

DEPARTMENT OF INDUSTRIAL RELATIONS
Division of Workers' Compensation
Subsequent Injuries Benefits Trust Fund
Tel: (916) 928-4601 Fax: (916) 928-4705

Mailing Address:
1750 Howe Avenue, Suite 370
Sacramento, CA 95825
Attn: SIBTF



JULY 6, 2023

WORKERS DEFENDERS ANAHEIM
751 S WEIR CANYON RD STE 157 455
ANAHEIM CA 92808

APPLICANT: SZYMON JERMAKOW
WCAB Case No.: ADJ 13487196
SIBTF Claim No.: SIF 13487196
DOI: 3/15/2020

DOCUMENTS REQUIRED IN CONNECTION WITH APPLICATION FOR SUBSEQUENT INJURIES FUND BENEFITS

Dear Applicant Attorney:

We received an application for Subsequent Injuries Fund benefits for the above-named Applicant. In order for us to evaluate the claim for benefits, we need additional information from you. Please provide the following documents and information within 30 days.

Eligibility Documents:

1. **Medical Reporting:** All med-legal reporting obtained by the parties in the subsequent injury case including all reporting by a Panel Qualified Medical Evaluator (PQME), Agreed Medical Evaluator (AME), and/or Vocational Rehabilitation Evaluator (VRE), and any final Permanent & Stationary Report (PR-4) from a treating physician. No medical treatment records are required at this time.
2. **Deposition Transcripts:** Any deposition transcript of Applicant or any evaluators in any industrial case in which Applicant was/is a party, including citation to relevant pages related to ratable permanent disability.
3. **Ratings:** Copies of all Disability Evaluation Unit (DEU) or independent ratings in the subsequent injury case and any prior workers' compensation case(s).
4. **AWW:** Proof of Applicant's average weekly wage at the time of the subsequent injury including earnings records for the 52 week period immediately preceding the date of the subsequent injury.

Benefit Documents:

1. **Prior Awards and Settlements:** All awards and/or judgments, and settlements, including:
 - a. All workers' compensation case Findings and Award, Stipulations with Request for Award and Award, and Compromise and Release and Order Approving Compromise and Release;
 - b. Civil judgments and settlements resulting from personal injury (include a copy of the civil complaint, judgment, and settlement documents); and,
 - c. Other documentation of claims, awards, and settlements, in which Applicant has been a party (such as motor vehicle accident(s)).
2. **Releases:** Signed and dated Social Security, Retirement/Pension and/or Long Term Disability, and CalPERS releases. These have been sent under separate cover.

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3. **Disability Benefits:** If Applicant has received, is receiving, or is entitled to receive, any disability benefit please provide the following: (1) documentation showing the date of entitlement (Notice of Award, notice of entitlement to benefit, etc.); and, (2) proof of benefit income from the date of entitlement to present (including 1099 or W-2 income statements from date of entitlement to present, benefit payment history, and benefit rate change notices). Disability benefits may include but are not limited to:

- a. Social Security Disability;
- b. Disability retirement;
- c. Disability pension; and,
- d. Long term disability (LTD).

(This is a continuing request. Please continue to provide proof of all future benefit income such as copies of 1099 or W-2 income statements and rate change notices.)

Other Documents:

1. **Other Documents:** Any other pertinent documents that support the claim for benefits or may entitle SIBTF to credit pursuant to Labor Code section 4753.

We need the documents and information listed above to determine whether your client is eligible for SIF benefits and, if so, the amount of benefits to which they are entitled.

Please be advised that SIBTF prefers to have physical documents served via U.S. mail. However, if documents are voluminous, SIBTF may also accept service of documents by CD. If you provide documents by CD, we require you to bates stamp the documents and include an index of the documents on the CD by (a) name of document, (b) author, (c) date, and (d) bates stamp number. Please provide copies of all requested documents to SIBTF Claims, 1750 Howe Ave, Suite 370, Sacramento, CA 95825.

