



FILE TRANSMITTAL TO:

2200B Douglas Boulevard, Suite 125
Roseville, CA 95661

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From	_____	Date Sent	_____
	_____	WCAB No(s)	_____
	_____	Claim No(s)	_____
	_____	Date(s) of Loss	_____
Claimant	_____	Policy Period	_____
Address	_____	Date of Knowledge	_____
	_____	Date of Delay	_____
Employer	_____	Date of Denial	_____

Is Employer insured for workers' compensation liability? Yes No

BENEFITS PAID:

Temporary Disability	_____	Rate(s)	_____	Wage Basis	_____
Periods paid	_____				

Permanent Disability	_____	Rate(s)	_____	Medical Paid	_____
Periods paid	_____				

Current benefit printout enclosed? Yes No

Has DWC-1 Form been filed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	date _____
Has a DOR or Application been filed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	date _____
Is there a hearing or deposition date?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	date _____
Is a medical exam pending?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	date/physician _____
Is claimant represented?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	attorney _____

SUGGESTED ISSUES:

<input type="checkbox"/> Injury	<input type="checkbox"/> Future Med.	<input type="checkbox"/> Rehab.	<input type="checkbox"/> Subro	<input type="checkbox"/> Jurisdiction	<input type="checkbox"/> Contribution	<input type="checkbox"/> Statute of Limitations
<input type="checkbox"/> Past Med.	<input type="checkbox"/> Employment	<input type="checkbox"/> Occupation	<input type="checkbox"/> Coverage	<input type="checkbox"/> Earnings	<input type="checkbox"/> T.D.	<input type="checkbox"/> P.D./Apportionment
<input type="checkbox"/> Utilization Review	<input type="checkbox"/> LC §132a	<input type="checkbox"/> S&W Misconduct	<input type="checkbox"/> Death Benefits			

CLIENT INSTRUCTIONS:

Please continue on additional page if necessary

CLIENT INSTRUCTIONS CONTINUED: