If Your Employer is

Illegally Uninsured

How to Apply for Workers' Compensation Benefits

Prepared by the

Institute for Research on Labor and Employment, University of California, Berkeley

For the

Division of Workers' Compensation, California Department of Industrial Relations

September 2023 (update from the original date of publication of June, 2011

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Acknowledgments

This booklet was prepared and designed by the Institute for Research on Labor and Employment (IRLE), University of California, Berkeley, under a contract with the California Commission on Health and Safety and Workers' Compensation (CHSWC). Its purpose is to help injured workers apply for workers' compensation benefits when their employers are illegally uninsured.

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Photos courtesy of iStockphoto.

Contents

How to Use This Booklet

If you get hurt on the job, the law requires your employer to provide workers' compensation benefits. These include medical care for your injury and payments if you are unable to work or have a permanent disability because of the injury. To learn about these benefits, see *Workers' Compensation in California: A Guidebook for Injured Workers*, 3rd Edition, November 2006, along with updates after 2006. Go to: **www.dir.ca.gov/chswc** (link to "Find the most recent Guidebook for Injured Workers").

Employers in California are required to buy workers' compensation insurance from an insurance company or become self-insured through a state program. If your employer is illegally uninsured and does not provide workers' compensation benefits for your injury, you may file a civil lawsuit against your employer for personal injury. You may also file a workers' compensation claim against your employer by requesting the state Workers' Compensation Appeals Board (WCAB) to decide what benefits you have a right to receive.

To give the WCAB the legal power to determine your benefits, you must find the exact legal name of your employer and notify the employer about your claim. If the WCAB decides that you have a right to receive benefits, the WCAB will issue an award requiring your employer to pay the benefits.

If your employer does not pay you, the benefits will be paid by the Uninsured Employers Benefits Trust Fund (UEBTF). This is a special California fund that provides workers' compensation benefits when an injured worker's employer does not do so. After paying your benefits, the UEBTF will collect from your employer. The rules on how you must name and notify your employer are strict and detailed to make it possible for the UEBTF to collect from your employer.

This booklet discusses 10 basic steps to apply for benefits if your employer is illegally uninsured. If possible, you should find

someone who knows these steps to guide you through the process. Some workers hire a workers' compensation applicants' attorney to handle these steps. (Applicants' attorneys represent injured workers in workers' compensation cases.) For workers who are not able to hire an attorney, this booklet discusses how you can work with a state Information & Assistance (I&A) officer.

Information about I&A officers is given in Appendix A. Information about applicants' attorneys is given in Appendix B. Specific forms and further instructions are given in Appendices C, D, F and G. Laws, regulations, and cases that govern the rights and duties discussed in this booklet are listed in Appendix E.

Regardless of who is assisting you, you should gather and organize the materials and other information listed below to support your claim. You should continue to do so until your claim is completed and closed:

- List of witnesses to the injury
- Notes of discussions with people involved in your claim
- Notes showing the progress of your medical condition and ability to work
- Medical reports
- Police and emergency services reports
- Medical bills, receipts for prescriptions and travel to medical appointments
- Proof of employment, such as pay stubs, W-2 forms, written work instructions, and job announcements or advertisements
- Information to identify your employer, such as identification badges, business cards, and the license plate number of your employer's vehicle

Steps to Apply for Benefits

STEP 1.
Report the Injury

If you get hurt at work or develop a work-related medical problem, report it to your employer. Make sure your boss, supervisor, or someone else in management knows as soon as possible. If your employer does not learn about your injury or illness in a timely fashion, you could lose the right to receive workers' compensation benefits.

STEP 2.
File a Claim Form

Your employer is required to give you a ***Workers' Compensation Claim Form (DWC 1)***. You use this form to request workers' compensation benefits in writing. If your employer does not give you a claim form, you can copy the one in Appendix G or get one from an Information & Assistance (I&A) officer.

Workers' Compensation Claim Form (DWC 1)

Read all of the information about workers' compensation that is attached to the form. Fill out the "Employee" portion. Type or print neatly. Describe your injury completely, and include every part of your body affected by the injury. Then sign the form. Make a copy for your records.

