



**Welcome to the New Jersey State Department of Labor
and Workforce Development Division of Workers'
Compensation**

Login Successful.

Certification of Confidentiality

I do hereby state under penalty of law, that I do not seek inspection of the records available on the Division of Workers' Compensation's COURTS on-line website for the purpose of selling or furnishing for a consideration to others and will not do so nor will I subsequently disclose any of the information to any person, organization, entity or governmental agency not entitled to receive the information from the Division of Workers' Compensation pursuant to R.S.34:15-1 et seq.

Please refer to [NJSA 34:15-128](#) for the complete text.

Hello,
JANE LAWYER
TEST RESPONDENT LAW
FIRM
Today is CW: 3 CD: 4

ALERT

- Home
- Inbox
- Case Search
- Print E-Filed Docs
- Hearing List Search
- Hearing List By Case
- Print Attorney Calendar
- Decision Wizard
- Help Center

COURTS on-line

NJ DIVISION OF WORKERS' COMPENSATION

[logout](#)

E-Filing	Inquiries	Reports
E-File a Document	New Claim	
Inbox	Re-Opener	
Draft Documents	Answer	
Decision Wizard	Amended Answers	
	Amended Pleading	
	Motion	



You are logged in as:
JANE LAWYER
TEST RESPONDENT LAW FIRM
 Today is 6/23/2011 and it is cycle week 3, cycle date 4.

Draft Documents
 There are no Draft Documents

System Alerts

Priority	Alert
Very High	WHEN YOU CREATE AN UNLISTED ATTORNEY OR CARRIER PLEASE DO NOT MAKE THE NAME "UNLISTED". WHEN WE GO THRU & TEST THE UNLISTED PARTIES WE JUST ADD THEM TO CLEAN THEM UP AND IT GETS CONFUSING WHEN THERE ARE MULTIPLE "UNLISTED" ENTRIES. THANK YOU. TRICKEY
Advisory	PLEASE GIVE ELIZABETH UDIJOHN THE CASE NUMBERS OF ANY/ALL NEW CASES & AMENDED. TRY TO CREATE PERSON INFO EXCEPTIONS AS MUCH AS POSSIBLE SO THEY CAN BE TESTED BY HEATHER.

Message Inbox

There are no Active Messages

[...view full Message Box](#)

Resource Center

- [Getting Started](#)
- [Procedures](#)
- [FAQ's](#)
- [Application Forms](#)
- Tech Support:**
609-777-4921 or 609-292-2556
courts@dol.state.nj.us
- [DWC Home Page](#)
- [Legal Disclaimer & Confidentiality Statement](#)



To begin the process of E-Filing Answer to a CP, go to the menu item "E-Filing", select "E-File a Document" and then select Answer.

Hello,
JANE LAWYER
TEST RESPONDENT LAW
FIRM
Today is CW: 3 CD: 4

E-Filing an Answer- case information.

* Year : * Case Number : * SSN: - -

- ALERT
- Home
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- Hearing List Search
- Hearing List By Case
- Print Attorney Calendar
- Decision Wizard
- Help Center

Enter in the Year, Case Number and the SSN of the petitioner. Hit **SEARCH**.

Note: If your firm previously submitted an Answer on this same case, a list of those documents will be displayed on the next screen for your reference to ensure that you are not duplicating this filing.

Also, If your firm has already created an Answer document for this case but has not had the chance to submit it yet, that "draft" document will be displayed on the next screen as well. This will help you avoid creating duplicate documents, which can get confusing to manage once you are ready to submit.

If none of the above, then you will go straight into the Answer template.

Hello,
JANE LAWYER
TEST RESPONDENT LAW
FIRM
Today is CW: 3 CD: 4

ALERT

- Home
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COURTS
NJ DIVISION OF WORKERS COMPENSATION

E-Filing Inquiries Reports

Answer to Claim Petition

Party Info Details Print and Submit

Case Title: *BURNS VS EMPLOYER*

Petitioner

* SSN: 116 - 56 - 8874

* First Name: JOE

* Last Name: BURNS

* Address Line1: 34 BROAD STREET

Address Line2:

* City: HAMILTON

* State: NJ

* Zip Code: 08610 -

* Country: UNITED STATES

Attorney For Respondent

* Company Name: TEST RESPONDENT LAW FIRM

* Address Line1: 1 ELM STREET ?

Address Line2:

* City: BRIDGEWATER

* State: NEW JERSEY

* Zip Code: 08807 -

* Telephone No: Area Code 908 Phone 2361476 Extension

Fax: Area Code 908 Fax 2361477

VS

Respondent

* Name: EMPLOYER

* Address Line1: 588 PARKWAY AVENUE

Address Line2:

* City: EWING

Insurance Carrier

* Name: Select

* Address Line1: ?

Address Line2:

* City: ...

This is the Answer to Claim Petition wizard – General Notes:

The appropriate document type (Answer to CP, DCP, MCP) or ARM) will be based on case type and status that is associated with the original CP filing.

The template is designed like a case folder, with the Case **Party Info** appearing on the first tab, the **Details** on the second and the **Print and Submit** options on the last tab.

Every time you navigate between the tabs, the system will save the template and run data validations on certain fields to help you avoid errors. Required fields are denoted by an asterisk. The question mark sign will provide you with data format hints.

Attorney for Respondent: This block will be pre-filled with your firm name, registered address and telephone number. You may change the data for purposes of this filing but this will not change the registered address. You will have to contact us directly to make such account changes.

Answer to Claim Petition Wizard: Party Info tab

- Print E-Filed Docs
- Hearing List Search
- Hearing List By Case
- Print Attorney Calendar
- Decision Wizard
- Help Center

Case Title: BURNS VS EMPLOYER

Petitioner

* SSN: 116 - 56 - 8874

* First Name: JOE

* Last Name: BURNS

* Address Line1: 34 BROAD STREET

Address Line2:

* City: HAMILTON

* State: NJ

* Zip Code: 08610 -

* Country: UNITED STATES

Attorney for Respondent

* Company Name: TEST RESPONDENT LAW FIRM

* Address Line1: 1 ELM STREET ?

Address Line2:

* City: BRIDGEWATER

* State: NEW JERSEY

* Zip Code: 08807 -

* Telephone No: Area Code Phone Extension
908 - 2361476

Area Code Fax
908 - 2361477

Fax:

Petitioner: This block will be pre-filled with petitioner data. The data is locked down.

vs

Respondent

* Name: EMPLOYER

* Address Line1: 588 PARKWAY AVENUE

Address Line2:

* City: EWING

* State: NJ

* Zip Code: 08618 -

* Country: UNITED STATES

Correct Name of Respondent if incorrect on claim petition
you can type in a different name here

Insurance Carrier

* Name: Select

* Address Line1: ?

