

Information & Assistance Unit guide 16

How to file a claim with the Uninsured Employers Benefits Trust Fund

California law requires all employers to have workers' compensation insurance. Employers can either get insurance from an insurance company or they can become self-insured through a state program. Even if your employer did not have valid workers' compensation insurance at the time of your work-related injury, you are entitled to medical treatment and other benefits. The state Uninsured Employers Benefits Trust Fund (UEBTF) is a special fund used to pay the claims of employees who get injured or become ill while working for an illegally uninsured employer. However, the benefits will not be paid automatically.

You must take the steps detailed below to pursue a claim for benefits from the UEBTF. You need a packet of information and forms you can get from your local Division of Workers' Compensation (DWC) Information and Assistance (I&A) officer. This packet includes DWC fact sheet F, I&A guides 16(A) and 16(B) and other forms.

This claim process may seem hard, but taking one step at a time will help. You may want to consult an attorney of your choice.

Follow these 11 steps in order and don't skip anything. It is very important to keep good records, including notes of anyone you have contact with.

1. Complete the employee section of the workers' compensation claim form. This is called "[DWC-1, Employee's Claim for Workers' Compensation Benefits](#)." See I&A guide 1 for assistance. Keep a copy of this form for your records. This is your temporary receipt. You may either hand-deliver or send three copies to your employer by certified mail, return-receipt requested. If you mail the forms, keep a copy of the return-receipt for your records. If you hand-deliver, make notes of when and to whom you delivered it.

2. To look for insurance coverage for the past five years go to <http://www.caworkcompcoverage.com>.

Otherwise you can complete the "Coverage Research Service Request" form in your packet and mail it to:

Workers' Compensation Insurance Rating Bureau (WCIRB)
Customer Service, Attn: Coverage Department
1221 Broadway Ste 900
Oakland, CA 94612

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The WCIRB will determine if your employer had workers' compensation insurance at the time of your injury. The name of your employer, business, or owner's name; address; and date of injury will help with coverage look up. The WCIRB waives its customary fees for injured workers. Keep a copy of the WCIRB response for your records.

Some employers are self-insured for their workers' compensation risk. Check this link for self-insured verification:

<http://www.dir.ca.gov/osip/databases/sisr/default.aspx>

3. While waiting for your response from the WCIRB, gather the following information to support your claim:

- Medical report(s) from your doctor to document your work injury
- Medical bills for your work injury, including receipts for things you have paid for (prescriptions, doctor visits, etc.)
- Proof of employment, such as pay stubs and W-2 forms from around the date you were injured. This will help calculate the benefits you may receive and show you worked for the employer
- Make a list of any possible witnesses to your injury.

4. If the response from the WCIRB shows your employer had no workers' compensation insurance at the time of your injury and you want to pursue a claim with the UEBTF, you must file several forms at your local Workers' Compensation Appeals Board (WCAB) office. Complete an application for adjudication of claim (see I&A guide 4). Read, sign and date the declaration pursuant to 4906(g) contained in guide 4. File the application, the 4906(g) and proof of service by mail (also contained in guide 4) forms at your local WCAB office. The office addresses are in your packet. You must show that you mailed a copy of these forms to your employer by using the proof of service by mail form.

Filing these forms opens a case for you with the WCAB. It allows the WCAB to help you resolve your claim. You should receive a notice of application from the WCAB in the mail with your case number on it.

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5. You must also complete the following forms in your packet:

- Declaration of readiness to proceed (see [I&A guide 5](#)). This form is your request for a conference with the WCAB to help resolve your claim
- Special notice of lawsuit. This form notifies your employer a legal action is being taken against it. Your employer must be correctly named and served. See I&A guide 16 (A) for more information on naming your employer. See I&A guide 16 (B) for more information on serving your employer
- Petition to join party defendant. This form requests a judge to formally make a claim (“join”) with the Uninsured Employers Benefits Trust Fund in your case.

6. Once you have your documentation and have completed all the forms, put the original documents in a package in the following order (top to bottom) for service on your employer:

- a) [Application of Adjudication of Claim](#)
- b) [Special notice of lawsuit](#)
- c) [Declaration of readiness to proceed](#)
- d) [DWC-1](#), employee’s claim for workers’ compensation benefits and registered mail return-receipt
- e) Medical report(s)
- f) Medical bill(s)
- g) Proof of employment
- h) WCIRB reply indicating employer did not have workers’ compensation insurance coverage
- i) Petition to join party defendant

7. Make three (3) copies of this packet. If your employer is a partnership, make additional copies for each partner.

8. One copy of this packet must be personally served on your employer. See I&A guide 16 (B) for information on how to serve your employer. A personal proof of service form is included in your packet. Note: The personal proof of service is different than the proof of service by mail done earlier. To make sure your personal service is done correctly, you should use a professional server such as the local sheriff’s office or a process serving company. If you use this method you will receive proof the service was completed or attempted three times on your employer.

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9. After the proof of service is returned to you, file the one copy of the packet at the WCAB district office near you. If it's been almost a year since you got injured and you haven't filed a claim yet, contact the I&A office near you immediately for help. See WCAB address list in your packet.

10. While not required to do so, the UEBTF can decide to pay your benefits before a workers' compensation judge issues an "award" in your case. To request benefits from the UEBTF, send a letter requesting benefits and one copy of the packet to the UEBTF office nearest to you:

UEBTF claims
1515 Clay Street
17TH Floor
OAKLAND CA 94612

UEBTF claims
320 W. 4th Street
6th Floor
LOS ANGELES CA 90013

11. Keep one original packet for your records. You should receive a notice of conference from the WCAB within a few weeks. Tell your local I&A officer if the UEBTF begins paying your benefits before a workers' compensation judge issues an "award" in your case.

You can also file a complaint against your employer for not having workers' compensation insurance. Contact the state Division of Labor Standards Enforcement, Bureau of Field Enforcement. Find them in the government pages of the phone book under state of California, Industrial Relations, Labor Standards Enforcement. You can also get a complaint form on line at www.dir.ca.gov/dlse. The Bureau of Field Enforcement may want a copy of the WCIRB response showing your employer had no insurance with the complaint form. The Bureau of Field Enforcement can fine and, in some cases, shut down illegally uninsured employers. You can also sue your uninsured employers in a legal action apart from the workers' compensation case, in Superior Court.

All documents filed with the WCAB must include a document cover sheet and document separator sheet. Please see I&A guides 17 and 18 to learn how to complete these forms. In addition all forms must be typed or handwritten in block letters to insure legibility. Additional form instructions can be found on the EAMS OCR handbook at http://www.dir.ca.gov/dwc/eams/SampleFiles/EAMS_OCR%20handbook.pdf.

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If you need help, call an [Information and Assistance \(I&A\) office](#), or attend a [workshop for injured workers](#). The local I&A phone numbers are attached to this guide. You can get information on a local workshop from the I&A office or on the Web at www.dwc.ca.gov.

If you do not have the name and address of your insurance company to complete a form, please link to <http://www.dir.ca.gov/DWC/EAMS/EAMS-LC/EAMSClaimsAdmins.asp>.

The information contained in this guide is general in nature and is not intended as a substitute for legal advice. Changes in the law or the specific facts of your case may result in legal interpretations different than those present here.

When sending documents to a district office, please make sure they are not folded or stapled. Send them in a large manila envelope. Please see the EAMS OCR forms handbook for further instructions.

