



State of Wisconsin DIVISION OF HEARINGS AND APPEALS

Brian Hayes, Administrator

Office of Worker's Compensation Hearings
P.O. Box 7922
Madison, WI 53707

Telephone: (608) 266-7709
FAX: (608) 266-0018
Email: DHAWCMail@wisconsin.gov

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. 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 personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

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	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:
Representing: Insurance carrier and the insured interests of employer	Insurance Carrier Employer
	Phone Number: