STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
STIPULATIONS WITH REQUEST FOR AWARD

ADJ11396739
Case No.

Date of Injury 12/01/2008-07/16/2018
MM/DD/YYYY

612-24-2291
SSN (Numbers Only)

Venue Choice is based upon: (Completion of this section is required)

☐ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

☐ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

☑ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

SBR
Select 3 Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

Applicant (Completion of this section is required)

ALBERTO
First Name

MI

HERNANDEZ
Last Name

11673 HUMMINGBIRD PL
Address/PO Box (Please leave blank spaces between numbers, names or words)

MORENO VALLEY
City

CA
State

92557
Zip Code

Employer #1 Information (Completion of this section is required)

☑ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

REYES COCA COLA BOTTLING LLC
Employer Name (Please leave blank spaces between numbers, names or words)

6270 NORTH RIVER ROAD STE 9000
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

ROSEMONT
City

IL
State

60018
Zip Code

Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)

ACE AMERICAN INSURANCE COMPANY
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

PO BOX 14450
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

LEXINGTON — City
KY — State
40512 — Zip Code

Claims Administrator Information (if known and if applicable)

SEDGWICK 14450 LONG BEACH
Name (Please leave blank spaces between numbers, names or words)

PO BOX 14450
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

LEXINGTON — City
KY — State
40512 — Zip Code

Employer #2 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City — State — Zip Code

Insurance Carrier Information
(if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City — State — Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Employer #3 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Insurance Carrier Information
(if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Employer #4 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Insurance Carrier Information
(if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

The parties hereto stipulate to the issuance of an Award and/or Order, based upon the following facts, and waive the requirements of Labor Code section 5313:

1. ALBERTO
Employees First Name

HERNANDEZ ,
Employees Last Name

birth date 10/10/1964 ,
MM/DD/YYYY

while employed at Rancho Cucamonga , CA
State

as a(n) WAREHOUSE WORKER , 360 in
Occupation Group

☐ More than 4 Companion Cases

☐ Specific Injury

ADJ11396739
Case Number 1

☑ Cumulative Injury

12/01/2008
(Start Date: MM/DD/YYYY)

07/16/2018
(End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: Cervical Spine Body Part 2: Lumbar Spine Body Part 3: Right Wrist

Body Part 4: _____ Other Body Parts: _____

☐ Specific Injury

_____
Case Number 2

☐ Cumulative Injury

_____
(Start Date: MM/DD/YYYY)

_____
(End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

☐ Specific Injury

_____
Case Number 3

☐ Cumulative Injury

_____
(Start Date: MM/DD/YYYY)

_____
(End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

☐ Specific Injury

_____
Case Number 4

☐ Cumulative Injury

_____
(Start Date: MM/DD/YYYY)

_____
(End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

by the employer(s) and their insurer(s) listed above and who sustained injury(ies) arising out of and in the course of employment to

Cervical Spine, Lumbar Spine and Right Wrist
per POME Alexanian
C/S: 80% [8-11-3606-13-16] = 13%
L/S: 70% [8-11-3606-13-16] = 11%
Right Wrist 80% [6-8-3605-8-10] = 8%
13 c 11 c 8 = 29% PD
(Please list all body parts injured)

2. The injury (ies) caused temporary disability for the period _____ (MM/DD/YYYY) through _____ (MM/DD/YYYY) for which indemnity has been paid at $ _____ (Indemnity Paid) per week.

2(a).The injury(ies) caused additional temporary disability for the period _____ (MM/DD/YYYY) through _____ (MM/DD/YYYY) at the rate of $ _____ (Rate) in the amount of $ _____ (Indemnity Paid)

3. The injury(ies) caused permanent disability of 29 % for which indemnity is payable at $ 290.00 (Indemnity Rate) per week beginning 2/13/2020 (MM/DD/YYYY) in the sum of $ 36,177.50 ess credit for such payments previously made. ☐ And a life pension of $ _____ (Life Pension) ~~per week thereafter~~.

An informal rating ☒ has / ☐ has not (Select one) been previously issued in case no(s) _____ .

4.There ☒ is ☐ is Not a need for medical treatment to cure or relieve from the effects of said injury (ies).

5. Medical-legal expenses and/or liens are payable by defendant as follows:

ADDENDUM "A" AND AFFIDAVIT OF DEFENDANT RE: RESOLUTION OF LIENS INCORPORATED BY REFERENCE.

6. Applicant's attorney requests a fee of $ 5,426.63

☒ Fees to be commuted as follows:

FROM THE FAR END OF THE AWARD.

7. Liens Against compensation are payable as follows:

NONE AT THIS TIME.