Finally, please do not schedule consultations with evaluators for the Subsequent Injuries Fund claim before you provide the documents and information requested in this letter to us. Otherwise, we may find it necessary to object to the reports and the bills for same that you incurred prematurely, and/or without providing notice to us.

Thank you in advance for your prompt response to this request.

Sincerely,

Alyssa Vasquez

A VASQUEZ for:
STEVE BURG
Workers' Compensation Consultant
(916) 928-4601

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RELEASE FORMS

Dear Sir/Madam:

Enclosed are the Authorization for Release for the Social Security Administration and a Request for Retirement/Pension and/or Long Term Disability Release. Please have your client complete and sign these forms to determine what credit, if any, may be applicable as offsets against any benefits paid by the Subsequent Injury Benefits Trust Fund, pursuant to Labor Code section 4753.

This required information must be provided at least 30 days before any hearing or settlement is scheduled at the WCAB.

If your client is receiving Social Security Disability from the Social Security Administration, a Disability Retirement/Pension, a Union Disability Pension and/or Long Term Disability, it will save time if he/she can provide a copy of the Award letter that indicates the start date, the amount received, as well as the dates and amount(s) of any changes in the monthly benefit.

Prior to resolution of the SIBTF liability, if your client begins to receive any of these types of benefits, you are under a continuing obligation to provide this information.

Thank you for your attention in this matter.

Sincerely,

Alyssa Vasquez

A VASQUEZ for:
STEVE BURG
Workers' Compensation Consultant
(916) 928-4601

Enclosure: Social Security Release, Retirement/Pension and/or Long Term Disability Release

SIF/13 3/9/23



RETIREMENT/PENSION AND/OR LONG / SHORT TERM DISABILITY RELEASE

NAME: SZYMON JERMAKOW DATE OF BIRTH: 5/4/1940

SOCIAL SECURITY NUMBER: 345-68-9822

ADDRESS: _____

SIF# 13487196

Retirement/Pension

Do you receive, have you ever received, or are you entitled to receive, benefits from an Employer Retirement or Pension Plan?

Yes _____ No _____

(If yes please complete the following information)

Employer: _____

Administered by: _____

Address: _____

Union

Do you receive, have you ever received, or are you entitled to receive, Pension benefits through a union?

Yes _____ No _____

(If yes please complete the following information)

Union Name: _____ Union# _____

Address: _____

Long Term / Short Term Disability

Do you receive, have you ever received, or are you entitled to receive, benefits through a Long Term / Short Term Disability Plan?

Yes _____ No _____

(If yes please complete the following information)

Administered by: _____

Address: _____

Please read, sign and date below:

I hereby grant permission to release retirement/pension and/or long term/ short term disability information to the Subsequent Injuries Benefits Trust Fund and declare under Penalty of Perjury under the laws of the State of California that the foregoing is true and correct.

Signature: X _____

Date: X _____

PLEASE RETURN THE COMPLETED FORM TO:
SUBSEQUENT INJURIES BENEFITS TRUST FUND
Office of the Director – Claims & Risk Management
1750 Howe Avenue, Suite 370
Sacramento, CA 95825

Consent for Release of Information

You must complete all required fields. We will not honor your request unless all required fields are completed. (*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).

TO: **Social Security Administration**

SZYMON JERMAKOW

5/4/1940

345-68-9822

* My Full Name

My Date of Birth
(MM/DD/YYYY)

*My Social Security Number

I authorize the Social Security Administration to release information or records about me to:

*NAME OF PERSON OR ORGANIZATION:

*ADDRESS OF PERSON OR ORGANIZATION:

State of California Subsequent Injury

1750 Howe Avenue, Suite 370

Benefits Trust Fund (SIBTF)

Sacramento, CA 95825

***I want this information released because: State of California needs this information to determine my eligibility for the Subsequent Injury Benefits Trust Fund.**

We may charge a fee to release information for non-program purposes

THIS REQUEST IS FOR DISABILITY INFORMATION ONLY

*Please release the following information selected from the list below:

Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. Verification of Social Security Number
2. Current monthly Social Security benefit amount
3. Current monthly Supplemental Security Income payment amount
4. My benefit or payment amounts from date SSD Start to date Present (LESS ALL DEDUCTIONS & OVERPAYMENTS)
5. My Medicare entitlement from date _____ to date _____
 - a. If you want us to release a minor child's medical records, do not use this form. Instead, contact your local social security office.
6. Medical records from my claims folder(s) from date _____ to date _____
7. Complete medical records from my claims folder(s)
8. Other record(s) from my file (we will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to \$5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

*Signature: _____ *Date: _____

**Address: _____ **Daytime Phone: _____

Relationship (if not the subject of the record): _____ **Daytime Phone: _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above

1. Signature of witness

2. Signature of witness

Address (Number and street, City, State, and Zip Code)

Address (Number and street, City, State, and Zip Code)

(FOR CalPERS MEMBERS ONLY)

Consent for Release of Information

You must complete all required fields. We will not honor your request unless all required fields are completed.
(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).

TO: CalPERS

<u>SZYMON JERMAKOW</u>	<u>5/4/1940</u>	<u>345-68-9822</u>
*My Full Name	*My Date of Birth (MM/DD/YYYY)	*My Social Security Number

I authorize CalPERS to release information or records about me to:

*NAME OF PERSON OR ORGANIZATION:	*ADDRESS OF PERSON OR ORGANIZATION:
<u>State of California Subsequent Injury</u>	<u>1750 Howe Ave Ste 370</u>
<u>Benefits Trust Fund (SIBTF)</u>	<u>Sacramento CA 95825</u>
_____	_____

*I want this information released because: State of California needs this information to determine my eligibility for the Subsequent Injury Benefits Trust Fund.

THIS REQUEST IS FOR DISABILITY INFORMATION ONLY

*Please release the following information selected from the list below:

1. Type of Retirement
2. Date of Entitlement
3. Breakdown of Payments
4. Body parts that the disability is based on

I am the individual, to whom the requested information or record applies. I hereby grant permission to release retirement/pension information to the Subsequent Injury Benefits Trust Fund.

*Signature: _____ *Date: _____

**Address: _____ *Daytime Phone _____

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SUPPORTING DOCUMENTATION CHECKLIST

This form is to be completed and provided with all supporting documentation to avoid delays.

Name of Injured Worker SZYMON JERMAKOW SIBTF Claim Number 13487196

Date of Subsequent Injury _____ Date of SIBTF Application _____

Prepared by: _____

Please check and complete applicable blank sections. All supporting documentation is to be submitted in order of this checklist and in chronological order with the newest information on top.

- Proof of Veteran's Administration Benefits.
- Signed and dated Social Security, Retirement/Pension and/or Long Term Disability releases.
- Settlement demand.
- Comprehensive review of the case stating how it qualifies for the Subsequent Injuries Benefits Trust Fund.
- Awards: Copies of Subsequent Industrial Awards, Motor Vehicle Accident(s), civil settlements and Prior Disability Awards providing level of Permanent Disability (Stipulations and Award, Compromise & Release, Findings and Award).
 - o Award Description: _____ Amount: _____
 - o Award Description: _____ Amount: _____
 - o Award Description: _____ Amount: _____
- All QME, AME, VRE, and any final Permanent & Stationary Reports from a treating physician.
 - o Dr. Name: _____

 - Type: _____
 - Date: _____
 - o Dr. Name: _____ Type: _____ Date: _____
 - o Dr. Name: _____ Type: _____ Date: _____
 - o Dr. Name: _____ Type: _____ Date: _____
- Copies of all DEU or Independent Ratings.
 - o Body parts: _____ Percentage: _____
 - o Body parts: _____ Percentage: _____
 - o Body parts: _____ Percentage: _____
- Depositions: Please cite relevant pages related to ratable Permanent Disability.
- Proof of Average Weekly Wage.
- Other: _____

