CASE NO. 6174 CRB-2-17-1 : COMPENSATION REVIEW BOARD
CLAIM NO. 500144188

MARILYN DABBO : WORKERS' COMPENSATION
CLAIMANT-APPELLANT COMMISSION

v. : MARCH 6, 2018

BECKMAN COULTER, INC.
EMPLOYER

and

GALLAGHER BASSETT SERVICES
INSURER
RESPONDENTS-APPELLEES

APPEARANCES: The claimant was represented by James H. McColl, Jr., Esq., The Dodd Law Firm, L.L.C., Ten Corporate Center, 1781 Highland Avenue, Suite 105, Cheshire, CT 06410.

The respondents were represented by Thomas M. McKeon, Esq., Bai, Pollock, Blueweiss & Mulcahey, P.C., Two Corporate Drive, Shelton, CT 06484.

This Petition for Review from the January 5, 2017 Finding and Dismissal of Thomas J. Mullins, the Commissioner acting for the Fifth District, was heard November 17, 2017 before a Compensation Review Board panel consisting of Commissioners Christine L. Engel, Daniel E. Dilzer and Ernie R. Walker. [1]

[1] We note that a Motion for Postponement was granted during the pendency of this matter.

OPINION

CHRISTINE L. ENGEL, COMMISSIONER: The claimant has appealed from a Finding and Dismissal in which the trial commissioner concluded that the moratorium for workers' compensation benefits, subsequent to a tort settlement, had not been exhausted. The claimant asserts that the trial commissioner reached an erroneous conclusion by not crediting the payments made by the group health care carrier for the claimant's treatment. The claimant believes that had the trial commissioner done so, the moratorium would be exhausted and she would be entitled to additional benefits at this time for her compensable injury. The respondents argue that the trial commissioner's decision was consistent with the law and the facts, citing appellate precedent on this issue. Upon review, we find the respondents' position more persuasive, and therefore affirm the Finding and Dismissal.

The trial commissioner reached the following findings at the conclusion of the formal hearing. He found the claimant had sustained a compensable shoulder injury on January 9, 2008, while working at the Margate Hotel. A voluntary agreement was approved on October 2, 2009 between the claimant and the respondents establishing that the claimant's shoulder was at maximum medical improvement as of July 2, 2008 with a 9.5 (nine and one-half) percent permanent impairment. Compensation for the permanency was paid in full by the respondents prior to 2016. The claimant filed a civil action against Klymeg Hotel, L.L.C., and Margate Incorporated, and the lawsuit was settled on or about April 27, 2012 for a total sum of $195,000. The claimant received $86,252.37 from the settlement of the civil claim after reimbursing the respondents $41,074.88 for workers' compensation benefits paid as of the date of settlement and

paying her attorneys a fee of $65,000 and $2,672.75 in costs. At a July 7, 2016 formal hearing, the parties stipulated that as a result of the claimant's net recovery from the settlement of the civil case, the respondents were entitled to a "moratorium," as defined in Enquist v. General Datacom, 218 Conn. 19 (1991), in the amount of $86,252.37 as of April 27, 2012.

The trial commissioner also considered issues related to the claimant's medical treatment after 2012. On September 4, 2013, the claimant underwent left-shoulder replacement surgery with Eric J. Olson, M.D., at St. Mary's Hospital in Waterbury, and treated with Dr. Olson after the operation on numerous occasions from 2013 to 2016. Following the September 2013 surgery, the claimant had sixteen physical therapy sessions at Physical Therapy & Sports Medicine Centers between September 17, 2013 and December 12, 2013. On April 15, 2015, Kevin P. Shea, M.D., conducted a Respondent's Medical Examination [hereinafter "RME"]. Dr. Shea concluded that the claimant's September 4, 2013 left-shoulder replacement surgery and the follow-up treatment through the date of the RME were reasonable and necessary, and the claimant's fall on January 9, 2008 was a substantial factor in causing the need for her September 4, 2013 left-shoulder replacement surgery.

