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

ADJ13204860
Case Number 1

Case Number 4

Case Number 2

Case Number 5

Case Number 3

623-68-1468
SSN (Numbers Only)

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

[X] 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).)

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

Employee(Completion of this section is required)

SEMEN
First Name

MI

LEV
Last Name

17547 WILLARD ST
Address/PO Box (Please leave blank spaces between numbers, names or words)

NORTHRIDGE
City

CA
State

91325
Zip Code

Employer Information (Completion of this section is required)

[X] Insured [ ] Self-Insured [ ] Legally Uninsured [ ] Uninsured

STORE 2 DOOR
Employer Name (Please leave blank spaces between numbers, names or words)

3801 W MAGNOLIA BLVD
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

BURBANK
City

CA
State

91505
Zip Code

ADJUSTER: VALARE HERVEY RIVERSIDE

Tracking Id: 26768338

Applicant's Attorney or Authorized Representative:

[X] Law Firm/Attorney [ ] Non Attorney Representative

NATALIA
First Name

FOLEY
Last Name

13792552
Law 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 HILLS | CA | 92808
City | State | Zip Code

Defendant's Attorney or Authorized Representative:

[X] Law Firm/Attorney [ ] Non Attorney Representative

ALINA
First Name

GOTTLIEB
Last Name

5223900
Law Firm Number

SCIF INSURED GLENDALE UNIT D
Law Firm Name

P O BOX 65005
Address/PO Box (Please leave blank spaces between numbers, names or words)

FRESNO | CA | 93650
City | State | Zip Code

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

STATE COMPENSATION INSURANCE FUND
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

PO BOX 65005
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

FRESNO | CA | 93650
City | State | Zip Code

Tracking Id: 26768338

Claims Administrator Information (if known and if applicable)

SCIF INSURED INLAND EMPIRE
Name (Please leave blank spaces between numbers, names or words)

PO BOX 65005
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

FRESNO — City
CA — State
93650 — Zip Code

IT IS CLAIMED THAT:

1. The injured employee, born 09/11/1960 (DATE OF BIRTH: MM/DD/YYYY), alleges that while employed as a(n)

DELI WORKER (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

ADJ13204860
Case Number 1

☒ Cumulative Injury

01/02/2020 (Start Date: MM/DD/YYYY)
04/20/2020 (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 420 BACK
Body Part 2: 398 UPPER EXT
Body Part 3: 513 KNEE
Body Part 4: 520 ANKLE
Other Body Parts: 841 STRESS

The injury occurred at 3801 W MAGNOLIA BLVD
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

BURBANK (City), CA (State) 91505 (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.

Tracking Id: 26768338

☐ 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 $ 360.00

TEMPORARY DISABILITY INDEMNITY PAID 0.00 Weekly Rate $ _____

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

PERMANENT DISABILITY INDEMNITY PAID 0.00 Weekly Rate $ _____

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

TOTAL MEDICAL BILLS PAID $ 0.00 Total Unpaid Medical Expense to be Paid By: DEFENDANTS

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

$ 15000.00
Settlement Amount

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

$ 0.00 for permanent disability advances through 07/23/2020

$ _____ for temporary disability indemnity overpayment, if any.

$ _____ payable to _____

$ _____ payable to _____

$ _____ payable to _____

$ _____ payable to _____

$ $2,250.00 requested as applicant's attorney's fee.

LEAVING A BALANCE OF $ $12,750.00, 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):

SEE ATTACHED: SUPPLEMENTAL JOB DISPLACEMENT BENEFIT ADDENDUM AND MEDICARE SET-ASIDE VERIFICATION ADDENDUM D, CONTINUATION OF PARAGRAPH 9, AND LIEN AFFIDAVIT.

DEFENDANT STATE FUND WILL PAY, ADJUST AND OR LITIGATE ALL LIENS OF RECORD PER OMFS, PROPERLY FILED AS PER EAMS FOR ALL THE DATES OF SERVICE PROVIDED THROUGH THE DATE OF THE SIGNING OF THIS C&R AND APPROVAL OF THE SAME. DEFENDANT RESERVES ITS RIGHT TO ANY AND ALL AVAILABLE DEFENSE AS TO THE LIENS, INCLUDING BUT NOT LIMITED TO MPN AND UR. BOARD TO RETAIN JURISDICTION REGARDING LIENS.

~~THIS CASE IS BEING SETTLED AS A DENIED CLAIM. APPLICANT IS NOT ENTITLED TO SJDB BENEFITS PER DEL TRAN.~~

APPLICANT IS NOT ALLEGING ANY INJURIES DURING THEIR EMPLOYMENT WITH STORE 2 DOOR OTHER THAN THE DATE OF THE INJURY BEING SETTLED IN THIS C&R.

APPLICANT IS NOT ALLEGING ANY INJURED "BODY PARTS" NOT IDENTIFIED IN THIS C&R.

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	
SL	VH	earnings
SL	VH	temporary disability
SL	VH	jurisdiction
SL	VH	apportionment
SL	VH	employment
SL	VH	injury AOE/COE
SL	VH	serious and willful misconduct
SL	VH	discrimination (Labor Code §132a)
SL		statute of limitations
SL	VH	future medical treatment
SL	VH	other ALL RETRO BENEFITS/ISSUES
SL	VH	permanent disability IN DISPUTE
SL	VH	self-procured medical treatment, except as provided in Paragraph 7
		vocational rehabilitation benefits/supplemental job displacement benefits

COMMENTS:

THIS COMPROMISE AND RELEASE SETTLES ANY & ALL FUTURE MEDICAL CARE. THIS COMPROMISE AND RELEASE RESOLVES ALL MILEAGE, DEPOSITION FEES, SANCTIONS, AND ALL ACCRUED PENALTIES AND INTERESTS AS PROVIDED BY LAW FOR A PERIOD OF THIRTY(30) DAYS FROM SERVICE OF ORDER APPROVING AWARD UPON DEFENDANTS.

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

10. It is agreed by a all pads 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 01 day of AUGUST, 2020 at ANAHEIM, CA

Witness 1	08/01/2020 (Date)	Applicant (Employee)	08/01/2020 (Date)
Witness 2	08/01/2020 (Date)	Attorney for Applicant	08/01/2020 (Date)
Interpreter	(Date)	Attorney for Defendant	(Date)
		~~Attorney~~ for Defendant REPRESENTATIVE	08/10/2020 (Date)
		Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)

Tracking Id: 26768338

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)**

Tracking Id: 26768338

APPLICANT: SEMEN LEV
EMPLOYER: Store 2 Door
WCAB CASE NUMBER(S): ADJ13204860
SCIF CLAIM NUMBER(S): 06521374

LIEN ADDENDUM

LIENS OF RECORD AND AFFIDAVIT RE: GOOD FAITH EFFORTS TO RESOLVE LIENS

The following are the liens of record as of this date. Defendants will pay, adjust, or litigate, the following liens, less credit for payments previously made.

Jurisdiction is reserved with the Workers' Compensation Appeals Board as to all issues that may arise regarding disposition of these liens.

Lien Claimant Name & Address	Amount	Description, Date & Result of Lien Resolution Efforts
There are no liens on record for this claim.		

I declare under penalty of perjury as follows:

I am the representative for defendant State Compensation Insurance Fund. I have made the above-referenced good faith efforts to resolve each of the listed liens.

Valarie Hervey — 08/10/2020

State Fund Representative — Date

APPLICANT: SEMEN LEV
SOCIAL SECURITY NUMBER: 623-68-1468
WCAB NUMBER: ADJ13204860
CLAIM NUMBER: 06521374

State Fund WCMSA Addendum D

I. Future Medical Care

The above-referenced applicant ("Applicant") and State Compensation Insurance Fund ("State Fund,") collectively the "Parties," understand and agree that Applicant is not currently receiving Social Security Disability or Medicare benefits; has not applied for or been denied Social Security Disability or Medicare benefits; has not appealed a denial of Social Security Disability or Medicare benefits; is not planning to apply for Social Security Disability or Medicare benefits within the next thirty (30) months; and does not have End Stage Renal Disease.

Serious and legitimate good faith issues exist which if determined adversely to Applicant would bar recovery. State Fund denied liability for this workers' compensation claim on 05/22/2020 because: POST-TERMINATION; NO SUBSTANTIAL MEDICAL EVIDENCE OF INJURY FROM A PHYSICIAN WITHIN STATE FUND'S MEDICAL PROVIDER NETWORK

The Parties wish to avoid further litigation and due to the complexity of the issues, the Parties are unable to disaggregate allocations but agree this settlement includes consideration for liability and compensability issues, and any claims for retroactive benefits including, but not limited to, temporary disability, permanent disability, mileage, out-of-pocket medical expense, and interest or penalties including sanctions, through the date of the Order Approving Compromise and Release.

Any medical care sought and/or received by the Applicant is denied by State Fund as unrelated to a compensable industrial injury and Applicant's medical care is to be provided through sources other than the workers' compensation insurer. The Parties have carefully considered whether or not the Medicare program has any interest in this workers' compensation settlement. Given the denied and disputed nature of the underlying workers' compensation claim, as well as Applicant's lack of connection to the Medicare program, the Parties have determined that the Centers for Medicare & Medicaid Services (CMS) has no interest in any post-settlement activities of the Parties and the settlement does not shift injury related medical care costs to Medicare pursuant to the Medicare Secondary Payer ("MSP") statute, 42 U.S.C. Section 1395y (b).

