

STATE OF CALIFORNIA
ARNOLD SCHWARZENEGGER, Governor

Deion Sanders WCAB #.....
 DEU File No: H78790 Age at DOI: 32
 Occupation : PROFESSIONAL FOOTBALL PLAYER
 EAMS Case No: DEU7348315
 Employee Representative: Employer Representative:

Date

CASE ID: ADJ7348315
{C887BB4E-238D-484D-BB86-897F4673EAD5}

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STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
APPLICATION FOR ADJUDICATION OF CLAIM

☐ Amended Application

RECEIVED

MAY 27 2010

DWC/WCAB
SANTA ANA

Case No. _____

SSN (Numbers Only) _____

Venue choice is based upon (Completion of this section is required)

- ☐ 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).)

ANA

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

Injured Worker (Completion of this section is required)

DEION

First Name

MI

SANDERS

Last Name

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

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

International Address (Please leave blank spaces between numbers, names or words)

PROSPER

City

TX
State

Zip Code

Applicant (If other than Injured Worker)

- ☐ Insurance Carrier ☐ Employer ☐ Lien Claimant

Name (Please leave blank spaces between numbers, names or words)

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

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

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Employer Information (Completion of this section is required)

☒ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

DALLAS COWBOYS

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

ONE COWBOY PARKWAY

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

IRVING

City

TX

State

75063

Zip Code

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

TRAVELERS / GULF

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

PO BOX 660281

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

DALLAS

City

TX

State

75266

Zip Code

Claims Administrator Information (If known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

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

City

State

Zip Code

IT IS CLAIMED THAT (Complete all relevant information):

1. The injured worker, born 08/09/1967, while employed as a(n) FOOTBALL PLAYER
 (DATE OF BIRTH: MM/DD/YYYY) (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)



specific injury

(Date of Injury: MM/DD/YYYY)

suffered a



cumulative injury

which began on

05/15/1995

(Start Date: MM/DD/YYYY)

and ended on

01/09/2000

(End Date: MM/DD/YYYY)

The injury occurred at

VARIOUS STADIUMS & PRACTICE FACILITIES

Street Address/PO Box - Please leave blank spaces between numbers, names or words

City

State

Zip Code

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(State which parts of the body were injured)

Body Part 1: 100 HEAD

Body Part 2: 200 NECK

Body Part 3: 398 UPPER EXT

Body Part 4: 519 LEG

Other Body
 Parts: 700 MULTIPLE

2. The injury occurred as follows:

(EXPLAIN WHAT THE WORKER WAS DOING AT THE TIME OF INJURY AND HOW THE INJURY OCCURED)

SUSTAINED INJURIES WHILE PLAYING FOOTBALL

3. Actual earnings at the time of injury:

Rate of Pay \$ MAX ☐ Monthly ☐ Weekly ☐ Hourly
 State value of tips, meals, lodging, or other advantages, regularly received \$ TBD ☐ Monthly ☐ Weekly ☐ Hourly

Number of hours worked per week MAX

4. The injury caused disability as follows:

Last day off work due to injury: 01/09/2000
 MM/DD/YYYY

First Period of Disability: Start Date TBD
 MM/DD/YYYY

End Date TBD
 MM/DD/YYYY

Second Period of Disability: Start Date TBD
 MM/DD/YYYY

End Date TBD
 MM/DD/YYYY

5. Compensation:

Compensation was paid: ☐ Yes ☒ No

Total paid: NONE

Weekly rate(s): N/A

Date of last payment: NONE
 MM/DD/YYYY

6. Has the worker received any unemployment insurance benefits and/or any unemployment compensation disability benefits (state disability) since the date of injury? ☒ Yes ☐ No

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7. Medical treatment:

Medical treatment was received:

☒ Yes ☐ No

All treatment was furnished by the Employer or Insurance Carrier:

☐ Yes ☒ No

Date of last treatment: UNKNOWN
MM/DD/YYYY

Other treatment was provided/paid by: UNKKNOWN

(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)

Did Medi-Cal pay for any health care related to this claim?

☐ Yes ☒ No

Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or examined for this injury, but that were not provided or paid for by the employer or insurance carrier:

Name of Doctor/Hospital/Clinic 1 (Please leave blank spaces between numbers, names or words)

Name of Doctor/Hospital/Clinic 2 (Please leave blank spaces between numbers, names or words)

8. Other cases have been filed for industrial injuries by this worker as follows:

Case Number 1

Case Number 3

Case Number 2

Case Number 4

9. This application is filed because of a disagreement regarding liability for:

☒ Temporary disability indemnity

☒ Permanent disability indemnity

☒ Reimbursement for medical expense

☒ Rehabilitation

☒ Medical treatment

☒ Supplemental Job Displacement/Return to Work

☒ Compensation at proper rate

☒ Other (Specify) BENEFIT LABOR CODE

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03/23/2010 10:31

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Is the Applicant Represented? ☒ Yes ☐ No If "No", applicant is to sign and date below.

If "Yes", applicant's representative is to complete the following and is to sign and date below.

☒ Law Firm/Attorney

☐ Non-Attorney Representative

NAMANNY BYRNE OWENS

Law Firm or Company Name (If Applicable)

Law Firm Number (If Applicable)

MEL

Attorney/Representative First Name

T

MI

OWENS

Attorney/Representative Last Name

24411 RIDGE ROUTE DRIVE SUITE 135

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

LAGUNA HILLS

City

CA

State

92653

Zip Code

Applicant Attorney/Representative Signature

Applicant Signature

Dated at

LAGUNA HILLS

City

California

Date

3/24/10
MM/DD/YYYY