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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)

☐ Rehabilitation

☐ Supplemental job displacement / return to work

☐ Permanent disability (IF APPORTIONMENT IS CLAIMED, SO STATE)

IT IS FURTHER ALLEGED:

1. Defendants have paid disability indemnity in the total amount of $ _____ at the rate of $ _____

a week beginning _____ (MM/DD/YYYY) through _____ (MM/DD/YYYY) plus _____

2. 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