# KEGEL, TOBIN & TRUCE

A PROFESSIONAL CORPORATION
ATTORNEYS AT LAW
www.kttlaw.us E-mail: info@kttlaw.us

REFER TO:

☐ P.O. BOX 76907 (90076-0907)
800 WILSHIRE BLVD., #1100
LOS ANGELES, CA 90017
TELEPHONE (213) 380-3880
FAX (213) 383-8346

☐ P.O. BOX 7779 (93006-7779)
5450 RALSTON STREET, #204
VENTURA, CA 93003
TELEPHONE (805) 644-2216
FAX (805) 644-8625

☐ P.O. BOX 3329 (91729-3329)
8686 HAVEN AVENUE, #350
RANCHO CUCAMONGA, CA 91730
TELEPHONE (909) 466-5555
FAX (909) 466-5562

☐ 330 GOLDEN SHORE DRIVE, #150
LONG BEACH, CA 90802
TELEPHONE (562) 437-1108
FAX (562) 435-3742

☐ 5333 MISSION CENTER ROAD, #356
SAN DIEGO, CA 92108
TELEPHONE (619) 696-0906
FAX (619) 696-0939

## FILE TRANSMITTAL FORM

**Assign To:** _____ TOTAL MEDICAL PAID: _____

CLAIMANT'S NAME _____ TOTAL INDEMNITY PAID: _____

SSN: _____ DOB: _____ NATURE/TYPE OF INJURY: _____

CLAIM NO. _____ DOI: _____ WEEKLY RATE: _____ DATE OF HIRE: _____

CARRIER: _____ POLICY PERIOD: _____

DOK: _____ DENIED Y☐ N☐ ACCEPTED Y☐ N☐ IF ON DELAY, DECISION DATE: _____

ADDITIONAL INJURIES AND/OR CROSS REFERENCE FILES: _____

_____

EMPLOYER: _____ EMPLOYER E-MAIL & PHONE#: _____

☐ Individual
☐ Corporation
☐ Permissibly Self-Insured
☐ Co-partnership
☐ Joint Venture
☐ Insured

EMPLOYER ADDRESS: _____

### Apparent Reasons For Litigation
### (Check box of reason below)

1. ☐ Compensation not paid because of -
   ☐ No Employer's Report ☐ No doctor's report
   ☐ No notice of claim form ☐ Delay of benefits
2. ☐ Disability
   ☐ Temporary ☐ Permanent
3. ☐ Medical Treatment
   ☐ Liability for past ☐ Need for further
4. ☐ Injury AOE/COE
5. ☐ Statute runs
6. ☐ Average Earnings
7. ☐ Apportionment
8. ☐ Occupation
9. ☐ Subrogation
10. ☐ Employment or employer identity disputed
11. ☐ Dependency or identity of dependents
12. ☐ Possible penalty issue
13. ☐ Coverage for employer or this employee
14. ☐ Other _____

### Preparation For Hearing

ADJ NO.: _____ Venue: _____ Have Defense Meds been served? Y☐ N☐

Type of Hearing & Date: _____ INTERPRETER NEEDED? Y☐ N☐ If Yes, what language: _____

Your recommendations re: further medical examination? _____

Date Appl./Claim Form Recv'd: _____ Date File Sent to KT&T: _____ Is case otherwise ready for litigation? Y☐ N☐

PTP NAME, PHONE# AND ADDRESS: _____

_____

REPORTS ALSO TO BE SENT TO: _____

_____ _____
(NAME OF COMPANY SENDING FILE & UAN) (NAME OF CLAIM EXAMINER)

_____ _____ _____
(COMPANY ADDRESS) (PHONE/FAX) (E-MAIL)