I&A

WORKERS' COMPENSATION APPEALS BOARD DISTRICT OFFICES

ANAHEIM, 92806-2131

1065 N PacificCenter Drive, Suite 170
Information & Assistance Unit (714) 414-1800

BAKERSFIELD, 93301-1929

1800 30th Street, Suite 100
Information & Assistance Unit (661) 395-2514

EUREKA, 95501-0481 * Satellite office *

100 "H" Street, Suite 202
Information & Assistance Unit (707) 441-5723

FRESNO, 93721-2219

2550 Mariposa Street, Suite 4078
Information & Assistance Unit (559) 445-5355

LONG BEACH, 90802-4339

300 OceanGate Street, Suite 200
Information & Assistance Unit (562) 590-5240

LOS ANGELES, 90013-1105

320 W 4th Street, 9th Floor
Information & Assistance Unit (213) 576-7389

MARINA DEL REY, 90292-6902

4720 Lincoln Boulevard, 2nd and 3rd floors
Information & Assistance Unit (310) 482-3858

OAKLAND, 94612-1499

1515 Clay Street, 6th Floor
Information & Assistance Unit (510) 622-2861

OXNARD, 93030-7912

1901 N Rice Avenue, Suite 100
Information & Assistance Unit (805) 485-3528

POMONA, 91768-1653

732 Corporate Center Drive
Information & Assistance Unit (909) 623-8568

REDDING, 96002-0940

250 Hemsted Drive, 2nd Fl, Ste. B
Information & Assistance Unit (530) 225-2047

RIVERSIDE, 92501-3337

3737 Main Street, Suite 300
Information & Assistance Unit (951) 782-4347

SACRAMENTO, 95834-2962

160 Promenade Circle, Suite 300
Information & Assistance Unit (916) 928-3158

SALINAS, 93906-2204

1880 N Main Street, Suites 100 & 200
Information & Assistance (831) 443-3058

SAN BERNARDINO, 92401-1411

464 W Fourth Street, Suite 239
Information & Assistance Unit (909) 383-4522

SAN DIEGO, 92108-4424

7575 Metropolitan Drive, Suite 202
Information & Assistance Unit (619) 767-2082

SAN FRANCISCO, 94102-7014

455 Golden Gate Avenue, 2nd Floor
Information & Assistance Unit (415) 703-5020

SAN JOSE, 95113-1402

100 Paseo de San Antonio, Suite 241
Information & Assistance Unit (408) 277-1292

SAN LUIS OBISPO, 93401-8736

4740 Allene Way, Suite 100
Information & Assistance Unit (805) 596-4159

SANTA ANA, 92701-4070

605 W Santa Ana Boulevard, Bldg 28, Suite 451
Information & Assistance Unit (714) 558-4597

SANTA BARBARA, 93101-7538 * Satellite office *

130 E Ortega St.
Information & Assistance Unit (805) 568-1390

SANTA ROSA, 95404-4771

50 "D" Street, Suite 420
Information & Assistance Unit (707) 576-2452

STOCKTON, 95202-2314

31 E Channel Street, Suite 344
Information & Assistance Unit (209) 948-7980

VAN NUYS, 91401-3370

6150 Van Nuys Boulevard, Suite 105
Information & Assistance Unit (818) 901-5374

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad



If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Attached is the form for filing a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If required you will be notified by the claims administrator, who is responsible for handling your claim, about your eligibility for benefits.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Your employer will then complete the "Employer" section, give you a dated copy, keep one copy and send one to the claims administrator. Benefits can't start until the claims administrator knows of the injury, so complete the form as soon as possible.

Medical Care: Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your claims administrator will pay the costs directly so you should never see a bill. There is a limit on some medical services.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness. Generally your employer selects the PTP you will see for the first 30 days, however, in specified conditions, you may be treated by your predesignated doctor or medical group. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Different rules apply if your employer is using a Health Care Organization (HCO) or a Medical Provider Network (MPN). A MPN is a selected network of health care providers to provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information. If your employer has not put up a poster describing your rights to workers' compensation, you may choose your own doctor immediately.

Within one working day after you file a claim form, your employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to be liable for up to \$10,000 in treatment until the claim is accepted or rejected.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same level of privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, for most injuries you will receive temporary disability payments for a limited period of time. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Return to Work: To help you to return to work as soon as possible, you should actively communicate with your treating doctor, claims administrator, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Se adjunta el formulario para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran, dependiendo de la índole de su reclamo. Si se requiere, el administrador de reclamos, quien es responsable por el manejo de su reclamo, le notificará sobre su elegibilidad para beneficios.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Entonces, su empleador completará la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos. Los beneficios no pueden comenzar hasta, que el administrador de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

Atención Médica: Su administrador de reclamos pagará toda la atención médica razonable y necesaria, para su lesión o enfermedad relacionada con el trabajo. Es posible que los beneficios médicos incluyan el tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio y las medicinas. Su administrador de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Hay un límite para ciertos servicios médicos.

El Médico Primario que le Atiende-Primary Treating Physician PTP es el médico con la responsabilidad total para tratar su lesión o enfermedad. Generalmente, su empleador selecciona al PTP que Ud. verá durante los primeros 30 días. Sin embargo, en condiciones específicas, es posible que usted pueda ser tratado por su médico o grupo médico previamente designado. Si el doctor dice que usted aún necesita tratamiento después de 30 días, es posible que Ud. pueda cambiar al médico de su preferencia. Hay reglas diferentes que se aplican cuando su empleador usa una Organización de Cuidado Médico (HCO) o una Red de Proveedores Médicos (MPN). Una MPN es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una HCO o una MPN. Hable con su empleador para más información. Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

Dentro de un día después de que Ud. presente un formulario de reclamo, su empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a la presunta lesión y será responsable por \$10,000 en tratamiento hasta que el reclamo sea aceptado o rechazado.

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes se revelarán. Si Ud. solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. recibirá pagos por incapacidad temporal para la mayoría de las lesiones por un periodo limitado. Es posible que estos pagos cambien o paren, cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad



be temporary or may be extended depending on the nature of your injury or illness.

Payment for Permanent Disability: If a doctor says your injury or illness results in a permanent disability, you may receive additional payments. The amount will depend on the type of injury, your age, occupation, and date of injury.

Supplemental Job Displacement Benefit (SJDB): If you were injured after 1/1/04 and you have a permanent disability that prevents you from returning to work within 60 days after your temporary disability ends, and your employer does not offer modified or alternative work, you may qualify for a nontransferable voucher payable to a school for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law based on your percentage of permanent disability.

Death Benefits: If the injury or illness causes death, payments may be made to relatives or household members who were financially dependent on the deceased worker.

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) benefits. Call State Employment Development Department at (800) 480-3287.

You can obtain free information from an information and assistance officer of the State Division of Workers' Compensation (DWC), or you can hear recorded information and a list of local offices by calling (800) 736-7401. You may also go to the DWC website at www.dwc.ca.gov.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at www.californiaspecialist.org.

por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estatales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no pueda trabajar durante más de 14 días.

Regreso al Trabajo: Para ayudarle a regresar a trabajar lo antes posible, Ud. debe comunicarse de manera activa con el médico que le atiende, el administrador de reclamos y el empleador, con respecto a las clases de trabajo que Ud. puede hacer mientras se recupera. Es posible que ellos coordinen esfuerzos para regresarle a un trabajo modificado, o a otro trabajo, que sea apropiado desde el punto de vista médico. Este trabajo modificado u otro trabajo podría ser temporal o podría extenderse dependiendo de la índole de su lesión o enfermedad.

Pago por Incapacidad Permanente: Si el doctor dice que su lesión o enfermedad resulta en una incapacidad permanente, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, su edad, su ocupación y la fecha de la lesión.

Beneficio Suplementario por Desplazamiento de Trabajo: Si Ud. Se lesionó después del 1/1/04 y tiene una incapacidad permanente que le impide regresar al trabajo dentro de 60 días después de que los pagos por incapacidad temporal terminen, y su empleador no ofrece un trabajo modificado o alternativo, es posible que usted reúna los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo entrenamiento y/o mejorar su habilidad. Si Ud. reúne los requisitos, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales basado en su porcentaje de incapacidad permanente.

Beneficios por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a los parientes o a las personas que viven en el hogar y que dependían económicamente del trabajador difunto.

Es ilegal que su empleador le castigue o despidan, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (El Código Laboral sección 132a.) De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatal de Incapacidad (SDI). Llame al Departamento Estatal del Desarrollo del Empleo (EDD) al (800) 480-3287.

Ud. puede obtener información gratis, de un oficial de información y asistencia, de la División Estatal de Compensación de Trabajadores (*Division of Workers' Compensation - DWC*) o puede escuchar información grabada, así como una lista de oficinas locales llamando al (800) 736-7401. Ud. también puede consultar con la página Web de la DWC en www.dwc.ca.gov.

Ud. puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California (*State Bar*) al (415) 538-2120, ó consulte con la página Web en www.californiaspecialist.org.



WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the "Employee" section and give the form to your employer. Keep a copy and mark it "Employee's Temporary Receipt" until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at (800) 736-7401. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Empleado: Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la División de Compensación al Trabajador al (800) 736-7401 para oír información gravada. En la hoja cubierta de esta forma esta la explicación de los beneficios de compensación al trabajador.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above Empleado—complete esta sección y note la notación arriba.

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde ocurrió el accidente.* _____

6. Describe injury and part of body affected. *Describe la lesión y parte del cuerpo afectada.* _____

7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. Empleador—complete esta sección y note la notación abajo.

9. Name of employer. *Nombre del empleador.* _____
10. Address. *Dirección.* _____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* _____

15. Insurance Policy Number. *El número de la póliza de Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Employer copy/Copia del Empleador Employee copy/ Copia del Empleado

Empleador: Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de **un día hábil** desde el momento de haber sido recibida la forma del empleado.

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

Claims Administrator/Administrador de Reclamos Temporary Receipt/Recibo del Empleado

Coverage Research Service Request Form 807 (Rev. 05/2015)

Instructions

Purpose of Form

Completion of this form is required for coverage requests made in connection with a pending workers' compensation claim. It may also be used by employers or insurers to request their own coverage information.

Use of Form

The WCIRB can provide coverage information to an insurance company, employer, injured worker, licensed health care provider, Third Party Entity (TPE) acting on behalf of a member insurer who has a TPE agreement with the WCIRB or an attorney involved in a pending workers' compensation claim.

Authorization

Before the coverage request will be processed, the requesting party must certify that he/she is entitled to receive the information, that the information will be used solely in connection with the pending workers' compensation claim and that the information will not be otherwise published, distributed or released to third parties other than in connection with the administration and/or litigation of the pending workers' compensation claim.

Employers or insurers may have access to their own information even if there is no pending workers' compensation claim.