The claimant entered into the evidentiary record bills related to her treatment. A bill from St. Mary's Hospital for the September 4, 2013 left-shoulder replacement surgery listed the total charges for medical services as $61,962.66, but the claimant's group health insurer, Anthem Blue Cross Blue Shield [hereinafter "Anthem"], made adjustments to reduce that bill by $41,452.66 and paid only $19,010 in satisfaction of that

bill.[2] The claimant's church paid $500 of the bill. The claimant did not prove that she had paid any portion of the bill from St. Mary's Hospital with her own funds. The claimant also produced a bill for physical therapy in the amount of $4,685, which Anthem had reduced by $2,961.88 and paid only $1,003.43 in satisfaction of that bill.[3] The claimant paid $720 of her own funds in the form of co-pays for her physical therapy. The claimant also produced bills from Waterbury Orthopaedic Associates, P.C., for medical treatments by Dr. Olson between 2013 and 2016. The total amount of the charges on those bills was $9,668.90, but Anthem made adjustments to reduce the bill by $5,397.84 and paid only $3,468.30 in satisfaction of those bills.[4] The claimant paid $798.86 from her own funds to Dr. Olson's practice in the form of co-pays.

The trial commissioner reviewed the claimant's insurance coverage. He found she had been covered by Blue Cross Blue Shield [hereinafter "BCBS"] while employed by Joseph Bowen, M.D., between October 2010 to May 2014, and Dr. Bowen had paid 100 (one hundred) percent of the BCBS premiums. In May 2014, the claimant transferred her employment from Dr. Bowen to St. Mary's Hospital. The claimant testified that St. Mary's paid some of the premiums for her health insurance coverage with BCBS from May 2014 to the present, but she did not know what percentage of the premiums she paid during this period. She testified that BCBS was the only health

[2] Our review of the invoice for St. Mary's Hospital indicates that the total charges amounted to $61,962.66, which charges were reduced by a $500 self-payment and an insurance adjustment in the amount of $42,452.66. See Exhibit 4 of Claimant's Exhibit G. We deem the trier's recitation of an incorrect insurance adjustment figure in Findings, ¶ 12, harmless scrivener's error. D'Amico v. Dept. of Correction, 73 Conn. App. 718, 729 (2002), *cert. denied*, 262 Conn. 933 (2003). We note that the correct adjustment figure is recited in Conclusion, ¶ H.

[3] Our calculations indicate that on the basis of the figures provided, Anthem would have actually paid $1,003.12.

[4] We are unable to determine the basis for the trier's calculations relative to the charges, payments and adjustments for Waterbury Orthopaedic Associates, P.C. See Findings, ¶ 14; Conclusion, ¶¶ J, L. Nevertheless, in the absence of a Motion to Correct, we have no reason to question their accuracy, other than to note that the payments to Waterbury Orthopaedics also included a special report fee in the amount of $3.90.

insurer which paid medical bills for her left-shoulder treatment from April 27, 2012 to the present. The trial commissioner noted that although the claimant provided evidence that she had paid co-pays for physical therapy and to Dr. Olson, she offered no evidence that she paid out of pocket for her treatment at St. Mary's Hospital.

The trial commissioner also considered the issue of additional compensation due to the claimant subsequent to the 2013 surgery. The commissioner noted that the claimant was totally disabled from work for a period of ten weeks after the surgery. He also noted that on May 20, 2016, Dr. Olson found that the claimant was at maximum medical improvement with a 25 (twenty-five) percent permanent partial disability to the left non-dominant shoulder. The parties stipulated at the formal hearing that as a result of the respondents' prior payment of the 9.5 (nine and one-half) percent rating in 2008, the claimant was only entitled to an increase of 15.5 (fifteen and one-half) percent of the non-dominant shoulder.[5] The trial commissioner noted that the parties had stipulated that the claimant's base compensation rate was $853 per week, and that the increase in the permanent disability rating entitled the claimant to 30.07 weeks of permanent partial disability benefits pursuant to General Statutes § 31-308.[6]

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[5] We note that in Findings, ¶ 22, of the Finding and Dismissal, the trial commissioner indicated that the claimant's prior permanent partial disability rating was 9 (nine) percent. We deem this harmless scrivener's error. D'Amico v. Dept. of Correction, 73 Conn. App. 718, 729 (2002), *cert. denied*, 262 Conn. 933 (2003). We also note that the correct rate of 9.5 (nine and one-half) percent was recited in Findings, ¶¶ 3, 4.

