State of California - Department of Insurance

Workers' Compensation Insurance Policy Appeal

CDI-002 (Rev. 10/2015)

PURPOSE OF THIS FORM: Use this form to file an appeal with the CDI's Administrative Hearing Bureau (AHB) from a written decision of a workers' compensation insurance company or the Workers' Compensation Insurance Rating Bureau (WCIRB) in response to requests for review, requests for policyholder information, and requests for reconsideration (Complaint and Request for Action) provided in Insurance Code sections 11737(f), 11752.6(c), 11753.1(a) and 11753.1(b). More information about how to file an appeal and administrative hearings can be found in California Code of Regulations, title 10, sections 2509.40 et seq**. The AHB does not accept fax or e-mail filings. Do not fax or e-mail this form.**

TIME LIMITS FOR FILING AN APPEAL – The time limits for filing an appeal are as follows:

(a) 30 days from the date your workers' compensation insurer or the WCIRB serves its rejection to review your Complaint and Request for Action;

(b) 30 days from the date your workers' compensation insurer or the WCIRB serves its rejection of your Complaint and Request for Action;

(c) 30 days from the date your workers' compensation insurer or the WCIRB serves its decision on reconsideration;

(d) 60 business days from the date you served the workers' compensation insurer or the WCIRB with a request for reconsideration if the insurer or the WCIRB fails to serve you with a decision;

(e) 120 days from the date you served the workers' compensation insurer or the WCIRB with the Complaint and Request for Action if the insurer or WCIRB fails to serve you with a decision.

APPELLANT (Person or business appealing final decision of insurance carrier or WCIRB)

1. Full name: _____
2. Mailing address: _____
3. Telephone No.: _____
4. Facsimile No.: _____
5. Email address: _____
6. Name of Appellant's representative (if applicable): _____
7. Representative's mailing address: _____
8. Representative's telephone number: _____
9. Representative's Facsimile number: _____
10. Representative's email address: _____
11. Insurance Policy Number(s) underlying the dispute: _____
12. Named Insured: _____
13. Policy Periods impacted by the dispute (mm/dd/year) to (mm/dd/year): _____

RESPONDENT (Entity whose final decision you are appealing)

(Check one or more boxes) **INSURANCE COMPANY** ☐ **WCIRB** ☐

14. If you checked the box for Insurance Company, provide the name of the company: _____

15. The name and/or address of Respondent's designated person for the receipt of Appeals: _____

16. Telephone number: _____

17. Facsimile number: _____

PRELIMINARY INFORMATION

18. Have you filed a Complaint and Request for Action with your insurance carrier or the WCIRB about the dispute?

    Yes ☐ No ☐

DO NOT COMPLETE THIS FORM IF YOUR ANSWER TO QUESTION 18 IS - NO -.

19. Date and to whom you submitted a Complaint and Request for Action: _____

20. Have you received a written final decision from the insurance carrier or the WCIRB on your Complaint and Request for Action?

    Yes ☐ No ☐

If your answer to question 20 is YES, you must include 2 copies of the following documents with your appeal.

1. a copy of your Complaint and Request for Action.
2. a copy of the final written decision by the insurance company or the WCIRB on your Complaint and Request for Action.

21. Have you previously contacted other departments within the Department of Insurance (e.g. CDI's Consumer Hotline, CDI's Consumer Services Division, CDI's Ombudsman,) regarding the same dispute underlying the appeal?

    Yes ☐ No ☐

If your answer to question 21 is YES, answer questions 22 – 26:

22. Name of CDI Department and/or CDI personnel contacted: _____

23. Date(s) contacted CD: _____

24. Action, if any, taken by CDI (e.g. file opened, letter sent, advice given): _____

25. CDI File No: (if any) _____

26. Attach to the appeal a copy of any correspondence you received form the CDI Department**.**

STATEMENT OF APPEAL

Identify the nature of the dispute on appeal. (For example: My insurance carrier assigned the wrong classification to my policy or the WCIRB incorrectly calculated my experience modification.). Then provide a complete and concise statement as to why the Appellant believes the insurance carrier's or WCIRB's written decision on your Complaint and Request for Action is wrong. Remember to attach all supporting documentation required in California Code of Regulations, title 10, section 2509.47.

APPEAL CHECKLIST

Initial each numbered question in the space provided to confirm that you have completed the numbered requirement for filing your appeal. If you have any questions about the CDI's appeal requirements or procedures, refer to California Code of Regulations, title 10, starting at section 2509.45. You also may contact the AHB at (415) 538-4251 or visit the CDI website at www.insurance.ca.gov for further information.

1. _____ Did you include two copies of the final decision letter from which you are appealing?

2. _____ Did you include two copies of all other correspondence between you and the insurance company and/or the Workers' Compensation Insurance Rating Bureau ("WCIRB") about your dispute?

3. _____ Did you include two copies of any other documents that support your claim?

4. _____ Did you sign and date the appeal?

5. _____ Did you make exact copies of the appeal and supporting documents to mail to the designated representatives of your workers' compensation insurance company AND the WCIRB?

6. _____ Did you attach a proof of service to each copy of the appeal you are mailing to the AHB and the designated representatives of your workers' compensation insurance company AND the WCIRB?

Signature: _____

Name: _____ Date: _____

Title: _____