Coverage Availability

The WCIRB is unable to supply coverage information prior to 1958.

Information Requirements

The WCIRB will not process your coverage research service request unless all sections of the form are completely filled out.

The requesting party must provide the WCIRB with necessary information regarding the pending workers' compensation claim for which the information is sought, including the name of the parties, date of injury, claim number (if known) and WCAB number (if assigned). Incomplete information will delay the completion of your request.

Form Completion

- This form can be completed electronically; however, the form **requires a signature** and must be printed and signed by an authorized individual.
- If not completed electronically, print or type all information.

- Under Coverage Information Requested, list both the physical address and the P.O. Box address, if the employer uses a P.O. Box. The WCIRB can only provide coverage information when the employer's address matches the address on the policy record.

Fees

The fee for coverage research is **\$10.00 per year, per employer**. Any portion of a year counts as a complete year.

Fee Examples

The examples are based on one employer.

Coverage Requested	Total No. Years	Fee
2009–2010	2	\$20
1/1/09–1/1/10	1	\$10
1/1/09–1/31/10	2	\$20
2009–3/1/12	4	\$40
2008–2012	5	\$50

Payment

Payment must be received before your request can be processed and is non-refundable. Calculating the correct fee for your request will expedite your order.

If you need assistance in calculating the fee, call WCIRB Customer Service.

- WCIRB member insurers may elect to be billed.
- TPEs, authorized by WCIRB member insurers, may elect to have the WCIRB bill the member insurer. The WCIRB is unable to bill TPEs directly.
- For all others, the WCIRB accepts payment by check only. Include your payment when submitting the Coverage Research Service Request form.

Delivery

MAIL Coverage research requests are mailed.

EMAIL Email delivery is available (see page 2).

Form Submission

This form must be mailed to the WCIRB.

MAIL WCIRB Customer Service
Attn: Coverage Department
1221 Broadway, Suite 900
Oakland, CA 94612

Questions

Call WCIRB Customer Service toll free
888.CA.WCIRB (229.2472) 7:30 a.m.–5:00 p.m. PST

All products and services are prepared by the WCIRB in the normal course of business pursuant to the regulations of the California Department of Insurance or for the benefit of the WCIRB's members. The WCIRB has made reasonable efforts to ensure the accuracy of the products and services.

You must make an independent assessment regarding the use of all WCIRB products and services based upon your particular facts and circumstances. The WCIRB cannot make such an assessment and shall not be liable for any damages, of any kind, whether direct, indirect, incidental, punitive or consequential, arising from the use, inability to use, or reliance upon WCIRB products and services.

Coverage Research Service Request Form 807 (Rev. 05/2015)

Original signature required. This form must be mailed.

Pending Workers' Compensation Claim Information

Injured Worker	Date of Injury
Employer	WCAB Number (If Assigned)
Insurer (If Known)	Claim Number (If Known)

Requesting Party Information

Print Name of Individual Requesting Information	Title/Position	
Company OR Injured Worker Represented	Telephone	
Address (If Injured Worker, Include Your Own Address)	If an Attorney, Indicate Party Represented	
City	State	Zip
Email Address (Required for Email Delivery)		

Coverage Information Requested [For additional employers, attach separate sheet(s).]

The WCIRB is unable to supply coverage information prior to 1958.

List the physical address and if the employer has a P.O. Box, the P.O. Box must also be included.

(1)	(2)	
Employer	Employer	
DBA (If Known)	DBA (If Known)	
Coverage Year(s) Requested	Coverage Year(s) Requested	
Physical Address	Physical Address	
Physical Address City	Physical Address City	
Physical Address State	Physical Address State	Zip
P.O. Box Address	P.O. Box Address	
P.O. Box City	P.O. Box City	
P.O. Box State	P.O. Box State	Zip

Coverage Research Service Request Form 807 (Rev. 05/2015)

Certification

The requesting individual hereby certifies that he/she is:

- the injured worker in the pending workers' compensation claim; **OR**
- an employee, partner, manager, officer or director of, and has the authority to bind, an employer, as defined by Labor Code 3300, in the pending workers' compensation claim; **OR**
- a licensed workers' compensation insurance insurer in the pending workers' compensation claim; **OR**
- an employer, as defined by Labor Code Section 3300, in the pending workers' compensation claim; **OR**
- a licensed health care provider in the pending workers' compensation claim; **OR**
- a Third Party Entity (TPE) that is authorized to obtain coverage information by a member insurer in the pending workers' compensation claim; **OR**
- an attorney representing any of the above individuals or entities in the pending workers' compensation claim.
- an employer, as defined by Labor Code Section 3300, or an insurer requesting their own information, or an attorney representing an employer or insurer. (If this box is checked, a signature is not required below.)

Restricted Use of Information if Requested in Connection with a Pending Workers' Compensation Claim

I agree that the coverage information provided shall be used solely in connection with the administration and/or litigation of the above-referenced pending workers' compensation claim, and for no other purpose. In addition, I agree that the information provided by the WCIRB is confidential and proprietary and shall not be published, distributed, released or communicated to third parties, other than in relation to the administration and/or litigation of the above-referenced pending workers' compensation claim. I affirm that all information provided on this form is true and correct.

Signature _____

Date _____

Fees

List the amount being paid. Refer to the chart under Fee Examples on the Instruction page.

\$ _____

Please complete page 3.

Coverage Research Service Request

Form 807 (Rev. 05/2015)

Payment Method — Members and TPEs

WCIRB Member Billing.

I am authorized by the insurer named in the Requesting Party Section of this form to request insurance policy information. I understand that my company will be billed for the information ordered by this form.

Authorized by	Authorized Signature Required
Title	Date

Member Authorized TPE. (Member will be billed. Include member billing information below.)

Authorized by	Signature
Title	Date

Member Company

Address

City	State	Zip
------	-------	-----

Payment Method — Others

The WCIRB accepts payment by check only. Make your check payable to "WCIRB" and mail to the address on this form.

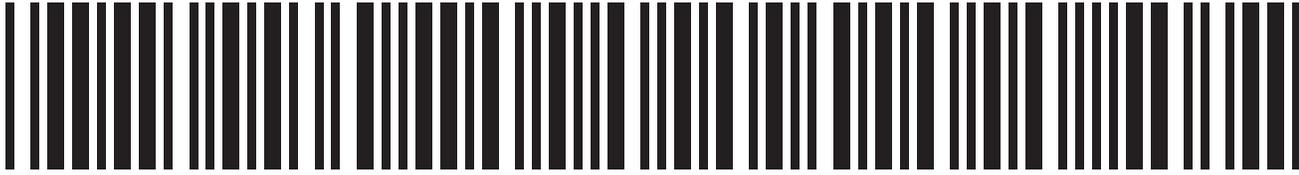
Check enclosed (non-refundable).

Email Delivery

Check this box for email delivery as an alternative to receiving via U.S. Mail.

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET



Is this a new case? Yes No Companion Cases Exist Walkthrough Yes No

More than 15 Companion Cases

Date:(MM/DD/YYYY)

SSN: _____

Specific Injury

Case Number 1

Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

Body Part 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____

Please check unit to be filed on (check only one box)

ADJ DEU SIF UEF INT RSU

Companion Cases

Specific Injury

Case Number 2

Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

Body Part 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____

Specific Injury

Case Number 3

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

Body Part 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____

Specific Injury

Case Number 4

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

Body Part 3: _____



Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____

Specific Injury

Case Number 5

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

Body Part 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____



Specific Injury

Case Number 6

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

Body Part 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____

Specific Injury

Case Number 7

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

Body Part 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____

Specific Injury

Case Number 8

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

Body Part 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____



Specific Injury

Case Number 9

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

Body Part 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____

Specific Injury

Case Number 10

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

Body Part 3: _____

Body Part 2: _____

Body Part 4: _____



Other Body Parts: _____

Specific Injury

Case Number 11

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

Body Part 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____



Specific Injury

Case Number 12

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

Body Part 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____

Specific Injury

Case Number 13

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

Body Part 3: _____



Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____

Specific Injury

Case Number 14

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

Body Part 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____



Specific Injury

Case Number 15

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

Body Part 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____



Specific Injury

Case Number 16

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

Body Part 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____



District office codes for place of venue

<i>Legend</i>	
Abbreviation	Office
AHM	Anaheim
ANA	Santa Ana
BAK	Bakersfield
EUR	Eureka
FRE	Fresno
GOL	Goleta
LAO	Los Angeles
LBO	Long Beach
MDR	Marina del Rey
OAK	Oakland
OXN	Oxnard
POM	Pomona
RDG	Redding
RIV	Riverside
SAC	Sacramento
SAL	Salinas
SBR	San Bernardino
SDO	San Diego
SFO	San Francisco
SJO	San Jose
SLO	San Luis Obispo
SRO	Santa Rosa
STK	Stockton
VNO	Van Nuys

Use this document to complete forms, but do not file this document with your forms.

Body Part Code List

The body part codes listed below are used to complete forms that require the listing of the part of the body that is in issue. Please do not file this document with your forms.