[6] General Statutes § 31-308 (b) states in relevant part: "With respect to the following injuries, the compensation, in addition to the usual compensation for total incapacity but in lieu of all other payments for compensation, shall be seventy-five per cent of the average weekly earnings of the injured employee, calculated pursuant to section 31-310, after such earnings have been reduced by any deduction for federal or state taxes, or both, and for the federal Insurance Contributions Act made from such employee's total wages received during the period of calculation of the employee's average weekly wage pursuant to said section 31-310, but in no case more than one hundred per cent, raised to the next even dollar, of the average weekly earnings of production and related workers in manufacturing in the state, as determined in accordance with the provisions of section 31-309, or less than fifty dollars weekly. All of the following injuries include the loss of the member or organ and the complete and permanent loss of use of the member or organ referred to…."

Based on this record, the trial commissioner determined that as of April 27, 2012, the date the claimant settled her civil case against Klymeg Hotel, L.L.C., and Margate Incorporated, the respondents' moratorium on liability for the payment of additional workers' compensation benefits amounted to $86,252.37. He concluded that the claimant had proven that she had a credit for the ten-week period of additional temporary total disability benefits, a credit for 30.07 weeks of additional permanent partial disability benefits, and a credit for the $1,518.86 in co-pays which she had paid out of her own funds. Therefore, the trial commissioner determined that the respondents' original moratorium had been reduced from $86,252.37 to $50,553.80.

The trial commissioner rejected the claimant's argument that she should receive credit for any health insurance premiums to BCBS she may have paid, or for the payments made by BCBS totaling $23,481.72 toward the bills from St. Mary's Hospital, Waterbury Orthopaedic Associates, P.C., and the Physical Therapy & Sports Medicine Center. The trial commissioner rejected the argument that the amount by which BCBS had adjusted or reduced the bills from providers should be credited against the moratorium, and he also rejected the position that the $500 paid by the claimant's church towards the St. Mary's bill should be credited against the moratorium. Having concluded that the respondents' moratorium had not been exhausted, the trial commissioner dismissed the claimant's claim for additional workers' compensation benefits.

The claimant did not file a Motion to Correct. She did file a timely appeal asserting that the trial commissioner erred by not crediting the health insurance premiums paid by the claimant against the moratorium, and by not crediting the payments for medical treatment made by BCBS. The claimant believes that had the trial commissioner

done so, the moratorium would have been exhausted. The respondents argue that the trial commissioner appropriately applied the law to the facts in this case. Upon review, we find the respondents' arguments more persuasive.

Given that the claimant did not file a Motion to Correct, on appeal we must accept the validity of the facts found by the trial commissioner in this matter. See Claros v. Keystone Pipeline Services, 5399 CRB-1-08-11 (October 28, 2009); Stevens v. Raymark Industries, Inc., 5215 CRB-4-07-4 (March 26, 2008), *appeal dismissed*, A.C. 29795 (June 26, 2008); and Corcoran v. Amgraph Packaging, Inc., 4819 CRB-2-04-6, 4948 CRB-2-05-5 (July 26, 2006). We therefore must limit our review on appeal to whether the trial commissioner appropriately applied the law. Nonetheless, we still extend great deference to the findings of a trial commissioner. "As with any discretionary action of the trial court, appellate review requires every reasonable presumption in favor of the action, and the ultimate issue for us is whether the trial court could have reasonably concluded as it did…." Burton v. Mottolese, 267 Conn. 1, 54 (2003). We may only reverse a decision under these circumstances if it is contrary to law. See Neville v. Baran Institute of Technology, 5383 CRB-8-08-10 (September 24, 2009) and Christensen v. H & L Plastics Co., Inc., 5171 CRB-3-06-12 (November 19, 2007).

The claimant argues that the trial commissioner's interpretation of General Statutes § 31-293 is in error.[7] As the claimant interprets the purpose of this statute, it

[7] General Statutes § 31-293 (a) states**: "**When any injury for which compensation is payable under the provisions of this chapter has been sustained under circumstances creating in a person other than an employer who has complied with the requirements of subsection (b) of section 31-284, a legal liability to pay damages for the injury, the injured employee may claim compensation under the provisions of this chapter, but the payment or award of compensation shall not affect the claim or right of action of the injured employee against such person, but the injured employee may proceed at law against such person to recover damages for the injury; and any employer or the custodian of the Second Injury Fund, having paid, or having become obligated to pay, compensation under the provisions of this chapter may bring an action against such person to recover any amount that he has paid or has become obligated to pay as compensation

exists to prevent double recoveries. Under the circumstances in this case, in which the claimant received medical treatment though her group health insurance carrier, the respondents have received an undeserved windfall. The claimant argues that the only

