



**STATE OF CALIFORNIA
 DIVISION OF WORKERS' COMPENSATION
 WORKERS' COMPENSATION APPEALS BOARD
 ANSWER TO APPLICATION FOR ADJUDICATION OF CLAIM**



Case Number _____

(Choose only one)

a specific injury on _____
 (MM/DD/YYYY)

a cumulative trauma injury which began on _____ and ended on _____
 (START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

 Name(s) of Answering Party(ies) (Please leave blank paces between names, numbers or words)

Injured Worker

 Last Name MI _____

 First Name

Employer Information

Insured Self-Insured Legally Uninsured Uninsured

 Employer Name (Please leave blank spaces between numbers, names or words)

 Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

 City State _____ Zip Code _____

Insurance Carrier Information (if applicable - include even if carrier is adjusted by claims administrator)

 Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

 Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

 City State _____ Zip Code _____



Claims Administrator Information (if applicable)

Name (Please leave blank spaces between numbers, names or words)



Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

ANSWERING DEFENDANTS deny the allegations of the application as indicated below with such explanations as expressly set forth and admit all other material allegations.

DENIALS

EXPLAIN BELOW

(Mark X if allegation is denied)

Employment

Occupation

Injury

(IF DENIAL IS BASED ON DATE OR PART OF BODY INJURED, EXPLAIN FULLY)

Insurance coverage

(STATE IF EMPLOYER HAS BEEN NOTIFIED TO APPEAR AND DEFEND)

Liability for self-procured treatment

Liability for future medical treatment

Medical-legal costs

Earnings



Periods of disability

(GIVE LAST DAY WORKED AND CORRECT DATE OF RETURN TO WORK, IF ANY)



[Empty box for Periods of disability]

Rehabilitation

[Empty box for Rehabilitation]

Supplemental job displacement / return to work

[Empty box for Supplemental job displacement / return to work]

Permanent disability

(IF APPORTIONMENT IS CLAIMED, SO STATE)

[Empty box for Permanent disability]

IT IS FURTHER ALLEGED:

1. Defendants have paid disability indemnity in the total amount of \$ _____ at the rate of \$ _____ a week beginning _____ through _____ plus _____
MM/DD/YYYY MM/DD/YYYY

2. Affirmative defenses and other matters :

[Large empty box for affirmative defenses and other matters]

The Answer to this Application is being filed on behalf of (Please check one only)

Employer

Insurance Carrier

Both

Defendant(s) do(es) not waive the right to raise additional issues in accordance with the provisions of law and the Rules of Practice and Procedure if other issues develop.

Dated: _____

Phone Number _____

Signature

Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

