

LAUGHLIN

FALBO

LEVY &

MORESI LLP

A Limited Liability Partnership

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- SAN JOSE • 1520 The Alameda • Suite 200 • 95126-2377 • (408) 286-8801 • Fax (408) 286-1935

FROM: Your Name: _____ Phone: _____

Company Name: _____

Address: _____

Insurance Carrier: _____

- STATE WORKERS COMPENSATION
 EMPLOYMENT
 L & H
 SUBROGATION
 LIABILITY
 Pre 1990 Injury
 Post 1990 Injury
 Post 1991 Injury
 Post 1993 Injury
 2004/2005 Injury

EMPLOYEE: _____ DOI: _____ Claim # _____

EMPLOYER: _____ POLICY PERIOD _____

APPLICANT'S ATTORNEY: _____ NONE

PRIOR RELATED INJURIES: DOI: _____ APP. FILED STILL OPEN

CLAIM FORM FILED ON: _____ APPLICATION FILED ON: _____

DENIAL LETTER FILED ON: _____ ANSWER FILED ON: _____

OR DENIAL DUE DATE: _____ LFLM TO FILE ANSWER

BENEFITS PAID:

TD \$ _____ PERIODS _____

VRTD \$ _____ PERIODS _____

PD \$ _____ PERIODS _____

MEDICAL EXPENSES \$ _____ VR EXPENSE \$ _____

WORKERS COMPENSATION ISSUES:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> 1. INJURY AOE-COE | <input type="checkbox"/> 5. EARNINGS | <input type="checkbox"/> 9. PAST MEDICAL | <input type="checkbox"/> 13. DEPENDENCY |
| <input type="checkbox"/> 2. EMPLOYMENT | <input type="checkbox"/> 6. TEMPORARY DISABILITY | <input type="checkbox"/> 10. FUTURE MEDICAL | <input type="checkbox"/> 14. PENALTIES
<small>(SEE REVERSE SIDE)</small> |
| <input type="checkbox"/> 3. OCCUPATION | <input type="checkbox"/> 7. PERMANENT DISABILITY | <input type="checkbox"/> 11. STATUTE OF LIMIT. | <input type="checkbox"/> 15. OTHER
<small>(EXPLAIN BELOW)</small> |
| <input type="checkbox"/> 4. COVERAGE | <input type="checkbox"/> 8. APPORTIONMENT | <input type="checkbox"/> 12. JURISDICTION | |

REQUESTED ACTION:

ATTEND HEARING: YES NO IF YES, DATE _____ TIME: _____ PLACE _____

DEPOSE APPLICANT: YES NO Need to Discuss _____

SCHEDULE MEDICAL EXAM: YES NO PHYSICIAN _____

SUBPOENA RECORDS: YES NO SOURCE _____

COMMENTS: _____

Laughlin, Falbo, Levy & Moresi LLP
Labor Code Section 4650, 5813 and 5814 Potential Penalty Transmittal Form

(For exposures exceeding \$5,000.00)

Date:
Client Name:
Claimant Name:
LFLM File Number:
Claims Adjuster:
Amount of Penalty:
Penalty Trigger Date (the date check or benefits should have gone out):
If Self-imposed increase owed per 4650(d), when was claim form (DWC-1) received?

Authorization Request

(Outline rationale for payment, negotiations, strategies & demand)

Applicant's attorney is alleging 5813 or 5814 penalties for the following: (use additional pages as needed).

1.

Potential Exposure:

Possible Defenses:

2.

Potential Exposure:

Possible Defenses:

3.

Potential Exposure:

Possible Defenses:

COMMENTS/SETTLEMENT AUTHORITY:

Client/Referring party's signature _____