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to the injured employee. If the employee, the employer or the custodian of the Second Injury Fund brings an action against such person, he shall immediately notify the others, in writing, by personal presentation or by registered or certified mail, of the action and of the name of the court to which the writ is returnable, and the others may join as parties plaintiff in the action within thirty days after such notification, and, if the others fail to join as parties plaintiff, their right of action against such person shall abate unless the employer, insurance carrier or Second Injury Fund gives written notice of a lien in accordance with this subsection. In any case in which an employee brings an action against a party other than an employer who failed to comply with the requirements of subsection (b) of section 31-284, in accordance with the provisions of this section, and the employer is a party defendant in the action, the employer may join as a party plaintiff in the action. The bringing of any action against an employer shall not constitute notice to the employer within the meaning of this section. If the employer and the employee join as parties plaintiff in the action and any damages are recovered, the damages shall be so apportioned that the claim of the employer, as defined in this section, shall take precedence over that of the injured employee in the proceeds of the recovery, after the deduction of reasonable and necessary expenditures, including attorneys' fees, incurred by the employee in effecting the recovery. If the action has been brought by the employee, the claim of the employer shall be reduced by one-third of the amount of the benefits to be reimbursed to the employer, unless otherwise agreed upon by the parties, which reduction shall inure solely to the benefit of the employee, except that such reduction shall not apply if the reimbursement is to the state of Connecticut or a political subdivision of the state including a local public agency, as the employer, or the custodian of the Second Injury Fund. The rendition of a judgment in favor of the employee or the employer against the party shall not terminate the employer's obligation to make further compensation which the commissioner thereafter deems payable to the injured employee. If the damages, after deducting the employee's expenses as provided in this subsection, are more than sufficient to reimburse the employer, damages shall be assessed in his favor in a sum sufficient to reimburse him for his claim, and the excess shall be assessed in favor of the injured employee. No compromise with the person by either the employer or the employee shall be binding upon or affect the rights of the other, unless assented to by him. For the purposes of this section, the claim of the employer shall consist of (1) the amount of any compensation which he has paid on account of the injury which is the subject of the suit, and (2) an amount equal to the present worth of any probable future payments which he has by award become obligated to pay on account of the injury. The word "compensation," as used in this section, shall be construed to include incapacity payments to an injured employee, payments to the dependents of a deceased employee, sums paid out for surgical, medical and hospital services to an injured employee, the burial fee provided by subdivision (1) of subsection (a) of section 31-306, payments made under the provisions of sections 31-312 and 31-313, and payments made under the provisions of section 31-284b in the case of an action brought under this section by the employer or an action brought under this section by the employee in which the employee has alleged and been awarded such payments as damages. Each employee who brings an action against a party in accordance with the provisions of this subsection shall include in his complaint (A) the amount of any compensation paid by the employer or the Second Injury Fund on account of the injury which is the subject of the suit, and (B) the amount equal to the present worth of any probable future payments which the employer or the Second Injury Fund has, by award, become obligated to pay on account of the injury. Notwithstanding the provisions of this subsection, when any injury for which compensation is payable under the provisions of this chapter has been sustained under circumstances creating in a person other than an employer who has complied with the requirements of subsection (b) of section 31-284, a legal liability to pay damages for the injury and the injured employee has received compensation for the injury from such employer, its workers' compensation insurance carrier or the Second Injury Fund pursuant to the provisions of this chapter, the employer, insurance carrier or Second Injury Fund shall have a lien upon any judgment received by the employee against the party or any settlement received by the employee from the party, provided the employer, insurance carrier or Second Injury Fund shall give written notice of the lien to the party prior to such judgment or settlement."

means to prevent this occurrence would be to either credit the amount paid by BCBS for medical treatment against the moratorium or, in the alternative, credit the group health care premiums paid by the claimant or her employer to BCBS against the moratorium. She argues that because the statute "is notably silent as to the actual accounting of moratorium expenses," Appellant's Brief, p. 7, the Workers' Compensation Commission [hereinafter "Commission"] should determine, on the basis of sound public policy, that either claims paid by group health insurers or premiums paid to obtain group health insurance coverage should be applied against a moratorium.

