DEN Badge Number (enter NA if no badge)	free form text	x		x	x	x

		REPORT TYPES *(x indicates the field is required)*				
DEN CONTRACTOR REPORT TYPE(S)	**Entry Field**	**Incident Report**	**Near Miss/ Lessons Learned**	**Vehicle / Equip. Incident**	**Builder's Risk/ Property Damage**	**GL and Pollution**
For Contractor Employee Injuries, complete the following:						
WC Claim Number	free form text	x				
Trade Association	*Single-select*: □ Pre-Apprentice □ Apprentice □ Journeyman □ Master □ No Association	x				
Trade Association Name	free form text	x				
Union Association	Yes, No	x				
Union Association Name	free form text	x				
Employee Position Type	*Single-select:* □ Non-Supervisor Trade Employee □ Lead □ Foreman □ Superintendent □ Non-Supervisory Project Personnel (i.e. Field Engineer) □ Supervisory Project Personnel (i.e. Project Manager) □ Other	x				
If Other, please describe:	free form text	x				
Employee Tenure on Project	*Single-select:* □ 0-6 Months □ 6-12 Months □ 1-2 Years □ 2-5 Years □ 5+ Years	x				
Employee Tenure with Company	*Single-select:* □ 0-6 Months □ 6-12 Months □ 1-2 Years □ 2-5 Years □ 5-10 Years □ 10-20 Years □ 20+ Years	x				

		REPORT TYPES *(x indicates the field is required)*				
DEN CONTRACTOR REPORT TYPE(S)	**Entry Field**	**Incident Report**	**Near Miss/ Lessons Learned**	**Vehicle / Equip. Incident**	**Builder's Risk/ Property Damage**	**GL and Pollution**
Employee Tenure in Trade	*Single-select:* □ 0-6 Months □ 6-12 Months □ 1-2 Years □ 2-5 Years □ 5-10 Years □ 10-20 Years □ 20+ Years	x				
Insurance Claim Number (or enter "First Aid")	free form text	x				
Injury Classification	*Single-select:* □ Hit- No First Aid □ First Aid □ Medical Treatment Only □ Restricted Duty □ Lost Time □ Permanent Disability □ Fatality	x				
If multiple Injuries, List all Names here:	free form text	x		x	x	x

PROPERTY DAMAGE AND POLLUTION INFORMATION		(Complete Section for: Builder's Risk, General Liability, Contractor's Pollution)				
Type of Loss	*Multi-select:* □ Fire □ Flood □ Hail □ Lightning □ Water □ Wind □ Theft □ Vandalism □ Air Pollution □ Ground Pollution □ Water Pollution □ Other				x	x
Is a water source threatened?	Yes, No					x
If yes, provide details.	free form text					x

		REPORT TYPES *(x indicates the field is required)*				
DEN CONTRACTOR REPORT TYPE(S)	**Entry Field**	**Incident Report**	**Near Miss/ Lessons Learned**	**Vehicle / Equip. Incident**	**Builder's Risk/ Property Damage**	**GL and Pollution**
Was any existing property damaged?	Yes, No		x	x	x	x
If yes						
Estimated Dollar Value of Property Damage	Whole numbers only, no symbols			x	x	x
Describe the property damage:	free form text			x	x	x
Property Owner's Name	free form text			x	x	x
Property Owner's Address (if DEN, NA)	free form text			x	x	x
Property Owner's Email (if DEN, NA)	free form text			x	x	x
Was any property under construction damaged?	Yes, No			x	x	x
If yes						
Estimated Dollar Value of Property Damage	Whole numbers only, no symbols			x	x	x
Estimated Dollar Value of Entire Loss	Whole numbers only, no symbols			x	x	x
Describe the property damage:	free form text			x	x	x
UTILITY INFORMATION						
Were any utilities damaged in this incident?	Yes, No	x	x	x	x	x
If yes:						
Utility Location	*Single-select:* □ Underground □ Overhead □ Floor □ Wall	x	x	x	x	x
Utility Damage Prevention plan and walk with DEN Safety completed?	Yes, No, NA	x	x	x	x	x
Locates complete and up to date?	Yes, No, NA	x	x	x	x	x
Was utility identified (i.e. known) by locates, SUE sweep, or drawings?	Yes, No, NA	x	x	x	x	x
Was utility depth confirmed via pothole or non-destructive means?	Yes, No, NA	x	x	x	x	x
Was utility exposed/visible at time of strike?	Yes, No, NA	x	x	x	x	x

		REPORT TYPES *(x indicates the field is required)*				
DEN CONTRACTOR REPORT TYPE(S)	**Entry Field**	**Incident Report**	**Near Miss/ Lessons Learned**	**Vehicle / Equip. Incident**	**Builder's Risk/ Property Damage**	**GL and Pollution**
Type of Utility	*multi-select:* □ electrical □ natural gas □ jet fuel □ water □ sanitarystorm □ communication □ fire supression □ FAA □ Other	x	x	x	x	x
If other, describe:	free form text	x	x	x	x	x
RESPONDER/AGENCY NOTIFICATION INFORMATION						
Select any agencies or departments that were contacted:	*multi-select:* □ Police □ Fire □ EMS □ DEN Environmental □ DEN Ops □ DEN Security □ 811 □ EPA □ State Agency □ FAA □ Other □ None	x	x	x	x	x
Does OSHA need to be notified or have they been notifed?	Yes, No	x				
If Other, list:	free form text	x	x	x	x	x
List Agency/Report Number(s):	free form text	x	x	x	x	x
List Agency/Contact Information:	free form text	x	x	x	x	x
WITNESS INFORMATION						
Were there any witnesses?	Yes, No	x	x	x	x	x
If yes:						
Name of Witness 1 (First & Last)	free form text	x	x	x	x	x
Address of Witness 1	free form text	x	x	x	x	x
Email of Witness 1	free form text	x	x	x	x	x
Phone Number of Witness 1	free form text	x	x	x	x	x
Witness 1 DEN Badge Number (enter NA if no badge)	free form text	x	x	x	x	x

		REPORT TYPES *(x indicates the field is required)*				
DEN CONTRACTOR REPORT TYPE(S)	**Entry Field**	**Incident Report**	**Near Miss/ Lessons Learned**	**Vehicle / Equip. Incident**	**Builder's Risk/ Property Damage**	**GL and Pollution**
Name of Witness 2 (First & Last)	free form text					
Address of Witness 2	free form text					
Email of Witness 2	free form text					
Phone Number of Witness 2	free form text					
Witness 2 DEN Badge Number (enter NA if no badge)	free form text					
Name of Witness 3 (First & Last)	free form text					
Address of Witness 3	free form text					
Email of Witness 3	free form text					
Phone Number of Witness 3	free form text					
Witness 3 DEN Badge Number (enter NA if no badge)	free form text					
Additional Witness Names if more than 3:	free form text					

8. SUMMARY OF REVISIONS

Version	**Date**	**Section**	**Page**	**Previous**	**Revision**	**Explanation**
1.0	09/23/2025			ROCIP4 Manual	N/A	New program manual