



# State of Wisconsin DIVISION OF HEARINGS AND APPEALS

Brian Hayes, Administrator  
Office of Worker's Compensation Hearings  
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## ADMISSION TO SERVICE AND ANSWER TO APPLICATION

You are the **RESPONDENT** in this matter.

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

WC Claim Number	Employee Name
Employee Social Security Number	Employer Name
Date of Alleged Injury	Employer Mailing Address
Insurance Company Name	Insurance Company Mailing Address
Respondent Attorney Name	Respondent Attorney Mailing Address

The enclosed hearing application must be answered within 20 days by mailing a copy of the answer to the Office of Worker's Compensation Hearings and to applicant's attorney or applicant if unrepresented. Provide such responses as are now known and amend your responses later as necessary. The worker's compensation insurer has a duty to defend and submit an answer on behalf of the employer except that the employer must defend and submit its own answer as to the following claims: (I) 15% increased compensation for safety violation, Wis. Stat. 102.57; (II) refusal to rehire, Wis. Stat. 102.35 (3); (III) penalty for late payment against employer, Wis. Stat. 102.22; (IV) penalty for illegal employment of minor, Wis. Stat. 102.60; and (V) bad faith against employer, Wis. Stat. 102.18 (1) (bp). **Failure by the employer or insurer to file a timely answer may result in liability by default order.**

In answer to the application, using reverse side if additional space is necessary, the respondent states as follows:	
1. The accident or occupational exposure occurred as alleged	<input type="checkbox"/> Admit <input type="checkbox"/> Deny
2. The relationship of employer and employee existed	<input type="checkbox"/> Admit <input type="checkbox"/> Deny
3. The parties were subject to the worker's compensation act	<input type="checkbox"/> Admit <input type="checkbox"/> Deny
4. At the time of alleged injury, the employee was performing service growing out of and incidental to employment	<input type="checkbox"/> Admit <input type="checkbox"/> Deny
5. The accident or disease causing injury arose out of the alleged employment	<input type="checkbox"/> Admit <input type="checkbox"/> Deny
6. Notice of injury was given to employer within 30 days/2 years of alleged injury	<input type="checkbox"/> Admit <input type="checkbox"/> Deny
7. Applicant was temporarily disabled for the period claimed	<input type="checkbox"/> Admit <input type="checkbox"/> Deny
If denied, state disability admitted:	
8. Applicant is permanently disabled to the extent claimed	<input type="checkbox"/> Admit <input type="checkbox"/> Deny
If denied, state disability admitted:	
9. The rate of wage claimed is correct	<input type="checkbox"/> Admit <input type="checkbox"/> Deny
If denied, state wage admitted: _____ and attach a fully updated WKC-13-A	
10. The alleged employer was insured or self-insured under the Worker's Compensation Act	<input type="checkbox"/> Admit <input type="checkbox"/> Deny
11. Do you contend that additional parties must be joined for a complete resolution of applicant's claim? If "yes," attach expert opinions supporting joinder and explain who should be joined and why.	<input type="checkbox"/> Admit <input type="checkbox"/> Deny
12. Do you contend the employee was discharged or suspended for misconduct or substantial fault after being released to return to a restricted type of work during the healing period?	<input type="checkbox"/> Admit <input type="checkbox"/> Deny
13. Do you contend that indemnity or death benefits were not paid because the employee violated the employer's policy on alcohol or drug use and the violation was causal to injury?	<input type="checkbox"/> Admit <input type="checkbox"/> Deny
14. Describe any matters in dispute not already noted above and state all reasons for denying liability not already noted above.	

**Insurance Carriers & Self-Insured Employers must attach an up-to-date WKC-13 and if wage is disputed, an up-to-date WKC-13-A.**

Respondent Signature:	Date Signed:
Printed Name: _____ Title: _____	Phone Number: (     )     -
Representing: <input type="checkbox"/> Insurance carrier and the insured interests of employer	<input type="checkbox"/> Insurance Carrier <input type="checkbox"/> Employer