

WORKERS' COMPENSATION APPEALS BOARD

(This form is for injuries occurring on or after January 1, 1990)

ANSWER OF: _____ CASE NO.: _____
(EMPLOYER, CARRIER, INJURED WORKER, DEPENDENT, LIEN CLAIMANT)

(INJURED WORKER) (ADDRESS)

(SOCIAL SECURITY NUMBER) (DATE OF ALLEGED INJURY) (CITY) (STATE) (ZIP CODE)

(APPLICANT IF OTHER THAN INJURED WORKER) (ADDRESS)

(CITY) (STATE) (ZIP CODE)

(CORRECT NAME OF EMPLOYER; INDICATE IF SELF INSURED) (ADDRESS)

(CITY) (STATE) (ZIP CODE)

(CORRECT NAME OF INSURANCE CARRIER OR, IF SELF INSURED, ADJUSTING AGENCY) (ADDRESS)

(CITY) (STATE) (ZIP CODE)

1. Answering party objects to the filing of the application for the following reasons:

(EXPLANATION MUST BE PROVIDED FOR ANY BOX CHECKED)

- No bona fide dispute exists
- Medical reports and other documents indicating nature of dispute not attached to application
- Medical reports alleged to have been served by applicant not received
- A claim form has not been filed with the employer
- A dated and completed claim form has not been attached to Application
- Efforts to resolve dispute not stated
- Efforts to resolve dispute not made
- 14 days have not elapsed since claim form was filed and the employer has not denied or refused to pay benefits.
- Other

Explain: (See Instructions) _____

(ATTACH ADDITIONAL PAGES IF NEEDED)

2. It is requested that the application, if filed, be dismissed for the following reasons: (See Instructions) _____

3. Other action requested _____

(READ INSTRUCTIONS BEFORE FILLING OUT ANSWER - PRINT OR TYPE NAMES AND ADDRESSES)

4. Answering party denies the allegations of the application as indicated below with such explanations as are expressly set forth and admits all other material allegations.

- | | |
|--|--|
| <input type="checkbox"/> Medical-legal costs _____ | <input type="checkbox"/> Employment _____ |
| <input type="checkbox"/> Earnings _____ | <input type="checkbox"/> Occupation _____ |
| <input type="checkbox"/> Periods of disability _____
<small>(GIVE LAST DAY WORKED & CORRECT DATE OF RETURN TO WORK)</small> | <input type="checkbox"/> Injury _____
<small>(IF DENIAL IS BASED ON DATE OR PART OF BODY INJURED, PLEASE EXPLAIN FULLY)</small> |
| <input type="checkbox"/> Rehabilitation _____ | <input type="checkbox"/> Insurance coverage _____
<small>(CHECK IF EMPLOYER HAS BEEN NOTIFIED TO APPEAR AND DEFEND)</small> |
| <input type="checkbox"/> Permanent disability _____ | <input type="checkbox"/> Liability for self-procured treatment _____ |
| <input type="checkbox"/> Apportionment _____ | <input type="checkbox"/> Liability for further medical treatment _____ |
| <input type="checkbox"/> Other _____ | |

(ATTACH ADDITIONAL PAGES IF NEEDED)

5. IT IS FURTHER ALLEGED THAT THE FOLLOWING BENEFITS HAVE BEEN PROVIDED:

Temporary disability indemnity in the total amount of \$ _____ at the rate of \$ _____ per week beginning _____ through _____. Rehabilitation maintenance allowance in the total amount of \$ _____ at the rate of \$ _____ per week beginning _____ through _____. Permanent disability indemnity in the total amount of \$ _____ at the rate of \$ _____ beginning _____ through _____.

(ATTACH ADDITIONAL PAGES IF NEEDED)

6. Affirmative defenses and other matters: _____

The right to raise additional issues in accordance with the provisions of law and the Rules of Practice and Procedure is not waived.

I, _____, declare under penalty of perjury that the facts set forth under paragraphs 1, 2 and 3 are true and correct.

Dated at _____, California, on _____

(Signature of answering party, attorney or representative)

(Print or Type) (Name of answering party, attorney or representative.)

(Address of answering party, attorney or representative)

(Telephone number)