Recvd 04/08/09

STATE OF CALIFORNIA Arnold Schwarzenegger, *Governor*

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
Subsequent Injuries Benefit Trust Fund – Claims Unit
2424 Arden Way, Suite 355
Sacramento, CA 95825
(916) 263-2774

April 1, 2009

CHARLES EDWARD CLARK
301 E. COLORADO BLVD, #807
PASADENA, CA 91101

Re: Claimant: VARTOUHI "ROSE" NORAYAN
Employer Name: SUBSEQUENT INJURIES BENEFIT TRUST FUND
District Office Case # ADJ3789188
SIBTF Case #: SIF3789188

Dear Sir / Madam:

I am enclosing Authorization for Release of Social Security Insurance Award and Request for Pension Information Forms for signature by your client. The purpose in asking your client to complete and sign these forms is to determine what credit, if any, may be applicable as offset against the subsequent injury claim pursuant to Labor Code section 4753. If your client is receiving such pension(s), please have your client sign and complete the upper portion of the enclosed form and return them to our office. It is imperative that the name and address of the entity providing such benefit be provided as well an any other identifying information the entity may need to locate their file.

If your client is receiving SSD from the Social Security Administration, it will save time if he/she can provide a copy of the Award letter that indicates his start date and the amount he received at that time. It can take four to six months, even up to one year, to get a response from the SSA in Baltimore MD.

If your client is not receiving monthly benefits from these or other sources, please so advise so we can note this in our file. 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 in this matter.

Sincerely,

Traci Johnson for:
Heather Gull
Claims Examiner

SIF/LTR 6

REQUEST FOR PENSION INFORMATION

APPLICANT: Please complete all blanks in the top portion of the form.

APPLICANT: _____
Signature

Name **VARTOUHI "ROSE" NORAYAN**

Address: _____

_____

Birth Date: _____/ _____/ _____

Social Security #: _____ - _____ - _____

Union Local #: _____

COMPANY PENSION PLAN OR
LONG TERM DISABILITY PROVIDER:

_____

Administered by: _____

Address: _____

_____

Union Name: _____

Address: _____

_____

_____

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PENSION REPRESENTATIVE: The State of California, Division of Workers' Compensation, Subsequent Injuries Fund requires information regarding my pension. Please complete the verification below for its confidential use.

1. Commencement Date of DISABILITY pension or Long Term Disability: _____/ _____/ _____
2. Medical conditions (disability) considered at the time of pension/LTD:

_____

3. The amount of the initial monthly benefit, and the effective date and amount of any changes:

_____

4. If the member were NOT disabled, would the member be eligible for regular retirement benefits now, in the past, or in the future?
No ( ) Yes ( ) If "yes", what would the first date of disability be and what monthly benefit amount?

_____

5. Will this member have a right to convert to REGULAR retirement at a later date?
No ( ) Yes ( ) If "yes" what would be the first date and what monthly benefit amount?

_____

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COMPLETED BY: _____ DATE: _____

TITLE: _____ PHONE: ( ) _____

PLEASE RETURN THE COMPLETED FORM TO:
SUBSEQUENT INJURIES FUND
Division of Workers' Compensation
2424 Arden Way, Suite 355
Sacramento, CA 95825

DWC SIF 60 3/91

AUTHORIZATION FOR RELEASE OF SOCIAL SECURITY DISABILITY INSURANCE AWARD

I, **VARTOUHI "ROSE" NORAYAN**, (Social Security Number: **568 – 63 – 8241**) hereby grant permission to the Social Security Administration to release a Certificate of Social Security Disability Insurance Award, and information regarding my social security benefits, to the Subsequent Injuries Fund of the State of California, now and at any time in the future.

Dated:_____

Applicant Signature:X_____

Address:_____

_____

PLEASE RETURN THE COMPLETED FORM TO:

SUBSEQUENT INJURIES FUND
Division of Workers' Compensation
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Sacramento, CA 95825

DWC SIF 61 4/91