



STATE OF CALIFORNIA
 DIVISION OF WORKERS' COMPENSATION
 WORKERS' COMPENSATION APPEALS BOARD
 ANSWER TO APPLICATION FOR ADJUDICATION OF CLAIM



RECEIVED

NOV 16 2009

DIVISION OF
 WORKERS COMPENSATION
 STOCKTON OFFICE

ADJ7004227

Case Number

(Choose only one)

a specific injury on 03/26/2009
 (MM/DD/YYYY)

a cumulative trauma injury which began on _____ and ended on _____
 (START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

STOCKWELL HARRIS SACRAMENTO

Name(s) of Answering Party(ies) (Please leave blank paces between names, numbers or words)

Injured Worker

ANDERSON

Last Name

MI

TIFFANY

First Name

Employer Information

Insured Self-Insured Legally Uninsured Uninsured

SAN JOAQUIN COUNTY MOSQUITO VECTOR CONTROL DISTRICT

Employer Name (Please leave blank spaces between numbers, names or words)

7759 S AIRPORT WAY

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

STOCKTON

City

CA

State

95206

Zip Code

Insurance Carrier Information (if applicable - include even if carrier is adjusted by claims administrator)

AIMS

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

PO BOX 269120

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

SACRAMENTO

City

CA

State

95826

Zip Code



Claims Administrator Information (if applicable)

AIMS

Name (Please leave blank spaces between numbers, names or words)

PO BOX 269120

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

SACRAMENTO

City

CA

State

95826

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)

DENIED

Insurance coverage

(STATE IF EMPLOYER HAS BEEN NOTIFIED TO APPEAR AND DEFEND)

Liability for self-procured treatment

REASONABLE AND NECESSARY

Liability for future medical treatment

REASONABLE AND NECESSARY

Medical-legal costs

REASONABLE AND NECESSARY

Earnings

Periods of disability

(GIVE LAST DAY WORKED AND CORRECT DATE OF RETURN TO WORK, IF ANY)



[Empty box for disability periods]

Rehabilitation

DENIED PENDING APPROPRIATE EVIDENCE AND/OR DEMANDS

[Empty box for rehabilitation details]

Supplemental job displacement / return to work

[Empty box for supplemental job displacement]

Permanent disability

(IF APPORTIONMENT IS CLAIMED, SO STATE)

APPORTIONMENT

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 :

ALL AFFIRMATIVE DEFENSES PERMITTED UNDER CALIFORNIA LAW, INCLUDING THE LABOR CODE, CALIFORNIA CODE OF REGULATIONS, AND CASE LAW; POST-TERMINATION DEFENSE AND NON-DISCRIMINATORY GOOD FAITH PERSONNEL ACTION; CONTRIBUTIONS AND CREDITS AND JUDICIAL NOTICE OF ALL OTHER CASES.

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: 11/10/2009


Signature

Phone Number (916) 924-1862

STOCKWELL HARRIS SACRAMENTO

Firm Name

1545 RIVER PARK DRIVE SUITE 330

Address/PO Box (Please leave blank spaces between numbers, names or words)

SACRAMENTO

City

CA
State

95815
Zip Code