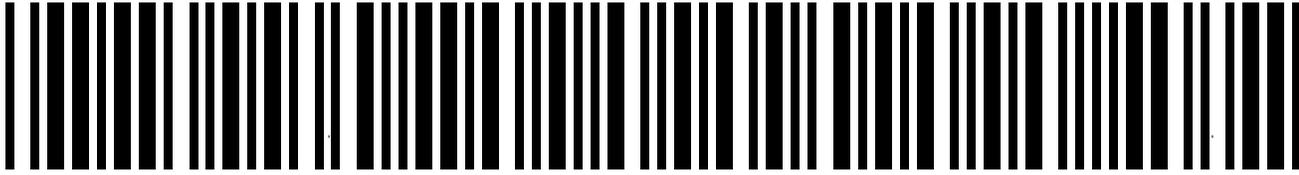
100	Head - not specified	500	Lower extremities - not specified
110	Brain	510	Legs - above ankles, not specified
120	Ear - not specified	511	Thigh femur
121	Ear - external	513	Knee Patella
124	Ear - internal including hearing	515	Lower leg tibia and fibula
130	Eye - including optic nerves and vision	518	Leg - multiple parts any combination of above parts
140	Face - not specified	519	Leg - not specified
141	Jaw - including chin and mandible	520	Ankle malleolus
144	Mouth - including lips, tongue, throat and taste	530	Foot not ankle or toe
145	Teeth	540	Toes
146	Nose - including nasal passages, sinus and smell	598	Lower extremities - multiple parts any combination of above parts
148	Face - multiple parts any combination of above parts	700	Multiple parts more than five major parts use only in fifth position of listing of body parts
149	Face - forehead, cheeks, eyelids	800	Body system - not specific
150	Scalp	801	Circulatory system - heart -other than heart attack, blood, arteries, veins, etc.
160	Skull	802	Circulatory system - Heart attack
198	Head - multiple injury any combination of above parts	810	Digestive system - stomach
200	Neck	820	Excretory system - kidneys, bladder, intestines, etc
300	Upper extremities - not specified	830	Musculo-skeletal system - bones, joints, tendons, muscles, etc.
310	Arm - above wrist not specified	840	Nervous system - not specified
311	Arm - upper arm humerus	841	Nervous system - stress
313	Arm - elbow head of radius	842	Nervous system - Psychiatric/psych
315	Arm -forearm radius and ulna	850	Respiratory system - lungs, trachea, etc.
318	Arm - multiple parts any combination of above parts	860	Skin dermatitis, etc.
319	Arm - not specified	870	Reproductive systems
320	Wrist	880	Other body systems
330	Hand - not wrist or fingers	999	Unclassified - insufficient information to identify body parts
340	Fingers		
398	Upper extremities - multiple parts any combination of above parts		
400	Trunk - not specified		
410	Abdomen - including internal organs and groin		
411	Hernia		
420	Back - including back muscles, spine and spinal cord		
430	Chest - including ribs, breast bone and internal organs of the chest		
440	Hips - including pelvis, pelvic organs, tailbone, coccyx and buttocks		
450	Shoulders - scapula and clavicle		
498	Trunk - use for side; multiple parts any combination of above parts		

Use this document to complete forms, but do not file this document with your forms.

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

SAMPLE

DOCUMENT COVER SHEET



Is this a new case? Yes No Companion Cases Exist Walkthrough Yes No

More than 15 Companion Cases

TODAY'S DATE

Date:(MM/DD/YYYY)

SSN: **YOUR SOCIAL SECURITY NUMBER**

Specific Injury

EAMS CASE NUMBER

Case Number 1

DATE OF INJURY

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

IF NEW CASE LEAVE BLANK

Body Part 1: _____

USE CODE FROM BODY PART CODE LIST, SEE PAGE 8

Body Part 3: _____

Body Part 2: _____

Body Part 4: _____

WHEN MORE THAN 5 BODY PARTS USE BODY PART NUMBER 700 IN THIS FIELD

Other Body Parts: _____

Please check unit to be filed on (check only one box)

ADJ DEU SIF UEF INT RSU

Companion Cases

Specific Injury

Case Number 2

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

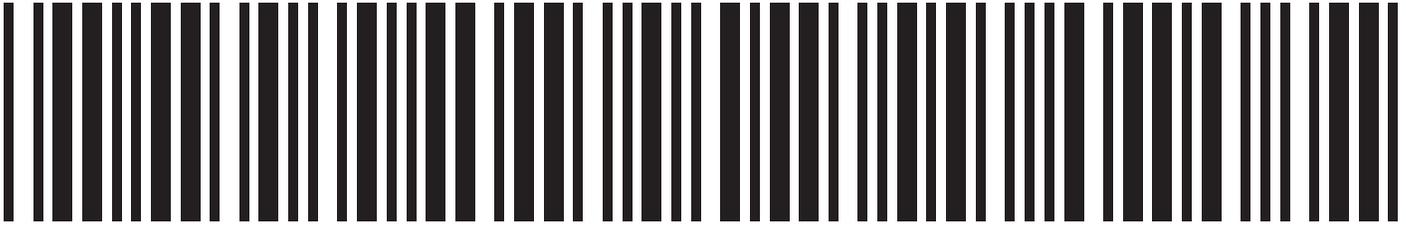
Body Part 3: _____

Body Part 2: _____

Body Part 4: _____

Other Body Parts: _____

DOCUMENT SEPARATOR SHEET



Product Delivery Unit

Document Type

Document Title

Document Date

MM/DD/YYYY

Author

Office Use Only

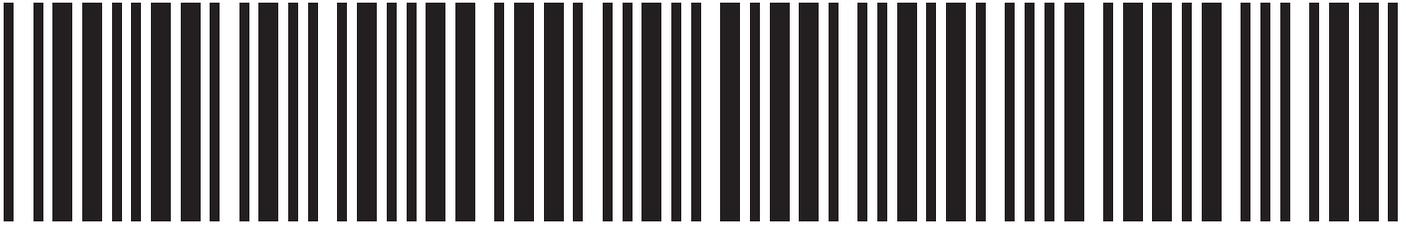
Received Date

MM/DD/YYYY



DOCUMENT SEPARATOR SHEET

SAMPLE



Product Delivery Unit

ADJ

Document Type

LEGAL DOCS

Document Title

APPLICATION FOR ADJUDICATION

Document Date

DATE YOU FILLED OUT THE FORM

MM/DD/YYYY

Author

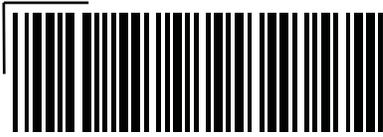
YOUR NAME

Office Use Only

Received Date

MM/DD/YYYY





**STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
APPLICATION FOR ADJUDICATION OF CLAIM**



Amended Application

Case No. _____

SSN (Numbers Only) _____

Venue choice is based upon (Completion of this section is required)

- County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)
- County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)
- County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

Select 3 - Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

Injured Worker (Completion of this section is required)

First Name _____ MI _____

Last Name _____

Street Address/PO Box (Please leave blank spaces between numbers, names or words) _____

Street Address2/PO Box (Please leave blank spaces between numbers, names or words) _____

International Address (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Applicant (If other than Injured Worker)

- Insurance Carrier
- Employer
- Lien Claimant

Name (Please leave blank spaces between numbers, names or words) _____

Street Address/PO Box (Please leave blank spaces between numbers, names or words) _____

Street Address2/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Employer Information (Completion of this section is required)

Insured

Self-Insured

Legally Uninsured

Uninsured



Employer Name (Please leave blank spaces between numbers, names or words)

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Insurance Carrier Information (If known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Claims Administrator Information (If known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

IT IS CLAIMED THAT (Complete all relevant information):

1. The injured worker, born _____, while employed as a(n) _____
(DATE OF BIRTH: MM/DD/YYYY) (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)

specific injury _____
(Date of injury: MM/DD/YYYY)

suffered a :

cumulative injury which began on _____ and ended on _____
(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

The injury occurred at _____

Street Address/PO Box - Please leave blank spaces between numbers, names or words

City

State

Zip Code

(State which parts of the body were injured)

Body Part 1: _____

Body Part 2: _____

Body Part 3: _____

Body Part 4: _____

Other Body Parts: _____

2. The injury occurred as follows:

(EXPLAIN WHAT THE WORKER WAS DOING AT THE TIME OF INJURY AND HOW THE INJURY OCCURED)

3. Actual earnings at the time of injury:

Rate of Pay \$ _____ Monthly Weekly Hourly
State value of tips, meals, lodging, or other advantages, regularly received \$ _____ Monthly Weekly Hourly

Number of hours worked per week _____

4. The injury caused disability as follows:

Last day off work due to injury: _____
MM/DD/YYYY

First Period of Disability: Start Date _____ End Date _____
MM/DD/YYYY MM/DD/YYYY

Second Period of Disability: Start Date _____ End Date _____
MM/DD/YYYY MM/DD/YYYY

5. Compensation:

Compensation was paid: Yes No

Total paid: _____

Weekly rate(s): _____

Date of last payment: _____
MM/DD/YYYY

6. Has the worker received any unemployment insurance benefits and/or any unemployment compensation disability benefits (state disability) since the date of injury?