II. Waiver and Severability

Applicant further agrees to waive any past, present or future actions against State Fund pursuant to the Medicare Secondary Payer statute including any private cause of action for damages under the MSP.

Should a tribunal or legislative body act to make any single provision of this addendum agreement unenforceable, all other terms therein shall be severable and shall remain in full force and effect as if the unenforceable provision did not exist.

III. Acknowledgment

Applicant acknowledges and verifies he/she has read (or has had read to him/her) the entire Compromise and Release, including the State Fund WCMSA Addendum D. Applicant acknowledges that he/she understands and accepts the provisions of these documents. Applicant acknowledges he/she has the right to discuss these documents with legal counsel, and if represented, he/she has had the opportunity to confidentially discuss same with legal counsel so as to fully understand the significance of these documents.

Signed this 01 day of AUGUST , 2020 , at ORANGE County, California.

APPLICANT _____ 08/01/2020

APPLICANT'S ATTORNEY _____ 08/01/2020

INTERPRETER _____

CERTIFICATION NUMBER _____

APPLICANT: SEMEN LEV
WCAB NO.: ADJ13204860
STATE FUND CLAIM NO.: 06521374

SJDB/ACCRUED Benefits Addendum (DOI 1/1/2013 & After)

SETTLEMENT OF ACCRUED BENEFITS

The settlement includes any claims for retroactive benefits and reimbursement, including, but not limited to, temporary disability indemnity, mileage reimbursement, out-of-pocket medical expense, and any interest or penalties, including, but not limited to, sanctions and self-imposed penalties, claimed up to the date of the Order Approving Compromise and Release

DWC-AD Form 10133.36 Form not received from physician.

APPLICANT _____ DATE 08/01/2020

APPLICANT'S ATTORNEY _____ DATE 08/01/2020

DEFENDANT'S ~~ATTORNEY~~ REPRESENTATIVE Valarie Hervey DATE 08/10/2020

APPLICANT: SEMEN LEV
WCAB CASE NUMBER(S): ADJ13204860
SCIF CLAIM NUMBER(S): 06521374

CONTINUATION OF PARAGRAPH 9

APPLICANT AND APPLICANT'S ATTORNEY, BY THEIR SIGNATURES, ATTEST TO THE FACT THAT THE APPLICANT ATTORNEY HAS EXPLAINED THIS DOCUMENT AND ALL ADDENDA TO THE APPLICANT IN A LANGUAGE THE APPLICANT HAS UNDERSTOOD AND THAT THE APPLICANT HAS BEEN MADE FULLY AWARE OF THE SIGNIFICANCE OF ALL PROVISIONS HEREIN.

THE APPLICANT HAS BEEN MADE AWARE OF HIS RIGHT TO A FINAL REPORT FROM A QME/AME AND /OR PTP. THESE REPORTS WOULD INDICATE THE LEVEL OF PERMANENT DISABILITY AND THE RIGHT TO FUTURE MEDICAL CARE. APPLICANT WAIVES HIS RIGHT TO SAID REPORT.

THERE ARE SERIOUS AND LEGITIMATE GOOD FAITH ISSUES, INCLUDING AOE/COE ISSUES AND LACK OF MEDICAL EVIDENCE, WHICH IF DETERMINED ADVERSELY TO APPLICANT, WOULD TOTALLY BAR RECOVERY. THE ALLEGED INJURIES TO THE BACK, UPPER EXTREMITIES, BILATERAL KNEES, BILATERAL ANKLES, BILATERAL HANDS, BILATERAL WRISTS, BILATERAL SHOULDERS, STRESS, ANXIETY, PSYCH ARE DENIED. THE PARTIES ENTER INTO THIS SETTLEMENT BECAUSE THEY WISH TO AVOID AMBIGUITIES, UNCERTAINTIES AND RISK OF LITIGATION AND WANT TO BUY THEIR PEACE.

APPLICANT _____ DATE 08/01/2020

APPLICANT'S ATTORNEY _____ DATE 08/01/2020

DEFENDANT'S ~~ATTORNEY~~ REPRESENTATIVE Valarie Hervey DATE 08/10/2020

Addendum to Compromise & Release
RE: SEMEN LEV vs STORE2DOOR INC
CASE #.: ADJ13204860

QME WAIVER ADDENDUM

I, **SEMEN LEV,** certify that Attorney NATALIA FOLEY explained me my rights to PQME evaluation in details, and I willfully, knowingly and freely waived my rights to final PQME evaluation.

By signing this Addendum, I knowingly waive my right to a Qualified Medical Evaluator.

Date: 08/01/2020 Applicant: _____
(signature)

Date: 08/01/2020 Applicant' Attorney: _____
(signature)