

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

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UDICATION OF CLAIM	ľ

RECF	IVE	
ADJ7004227 Case Number NOV 1 6	VED	
Case Number NOV 1 6	2009	
(Choose only one) WORKERS SION O	F	
(Choose only one) ✓ a specific injury on (MM/DD/YYYY) WORKERS COMPE STOCKTON OF	NEATION TOE	
(MIM/DD/1111)		
a cumulative trauma injury which began on and ended	on	
(START DATE: MM/DD/YYYY)	(END DATE: M	M/DD/YYYY)
STOCKWELL HARRIS SACRAMENTO		
Name(s) of Answering Party(ies) (Please leave blank paces between names, number	rs or words)	
Injured Worker		
ANDERSON		
Last Name	MI	
TIFFANY		
First Name		,
Employer Information		
✓ Insured Self-Insured Legally Uninsured	Uninsu	red
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, nar	nes or words)	
	C 4	
STOCKTON	CA	95206
City	State	Zip Code
Insurance Carrier Information (if applicable - include even if carrier is adjusted by	y claims adminis	strator)
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, name	es or words)	
SACRAMENTO	-CA State	95826 Zip Code
City	Glate	ZIP OUGE
DWC/ WCAB Form 10 (Page 1) (REV. 11/2008)		WCAB10

Claims Administrator Information (if app	plicable)				
AIMS					
Name (Please leave blank spaces between nu	mbers, names or words)				
PO BOX 269120					
Street Address/PO Box (Please leave blank sp	aces between numbers, nam	es or words)			
SACRAMENTO			CA	95826	
City			State	Zip Code	
ANSWERING DEFENDANTS deny the	allegations of the applic	cation as indicated b	elow with	such explanati	ons as
expressly set forth and admit all other r	naterial allegations.				
DENIALS (Mark X if allegation is denied)		EXPLAIN BEL	ow		
				····	
Employment			•		
Occupation					
-					
✓ Injury	(IF DENIAL IS BASED ON DENIED	DATE OR PART OF BO	DY INJURE	D, EXPLAIN FULL	_Y)
	DENIED				
Insurance coverage	(STATE IF EMPLOYER HA	AS BEEN NOTIFIED TO	APPEAR AN	ID DEFEND)	
·	. "				
Liability for self-procured treatment	REASONABLE AND	NECESSARY		1 111 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
	REASONABLE AND	NECESSARV			
✓ Liability for future medical treatment	ICEASOTABLE AND	NECESSARI			
✓ Medical-legal costs	REASONABLE AND	NECESSARY			
	·				
Earnings					
I					
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✓ Periods of disability	(GIVE LAST DAY WORKED AND CORRECT DA	TE OF RETU	JRN TO WORK, IF ANY)
I	·		
✓ Rehabilitation	DENIED PENDING APPROPRIATE E	VIDENCE	AND/OR DEMANDS
Tendomatori			
Supplemental job displacement / return to work			
ietum to work			
Permanent disability	(IF APPORTIONMENT IS CLAIMED, SO STATE)	1	
Y emailer disability	(II ALT ONTIONMENT TO CEATMED, OC OTATE)		
	APPORTIONMENT		
IT IO FURTUED ALL FOED.			
IT IS FURTHER ALLEGED:			
1. Defendants have paid disability indemnit	y in the total amount of \$	at the rate	of \$
a week beginning	through	plus	
MM/DD/YYYY 2. Affirmative defenses and other matters:	MM/DD/YYYY		
	RMITTED UNDER CALIFORNIA LAW,	INCLUDI	NG THE LABOR
CODE, CALIFORNIA CODE OF REC	FULATIONS, AND CASE LAW; POST-T	TERMINAT	ΓΙΟΝ DEFENSE AND
NON-DISCRIMINATORY GOOD FA JUDICIAL NOTICE OF ALL OTHER	ITH PERSONNEL ACTION; CONTRIBI	UTIONS A	ND CREDITS AND
JODICIAL NOTICE OF ALL OTHER	CASES.	•	
The Answer to this Application is being filed	on behalf of (Please check one only)		
Employer	Insurance Carrier	✓ Both	
	ise additional issues in accordance with the p	rovisions of l	law and the Rules of Practice
and Procedure if other issues develop.			
Dated: 11/10/2009			
	Phone 1	Number <u>(91</u>	6) 924-1862
Signature			
STOCKWELL HARRIS SACRAMENT	0		
Firm Name			
1545 RIVER PARK DRIVE SUITE 330			
Address/PO Box (Please leave blank spaces bet			
SACRAMENTO		CA	95815
City		State	Zip Code
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PROOF OF SERVICE

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STATE OF CALIFORNIA

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COUNTY OF SACRAMENTO

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I am in the County of Sacramento, State of California. I am over the age of 18 years and not a party to the within action. My business address is 1545 River Park Drive, Suite 330, Sacramento, California 95815-4616.

I served the foregoing document described as: Notice of Representation; Declaration

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of 4906(g); and Answers (3) to Application for Adjudication of Claim (ADJ7004221, ADJ7004227; and ADJ7010682) on all interested parties in this action by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid in the United States mailed at Sacramento, California, addressed as follows:

Workers' Compensation Appeals Board

31 E. Channel Street, Room 344

Stockton, CA 95202

Mr. Ronald M. Stein

Ronald M. Stein Law Offices

4521 Quail Lakes Drive Stockton, CA 95207

Ms. Mackenzie Dawson

AIMS Insurance

Mr. John Stroh

Post Office Box 269120

Sacramento, California 95826-9120

San Joaquin County Mosquito & Vector Control District

7759 S. Airport Way

Stockton, CA 95206

I certify, under penalty of perjury, that the foregoing is true and correct.

Executed on November 12, 2009, at Sacramento, California.

By: Kathi Stokes