ADMISSION TO SERVICE AND ANSWER TO APPLICATION

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

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave.
P.O. Box 7901
Madison, WI 53707
Telephone: (608) 266-1340
Fax: (608) 260-3053
https://dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay. The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats. The purpose of this form is to assist with the procurement of information related to or required by Chapter 102. Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102. DWD may use the personal identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected. Do not email this form.

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 Worker's Compensation Division 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	☐ Admit ☐ Deny
2. The relationship of employer and employee existed	☐ Admit ☐ Deny
3. The parties were subject to the Worker's Compensation Act	☐ Admit ☐ Deny
4. At the time of alleged injury, the employee was performing service growing out of and incidental to employment	☐ Admit ☐ Deny
5. The accident or disease causing injury arose out of the alleged employment	☐ Admit ☐ Deny
6. Notice of injury was given to employer within 30 days/2 years of alleged injury	☐ Admit ☐ Deny
7. Applicant was temporarily disabled for the period claimed If denied, state disability admitted:	☐ Admit ☐ Deny
8. Applicant is permanently disabled to the extent claimed If denied, state disability admitted:	☐ Admit ☐ Deny
9. The rate of wage claimed is correct If denied, state wage admitted: and attach a fully updated WKC-13-A	☐ Admit ☐ Deny
10. The alleged employer was insured or self-insured under the Worker's Compensation Act	☐ Admit ☐ 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.	☐ Admit ☐ 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?	☐ Admit ☐ 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?	☐ Admit ☐ 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: ☐ Insurance carrier and the insured interests of employer ☐ Insurance Carrier ☐ Employer