Address Line2:

* City: ...

* State: NEW JERSEY

* Zip Code: - ...

Carrier Claim Number:

Add TPA

Respondent: This block will be pre-filled with respondent data. If there are multiple respondents, you will have to select from the drop-down.

Respondent: you cannot directly change the respondent name or address on the form, but you may supply the correct name of the respondent if incorrect.

Clear Cancel Save and Continue

- Print E-Filed Docs
- Hearing List Search
- Hearing List By Case
- Print Attorney Calendar
- Decision Wizard
- Help Center

Case Title: **BURNS VS EMPLOYER** Draft #: 2011-7933

Petitioner

* SSN: 116 - 56 - 8874

* First Name: JOE

* Last Name: BURNS

* Address Line1: 34 BROAD STREET

Address Line2:

* City: HAMILTON

* State: NJ

* Zip Code: 08610 -

* Country: UNITED STATES

Attorney For Respondent

* Company Name: TEST RESPONDENT LAW FIF

* Address Line1: 1 ELM STREET ?

Address Line2:

* City: BRIDGEWATER

* State: NEW JERSEY

* Zip Code: 08807 -

* Telephone No: Area Code Phone Extension
908 - 2361476

* Fax: Area Code Fax
908 - 2361477

Insurance Carrier: The names of the insurance carrier(s) already on the case will be presented in a drop-down for you to select. You also have the option of searching for a new insurance carrier if it is not in the list.
In this example, we will select "New".

* City: EWING

* State: NJ

* Zip Code: 08618 -

* Country: UNITED STATES

Insurance Carrier

* Name: Select

* Address Line1: Select ?
New
TEST CARRIER2
LIBERTY MUTUAL INS

Address Line2:

* City: ...

* State: NEW JERSEY

* Zip Code: - ...

Carrier Claim Number:

Add TPA

Correct Name of Respondent if incorrect on claim petition
you can type in a different name here

Clear Cancel Save and Continue

- Print E-Filed Docs
- Hearing List Search
- Hearing List By Case
- Print Attorney Calendar
- Decision Wizard
- Help Center

Case Title: **BURNS VS EMPLOYER** Draft #: 2011-7933

Petitioner

* SSN: 116 - 56 - 8874

* First Name: JOE

* Last Name: BURNS

* Address Line1: 34 BROAD STREET

Address Line2:

* City: HAMILTON

* State: NJ

* Zip Code: 08610 -

* Country: UNITED STATES

Attorney For Respondent

* Company Name: TEST RESPONDENT LAW FIRM

* Address Line1: 1 ELM STREET ?

Address Line2:

* City: BRIDGEWATER

* State: NEW JERSEY

* Zip Code: 08807 -

* Telephone No: Area Code Phone Extension
908 - 2361476

Area Code Fax
908 - 2361477

Fax:

Insurance Carrier: After selecting "New" from the drop-down, hit the Search widget (the button with the 3 dots) to search for a new insurance carrier or a Self-insurer.

* Address Line1: 588 PARKWAY AVENUE

Address Line2:

* City: EWING

* State: NJ

* Zip Code: 08618 -

* Country: UNITED STATES

Insurance Carrier

New

* Name: ...

* Address Line1: ?

Address Line2:

* City: ...

* State: NEW JERSEY

* Zip Code: - ...

Carrier Claim Number:

Add TPA

Correct Name of Respondent if incorrect on claim petition
you can type in a different name here

Clear Cancel Save and Continue

File Edit View Favorites Tools Help

Convert Select

Favorites Mercury Quality Center

- Print E-Filed Docs
- Hearing List Search
- Hearing List By Case
- Print Attorney Calendar
- Decision Wizard
- Help Center

Case Title: BURNS VS

- * SSN:
- * First Name:
- * Last Name:
- * Address Line1:
- Address Line2:
- * City:
- * State:
- * Zip Code:
- * Country:

- * Name:
- * Address Line1:
- Address Line2:
- * City:
- * State:
- * Zip Code:
- * Country:

Correct Name of Res
you can type in a diff

Courts - Microsoft Internet Explorer provided by New Jersey Department of Labor

http://courts-app2.dol.state.nj.us/courts4/courtsonline-ajax.htm?_flowExecutionKey=_c98732B25-C2B0-08D5-E94D-1D0E87!

Search Insurance Carriers

Carrier Name

Contains

Search

File Edit View Favorites Tools Help

Convert Select

Favorites Mercury Quality Center

- Print E-Filed Docs
- Hearing List Search
- Hearing List By Case
- Print Attorney Calendar
- Decision Wizard
- Help Center

Case Title: **BURNS VS**

- * SSN:
- * First Name:
- * Last Name:
- * Address Line1:
- Address Line2:
- * City:
- * State:
- * Zip Code:
- * Country:

- * Name:
- * Address Line1:
- Address Line2:
- * City:
- * State:
- * Zip Code:
- * Country:

Correct Name of Res
you can type in a diff

Courts - Microsoft Internet Explorer provided by New Jersey Department of Labor

http://courts-app2.dol.state.nj.us/courts4/courtsonline-ajax.htm?_flowExecutionKey=_c98732B25-C2B0-08D5-E94D-1D0E87!

Search Insurance Carriers

Carrier Name

Contains

Search

File Edit View Favorites Tools Help

Convert Select

Mercury Quality Center

Print E-Filed Docs

Hearing List Search

Hearing List By Case

Print Attorney Calendar

Decision Wizard

Help Center

Case Title: BURNS VS

* SSN:

* First Name:

* Last Name:

* Address Line1:

Address Line2:

* City:

* State:

* Zip Code:

* Country:

* Name:

* Address Line1:

Address Line2:

* City:

* State:

* Zip Code:

* Country:

Correct Name of Res

you can type in a diff

Courts - Microsoft Internet Explorer provided by New Jersey Department of Labor

http://courts-app2.dol.state.nj.us/courts4/courtsonline-ajax.htm?_flowExecutionKey=_c98732B25-C2B0-08D5-E94D-1D0E87!