Yes No

7. Medical treatment:

Medical treatment was received:

Yes No

All treatment was furnished by the Employer or Insurance Carrier:

Yes No

Date of last treatment: _____
MM/DD/YYYY

Other treatment was provided/paid by: _____
(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)

Did Medi-Cal pay for any health care related to this claim?

Yes No

Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or examined for this injury, but that were not provided or paid for by the employer or insurance carrier:

Name of Doctor/Hospital/Clinic 1 (Please leave blank spaces between numbers, names or words)

Name of Doctor/Hospital/Clinic 2 (Please leave blank spaces between numbers, names or words)

8. Other cases have been filed for industrial injuries by this worker as follows:

Case Number 1

Case Number 3

Case Number 2

Case Number 4

9. This application is filed because of a disagreement regarding liability for:

- | | |
|--|---|
| <input type="checkbox"/> Temporary disability indemnity | <input type="checkbox"/> Permanent disability indemnity |
| <input type="checkbox"/> Reimbursement for medical expense | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Medical treatment | <input type="checkbox"/> Supplemental Job Displacement/Return to Work |
| <input type="checkbox"/> Compensation at proper rate | <input type="checkbox"/> Other (Specify) _____ |

Is the Applicant Represented? Yes No If "No", applicant is to sign and date below.

If "Yes", applicant's representative is to complete the following and is to sign and date below.

Law Firm/Attorney Non-Attorney Representative

Law Firm or Company Name (If Applicable)

Law Firm Number (If Applicable)

Attorney/Representative First Name _____
MI

Attorney/Representative Last Name

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City _____
State _____
Zip Code

Applicant Attorney/Representative Signature _____
Applicant Signature

Dated at _____, California
City

Date _____
MM/DD/YYYY

INSTRUCTIONS

FILING AND SERVICE OF A DECLARATION OF READINESS IS A PREREQUISITE TO THE SETTING OF A CASE FOR HEARING.

Effect of Filing Application

Filing of this application begins formal proceedings against the defendant(s) named in your application.

Assistance in Filling Out Application

You may request the assistance of an information and assistance officer of the Division of Workers' Compensation.

Right to Attorney

You may be represented by an attorney or agent, or you may represent yourself. The attorney's fee will be set by the Workers' Compensation Appeals Board at the time the case is decided and is ordinarily payable out of your award.

Filling Out Application

For "amended" applications, the venue choice must be the same as that specified on the original application, unless an order changing venue has issued. A street or P.O. Box address within the United States must be entered for the place where the injury occurred. Therefore, if the injury did not occur at a fixed or identifiable location (such as a field, a highway, or on water), or if the injury occurred outside of the United States, the employer's business address or another appropriate address must be specified; however, a short explanation regarding the place of injury may be appended to the application. If medical treatment has been paid for by Medi-Cal, Medicare, group health insurance, or a private carrier, please specify.

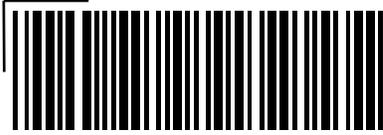
Service of Documents

Your attorney or agent will serve all documents in accordance with Labor Code section 5501 and the Workers' Compensation Appeals Board's Rules of Practice and Procedure.

If you have no attorney or agent, copies of this application will be served by the Workers' Compensation Appeals Board on all parties. If you file any other document, you must mail or deliver a copy of the document to all parties in the case.

IMPORTANT!

If any applicant is under 18 years of age, it will be necessary to file a Petition for Appointment of Guardian ad Litem. Forms for this purpose may be obtained at the district office of the Workers' Compensation Appeals Board, or by calling the district office and requesting this form.



**STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
APPLICATION FOR ADJUDICATION OF CLAIM**

SAMPLE

LEAVE BLANK

Amended Application

Case No. _____

YOUR SSN

SSN (Numbers Only) _____

Venue choice is based upon (Completion of this section is required)

- County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)
- County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)
- County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

← **SELECT ONE**

USE 3 LETTER OFFICE CODE FROM DOCUMENT COVER SHEET

Select 3 - Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

Injured Worker (Completion of this section is required)

YOUR FIRST NAME

First Name _____ MI _____

YOUR LAST NAME

Last Name _____

YOUR MAILING ADDRESS

Street Address/PO Box (Please leave blank spaces between numbers, names or words) _____

Street Address2/PO Box (Please leave blank spaces between numbers, names or words) _____

International Address (Please leave blank spaces between numbers, names or words) _____

YOUR CITY

City _____ State _____ Zip Code _____

Applicant (If other than Injured Worker)

- Insurance Carrier
- Employer
- Lien Claimant

Name (Please leave blank spaces between numbers, names or words) _____

Street Address/PO Box (Please leave blank spaces between numbers, names or words) _____

Street Address2/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Employer Information (Completion of this section is required)

SAMPLE

Insured

Self-Insured

Legally Uninsured

Uninsured

NAME OF COMPANY YOU WERE WORKING FOR AT TIME OF INJURY

Employer Name (Please leave blank spaces between numbers, names or words)

COMPANY ADDRESS

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

COMPANY CITY

City

State

Zip Code

Insurance Carrier Information (If known and if applicable - include even if carrier is adjusted by claims administrator)

NAME OF COMPANY INSURANCE CARRIER

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

INSURANCE CARRIER ADDRESS

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

INSURANCE CARRIER CITY

City

State

Zip Code

Claims Administrator Information (If known and if applicable)

NAME OF CLAIMS ADMINISTRATOR

Name (Please leave blank spaces between numbers, names or words)

CLAIMS ADMINISTRATOR ADDRESS

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

CLAIMS ADMINISTRATOR CITY

City

State

Zip Code

IT IS CLAIMED THAT (Complete all relevant information):

1. The injured worker, born **YOUR BIRTH DATE**, while employed as a(n) **YOUR JOB TITLE WHEN INJURED**
(DATE OF BIRTH: MM/DD/YYYY) (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)

specific injury

DATE OF ACCIDENT

(Date of injury: MM/DD/YYYY)

suffered a :

cumulative injury

which began on

(Start Date: MM/DD/YYYY)

and ended on

(End Date: MM/DD/YYYY)

The injury occurred at

ADDRESS WHERE ACCIDENT TOOK PLACE

Street Address/PO Box - Please leave blank spaces between numbers, names or words

City

State

Zip Code

(State which parts of the body were injured)

Body Part 1: PART OF BODY THAT WAS INJURED, USE LIST FROM DOCUMENT COVERSHEET

Body Part 2: _____

Body Part 3: _____

Body Part 4: _____

Other Body Parts: _____

2. The injury occurred as follows:

(EXPLAIN WHAT THE WORKER WAS DOING AT THE TIME OF INJURY AND HOW THE INJURY OCCURED)

INDICATE WHAT YOU WERE DOING AT THE TIME OF INJURY

3. Actual earnings at the time of injury:

Rate of Pay \$ _____ Monthly Weekly Hourly

State value of tips, meals, lodging, or other advantages, regularly received \$ _____ Monthly Weekly Hourly

Number of hours worked per week _____

4. The injury caused disability as follows:

Last day off work due to injury: LAST DAY WORKED
MM/DD/YYYY

First Period of Disability: Start Date FIRST DAY OFF WORK End Date DATE RETURNED TO WORK
MM/DD/YYYY MM/DD/YYYY

Second Period of Disability: Start Date _____ End Date _____
MM/DD/YYYY MM/DD/YYYY

5. Compensation:

Compensation was paid: Yes No

Total paid: _____

Weekly rate(s): FROM CLAIMS ADMINISTRATOR

Date of last payment: _____
MM/DD/YYYY

6. Has the worker received any unemployment insurance benefits and/or any unemployment compensation disability benefits (state disability) since the date of injury?

Yes No

7. Medical treatment:

Medical treatment was received:

Yes No

All treatment was furnished by the Employer or Insurance Carrier:

Yes No

Date of last treatment: _____
MM/DD/YYYY

IF YOU OR PRIVATE INSURANCE PAID FOR MEDICAL TREATMENT

Other treatment was provided/paid by: _____

(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)

Did Medi-Cal pay for any health care related to this claim?

