STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
COMPROMISE AND RELEASE

ADJ 10825285
Case Number 1

Case Number 2

Case Number 3

Case Number 4

Case Number 5

130-38-8510
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).)

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

Employee(Completion of this section is required)

Floreen
First Name

MI

Rooks
Last Name

125 North Allen Ave Unit 321
Address/PO Box (Please leave blank spaces between numbers, names or words)

Pasadena
City

CA
State

91106
Zip Code

Employer Information (Completion of this section is required)

☒ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

D'Veal Family and Youth Services
Employer Name (Please leave blank spaces between numbers, names or words)

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

Pasadena
City

CA
State

91103
Zip Code

Applicant's Attorney or Authorized Representative:

☒ Law Firm/Attorney ☐ Non Attorney Representative

Natalia
First Name

Foley
Last Name

11964930
Law Firm Number

Natalia Foley Beverly Hills
Law Firm Name

8306 Wilshire Blvd #115
Address/PO Box (Please leave blank spaces between numbers, names or words)

Beverly Hills CA 90211
City State Zip Code

Defendant's Attorney or Authorized Representative:

☒ Law Firm/Attorney ☐ Non Attorney Representative

Rudy
First Name

Grob
Last Name

5881517
Law Firm Number

Pearlman Brown Encino
Law Firm Name

15910 Ventura Blvd Floor 18
Address/PO Box (Please leave blank spaces between numbers, names or words)

Encino CA 91436
City State Zip Code

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

New York Marine and General Insurance Co.
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

412 Mount Kemble Suite 300C
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

Morristown [redacted]NJ 07960
City State Zip Code

Claims Administrator Information (if known and if applicable)

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

PO Box 349016
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

Sacramento | CA | 95834
City | State | Zip Code

IT IS CLAIMED THAT:

1. The injured employee, born 06/20/1949 (DATE OF BIRTH: MM/DD/YYYY), alleges that while employed as a(n)

therapist (OCCUPATION AT THE TIME OF INJURY), sustained injury arising out of and in the course of employment at the locations and during the dates listed below:

(State with specificity the date(s) of injury(ies) and what part(s) of body, conditions or systems are being settled.)

☐ Specific Injury

ADJ10825285 (Case Number 1) ☒ Cumulative Injury 12/30/2014 (Start Date: MM/DD/YYYY) 04/16/2016 (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 130 Body Part 2: 300 Body Part 3: 420

Body Part 4: 500 Other Body Parts: 841

The injury occurred at 855 Orange Grove Blvd.
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

Pasadena (City), CA (State) 91103 (Zip Code).

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ 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: _____

The injury occurred at _____
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

_____ City , _____ State _____ Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ 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: _____

The injury occurred at _____
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

_____ City , _____ State _____ Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ 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: _____

The injury occurred at _____
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

_____ City , _____ State _____ Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ Specific Injury

Case Number 5 ☐ 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: _____

The injury occurred at _____

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

_____ City _____ State _____ Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

2. Upon approval of this compromise agreement by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge and payment in accordance with the provisions hereof, the employee releases and forever discharges the above-named employer(s) and insurance carrier(s) from all claims and causes of action, whether now known or ascertained or which may hereafter arise or develop as a result of the above-referenced injury(ies), including any and all liability of the employer(s) and the insurance carrier(s) and each of them to the dependents, heirs, executors, representatives, administrators or assigns of the employee. Execution of this form has no effect on claims that are not within the scope of the workers' compensation law or claims that are not subject to the exclusivity provisions of the workers' compensation law, unless otherwise expressly stated.

3. This agreement is limited to settlement of the body parts, conditions, or systems and for the dates of injury set forth in Paragraph No. 1 and further explained in Paragraph No. 9 despite any language to the contrary elsewhere in this document or any addendum.

4. Unless otherwise expressly stated, approval of this agreement RELEASES ANY AND ALL CLAIMS OF APPLICANT'S DEPENDENTS TO DEATH BENEFITS RELATING TO THE INJURY OR INJURIES COVERED BY THIS COMPROMISE AGREEMENT. The parties have considered the release of these benefits in arriving at the sum in Paragraph 7. Any addendum duplicating this language pursuant to Sumner v WCAB (1983) 48 CCC 369 is unnecessary and shall not be attached.

5. Unless otherwise expressly ordered by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge, approval of this agreement does not release any claim applicant may have for vocational rehabilitation benefits or supplemental job displacement benefits.

6. The parties represent that the following facts are true: (If facts are disputed, state what each party contends under Paragraph No. 9.)

EARNINGS AT TIME OF INJURY $ _____

TEMPORARY DISABILITY INDEMNITY PAID $0 Weekly Rate $ _____

Period(s) Paid _____ (Start Date: MM/DD/YYYY) _____ (End Date: MM/DD/YYYY)

PERMANENT DISABILITY INDEMNITY PAID $0 Weekly Rate $ _____

Period(s) Paid _____ (Start Date: MM/DD/YYYY) End date _____ (End Date: MM/DD/YYYY)

TOTAL MEDICAL BILLS PAID $ 0 Total Unpaid Medical Expense to be Paid By: Defendant Per. par. 8

Unless otherwise specified herein, the employer will pay no medical expenses incurred after approval of this agreement.