Search Insurance Carriers

Carrier Name

Contains TRAVELERS

Search

Search Results

8 items found, displaying all items

IDN	Carrier Name	Address	Phone Number
2	UNLISTED	NJ	
22167	ST PAUL TRAVELERS	PO BOX 530,MORRIS PLAINS,NJ,07950	973-401-3043
16555	SYNCHRONY TRAVELERS MET LIFE	PO BOX 150448,HARTFORD,CT,06102	
22333	TRAVELERS INDEMNITY CO	PO BOX 530,MORRIS PLAINS,NJ,07950	973-401-3082
15407	TRAVELERS INDEMNITY CO OF AMERICA	PO BOX 530,MORRIS PLAINS,NJ,07950	973-401-3043
22137	TRAVELERS INDEMNITY CO OF CONNECTICUT	PO BOX 530,MORRIS PLAINS,NJ,07950	
3238	TRAVELERS INSURANCE CO	PO BOX 530,MORRIS PLAINS,NJ,07950	973-401-3043
17586	TRAVELERS PROPERTY CASUALTY CO	PO BOX 530,MORRIS PLAINS,NJ,07950	

1) If you find the company you're searching for but with a different address than what your records show, select the company from the list. Once you're back in the template, you can change the address to one you wish to use for this filing.

2) If you cannot find the company at all, please select 'Unlisted'. Once you're back in the document template, you can key in the name of the company and their mailing address in the appropriate fields.

Note: After searching for a carrier name, you can select the carrier from the results below by clicking on the hyperlinked ID #, and then hitting OK. The name and address of that carrier will pre-fill into the template.

File Edit View Favorites Tools Help

Convert Select

Mercury Quality Center

Print E-Filed Docs

Hearing List Search

Hearing List By Case

Print Attorney Calendar

Decision Wizard

Help Center

Case Title: BURNS VS

* SSN:

* First Name:

* Last Name:

* Address Line1:

Address Line2:

* City:

* State:

* Zip Code:

* Country:

* Name:

* Address Line1:

Address Line2:

* City:

* State:

* Zip Code:

* Country:

Correct Name of Res

you can type in a diff

Search Insurance Carriers

Carrier Name

Contains

Search

Note: Hit OK. The name and address of that carrier will pre-fill into the template.

You Have Selected

Carrier Name

TRAVELERS INSURANCE CO

OK

Search Results

8 items found, displaying all items

IDN	Carrier Name	Address	Phone Number
2	UNLISTED	NJ	
22167	ST PAUL TRAVELERS	PO BOX 530,MORRIS PLAINS,NJ,07950	973-401-3043
16555	SYNCHRONY TRAVELERS MET LIFE	PO BOX 150448,HARTFORD,CT,06102	
22333	TRAVELERS INDEMNITY CO	PO BOX 530,MORRIS PLAINS,NJ,07950	973-401-3082
15407	TRAVELERS INDEMNITY CO OF AMERICA	PO BOX 530,MORRIS PLAINS,NJ,07950	973-401-3043
22137	TRAVELERS INDEMNITY CO OF CONNECTICUT	PO BOX 530,MORRIS PLAINS,NJ,07950	
3238	TRAVELERS INSURANCE CO	PO BOX 530,MORRIS PLAINS,NJ,07950	973-401-3043
17586	TRAVELERS PROPERTY CASUALTY CO	PO BOX 530,MORRIS PLAINS,NJ,07950	

1) If you find the company you're searching for but with a different address than what your records show, select the company from the list. Once you're back in the template, you can change the address to one you wish to use for this filing.

2) If you cannot find the company at all, please select 'Unlisted'. Once you're back in the document template, you can key in the name of the company and their mailing address in the appropriate fields.

- Print E-Filed Docs
- Hearing List Search
- Hearing List By Case
- Print Attorney Calendar
- Decision Wizard
- Help Center

Case Title: **BURNS VS EMPLOYER** Draft #: 2011-7933

Petitioner

* SSN: 116 - 56 - 8874

* First Name: JOE

* Last Name: BURNS

* Address Line1: 34 BROAD STREET

Address Line2:

* City: HAMILTON

* State: NJ

* Zip Code: 08610 -

* Country: UNITED STATES

Attorney For Respondent

* Company Name: TEST RESPONDENT LAW FIF

* Address Line1: 1 ELM STREET ?

Address Line2:

* City: BRIDGEWATER

* State: NEW JERSEY

* Zip Code: 08807 -

* Telephone No: Area Code Phone Extension
908 - 2361476

Fax: Area Code Fax
908 - 2361477

VS

Respondent

* Name: EMPLOYER

* Address Line1: 588 PARKWAY AVENUE

Address Line2:

* City: EWING

* State: NJ

* Zip Code: 08618 -

* Country: UNITED STATES

Insurance Carrier

Name: New

* Name: TRAVELERS INSURANCE CO ...

* Address Line1: PO BOX 530 ?

Address Line2:

* City: MORRIS PLAINS ...

* State: NEW JERSEY

* Zip Code: 07950 - ...

Carrier Claim Number:

Correct Name of Respondent if incorrect on claim petition
you can type in a different name here

Adding TPA: If you want to identify the name of a TPA that is handling the selected carrier (or self-insurer's) cases, click on the button "Add TPA".



Clear Cancel Save and Continue Add TPA

Zip Code: 08610 - []
 * Country: UNITED STATES
 Area Code: 908 - Fax: 2361477

vs

Respondent

* Name: EMPLOYER
 * Address Line1: 588 PARKWAY AVENUE
 Address Line2: []
 * City: EWING
 * State: NJ
 * Zip Code: 08618 - []
 * Country: UNITED STATES

Correct Name of Respondent if incorrect on claim petition
 you can type in a different name here

Insurance Carrier

New
 * Name: TRAVELERS INSURANCE CO ...
 * Address Line1: PO BOX 530 ?
 Address Line2: []
 * City: MORRIS PLAINS ...
 * State: NEW JERSEY
 * Zip Code: 07950 - [] ...
 Carrier Claim Number: []

Third Party Administrator

* Name: [] ...
 * Address Line1: [] ?
 Address Line2: []
 * City: [] ...
 * State: Select
 * Zip Code: [] - [] ...
 TPA Claim Number: []

Remove TPA

TPA: Hit the Search widget next to the Name field (the button with the 3 dots) to search for the name of a Third Party Administrator.

Zip Code: 08610 - []
 * Country: UNITED STATES
 Area Code: 908 - Fax: 2361477

vs

Respondent

* Name: EMPLOYER
 * Address Line1: 588 PARKWAY AVENUE
 Address Line2: []
 * City: EWING
 * State: NJ
 * Zip Code: 08618 - []
 * Country: UNITED STATES

Correct Name of Respondent if incorrect on claim petition
 you can type in a different name here

Insurance Carrier

Name: New
 * Name: TRAVELERS INSURANCE CO ...
 * Address Line1: PO BOX 530 ?
 Address Line2: []
 * City: MORRIS PLAINS ...
 * State: NEW JERSEY
 * Zip Code: 07950 - [] ...
 Carrier Claim Number: []

TPA: The TPA identified will now be a part of this Answer document. They will have access to the case via COURTS on-line if they are an established participant of the program.