Yes No

Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or examined for this injury, but that were not provided or paid for by the employer or insurance carrier:

Name of Doctor/Hospital/Clinic 1 (Please leave blank spaces between numbers, names or words)

Name of Doctor/Hospital/Clinic 2 (Please leave blank spaces between numbers, names or words)

8. Other cases have been filed for industrial injuries by this worker as follows:

LIST ANY OTHER CASES FILED WITH DWC

Case Number 1

Case Number 3

Case Number 2

Case Number 4

9. This application is filed because of a disagreement regarding liability for:

- | | |
|--|---|
| <input type="checkbox"/> Temporary disability indemnity | <input type="checkbox"/> Permanent disability indemnity |
| <input type="checkbox"/> Reimbursement for medical expense | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Medical treatment | <input type="checkbox"/> Supplemental Job Displacement/Return to Work |
| <input type="checkbox"/> Compensation at proper rate | <input type="checkbox"/> Other (Specify) _____ |



Is the Applicant Represented? Yes No If "No", applicant is to sign and date below.

SAMPLE

If "Yes", applicant's representative is to complete the following and is to sign and date below.

Law Firm/Attorney Non-Attorney Representative

Law Firm or Company Name (If Applicable)

Law Firm Number (If Applicable)

Attorney/Representative First Name MI

Attorney/Representative Last Name

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

YOUR SIGNATURE

Applicant Attorney/Representative Signature

Applicant Signature

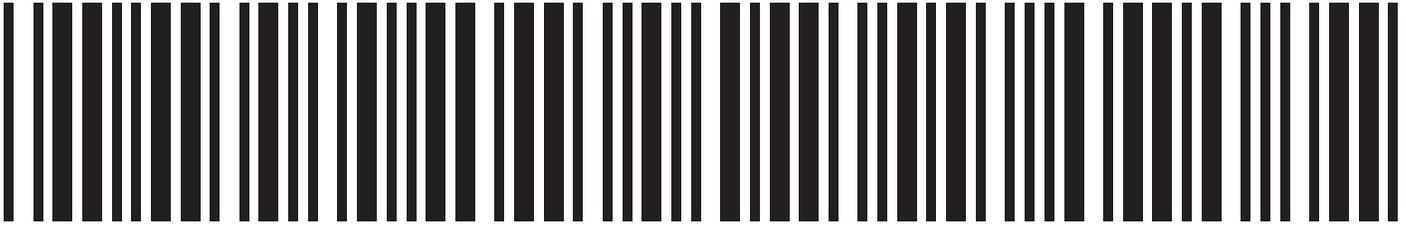
Dated at _____, California
City

Date TODAY'S DATE

MM/DD/YYYY



DOCUMENT SEPARATOR SHEET



Product Delivery Unit

Document Type

Document Title

Document Date

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Author

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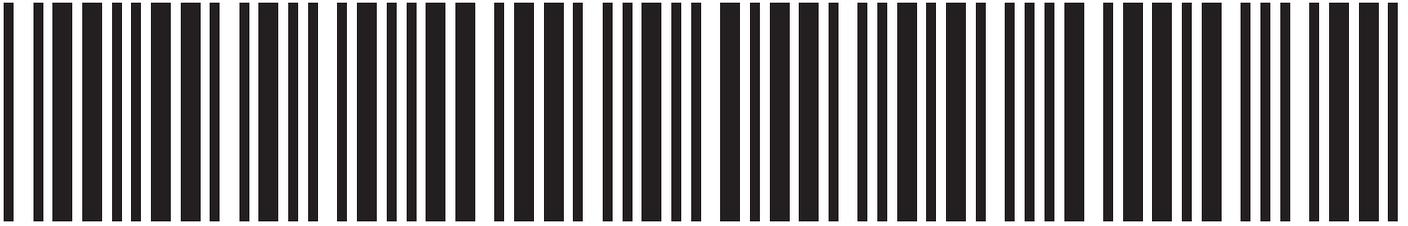
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DOCUMENT SEPARATOR SHEET

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LEGAL DOCS

Document Title

DECLARATION OF READINESS TO PROCEED

Document Date

DATE YOU FILLED OUT THE FORM

MM/DD/YYYY

Author

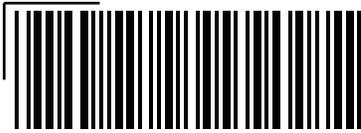
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Received Date

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**STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
DECLARATION OF READINESS TO PROCEED**



NOTICE: Any objection to the proceedings requested by a Declaration of Readiness to proceed shall be filed and served within ten (10) days after service of the Declaration.

Case No. _____

Applicant

First Name _____

MI

Last Name _____

VS

Employer Information

Employer Name (Please leave blank spaces between numbers, names or words) _____

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____

State _____

Zip Code _____

Declarants: Please designate your role (Please Select Only One)

- Employee Applicant Defendant Lien Claimant

Declarant requests: (Please Select Only One)

- Mandatory Settlement Conference Status Conference Rating MSC* Priority Conference
 Lien Conference

At the present time the principal issues are: (Check all that apply)

- Compensation Rate Rehabilitation/SJDB Temporary Disability Self-Procured Medical Treatment
 Permanent Disability Future Medical Treatment AOE/COE Discovery
 Employment Other _____

Declarant relies on the report(s) of:

Doctors (s) _____ date _____

MM/DD/YYYY

*For a Rating MSC, all ratable medical reports, including treating physician, QME and AME reports, must be filed with this Declaration of Readiness, unless they have been previously filed. A Rating MSC will be set only where the issues are limited to permanent disability and the need for future medical treatment.

Declarant states under penalty perjury that he or she is presently ready to proceed to hearing on the issues below and has made the following specific, genuine, good faith efforts to resolve the dispute(s) listed below:

Unless a status or priority conference is requested, I have completed discovery on the issues listed above, and that all medical reports in my possession or control have been filed and served as required by the rules promulgated by the Court Administrator.

Copies of this Declaration have been served this date as shown on the attached proof of service.

Declarant's Signature _____

Name of declarant or name of the law firm of the declarant (Print or Type)

Address (Please leave blank spaces between numbers, names or words)

Phone Number

Date _____
MM/DD/YYYY

INSTRUCTIONS

1. This Declaration must be completed and filed before any case will be set for hearing at the request of any party. A party may request a mandatory settlement conference hearing, status conference hearing, rating mandatory settlement conference hearing, priority conference hearing or a lien conference.

A mandatory settlement conference is held to assist the parties in resolving the dispute. If the dispute cannot be resolved at that time, the parties should be ready to frame issues, record stipulations, list exhibits, and list the witnesses who will testify at trial. A trial is set only at the discretion of the judge and is set for the purpose of receiving evidence.

A rating mandatory settlement conference is a mandatory settlement conference but ratings of the medical reports will be available at the time of the conference.

A status conference is not a mandatory settlement conference but a proceeding for which judicial attention is required. It can include, but is not limited to, a conference in a complicated case in which discovery is not complete and the parties need the judge's guidance.

A priority conference is a conference held under Labor Code section 5502(c) in which the injured worker is represented **by an attorney and the issues include employment and/or injury arising out of and in the course of employment.**

A lien conference is a proceeding for which judicial attention is required to resolve disputes on liens. If the dispute cannot be resolved at that time, the parties should be ready to frame issues, record stipulations, list exhibits, and list the witnesses who will testify at trial.

2. A lien claimant may file a declaration of readiness to proceed only after the underlying case has been resolved or where the applicant chooses not to proceed with his or her case. (Labor Code § 4903.6 (b).) A declaration of readiness filed by a lien claimant shall be accompanied by the verification required by section 10770.6 of title 8 of the California Code of Regulation. The failure to attach the verification or an incorrect verification may be a basis for sanctions.

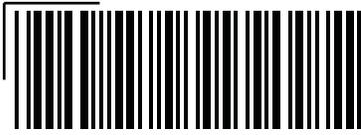
3. Unless notified otherwise, no witness other than the applicant need attend conference hearings. **Claims adjusters and lien claimants must be present or available by telephone.**

4. The party requiring an interpreter must arrange for the presence of an interpreter, except that the defendant(s) must arrange for the presence of the interpreter if the injured worker is not represented by an attorney.

5. Continuances are not favored and none will be granted after the filing of this Declaration without a clear and timely showing of good cause.

6. The Workers' Compensation Appeals Board favors the presentation of medical evidence in the form of written reports.

Workers' Compensation Information and Assistance - 1 (800) 736-7401



STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
DECLARATION OF READINESS TO PROCEED

SAMPLE

NOTICE: Any objection to the proceedings requested by a Declaration of Readiness to proceed shall be filed and served within ten (10) days after service of the Declaration.

EAMS CASE NUMBER

Case No.

Applicant

YOUR FIRST NAME

First Name MI

YOUR LAST NAME

Last Name VS

Employer Information

NAME OF COMPANY YOU WERE WORKING FOR AT TIME OF INJURY

Employer Name (Please leave blank spaces between numbers, names or words)

COMPANY ADDRESS

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

COMPANY CITY

City State Zip Code

Declarants: Please designate your role (Please Select Only One)

- Employee Applicant Defendant Lien Claimant

SELECT THE TYPE OF HEARING YOU WANT. (SEE PAGE 3, INSTRUCTION SHEET FOR DEFINITIONS)

Declarant requests: (Please Select Only One)

- Mandatory Settlement Conference Status Conference Rating MSC* Priority Conference Lien Conference

At the present time the principal issues are: (Check all that apply)

- Compensation Rate Rehabilitation/SJDB Temporary Disability Self-Procured Medical Treatment Permanent Disability Future Medical Treatment AOE/COE Discovery Employment Other

Declarant relies on the report(s) of:

Doctors (s) NAME OF THE DOCTOR'S REPORT YOU ARE USING date DATE OF REPORT

MM/DD/YYYY

*For a Rating MSC, all ratable medical reports, including treating physician, QME and AME reports, must be filed with this Declaration of Readiness, unless they have been previously filed. A Rating MSC will be set only where the issues are limited to permanent disability and the need for future medical treatment.

