



**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**

**(Mark X if allegation is denied)**

**EXPLAIN BELOW**

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 details]

Rehabilitation

[Empty box for Rehabilitation details]

Supplemental job displacement / return to work

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

Permanent disability

(IF APPORTIONMENT IS CLAIMED, SO STATE)

[Empty box for Permanent disability details]

**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