If you wish to remove the TPA, click on the "Remove TPA" button.

Third Party Administrator

* Name: GALLAGHER BASSETT SERV: ...
 * Address Line1: 2040 BRIGGS ROAD SUITE / ?
 Address Line2: []
 * City: MT LAUREL ...
 * State: NEW JERSEY
 * Zip Code: 08054 - [] ...
 TPA Claim Number: []

Remove TPA

Clear Cancel Save and Continue

Zip Code: 08610 -
 * Country: UNITED STATES
 Area Code: 908 - Fax: 2361477

vs

Respondent

* Name: EMPLOYER
 * Address Line1: 588 PARKWAY AVENUE
 Address Line2:
 * City: EWING
 * State: NJ
 * Zip Code: 08618 -
 * Country: UNITED STATES

Correct Name of Respondent if incorrect on claim petition

Insurance Carrier

Name: New
 * Name: TRAVELERS INSURANCE CO ...
 * Address Line1: PO BOX 530 ?
 Address Line2:
 * City: MORRIS PLAINS ...
 * State: NEW JERSEY
 * Zip Code: 07950 - ...
 Carrier Claim Number:

Third Party Administrator

* Name: GALLAGHER BASSETT SERV: ...
 * Address Line1: 2040 BRIGGS ROAD SUITE ?
 Address Line2:
 * City: MT LAUREL ...
 * State: NEW JERSEY
 * Zip Code: 08054 - ...
 TPA Claim Number:

Remove TPA

Save & Continue:
 At this point, you are done with the 1st tab. You should hit the "Save and Continue" button at the bottom of the form to save the data entered thus far. You can also hit the "Details" Tab at the top and it will also save.

Clear Cancel Save and Continue

Answer to Claim Petition

Party Info **Details** Print and Submit

Case Title: **BURNS VS EMPLOYER** Draft #: 2011-7933

Petitioner was in employment on date alleged in petition [Select] ▼	Correct date of accident or exposure if incorrect on Claim Petition <input type="text"/> ?	Arose out of and in the course of employment [Select] ▼	Coverage was provided on date of accident or exposure [Select] ▼
How and where injury or disease occurred <input style="width: 100%; height: 30px;" type="text"/> <small>Characters left: 400</small>		Nature of injury or disease <input style="width: 100%; height: 30px;" type="text"/> <small>Characters left: 350</small>	
Petitioner's occupation <input style="width: 100%;" type="text"/>	Date respondent had knowledge or notice of injury or disease <input style="width: 100%;" type="text"/>	Date petitioner stopped work <input style="width: 100%;" type="text"/>	Date returned to work <input style="width: 100%;" type="text"/>
Wage Period [WEEKLY] ▼	Gross Wages \$ <input style="width: 50%;" type="text"/>	Rate of compensation \$ <input style="width: 50%;" type="text"/>	Weeks Temporary Paid <input style="width: 50%;" type="text"/>
Temporary Payments continuing [Select] ▼		Temporary Disability Paid \$ <input style="width: 50%;" type="text"/>	
Permanent Disability Paid <input type="checkbox"/> or being paid <input type="checkbox"/> <input style="width: 30%;" type="text"/> % disability of <input style="width: 30%;" type="text"/> (# <input style="width: 20%;" type="text"/> weeks @ \$ <input style="width: 20%;" type="text"/> totaling \$ <input style="width: 20%;" type="text"/>)			
Respondent rendered aid to the petitioner : [Select] ▼			
If YES, please list the individuals and/or institutions providing aid or treatment <input style="width: 100%; height: 20px;" type="text"/>			

Save & Continue: After hitting the “**Save and Continue**” button at the bottom of the Party Info tab, you will be taken to the “**Details**” Tab. During the Save process, a draft version of this document will be created. A Draft Document # will also be assigned.

If you wish to end your session at this point, you may do so without losing the data. Note the Draft Document # for your reference.

To get back to the form to continue with your filing, go to the **Draft Documents** menu item and select this document. The system will bring you back into the template. (Refer to the Draft Document section for further details about this process).

Hello, JANE LAWYER
TEST RESPONDENT LAW FIRM
Today is CW: 3 CD: 4

ALERT

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E-Filing Inquiries Reports

Details: This is the main part of the Answer to claim petition form. Enter data as appropriate. Take note of required data formatting (for further help, hover over the question mark icons).

Answer to Claim Petition

Required Field =*

Party Info **Details** Print and Submit

Case Title: **BURNS VS EMPLOYER** Draft #: 2011-7933

Petitioner was in employment on date alleged in petition	Correct date of accident or exposure if incorrect on Claim Petition	Arose out of and in the course of employment	Coverage was provided on date of accident or exposure
Yes <input type="button" value="v"/>	<input type="text"/> ?	Select <input type="button" value="v"/>	Select <input type="button" value="v"/>

How and where injury or disease occurred	Nature of injury or disease
<input type="text" value="FELL OFF ROOF"/>	<input type="text" value="broken arm, dislocated shoulder, torn ligaments"/>
Characters left: <input type="text" value="387"/>	Characters left: <input type="text" value="303"/>

Petitioner's occupation	Date respondent had knowledge or notice of injury or disease	Date petitioner stopped work	Date returned to work
<input type="text"/>	<input type="text" value="to be submitted"/>	<input type="text"/>	<input type="text" value="NEVER RTW"/>
Wage Period	Gross Wages	Rate of compensation	Weeks Temporary Paid
<input type="text" value="WEEKLY"/>	<input type="text" value="\$1000"/>	<input type="text" value="\$max"/>	<input type="text"/>

Temporary Payments continuing	Temporary Disability Paid
<input type="text" value="No"/>	<input type="text" value="\$"/>

