Law Offices of
LAUGHLIN
FALBO
LEVY &
MORESI LLP
A Limited Liability Partnership

❑ ANAHEIM ● P.O. Box 25505 ●92825-5505 ● (714) 385-9400 ● Fax (714) 385-9055
❑ FRESNO ● 575 E. Locust ● Suite 311 ● 93720-2928 ● (559) 431-4900 ● Fax (559) 431-4046
❑ OAKLAND ● 555 12th Street ● Suite 1900 ● 94607 ● (510) 628-0496 ● Fax (510) 628-0499
❑ PASADENA ● 200 S. Los Robles ● Suite 500 ● 91101-2431 ● (626) 568-9700 ● Fax (626) 568-3905
❑ REDDING ● P.O. Box 492617 ● 96049-2617 ● (530) 222-0268 ● Fax (530) 222-5705
❑ SACRAMENTO ● One Capitol Mall ● Suite 400 ● 95814-3297 ● (916) 441-6045 ● Fax (916) 441-7067
❑ SAN BERNARDINO ● 625 E. Carnegie Drive ● Suite 120 ● 92408 ● (909) 890-2265 ● Fax (909) 890-2377
❑ SAN DIEGO ● 600 B Street ● Suite 2300 ● 92101 ● (619) 233-9898 ● Fax (619) 233-6862
❑ SAN FRANCISCO ● 255 California Street ● Suite 700 ● 94111-4912 ● (415) 781-6676 ● Fax (415) 781-6823
❑ 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:

☐ 1. INJURY AOE-COE ☐ 5. EARNINGS ☐ 9. PAST MEDICAL ☐ 13. DEPENDENCY
☐ 2. EMPLOYMENT ☐ 6. TEMPORARY DISABILITY ☐ 10. FUTURE MEDICAL ☐ 14. PENALTIES (SEE REVERSE SIDE)
☐ 3. OCCUPATION ☐ 7. PERMANENT DISABILITY ☐ 11. STATUTE OF LIMIT. ☐ 15. OTHER (EXPLAIN BELOW)
☐ 4. COVERAGE ☐ 8. APPORTIONMENT ☐ 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 _____