The difficulty with this argument is that our precedent uniformly stands for the proposition that such expenses cannot be applied as credits against a moratorium. We have had a number of opportunities to consider similar issues subsequent to our Supreme Court's ruling in Enquist, supra. None of the cases support the claimant's position. For instance, Bilodeau v. Bristol Assn. for Retarded Citizens, 4245 CRB-6-00-5 (May 29, 2001), *appeal dismissed*, A.C. 22031 (February 22, 2002), fully considered the issues presented herein.

In Bilodeau, the claimant attempted to bypass the impact of a $33,562.63 moratorium subsequent to settling a civil suit by submitting the bills for his upcoming neck surgery to his health insurance carrier, and allowing the respondents, who otherwise would have been liable for such surgery, to deduct the cost of his medical bills from the $33,562.63 offset rather than having them take a full credit against his not-yet-paid permanency benefits. The respondents did not agree with this strategy and contended their moratorium was still fully in place. The claimant argued that the respondents' position constituted an unfair windfall for the employer and insurer. We, however, noted

that neither our statutes nor precedent allowed the Commission to proceed as the claimant desired.

> Our Supreme Court has held that, where a medical insurance carrier covers the cost of a workers' compensation claimant's medical bills and then fails to assert a lien against the workers' compensation insurer, the latter is not required to pay to the claimant the amount of his medical bills. Pokorny v. Getta's Garage, 219 Conn. 439 (1991). The Pokorny Court had to balance the remedial purpose of the Act, which favors a broad construction benefiting disabled employees, with the Act's prohibition of double recovery by a claimant. Id., 453-54. "The language of § 31-294(c) [now § 31-294d] requires an employer to provide medical care to the injured employee. This language does not support an interpretation requiring the employer to pay to the employee the cost of such medical care when the employee has not been burdened by that cost…. [Instead,] § 31-294 establishes a direct relationship between the employer and its compensation carrier, and the medical provider, to the exclusion of the employee…. Id., 455-56.
> The Court concluded that the legislature did not intend that an employee would receive the amount of his medical bills in addition to the health care itself. By receiving medical care, albeit at his own medical insurer's expense, he had received all that he was entitled to under the Act, "and any issue regarding [the respondents'] obligations to pay for those bills lies between them and the medical insurance carrier. Id., 457.

Bilodeau, supra.

We also considered the argument regarding the inequitable windfall which the claimant in Bilodeau believed the respondents had received to his detriment. We noted that our review of Enquist, supra, did not support the claimant's construction of the law which he believed would have prevented such a windfall, and the onus for seeking reimbursement of such costs rested on the claimant's insurer.

> The claimant states in his reply brief that the "double set off" obtained by the respondents in the instant case provided them with a windfall at the cost of the claimant receiving any net benefit from the third-party claim. Id., p. 8. The relevant law provides, however, that the claimant is not entitled to receive a net benefit

> from his third-party claim until the respondents' credit under § 31-293 has been satisfied, i.e., they have been repaid for those compensation benefits that the claimant has received from them. See Enquist, supra. There are many third-party cases in which a claimant's recovery is less than the amount of his employer's credit for compensation benefits paid, thus leaving him with no net financial gain from the lawsuit. The ability of employers to bring their own third-party actions under § 31-293 reflects this possibility, as a claimant might not always be personally motivated to sue. As such, the failure of the claimant's group medical insurer to press its reimbursement rights against the respondents, thereby leaving them with more than the drafters of the Act might have intended or expected, does not translate into a financial misdeed against the claimant.

Bilodeau, supra.[8]

We believe our decision in Bilodeau is dispositive of the question of whether medical expenses paid by a group health insurer should be credited against a claimant's moratorium.

The second argument raised by the claimant in this case is that she should receive a credit for the group health insurance premiums that either she or her employer paid to obtain coverage through BCBS. This board has also previously considered this argument. In Gallagher v. John A. Dudley, D.M.D., 5067 CRB-4-06-3 (March 20, 2007), we rejected the claimant's argument that her group health insurance premiums should be effectively reimbursed by the respondents.

> In this instance the respondents argue that to permit the claimant to credit her insurance premiums so as to reduce the amount due to moratorium is improper. Our holding in Bilodeau supports this view. It is not the claimant who is entitled to an offset but rather her group health carrier. "Both § 31-299a(b) and § 38a-470

[8] We also considered many of these issues in Bombria v. Anthony J. Bonafine, 5740 CRB-2-12-3 (March 6, 2013), in which we remanded the matter so the trial commissioner could find the subordinate facts that would either support the claimant's bid for reimbursement of medical expenses or justify the denial of some or all of the claim. We noted that General Statutes § 31-299a provides a specific mechanism to effectuate such reimbursement to medical providers, but the record in that case was bereft of any evidence of compliance with this statute.

