This packet is an example of the order in which documents should be filed. These are not examples of how to fill out forms/documents.

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET

Is this a new case? Yes ☐ No ☑ Companion Cases Exist ☐ Walkthrough Yes ☐ No ☑

More than 15 Companion Cases ☐

09/10/2008
Date:(MM/DD/YYYY)

SSN: [redacted]

ADJ12345
Case Number 1

☑ Specific Injury
☐ Cumulative Injury

02/02/2004
(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 420

Body Part 2: 100

Body Part 3:

Body Part 4:

Other Body Parts:

Please check unit to be filed on (check only one box)

☑ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ VOC ☐ INT ☐ RSU

Companion Cases

☐ Specific Injury

Case Number 2

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1:

Body Part 2:

Body Part 3:

Body Part 4:

Other Body Parts:

DOCUMENT SEPARATOR SHEET

Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title ANSWER TO APPLICATION FOR ADJUDICATION OF CLAIM

Document Date _____
MM/DD/YYYY

Date of document following Document Separator Sheet

Author UNIFORM ASSIGNED NAME

Office Use Only

Received Date _____
MM/DD/YYYY

DWC-CA form 10232.2

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 _____ (START DATE: MM/DD/YYYY) *and ended of* _____ (END DATE: MM/DD/YYYY)

Name of Answering Party (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	(CHECK 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)

☐ 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 Company ☐ Both

Defendants do 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 at _____, _____ (City), _____ (State)

_____
Signature

DOCUMENT SEPARATOR SHEET

Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title 4906(g) DECLARATION

Date of document following Document Separator Sheet

Document Date _____
MM/DD/YYYY

Author UNIFORM ASSIGNED NAME

Office Use Only

Received Date _____
MM/DD/YYYY

DWC-CA form 10232.2

4906g

DOCUMENT SEPARATOR SHEET

Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title PROOF OF SERVICE

Date of document following Document Separator Sheet

Document Date _____
MM/DD/YYYY

Author UNIFORM ASSIGNED NAME

Office Use Only

Received Date _____
MM/DD/YYYY

DWC-CA form 10232.2

Proof of Service
with
Answer to Application for Adjudication of Claim and 4906(g)