Declarant states under penalty perjury that he or she is presently ready to proceed to hearing on the issues below and has made the following specific, genuine, good faith efforts to resolve the dispute(s) listed below:

LIST THE EFFORTS YOU HAVE MADE TO RESOLVE THE DISPUTE

Unless a status or priority conference is requested, I have completed discovery on the issues listed above, and that all medical reports in my possession or control have been filed and served as required by the rules promulgated by the Court Administrator.

Copies of this Declaration have been served this date as shown on the attached proof of service.

Declarant's Signature **YOUR SIGNATURE**

IF YOU DO NOT HAVE AN ATTORNEY, PRINT YOUR NAME

Name of declarant or name of the law firm of the declarant (Print or Type)

YOUR MAILING ADDRESS

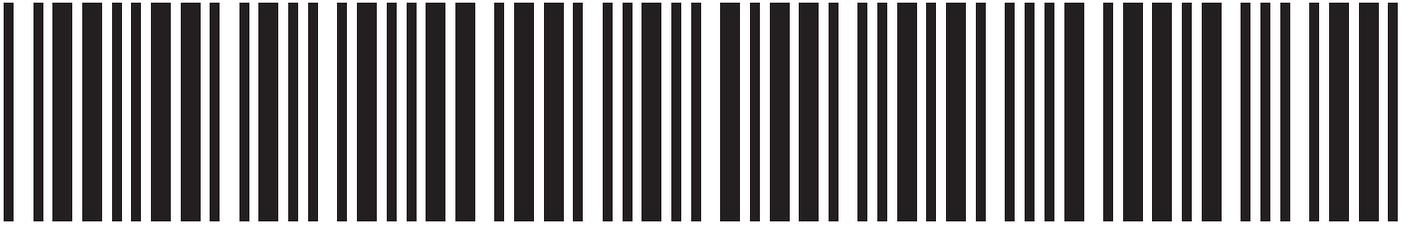
Address (Please leave blank spaces between numbers, names or words)

YOUR PHONE

Phone Number

Date **TODAY'S DATE**
MM/DD/YYYY

DOCUMENT SEPARATOR SHEET



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Document Type

Document Title

Document Date

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Author

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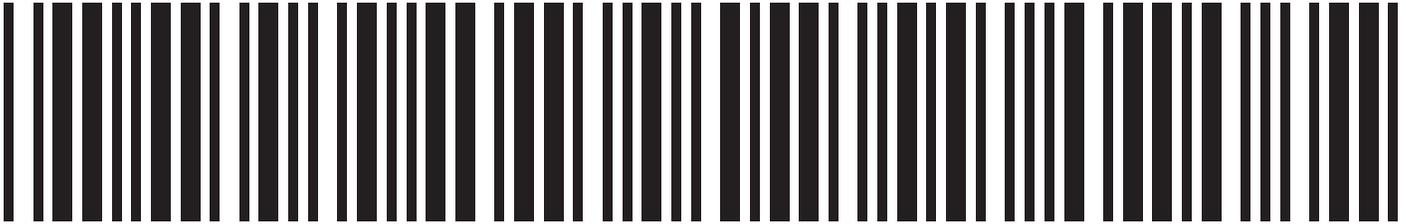
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LEGAL DOCS

Document Title

SPECIAL NOTICE OF LAWSUIT

Document Date

DATE YOU FILLED OUT THE FORM

MM/DD/YYYY

Author

YOUR NAME

Office Use Only

Received Date

MM/DD/YYYY



**WORKERS' COMPENSATION APPEALS BOARD
SPECIAL NOTICE OF LAWSUIT**

(Pursuant to Labor Code 3716 and Code of Civil Procedure Sections 412.20 and 412.30)

WCAB NO.:

To: **DEFENDANT, ILLEGALLY UNINSURED EMPLOYER:**

AVISO: Usted está siendo demandado. La corte puede expedir una decisión en contra suya sin darle la oportunidad de defenderse a menos que usted actúe pronto. Lea la siguiente información.

Applicant.	Defendant(s).
------------	---------------

NOTICES

1) A lawsuit, the Application for Adjudication of Claim, has been filed with the Workers' Compensation Appeals Board against you as the named defendant by the above-named applicant(s).

You may seek the advice of an attorney in any matter connected with this lawsuit and such attorney should be consulted promptly so that your response may be filed and entered in a timely fashion.

If you do not know an attorney, you may call an attorney reference service or a legal aid office. You may also request assistance / information from an Information and Assistance Officer of the Division of Workers' Compensation. (See telephone directory.)

2) An Answer to the Application must be filed and served within six days of the service of the Application pursuant to Appeals Board rules; therefore, your written response must be filed with the Appeals Board promptly; a letter or phone call will not protect your interests.

3) You will be served with a Notice(s) of Hearing and must appear at all hearings or conferences. After such hearing, even absent your appearance, a decision may be made and an award of compensation benefits may issue against you. The award could result in the garnishment of your wages, taking of your money or property, or other relief.

If the Appeals Board makes an award against you, your house or other dwelling or other property may be taken to satisfy that award in a non-judicial sale, with no exemptions from execution.

A lien may also be imposed upon your property without further hearing and before the issuance of an award.

4) You must notify the Appeals Board of the proper address for the service of official notices and papers and notify the Appeals Board of any changes in that address.

**TAKE ACTION NOW TO PROTECT YOUR INTERESTS!
Issued by: WORKERS' COMPENSATION APPEALS BOARD**

Name and Address of Appeals Board: **WORKERS' COMPENSATION APPEALS BOARD**

Name and Address of Applicant's Attorney:

FORM COMPLETED BY:

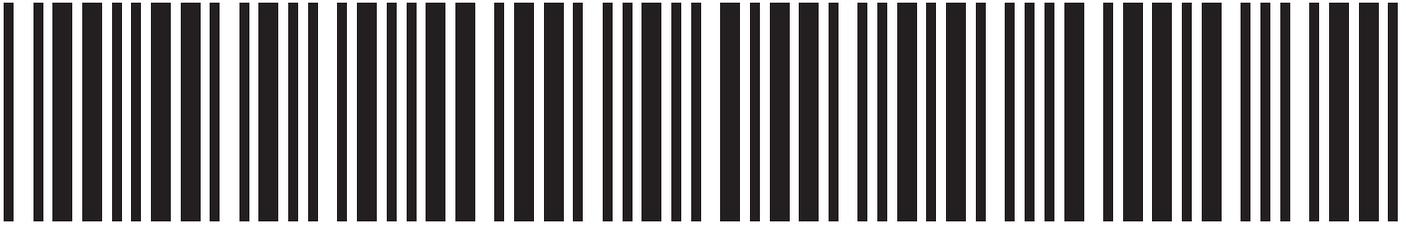
Telephone No.:

NOTICE TO THE PERSON SERVED: You are served:

1. as an individual defendant
2. as the person sued under the fictitious name of (specify):
3. on behalf of (specify):

under: <input type="checkbox"/>	CCP 416.10 (corporation)	<input type="checkbox"/>	CCP 416.60 (minor)
<input type="checkbox"/>	CCP 416.20 (defunct corporation)	<input type="checkbox"/>	CCP 416.70 (conservatee)
<input type="checkbox"/>	CCP 416.40 (association or partnership)	<input type="checkbox"/>	CCP 416.90 (authorized person)
<input type="checkbox"/>	other (specify):		
4. by personal delivery on (date):

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Document Type

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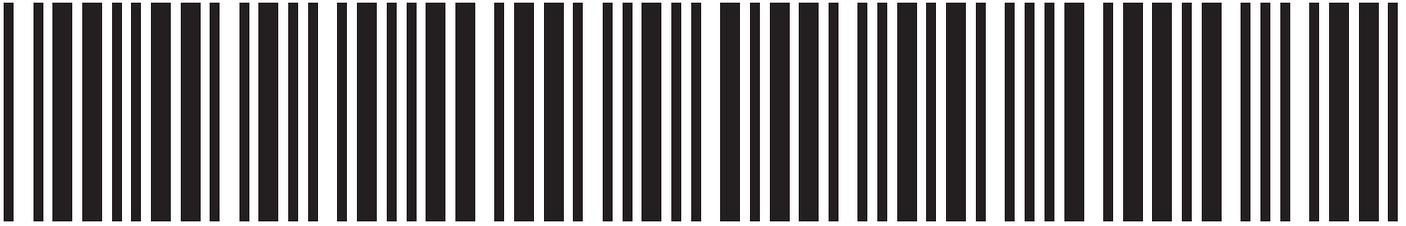
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DOCUMENT SEPARATOR SHEET

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LEGAL DOCS

Document Title

PETITION TO JOIN UEBTF

Document Date

DATE YOU FILLED OUT FORM

MM/DD/YYYY

Author

YOUR NAME

Office Use Only

Received Date

MM/DD/YYYY



State of California
Department of Industrial Relations
Division of Workers' Compensation
Workers' Compensation Appeals Board

Applicant

EAMS Case No:

Vs.