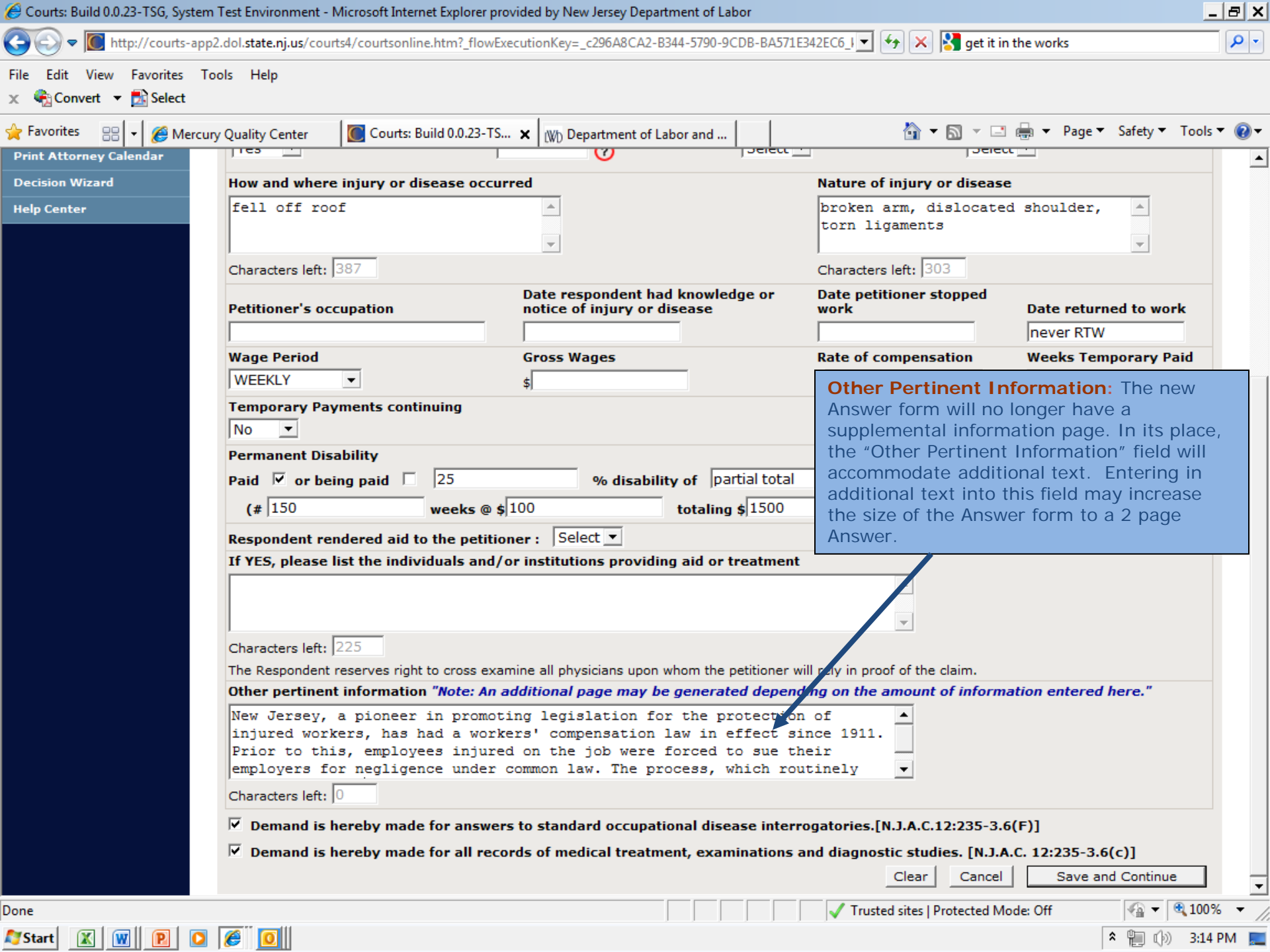
Permanent Disability

Paid or being paid % disability of

(# weeks @ \$ totaling \$)

Respondent rendered aid to the petitioner :

If YES, please list the individuals and/or institutions providing aid or treatment



Print Attorney Calendar

Decision Wizard

Help Center

How and where injury or disease occurred

fell off roof

Characters left: 387

Nature of injury or disease

broken arm, dislocated shoulder, torn ligaments

Characters left: 303

Petitioner's occupation

Date respondent had knowledge or notice of injury or disease

Date petitioner stopped work

Date returned to work

never RTW

Wage Period

WEEKLY

Gross Wages

\$

Rate of compensation

Weeks Temporary Paid

Temporary Payments continuing

No

Permanent Disability

Paid or being paid 25 % disability of partial total

(# 150 weeks @ \$100 totaling \$1500

Respondent rendered aid to the petitioner : Select

If YES, please list the individuals and/or institutions providing aid or treatment

Characters left: 225

The Respondent reserves right to cross examine all physicians upon whom the petitioner will rely in proof of the claim.

Other pertinent information *Note: An additional page may be generated depending on the amount of information entered here.*

New Jersey, a pioneer in promoting legislation for the protection of injured workers, has had a workers' compensation law in effect since 1911. Prior to this, employees injured on the job were forced to sue their employers for negligence under common law. The process, which routinely

Characters left: 0

Demand is hereby made for answers to standard occupational disease interrogatories.[N.J.A.C.12:235-3.6(F)]

Demand is hereby made for all records of medical treatment, examinations and diagnostic studies. [N.J.A.C. 12:235-3.6(c)]

Clear Cancel Save and Continue

Other Pertinent Information: The new Answer form will no longer have a supplemental information page. In its place, the "Other Pertinent Information" field will accommodate additional text. Entering in additional text into this field may increase the size of the Answer form to a 2 page Answer.

How and where injury or disease occurred

fell off roof

Characters left: 387

Petitioner's occupation

Date respondent had knowledge or notice of injury or disease

Date petitioner stopped work

Date returned to work
never RTW

Wage Period
WEEKLY

Gross Wages
\$

Rate of compensation
\$

Weeks Temporary Paid

Temporary Payments continuing
No

Temporary Disability Paid
\$

Permanent Disability

Paid or being paid 25 % disability of partial total
(# 150 weeks @ \$100 totaling \$1500)

Respondent rendered aid to the petitioner : Select

If YES, please list the individuals and/or institutions providing aid or treatment

Characters left: 225

The Respondent reserves right to cross examine all physicians upon whom the petitioner will rely in proof of the claim.

