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 Ave, STE 370,
Sacramento, CA 95825
Attn: SIBTF

10/28/2024

KOSZDIN FIELDS VAN NUYS
6151 VAN NUYS BLVD
VAN NUYS, CA 91401

Re: Applicant:	STEEVIO BARDAKJIAN
WCAB Case No.:	ADJ 11540526
SIBTF Claim No.:	SIF 11540526
Applicant's DOI Date:	7/3/2018

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:

5. 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)).
6. 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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7. 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:

    d. Social Security Disability;

    e. Disability retirement;

    f. Disability pension; and,

    g. 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:

8. 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 copies of all requested documents served via U.S. mail to SIBTF Claims, 1750 Howe Ave, Suite 370, Sacramento, CA 95825. For electronic delivery of the documents over 200 pages, please send a request to sibtf@dir.ca.gov, to arrange for service of documents in pdf format by secure email or Share Point folder link. **Please be advised that SIBTF does not accept the service of documents by means of external devices such as CD or USB due to DIR's IT policy.** Individual pdf documents should be titled using the following naming convention: "[name of document] – [author] – [date]". Multiple documents in a single pdf must be accompanied by an index with the (a) name of document, (b) author, (c) date, and (d) pdf page number.

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,

A VASQUEZ

A VASQUEZ for:
JOANNA ARIZABAL
Workers' Compensation Consultant
Subsequent Injuries Benefits Trust Fund
Phone: (916) 928-4601
Email: sibtf@dir.ca.gov

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10/28/2024

KOSZDIN FIELDS VAN NUYS
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Re: Applicant:	STEEVIO BARDAKJIAN
WCAB Case No.:	ADJ 11540526
SIBTF Claim No.:	SIF 11540526
Applicant's DOI Date:	7/3/2018

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 to this matter.

Sincerely,

A VASQUEZ

A VASQUEZ for: JOANNA ARIZABAL

Workers' Compensation Consultant
Subsequent Injuries Benefits Trust Fund
Phone: (916) 928-4601
Email: sibtf@dir.ca.gov

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

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

NAME: STEEVIO BARDAKJIAN **DATE OF BIRTH: 5/23/1970** **SSN: 554-81-2130**

SIF #: SIF 11540526

****

1) Does this Applicant receive, or have they ever received **Disability Retirement/Pension, Long Term Disability, Industrial Disability or Disability Income?**

Yes _____ No _____

(If yes please complete the following questions)

2) What type of Disability benefit is he/she receiving, or have they received?

_____

3) What is the Date of Entitlement? _____/_____/_____

4) Please provide a breakdown of Disability payments from the date of entitlement to the present as well as any deductions and overpayments. If more space is needed, please attach a separate sheet with the breakdown.

_____

_____

5) If the applicant is receiving or has received disability retirement/pension benefits, will they be entitled to regular retirement benefits in the future? Yes _____ No _____

6) If yes, what would the first date of regular retirement be? _____/_____/_____

7) If the applicant is receiving or has received Industrial Disability, please indicate the body parts the benefit is based on. (e.g. back, left hip, heart, psych)

_____

_____

COMPLETED BY: _____ DATE: _____

TITLE: _____ PHONE: ( ) _____

COMPANY NAME: _____

ADDRESS: _____

PLEASE RETURN THE COMPLETED FORM TO:
SUBSEQUENT INJURIES BENEFITS TRUST FUND
Division of Workers' Compensation
1750 Howe Avenue, Suite 370
Sacramento, CA 95825

Consent for Release of Information

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). You may complete this form to release only the minor's non-medical records, if you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child. We require proof of relationship, if you are not the subject of the record. We may charge a fee for providing the information, if you are requesting the information for a purpose unrelated to the administration of a program under the Social Security Act. If you are requesting information, such as a Social Security Statement or benefit verification letter, you can also access this information by creating an account at https://www.ssa.gov/myaccount/.

NOTE: Do NOT use this form to request:

- **The release of a minor child's medical records. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or**
- **Detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.**

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form.

