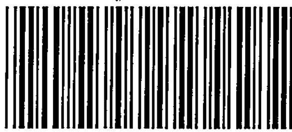
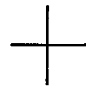


STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
ANSWER TO APPLICATION FOR ADJUDICATION OF CLAIM



ADJ7004227
Case Number

RECEIVED
NOV 16 2009
DIVISION OF WORKERS COMPENSATION STOCKTON OFFICE

(Choose only one)

☑ a specific injury on 07/02/2009
(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)

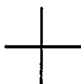
STOCKTON | CA | 95206
City | State | Zip Code

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 | CA | 95826
City | State | Zip Code



Claims Administrator Information (if applicable)

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

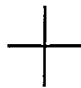
PO BOX 269120
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

SACRAMENTO	CA	95826
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) 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)



☑ Rehabilitation — DENIED PENDING APPROPRIATE EVIDENCE AND/OR DEMANDS

☑ Supplemental job displacement / return to work

☑ 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 ________ (MM/DD/YYYY) through ________ (MM/DD/YYYY) plus ________

2. Affirmative defenses and other matters :

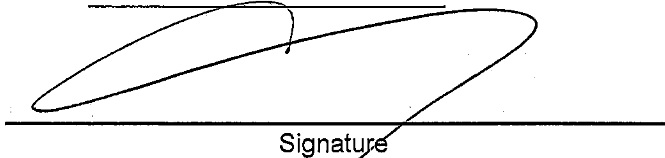
ALL AFFIRMATIVE DEFENSES PERMITTED UNDER CALIFORNIA LAW, INCLUDING THE LABOR CODE, CALIFORNIA CODE OF REGULATIONS, AND CASE LAW; POST-TERMINATION DEFENSE AND NON-DISCRIMINATORY GOOD FAITH PERSONNEL ACTION; CONTRIBUTIONS AND CREDITS AND JUDICIAL NOTICE OF ALL OTHER CASES.

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