**PETITION TO JOIN PARTY
DEFENDANT**

Defendant(s)

Petitioner hereby requests that the following be joined as a party defendant:

(Select office nearest your residence)

_____ Uninsured Employers Benefits Trust Fund, 1515 Clay Street, 17th Floor, Oakland, CA 94612

_____ Uninsured Employers Benefits Trust Fund, 320 West 4th Street, 6th Floor, Los Angeles, CA 90013

Proof of Service:

On _____ at _____
(Date) (Place)

Petitioner (print name)

Copies mailed to following addresses:

1. _____

2. _____

3. _____

X _____
Signature of Petitioner

SAMPLE

State of California
Department of Industrial Relations
Division of Workers' Compensation
Workers' Compensation Appeals Board

YOUR NAME

Applicant

EAMS Case No:

YOUR EAMS NUMBER

Vs.

**PETITION TO JOIN PARTY
DEFENDANT**

YOUR EMPLOYER'S NAME

Defendant(s)

Petitioner hereby requests that the following be joined as a party defendant:

(Select office nearest your residence)

_____ Uninsured Employers Benefits Trust Fund, 1515 Clay Street, 17th Floor, Oakland, CA 94612

_____ Uninsured Employers Benefits Trust Fund, 320 West 4th Street, 6th Floor, Los Angeles, CA 90013

Proof of Service:

On **DATE** at **CITY, STATE**
(Date) (Place)

PRINT YOUR NAME
Petitioner (print name)

Copies mailed to following addresses:

- 1. **WCAB**
- 2. **YOUR EMPLOYER**
- 3. _____

X **YOUR SIGNATURE**
Signature of Petitioner

VERIFICATION

STATE OF CALIFORNIA

County of _____

I, the undersigned, say that I am _____, a party to this action. I have read the foregoing Petition to Join UEBTF and know the contents thereof, and that the same is true of my own knowledge, except as to the matters which are therein stated upon my information or belief, and as to those matters that I believe to be true.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on _____ at _____, California.

Petitioner

VERIFICATION

STATE OF CALIFORNIA

County of your county

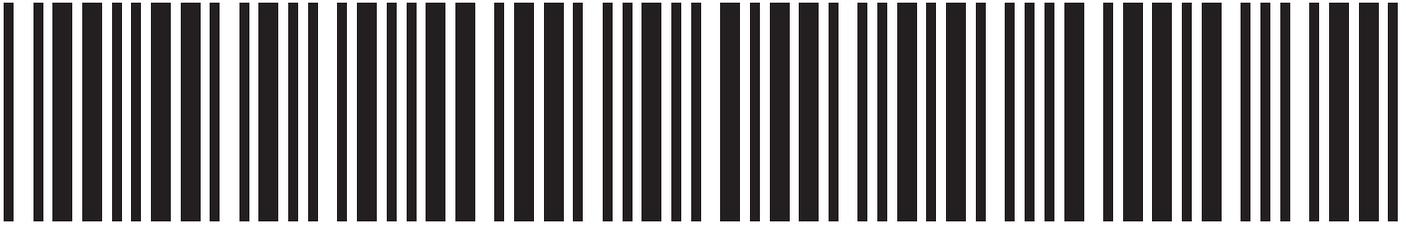
I, the undersigned, say that I am your name, a party to this action. I have read the foregoing Petition to Join UEBTF and know the contents thereof, and that the same is true of my own knowledge, except as to the matters which are therein stated upon my information or belief, and as to those matters that I believe to be true.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date mailed at your city, California.

your signature
Petitioner

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Document Title

Document Date

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Author

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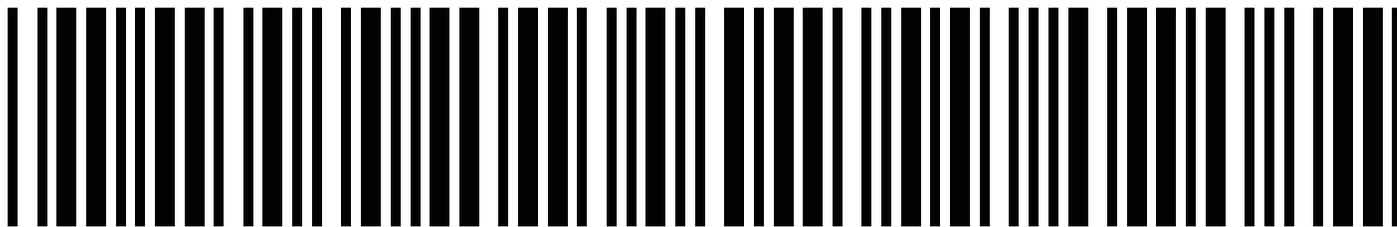
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Document Title

PROOF OF SERVICE

Document Date

DATE YOU FILLED OUT THE FORM

MM/DD/YYYY

Author

YOUR NAME

Office Use Only

Received Date

MM/DD/YYYY

Proof Of Service By Mail

I declare that:

I am (resident of/employed in) the county of _____ California. I am over the age of eighteen years, my (business/residence) address is:

On _____, I served the attached _____ on the _____ in said case, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United State mail at

_____ addressed as follows _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on

(date) _____, at _____ California.

Type or print name _____

Signature _____

SAMPLE

Proof Of Service By Mail

I declare that:

I am (resident of/employed in) the county of YOUR COUNTY California. I am over the age of eighteen years, my (business/residence) address is:

PUT YOUR HOME ADDRESS HERE

On TODAY'S DATE, I served the attached NAME OF DOCUMENT on the

INSURANCE COMPANY in said case, by placing a true copy thereof enclosed in a

sealed envelope with postage thereon fully paid, in the United State mail at

CITY WHERE YOU MAILED THIS

addressed as follows

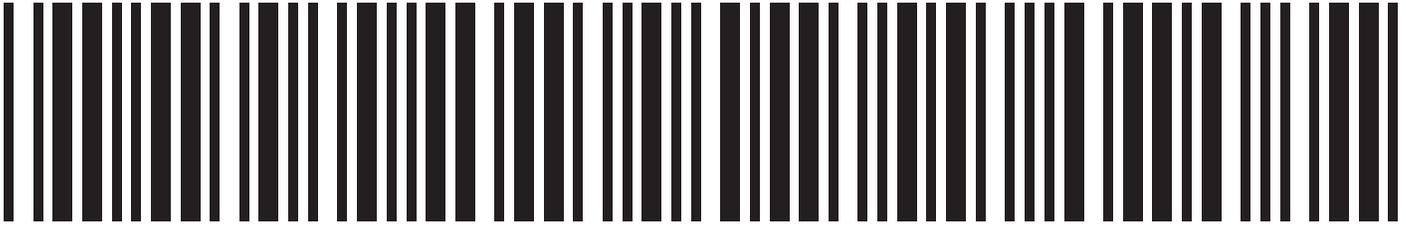
I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on

(date) TODAY'S DATE, at CITY California.

Type or print name PRINT YOUR NAME

Signature SIGN YOUR NAME

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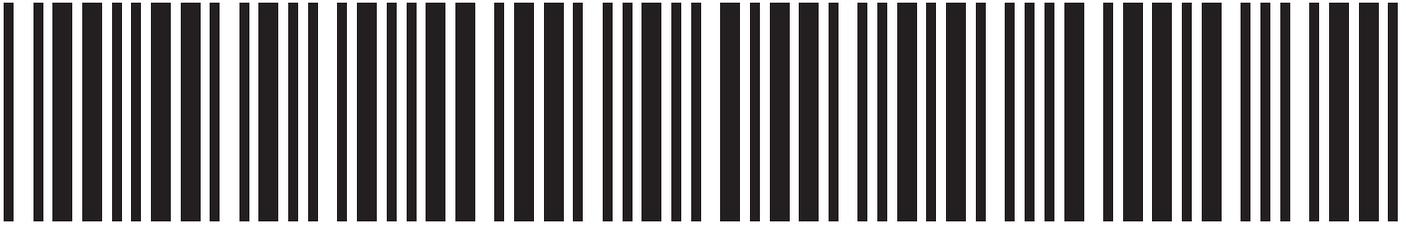
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LEGAL DOCS

Document Title

4906(g) DECLARATION

Document Date

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Author

YOUR NAME

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DECLARATION PURSUANT TO LABOR CODE SECTION 4906(g)

Pursuant to Labor Code Section 4906(g), I declare under penalty of perjury that I have not violated Section 139.3 and I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

Dated: _____

Signature

Before signing this form, you should be aware that: "Any person who makes or causes to be made any knowingly false or fraudulent material statement or representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony."