- Fill in the name, date of birth, and social security number of the subject of the record.
- Fill in the name and address of the person or organization of where you want us to send the requested information.
- Specify the reason you want us to release the information (e.g., litigation, investigation, determining eligibility for benefits). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child or legally incompetent adult, you must state how the release of information is in the best interest of the minor child or legally incompetent adult.
- Check the box next to the type(s) of information you want us to release including specific date ranges, where applicable.

NOTE: Unless otherwise specified, the consent form is valid for one-time use only. Also, it is valid for one year from the date of signature, unless you are requesting medical records. A consent form that includes a request for medical records is valid for 90 days from the date of signature.

Send or bring the completed form to the subject of the record's local servicing office. To locate the appropriate servicing office, visit https://secure.ssa.gov/ICON/main.jsp, and input the subject of the record's ZIP code.

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. **These are not mandatory fields for the consent form to be acceptable. Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

STEEVIO BARDAKJIAN	5/23/1970	554-81-2130
***Full Name**	***Date of Birth**	***Full 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: ** PHONE NUMBER OF PERSON OR ORGANIZATION:
State of California - Subsequent Injuries	1750 Howe Avenue, Suite 370
Benefits Trust Fund (SIBTF)	Sacramento, CA 95825-3367

***I want this information released because:**
We may charge a fee to release information for non-program purposes.
I have applied for benefits from the SIBTF (which is a state-administered fund). SIBTF requires the below SSDI records, in order to determine benefits in accordance with Cal. Labor Code 4753.

***Please release the following information selected from the list below:**
Check at least one box. If requesting medical records, do not check both boxes 7 and 8. We will not disclose records unless you include specific 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. ☒ Social Security benefit amounts from date SSDI start to date present
5. ☐ Supplemental Security Income payment amounts from date _____ to date _____
6. ☐ Medicare entitlement from date _____ to date _____
7. ☐ Medical records from date _____ to date _____
8. ☒ Complete medical records
9. ☒ Other Social Security record(s) (We will not honor a request for "any and all records" or "the entire file." You must specify which records you are seeking. For example, award/denial notices, benefit applications, appeals)
   All award/denial notices, benefit applications, appeals, all documents that indicate the basis for granting (or denying) SSDI benefits, 1099's for all disability benefits rec'd.

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 § 1746) 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 seeks or obtains access to records about another person under false pretenses is punishable by a fine of up to $5,000.

***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)

Privacy Act Statement
Collection and Use of Personal Information

The Privacy Act (5 U.S.C. 552a) and Section 205(a) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from honoring the request to release information or records about you. We will use the information you provide to respond to the request for Social Security Administration (SSA) records. We may share the information for the following purposes, called routine uses:

- To contractors and other Federal agencies, as necessary, for the purpose of assisting SSA in the efficient administration of its programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784; 60-0320, entitled Electronic Disability Claim File, as published in the FR on December 22, 2003, at 68 FR 71210; and 60-0340, entitled FOIA and Privacy Act Record Request and Appeal System, as published in the FR on July 13, 2016, at 81 FR 45352. Additional information, and a full listing of all our SORNs, is available on our website at www.ssa.gov/privacy.

Paperwork Reduction Act Statement

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 5 minutes to read the instructions, gather the facts, and answer the questions. You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

(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**

STEEVIO BARDAKJIAN	5/23/1970	554-81-2130
*My Full Name	*My Date o/f Birth (MM/DD/YYYY)	*My Social Security Number

CalPERS Member Number:

I authorize CalPERS 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 Ave Ste 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.

THIS REQUEST IS FOR DISABILITY INFORMATION ONLY

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

1. [X] Type of Retirement
2. [X] Date of Entitlement
3. [X] Breakdown of Payments
4. [X] 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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Mailing Address:
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Sacramento, CA 95825
Attn: SIBTF

SUPPORTING DOCUMENTATION CHECKLIST

This form is to be completed and provided with all supporting documentation to avoid delays.
Name of Injured Worker **STEEVIO BARDAKJIAN** SIBTF Claim Number: **SIF11540526**
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: _____
  _____
  _____