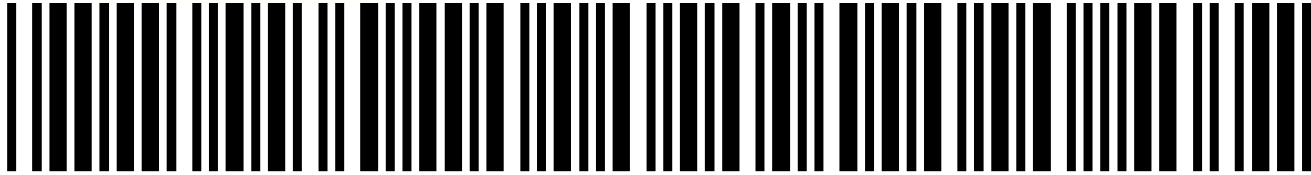


This packet is an example of the order in which documents should be filed. These are not examples of how to fill out forms/documents.

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: XXXXXXXXXX

ADJ12345

Specific Injury

02/02/2004

Case Number 1

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: 420

Body Part 3: _____

Body Part 2: 100

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: _____

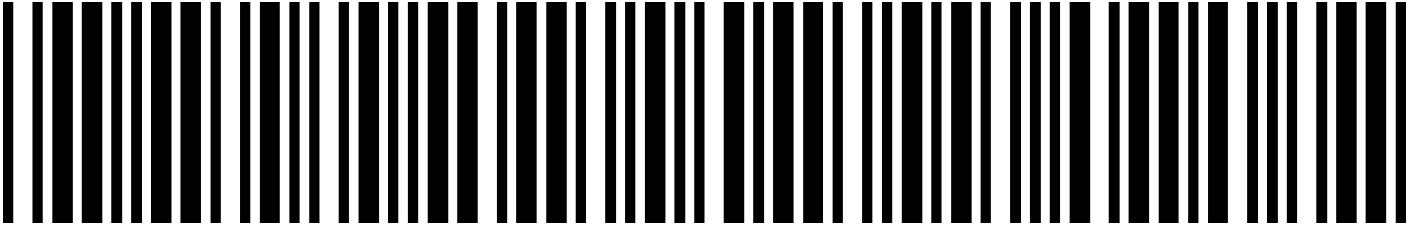
Body Part 3: _____

Body Part 2: _____

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

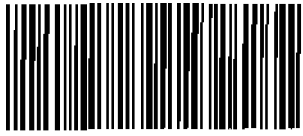


Author UNIFORM ASSIGNED NAME

Office Use Only

Received Date _____
MM/DD/YYYY





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

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

(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)

+

[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 Company

Both

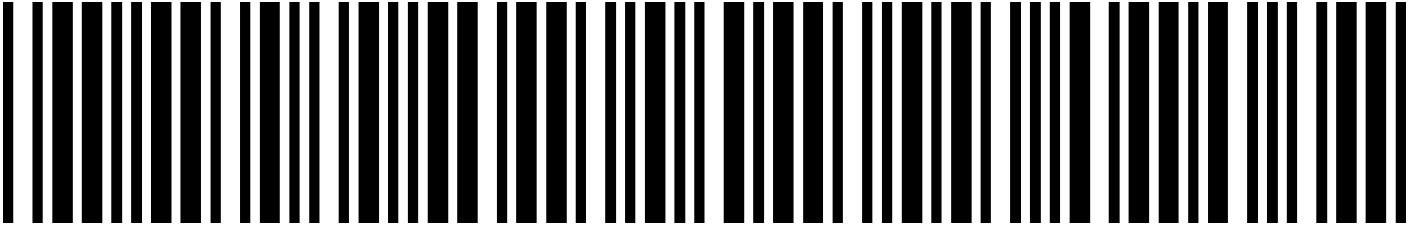
Defendants do not waive the right to raise *additional* issues in accordance with the provisions of law and the Rules of Practice and Procedure if other issues develop.

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

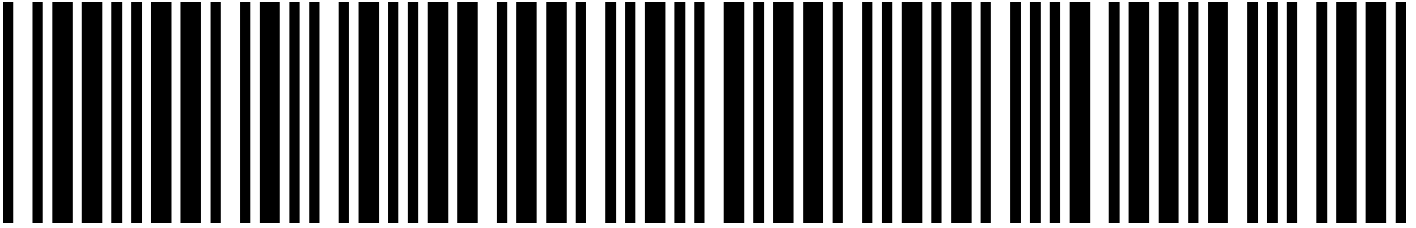
Office Use Only

Received Date MM/DD/YYYY



4906g

DOCUMENT SEPARATOR SHEET



Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title PROOF OF SERVICE

Document Date _____
MM/DD/YYYY

Date of document following
Document Separator Sheet

Author UNIFORM ASSIGNED NAME

Office Use Only

Received Date _____
MM/DD/YYYY



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