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FILE TRANSMITTAL TO: _____

From _____
_____
_____
_____

Claimant _____
Address _____
_____

Employer _____

Date Sent _____
WCAB No(s) _____
Claim No(s) _____
Date(s) of Loss _____
Policy Period _____
Date of Knowledge _____
Date of Delay _____
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? ☐ Yes ☐ No date _____
Has a DOR or Application been filed? ☐ Yes ☐ No date _____
Is there a hearing or deposition date? ☐ Yes ☐ No date _____
Is a medical exam pending? ☐ Yes ☐ No date/physician _____
Is claimant represented? ☐ Yes ☐ No attorney _____

SUGGESTED ISSUES:

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

CLIENT INSTRUCTIONS:

Please continue on additional page if necessary

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CLIENT INSTRUCTIONS CONTINUED:

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