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DATE	CLAIMS EXAMINER / TECHNICIAN	CLAIM NUMBER	WCAB CASE NUMBER	HEARING DATE ☐ DEPO ☐ CONF ☐ TRIAL

APPLICANT (VS) EMPLOYER	DATE OF INJURY	AGE	OCCUPATION	DECLARATION OF READINESS FILED ☐ YES ☐ NO

POLICY NUMBER	POLICY TERM - FROM	TO	CORP.	PART.	INDIV.	OTHER	CROSS REFERENCE FILES CLAIM NUMBERS	CASE NUMBERS

APPLICANTS ATTORNEY	ADDRESS	PHONE ( )

APPLICANT	ADDRESS	PHONE ( )

BENEFITS PAID

WAGE BASIS ☐ WK ☐ MO ☐ YR	RATE	FROM	TO	TOTAL	DATE RETURNED TO WORK	DATE RELEASED TO RETURN TO WORK
TD ►				$		

				LUMP SUMS PAID	TOTAL	STILL ADVANCING
PD ►					$	☐ YES ☐ NO

TOTAL PAID	AS OF (DATE)	MEDICAL – LEGAL PAID (AMOUNT) TO (WHOM)							
MED ►		$	TO	$	TO	$	TO	$	TO
		$	TO	$	TO	$	TO	$	TO

REHABILITATION

REHABILITATION ☐ YES ☐ NO	CASE NUMBER	LOCATION	REHABILITATION VENDOR

WAGE BASIS	RATE	FROM	TO	TOTAL	STILL PAYING
VRTD ►				$	☐ YES ☐ NO

SUBROGATION

SUBROGATION ☐ YES ☐ NO	COURT CASE NUMBER	LOCATION OF COURT	PLAINTIFFS ATTORNEY (IF DIFFERENT FROM ABOVE) PHONE ( )

SUGGESTED ISSUES

- ☐ 1. COVERAGE _____
- ☐ 2. JURISDICTION _____
- ☐ 3. EMPLOYMENT_____
- ☐ 4. AOE / COE _____
- ☐ 5. EARNINGS _____
- ☐ 6. TD _____
- ☐ 7. PD _____
- ☐ 8. MEDICAL TREATMENT _____
- ☐ 9. OCCUPATION _____
- ☐ 10. AGE _____
- ☐ 11. DEPENDENCY _____
- ☐ 12. STATUE OF LIMITATIONS _____
- ☐ 13. APPORTIONMENT _____
- ☐ 14. FUTURE MEDICAL _____
- ☐ 15. SELF PROCURED TREATMENT _____

ACTION TO BE TAKEN

- ☐ 1. SET MEDICAL EXAMINATIONS AS NEEDED _____
- ☐ 2. SUBPOENA RECORDS AS NEEDED _____
- ☐ 3. SET DEPOSITION OF APPLICANT _____
- ☐ 4. SUBPOENA WITNESSES AS NEEDED _____

COMMENTS OR RECOMMENDATIONS

INSURANCE COMPANY / ADMINISTRATOR

NAME

ADDRESS

PHONE ( )