7. The parties agree to settle the above claim(s) on account of the injury(ies) by the payment of the SUM OF

$ 24,000.00
Settlement Amount

The following amounts are to be deducted from the settlement amount:

$ 0 for permanent disability advances through _____

$ 0 for temporary disability indemnity overpayment, if any.

$ _____ payable to _____

$ _____ payable to _____

$ _____ payable to _____

$ _____ payable to _____

$ $3,600.00 requested as applicant's attorney's fee.

LEAVING A BALANCE OF $ $20,400.00, after deducting the amounts set forth above and less further permanent disability advances made after the date set forth above. Interest under Labor Code section 5800 is included if the sums set forth herein are paid within 30 days after the date of approval of this agreement.

8. Liens not mentioned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary):

Defendant shall pay, adjust or litigate all liens filed with the WCAB.
Defendant incorporates by reference its lien affidavit.

9. The parties wish to settle these matters to avoid the costs, hazards and delays of further litigation, and agree that a serious dispute exists as to the following issues (initial only those that apply). ONLY ISSUES INITIALED BY THE APPLICANT OR HIS/HER REPRESENTATIVE AND DEFENDANTS OR THEIR REPRESENTATIVES ARE INCLUDED WITHIN THIS SETTLEMENT.

Applicant	Defendant	
fr	RG	earnings
fr	RG	temporary disability
		jurisdiction
fr	RG	apportionment
		employment
fr	RG	injury AOE/COE
		serious and willful misconduct
		discrimination (Labor Code §132a)
		statute of limitations
fr	RG	future medical treatment
fr	RG	other parking, mileage and out of pocket expenses
fr	RG	permanent disability
fr	RG	self-procured medical treatment, except as provided in Paragraph 7
		vocational rehabilitation benefits/supplemental job displacement benefits

COMMENTS:

Applicant and her attorney waive penalties for 30 days from Service of the Order Approving C&R. See addendum A incorporated herein by reference

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

10. It is agreed by all parties hereto that the filing of this document is the filing of an application, and that the workers' compensation administrative law judge may in its discretion set the matter for hearing as a regular application, reserving to the parties the right to put in issue any of the facts admitted herein and that if hearing is held with this document used as an application, the defendants shall have available to them all defenses that were available as of the date of filing of this document, and that the workers' compensation administrative law judge may thereafter either approve this Compromise and Release or disapprove it and issue Findings and Award after hearing has been held and the matter regularly submitted for decision.

11. WARNING TO EMPLOYEE: SETTLEMENT OF YOUR WORKERS' COMPENSATION CLAIM BY COMPROMISE AND RELEASE MAY AFFECT OTHER BENEFITS YOU ARE RECEIVING TO WHICH YOU BECOME ENTITLED TO RECEIVE IN THE FUTURE FROM SOURCES OTHER THAN WORKERS' COMPENSATION, INCLUDING BUT NOT LIMITED TO SOCIAL SECURITY, MEDICARE AND LONG-TERM DISABILITY BENEFITS.

THE APPLICANT'S (EMPLOYEE'S) SIGNATURE MUST BE ATTESTED TO BY TWO DISINTERESTED PERSONS OR ACKNOWLEDGED BEFORE A NOTARY PUBLIC

By signing this agreement, applicant (employee) acknowledges that he/she has read and understands this agreement and has had any questions he/she may have had about this agreement answered to his/her satisfaction.

Witness the signature hereof this 6 day of November 2018 at Beverly Hills CA

	11/6/2018		11/6/2018
Witness 1	(Date)	Applicant (Employee)	(Date)
	11/6/2018		11/6/2018
Witness 2	(Date)	Attorney for Applicant	(Date)
Interpreter	(Date)	Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)

ACKNOWLEDGMENT

State of California
County of _____)

On _____ before me, _____
(insert name and title of the officer)

personally appeared _____,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ **(Seal)**

Addendum A to Compromise and Release

Re: Floreen Rooks v. D'Veal Family & Youth Services (ADJ10825

The applicant is a Medicare beneficiary. Therefore, the parties must consider Medicare's interests. The parties are not attempting to shift liability for future medical treatment to Medicare, as defendant is not the primary payor of medic treatment regarding ADJ10825285. This is due to the fact that the defendant has denied liability for the alleged work related injury of 12/30/2014 to 04/16/16 pursua to Labor Code Sections 3600(a)(10), 3208.3(e) and 3208.2(f That is, defendant disputes the claimed injury because it was not reported to D'Veal Family and Youth Services before Ms. Rooks was terminated.

Moreover, this settlement does not meet the $25,000 threshold for submission of a Medicare Set Aside to Centers for Medicare Services.

× Floreen Rooks
Applicant

× 11/6/18
Dated

×
Natalie Foley for applicant

11/6/18
× Dated

×
Rudy Grob for defendant

× Dated