Other pertinent information *Note: An additional page may be generated depending on the amount of information entered here.*

New Jersey, a pioneer in promoting legislation for the protection of injured workers, has had a workers' compensation law in effect since 1911. Prior to this, employees injured on the job were forced to sue their employers for negligence under common law. The process, which routinely

Characters left: 0

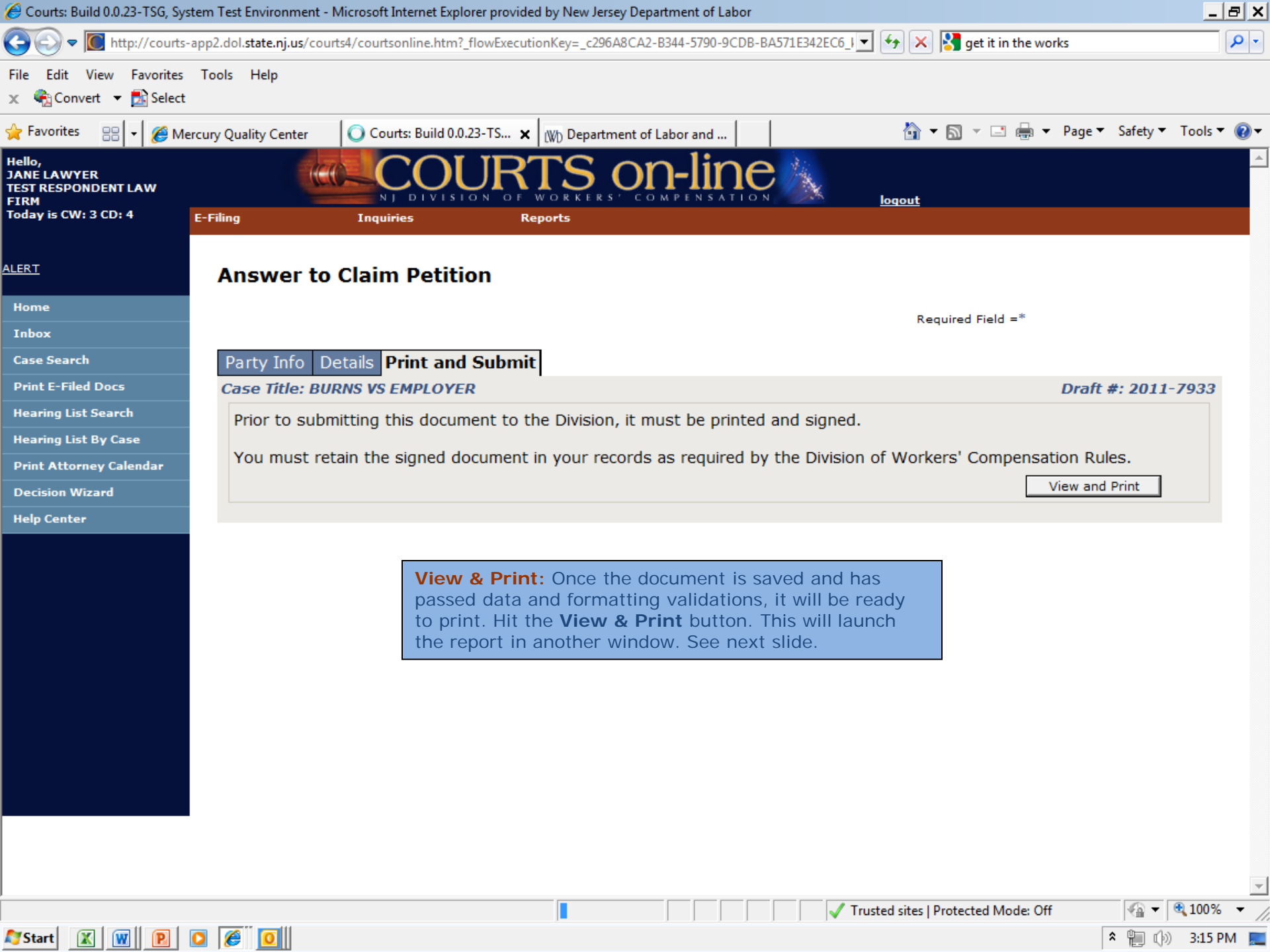
Demand is hereby made for answers to standard occupational disease interrogatories.[N.J.A.C.12:235-3.6(F)]

Demand is hereby made for all records of medical treatment, examinations and diagnostic studies. [N.J.A.C. 12:235-3.6(c)]

Clear Cancel Save and Continue

Save & Continue: After you are done entering data into this page, you should hit the "Save and Continue" button at the bottom of the form or hit the "Print & Submit" Tab at the top of the form to save the data entered thus far.

In addition to saving the data, validations will take place to ensure that the required fields, if any, are complete and that data is formatted correctly. Any errors found will be displayed at the top of the page in red.



- Hello, JANE LAWYER
- TEST RESPONDER LAW FIRM
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NJ DIVISION OF WORKERS' COMPENSATION

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E-Filing Inquiries Reports

Answer to Claim Petition

Required Field =*

Party Info Details **Print and Submit**

Case Title: *BURNS VS EMPLOYER* Draft #: 2011-7933

Prior to submitting this document to the Division, it must be printed and signed.

You must retain the signed document in your records as required by the Division of Workers' Compensation Rules.

[View and Print](#)

View & Print: Once the document is saved and has passed data and formatting validations, it will be ready to print. Hit the **View & Print** button. This will launch the report in another window. See next slide.

File Edit View Favorites Tools Help
 x Convert Select

★ Favorites Mercury Quality Center

Hello, JANE LAWYER
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 Today is CW: 3 CD: 4

E-Filing Inq

Answer to Claim

Party Info Details

Case Title: **BURNS VS**

Prior to submitting

You must retain the

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State of New Jersey Department of Labor and Workforce Development Division of Workers' Compensation PO Box 381 Trenton, New Jersey 08625-0381		RESPONDENT'S ANSWER TO CLAIM PETITION WC367		Case No.: 2011 - 7933 Vicinage: TRENTON
PETITIONER	SOCIAL SECURITY OR IDENTIFICATION NUMBER: 116-56-8874	ATTORNEY FOR RESPONDENT	NAME: TEST RESPONDENT LAW FIRM	
	NAME: JOE BURNS		ADDRESS: 1 ELM STREET BRIDGEWATER, NJ 08807	
	ADDRESS: 34 BROAD STREET HAMILTON, NJ 08610		TELEPHONE NUMBER: (908) 236-1476	FAX NUMBER: (908) 236-1477
VS				
RESPONDENT	NAME: EMPLOYER	INSURANCE CARRIER	NAME: TRAVELERS INSURANCE CO	
	ADDRESS: 588 PARKWAY AVENUE EWING, NJ 08618		ADDRESS: PO BOX 530 MORRIS PLAINS, NJ 07950	
CORRECT NAME OF RESPONDENT IF INCORRECT ON CLAIM PETITION: YOU CAN TYPE IN A DIFFERENT NAME HERE		THIRD PARTY ADMINISTRATOR	NAME: GALLAGHER BASSETT SERVICES	
PETITION IN THIS CAUSE : Correct date of accident or exposure if incorrect on Claim Petition:			ADDRESS: 2040 BRIGGS ROAD SUITE A MT LAUREL, NJ 08054	

View & Print: Print this document by using your Browser Print option. You can then close the pop-up window. You may also leave the e-filing flow without losing any data.

