Form AR- 2	ARKANSAS WORKERS' COMPENSATION COMMISSION	2
Authority: Ark. Code Ann. §11-9-803, -810 Revised 1-1-2013	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

EMPLOYER'S INTENT TO ACCEPT OR CONTROVERT CLAIM

❑ **Initial Filing** ❑ **Amended Filing**

AWCC File No.	Carrier Claim No.	Employee Name (Last, First, MI)	Employee SS Number
Employer Name			Fed. Employer I.D. 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
	.00	Was Disability Continuous During the First 8 Days? ❑ Yes ❑ No	
Average Weekly Wage	Wkly TTD Comp. Rate (rounded)		Date Indemnity Triggered

STATEMENT OF POSITION

Date of injury or death: _______________ City, State of Injury: ____________________ State your position. If controverting, state the grounds therefore:

____
____
____
____
____

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	Relationship to deceased	Weekly benefit amount

CERTIFICATION

I certify 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 or equivalent information has been provided to the employee or beneficiaries.

		Title:	
Signature	Printed or Typewritten Name	Phone:	Date

If insurer is represented by an attorney, that legal representative must sign below pursuant to Ark. Code Ann. § 11-9-717	
Name and Address of Attorney	Signature

AWCC Form 2

(Employer's Intent to Accept or Controvert Claim)

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

Help With AWCC Form 2:

1. The first payment to the employee is due by the 15th day after the employer has notice of the injury or death. **(Ark. Code Ann. §11-9-802)**

2. The AWCC is notified "upon making the first payment." **(Ark. Code Ann. §11-9-810)**

3. A controversion notice is due on or before the 15th day after notice of the death or alleged injury. **(Ark. Code Ann. §11-9-803)**

4. Therefore, **AWCC Form 2** in all cases is required 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.

Be sure to include on **AWCC Form 2**:

5. A mark in either the Initial Filing Box or Amended Filing Box.

6. The AWCC File Number (obtained from **AWCC Form A-110**) and your company's file number for this case.

Be sure to bear in mind:

7. **Form 2** is NOT interchangeable with the required written response to the 15-day letter for **Form C**.

8. If respondents need additional time for investigation, an extension request must be sent in before the **Form 2** deadline. Using **Form 2** to report that the respondent needs more time is invalid.

9. If a case is opened at the AWCC on **Form 1** or **Form C**, an AWCC **Form 2** is required, even if the case upon investigation is determined to be a medical-only claim.

Questions about a specific Form 2, or general information or assistance on completing or filing a Form 2, may be directed to the AWCC Operations and Compliance Division, which processes this form (1-800-622-4472 or 501-682-3930).

Ark. Code Ann. §11-9-106(a): Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission.

Ark. Code Ann. §11-9-717: Any person or attorney signing a claim, request for benefits, controversion of benefits request for hearing or other paper of a party, certifies the action is taken after reasonable inquiry; is well grounded in fact; is warranted by existing law or a good faith argument for extension, modification or reversal of existing law; and is not interposed for any improper purpose or for delay. Violators of this provision may be subject to sanctions, which may include payment of reasonable expenses incurred by others and reasonable attorney fees for responding to the claim, request or motion, or for failure to appear at a hearing, deposition or other scheduled matter.