8.Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

9.Other stipulations:

1. SEE ATTACHED ADDENDUM "A" INCORPORATED BY REFERENCE.
2. THE APPLICANT IS UNAWARE OF ANY OTHER INJURIES, ILLNESSES, OR CONDITIONS TO ANY PARTS OF THE BODY OR SYSTEMS DURING EMPLOYMENT WITH REYES COCA COLA BOTTLING LLC.
3. THE SUMS SET FORTH IN PARAGRAPH 2 REPRESENT AMOUNTS PAID BY THE DEFENSE, EITHER SAID PERIOD(S) OR RATE(S) ARE OR WERE DISPUTED. THE PARTIES STIPULATE THAT ALL PERIODS OF DISABILITY IN PARAGRAPH 2 HAVE BEEN AND ARE HEREBY ADEQUATELY COMPENSATED.
4. ANY ACCRUED, OWED, OR INCURRED CLAIMS FOR LABOR CODE SECTION 4650 PENALTIES ARE INCLUDED IN THIS SETTLEMENT AND UNLESS EXPRESSLY EXCLUDED.
5. ANY STIPULATIONS HEREIN WITH REGARD TO THE BEGINNING OR ANY PERIOD OR PAYMENTS SHALL NOT BE DEEMED A STIPULATION UPCOMING WHICH A LABOR CODE SECTION 5814 PENALTY CASE BE BASED.
6. THIS STIPULATIONS WITH REQUEST FOR AWARD SETTLES ALL CLAIMS TO ATTORNEY FEES INCLUDING BUT NOT LIMITED TO THOSE UNDER LABOR CODE SECTIONS 5811, 5813, AND 5814.5.
7. All body parts other than the Right Wrist, Cervical Spine and Lumbar Spine are Dismissed with Prejudice Δ π NF AH

Dated 08/11/2020
MM/DD/YYYY

Applicant

Applicant's Attorney or Authorized Representative:

☑ Law Firm/Attorney ☐ Non Attorney Representative

NATALIA
First Name

FOLEY
Last Name

13792552
Firm Number

WORKERS DEFENDERS ANAHEIM
Law Firm name

8018 E SANTA ANA CANYON RD STE 100 215
Address/PO Box (Please leave blank spaces between numbers, names or words)

ANAHEIM
City

CA
State

92808
Zip Code

Dated 08/11/2020
MM/DD/YYYY

Applicant Attorney Signature

Defendant's Attorney or Authorized Representative:

☑ Law Firm/Attorney ☐ Non Attorney Representative

TIMOTHY
First Name

MORGAN
Last Name

12232713
Firm Number

MORGAN LEAHY WOODLAND HILLS
Law Firm Name

21031 VENTURA BLVD STE 210
Address/PO Box (Please leave blank spaces between numbers, names or words)

WOODLAND HILLS — City
CA — State
91364 — Zip Code

Dated _____ MM/DD/YYYY

_____ Defense Attorney Signature

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City — State — Zip Code

Dated _____ MM/DD/YYYY

_____ Defense Attorney Signature

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Dated MM/DD/YYYY

Defense Attorney Signature

Interpreter License Number:

Interpreter Name

Interpreter License Number

ADDENDUM "A" TO STIPULATIONS WITH REQUEST FOR AWARD

A. The sums set forth in paragraph 2 represent amounts paid by the defendant, whether said period(s) or rate(s) are or were disputed. The parties stipulate that all periods of temporary disability, vocational rehabilitation temporary disability and vocational rehabilitation maintenance allowance have been and are hereby adequately compensated.

B. The sum of $36,177.50 in paragraph #3 is subject to a credit for any and all previously paid permanent disability advances paid to the date of this Award. The defendant is entitled to take credit for any and all permanent disability advances paid up to the date of this Award.

C. Liability for future medical treatment commences upon written demand by the applicant and authorization by the defendant.

D. The applicant agrees and hereby stipulates that all medical treatment pursuant to this Award shall be sought and performed or prescribed by a physician within the Medical Provider Network, if applicable. The defendant shall have no liability for any medical treatment, bills, or liens resulting from any treatment performed or prescribed by any person or business that is not a member of the Medical Provider Network.

E. The gross sum of $36,177.50 in paragraph #3 contemplates any and all penalty and interest due and payable if the first or forthwith payment is made within 30 days from the date of the Award.

F. The applicant stipulates that no penalties per Labor Code Section 5814 or Labor Code Section 4650 have been incurred, have accrued, or are owed by the defendant on any species of benefits up to the date of issuance of the Award. The parties stipulate that Labor Code Section 5800 interest is waived. Payment of the Award is to be made no later than 30 days after receipt by the defendant of the signed Award.

G. Any stipulations herein with regard to beginning payments or any period of payments shall not be deemed to be a stipulation upon which a Labor Code Section 5814 penalty is to be based.

H. This Stipulations with Request for Award settles any and all claims to attorney fees made by the applicant's counsel including but not limited to those delineated in Labor Code §5710, §5814.5, §5811.

I. In addition to the sums set forth above, defendant shall pay or adjust or litigate the lien claims filed timely, pursuant to *Labor Code* § 4903.5 and/or medical bills, as shown on the attached Lien Addendum, less credit for sums previously paid. Jurisdiction reserved within the Workers' Compensation Appeals Board.

J. Provided that the defendant employer maintains a medical provide network, the following is hereby stipulated to by the applicant: The defendant has complied with all statutes and regulations regarding the medical provider network; the defendant has had at all times since the date(s) of injury the right to medical provider network control; the defendant provided all required medical provider network notices to the applicant on a timely basis; and, the applicant received all required medical provider network notices on a timely basis.

The defendant disputes all medical bills and lien claims relating to treatment provided by any person or entity not within the medical provider network. The defendant reserves the right to litigate the issue of reasonableness and necessity of all costs, treatment, and services procured outside the medical provider network, and the defendant expressly reserves to itself all statutory and regulatory defenses, whether expressly or implicitly set forth in the Labor Code and all applicable regulatory sections.

DATED: 08/11/2020

Alberto Hernandez
Applicant

DATED: 08/11/2020

Applicants Attorney