Review the form for errors and have it signed. Once you have a signed form in hand, you will then be ready to submit the document to the Division.

If you are still in the e-filing flow, simply Hit the Submit button on the screen (see next screen).

If you have left the e-filing flow, go to the **Draft Document** list, select the document that you saved and you will be returned to the template so that you can Submit the document to the Division.

Hello, JANE LAWYER
TEST RESPONDER LAW FIRM
Today is CW: 3 CD: 4



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Answer to Claim Petition

Required Field =*

Party Info Details **Print and Submit**

Case Title: *BURNS VS EMPLOYER* Draft #: 2011-7933

Prior to submitting this document to the Division, it must be printed and signed.

You must retain the signed document in your records as required by the Division of Workers' Compensation Rules.

Submit: Once the document has been printed and signed, the electronic version is ready to be Submitted to the Division. Hit the **Submit** button.

Hello, JANE LAWYER
TEST RESPONDENT LAW FIRM
Today is CW: 3 CD: 4

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Answer to Claim Petition

Required Field =*

Party Info Details **Print and Submit**

Case Title: **BURNS VS EMPLOYER** Draft #: 2011-7933

Prior to submitting **Message from webpage**

You must retain the

Workers' Compensation Rules.

Message from webpage

Has the Latest Version of this Document Been Printed and Signed?
Requires Ok to Continue

Submit: You will get a prompt asking you if the document has been printed and signed. Hit **OK** to continue.

Hello, JANE LAWYER
TEST RESPONDENT LAW FIRM
Today is CW: 3 CD: 4

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E-Filing Inquiries Reports

Answer to Claim Petition

This document has been successfully filed.

The following are the details

Case Number:	2011-7933
Case Title:	BURNS VS EMPLOYER

The Petitioner's Attorney is not an e-filer. Please forward a copy of this document to them via US Mail.
The Insurance Carrier is an e-filer and will be notified of this filing electronically.
The TPA is not an e-filer. Please forward a copy of this document to them via US Mail.

[File Another Document](#) [View Filed Document](#)

Submit Confirmation: Once the document has been successfully submitted, you will get a confirmation message as noted above.

The message will advise you on whether the Division is sending a courtesy copy of this filing to the petitioner (Applicant) Attorney and the carrier/TPA identified on the Answer form. Parties that are participants of the e-filing program will get this courtesy copy. For others, you will have to manually send them a copy of the Answer.

You may print this page for your records if you wish. There will also be a link to the e-filed version of the document (this is the version that is served on the Division). Click on "View Filed Document" .

You are now done with E-Filing an Answer to Claim Petition. You can file another document (click on **File Another Document**) or leave the wizard altogether by clicking on any other menu item.

The following screens will explain **Draft Documents**, how to retrieve a saved document so that it can be submitted at a later time.

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JANE LAWYER
TEST RESPONDENT LAW
FIRM
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- E-Filing
- Inquiries
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You are logged in as:
JANE LAWYER
TEST RESPONDENT LAW FIRM
 Today is 6/23/2011 and it is cycle week 3, cycle date 4.

Draft Documents: During the process of creating a document for e-filing, you will be required to Save that document. The saved document will be stored in a folder called "Draft Documents". Doing this will allow you to leave the e-filing flow (before Submitting) without losing your data.

The **Draft Documents** listing is available as a link from the home page or from the top menu under E-Filing.

Draft Documents

Date Saved	Ref#	Petitioner Last Name	Document Type
06/23/2011	2011-7933	BURNS	ANS CP

[...view full Draft Document List](#)