> provide that a group health insurer possesses reimbursement rights against an employer or its compensation carrier when, pursuant to a health insurance policy, it pays benefits for medical treatment that is later shown to be related to a compensable injury. Id. Additionally, the respondents cite case law specifically proscribing the reimbursement of health insurance premiums by a workers' compensation carrier. In Civardi v. Norwich, 231 Conn. 287 (1994) the Supreme Court determined that health insurance premiums were not "compensation," Id., 298. Their decision determined a U.S. Supreme Court case District of Columbia v. Greater Washington Board of Trade, 506 U.S. 125, 127 (1992) placed this situation within the realm of preemption by the federal ERISA statute. Civardi, supra, 298-299 n.14. We have followed this reasoning in our decisions. In Luce v. UTC/Pratt & Whitney, 3080 CRB 1-95-6 (December 16, 1996), *aff'd*, 47 Conn. App. 909 (1997) (per curiam), *aff'd*, 247 Conn. 126, 130-131 fn.8 (1998); we held, "[w]e would undeniably be disregarding the spirit of the [United States] Supreme Court decision in Greater Washington Board of Trade, if we were to allow a claimant to collect the value of insurance premiums as compensation even though direct payment of those premiums by a private employer cannot be mandated by state law. Id. Therefore, the claimant's argument that the value of his medical, dental, life, disability, and accidental death and dismemberment insurance premiums should be included in the average weekly wage under § 31-310 must fail on appeal." Luce, supra. Since we cannot see any difference between directly reimbursing a party for insurance premiums, which is impermissible as per Luce, and crediting them so as to reduce a credit due under moratorium, we reverse the Finding and Award in relation to the claimant's insurance premiums.

Id.

We note that the record of the present matter contains no representation that the claimant actually paid out of pocket for any group health insurance premiums. However, even if the evidentiary foundation existed which would allow the premiums to be credited against the moratorium, Gallagher would bar such relief.

Essentially, the claimant in this matter seeks to have this tribunal revisit binding precedent on the issues raised herein and reach a different result more favorable to her interests. Such an endeavor would impugn the concept of stare decisis. In Mitchell v.

J.B. Retail Inventory Specialists, 3458 CRB-2-96-10 (March 31, 1998), this board rejected a similar effort to undo standing precedent, stating:

> Stare decisis, although not an end in itself, serves the important function of preserving stability and certainty in the law. Accordingly, "a court should not overrule its earlier decisions unless the most cogent reasons and inescapable logic require it. Maltbie, Conn. App. Proc., p. 226."

Kluttz v. Howard, 228 Conn. 401, 406 (1994), *quoting* Herald Publishing Co. v. Bill, 142 Conn. 53, 62 (1955).

We find that the trial commissioner's decision in this case comports with binding precedent on the issue of how to calculate a moratorium under General Statutes § 31-293. The claimant's legal arguments do not rise to the level necessary to overturn this precedent; nor do they constitute matters of reversible error. Rather, the arguments implicate policy questions that are best reserved for the consideration of appellate courts or the General Assembly.

Having found no error, the January 5, 2017 Finding and Dismissal of Thomas J. Mullins, the Commissioner acting for the Fifth District, is accordingly affirmed.

Commissioners Daniel E. Dilzer and Ernie R. Walker concur in this opinion.

CERTIFICATION

THIS IS TO CERTIFY THAT a copy of the foregoing was mailed this 6th day of March 2018 to the following parties:

MARILYN DABBO
197 Delaware Avenue
Waterbury, CT 06708

JAMES H. McCOLL, ESQ. 7011 2970 0000 6088 7381
The Dodd Law Firm, L.L.C.
Ten Corporate Center
1781 Highland Avenue, Suite 105
Cheshire, CT 06410

BECKMAN COULTER, INC.
4300 North Harbor Boulevard
Fullerton, CA 92834-3100

THOMAS M. McKEON, ESQ. 7011 2970 0000 6088 7398
Bai, Pollock, Blueweiss & Mulcahey, P.C.
Two Corporate Drive
Shelton, CT 06484

____
Jackie E. Sellars
Administrative Hearings Specialist
Compensation Review Board
Workers' Compensation Commission