Message Inbox

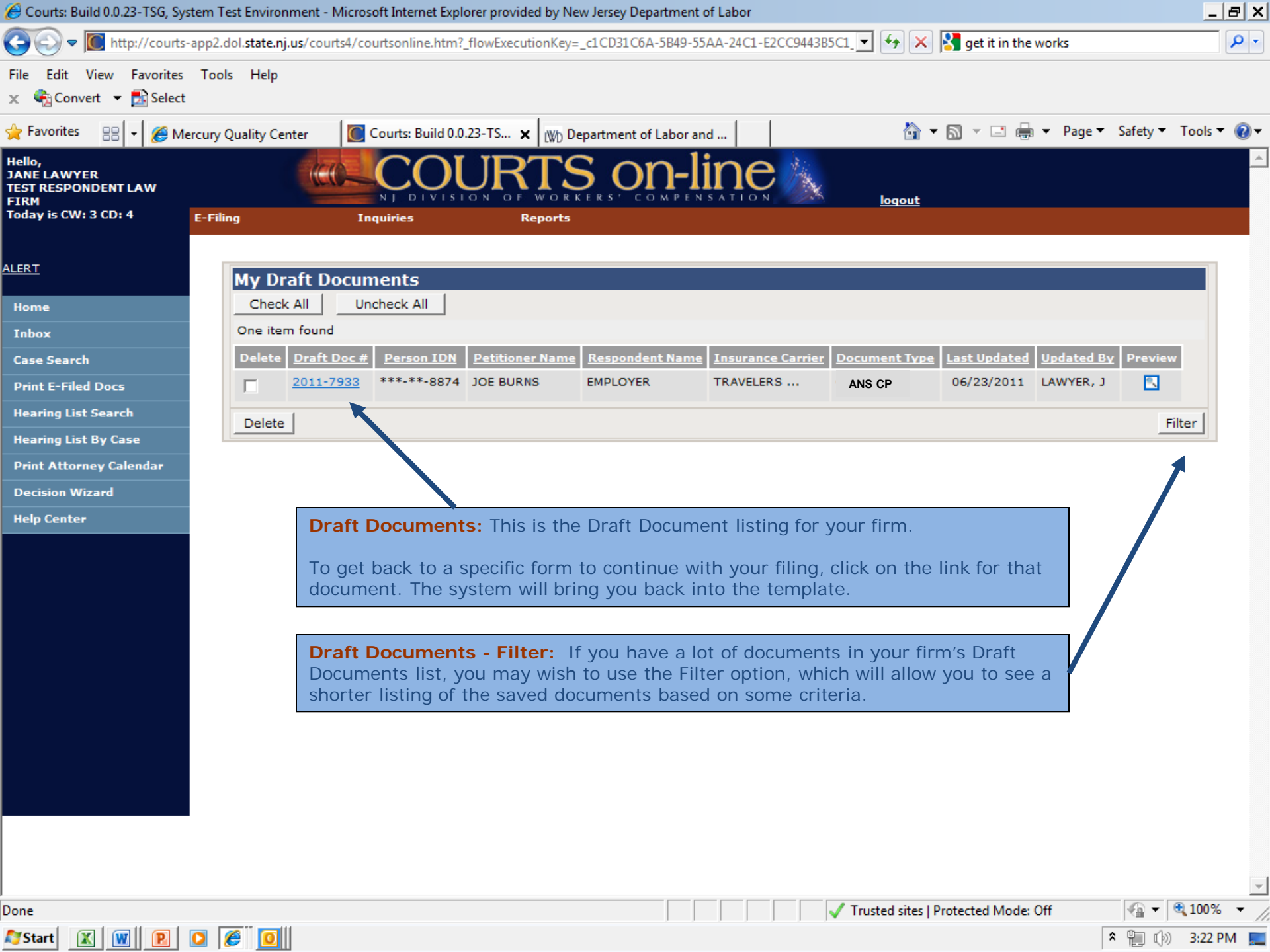
There are no Active Messages

[...view full Message Box](#)

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courts@dol.state.nj.us
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My Draft Documents

One item found

Delete	Draft Doc #	Person IDN	Petitioner Name	Respondent Name	Insurance Carrier	Document Type	Last Updated	Updated By	Preview
<input type="checkbox"/>	2011-7933	***-**-8874	JOE BURNS	EMPLOYER	TRAVELERS ...	ANS CP	06/23/2011	LAWYER, J	

Draft Documents: This is the Draft Document listing for your firm.

To get back to a specific form to continue with your filing, click on the link for that document. The system will bring you back into the template.

Draft Documents - Filter: If you have a lot of documents in your firm's Draft Documents list, you may wish to use the Filter option, which will allow you to see a shorter listing of the saved documents based on some criteria.

Hello, JANE LAWYER
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Today is CW: 3 CD: 4

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Answer to Claim Petition

Required Field =*

Party Info Details **Print and Submit**

Case Title: BURNS VS EMPLOYER *Draft #: 2011-7933*

Prior to submitting this document to the Division, it must be printed and signed.

You must retain the signed document in your records as required by the Division of Workers' Compensation Rules.

Print and Submit: Clicking on the draft document # will take you back into the e-filing wizard (the template). Complete the template if it is incomplete. If you are done, hit **View & Print**, have the form signed (if you have not done so previously) and then hit **Submit** and the document will be submitted to the Division.

You are now done with e-filing an Answer to Claim Petition.

Create ▾ |
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1 / 1 |
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 58.8% ▾ |

Filed version of the Answer to Claim Petition:
 This is the e-filed version of the document that is submitted to the Division.

It differs slightly from the version that was printed prior to submitting. It has the date of e-filing, and the signature lines are replaced with legal language to indicate that the original has been signed.

State of New Jersey Department of Labor and Workforce Development Division of Workers' Compensation PO Box 381 Trenton, New Jersey 08625-0381	RESPONDENT'S ANSWER TO CLAIM PETITION WC367	Case No.: 2011 - 7933 Vichage: TRENTON
SOCIAL SECURITY OR IDENTIFICATION NUMBER: 116-56-8874 NAME: JOE BURNS ADDRESS: 34 BROAD STREET HAMILTON, NJ 08610	PETITIONER	This document was electronically filed on: 06/23/2011 by: NAME: TEST RESPONDENT LAW FIRM ADDRESS: 1 ELM STREET BRIDGEWATER, NJ 08807 TELEPHONE NUMBER: (908) 236-1476 FAX NUMBER: (908) 236-1477
VS	ATTORNEY FOR RESPONDENT	NAME: TRAVELERS INSURANCE CO ADDRESS: PO BOX 530 MORRIS PLAINS, NJ 07950 CARRIER CLAIM NUMBER:
NAME: EMPLOYER ADDRESS: 588 PARKWAY AVENUE EWING, NJ 08618 CORRECT NAME OF RESPONDENT IF INCORRECT ON CLAIM PETITION: YOU CAN TYPE IN A DIFFERENT NAME HERE	RESPONDENT	INSURANCE CARRIER
IN ANSWER TO CLAIM PETITION IN THIS CAUSE RESPONDENT STATES: Petitioner was in employment on date alleged in petition: YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Correct date of accident or exposure if occurred on Claim Petition: _____ Accrue out of and in the course of employment: YES <input type="checkbox"/> NO <input type="checkbox"/> Coverage was provided on date of accident or exposure: YES <input type="checkbox"/> NO <input type="checkbox"/>		THIRD PARTY ADMINISTRATOR
IN ANSWER TO CLAIM PETITION IN THIS CAUSE RESPONDENT STATES: Petitioner was in employment on date alleged in petition: YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Correct date of accident or exposure if occurred on Claim Petition: _____ Accrue out of and in the course of employment: YES <input type="checkbox"/> NO <input type="checkbox"/> Coverage was provided on date of accident or exposure: YES <input type="checkbox"/> NO <input type="checkbox"/>		NAME: GALLAGHER BASSETT SERVICES ADDRESS: 2040 BRIGGS ROAD SUITE A MT LAUREL, NJ 08054 IFA CLAIM NUMBER:
How and where injury or disease occurred: FELL OFF ROOF		
Nature of injury or disease: broken arm, dislocated shoulder, torn ligaments		
Petitioner's occupation: _____ Date respondent had knowledge or notice of injury or disease: _____ Date petitioner stopped work: _____ Date returned to work: NEVER RTW		
TO BE SUBMITTED		
Wage Period: Weekly	Gross Wages: \$ 1000	Rate of compensation: \$ MAX
Weeks Temporary Paid: _____	Temporary Payments continuing: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Temporary disability paid: \$ _____		
Permanent Disability: Paid: <input checked="" type="checkbox"/> or being paid: <input type="checkbox"/> 25 % disability of: PARTIAL TOTAL (# 150 weeks @ \$ 100.00 totaling \$ 1,500.00)		
Respondent rendered aid to the petitioner: YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, please list the individuals and/or institutions providing aid or treatment:		
The Respondent reserves the right to cross examine all physicians upon whom the petitioner will rely in proof of the claim		
Other pertinent information: New Jersey, a pioneer in promoting legislation for the protection of injured workers, has had a workers' compensation law in effect since 1911. Prior to this, employees injured on the job were forced to sue their employers for negligence under common law. The process, which routinely took many years		

Demand is hereby made for answers to standard occupational disease interrogatories [N.J.A.C. 12:235-3.6 (f)]

Demand is hereby made for all records of medical treatment, examinations and diagnostic studies [N.J.A.C. 12:235-3.6 (c)]