Give or mail the form to your employer. This is called "filing" the claim form. If mailing, use first-class or certified mail, and buy a return receipt. If you do not know where to send the form, you can ask the I&A officer for help.

STEP 3.

Identify and Correctly Name Your Employer

Ask for the name of your employer's insurance company if you think your employer is uninsured

If your employer refuses to send you for treatment or pays for your treatment directly without going through workers' compensation insurance, your employer may be uninsured. If this happens, ask your employer for the name of the employer's workers' compensation insurance company.

Search for your employer's exact legal name if you cannot get the name of the insurance company

If your employer does not give you the name of the insurance company and you suspect your employer is uninsured, do a search to find your employer's legal name. The name your employer uses may not necessarily be your employer's legal name:

- If your employer is an individual person or individual owner, the legal name is the name of that person.
- If your employer is a partnership, the legal name includes the name of each partner.
- If your employer is a corporation, limited liability company, or limited partnership, the legal name is the name your employer has on file with the California Secretary of State.

To find your employer's legal name, look in the following places:

- Paychecks or other papers from your employer
- Telephone directory
- City's business licensing bureau
- City or county tax assessor's office
- County clerk's "Fictitious Business Name" index, which lists true legal names of some businesses and the names they are doing business as ("DBA")
- California Secretary of State: **www.sos.ca.gov** (link to "Business Entities," then link to "Business Search")
- California Department of Consumer Affairs, Contractors State License Board: **www.cslb.ca.gov** (link to "Consumers," then link to "Check a License")

Ask for help if necessary

If you cannot find your employer's legal name, you can ask the I&A officer for help to request information from the Office of the Director of Industrial Relations, Legal Unit, which represents the UEBTF. This office is also called OD Legal. See the instructions in the box below.

To request information from OD Legal:

1. Describe everything you have done to:
   a. Identify the employer;
   b. Find out whether it is an individual, a partnership or association, or a corporation or company;
   c. Find its address.
2. State that in spite of these efforts you cannot find the information needed.
3. State that the information is necessary to bring legal action against the employer to allow you to apply for benefits

Write out the legal name of your employer

Use the information you found to write out all possible versions of your employer's legal name. See the box below.

Naming your employer

- If your employer is an individual person or a partnership, write each person's first name, middle initial (if known), and last name. (Example: Thomas R. Thompson and Samuel L. Smith)
- If your employer is a business owned by an individual person, write the name of the owner and the name of the business. (Example: Thomas R. Thompson, an individual, doing business as Tom's Tires.
- If your employer is a business owned by a partnership, write the names of the owners and the name of the business. (Example: Tom's Tires, a partnership, and Thomas R. Thompson and Samuel L. Smith, individuals and partner; or Thomas R. Thompson and Samuel L. Smith , individuals and partners doing busing as Tom's Tires.)
- If your employer is another type of business entity, write its exact name. Include any division, corporate subsidiary, or fictitious business name the business uses. (Example: Toledo Tires, Inc., a Delaware corporation; or Toledo Tires, Inc., a Delaware corporation doing business as New Tires for Less.)

STEP 4.

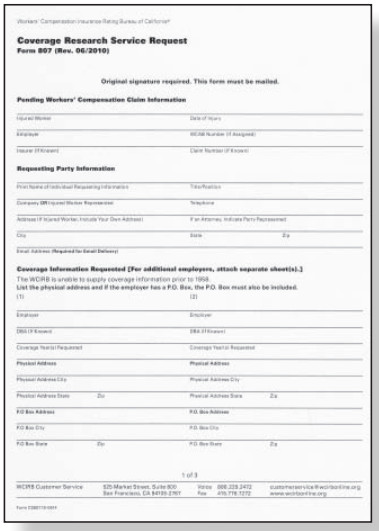
Request Information About Coverage

You can ask the I&A officer whether he or she can do a search

To learn whether your employer has workers' compensation insurance, you can ask whether the I&A officer can do a search in the database of the Workers' Compensation Insurance Rating Bureau (WCIRB), or whether he or she can contact the WCIRB directly.

Request services from the WCIRB if necessary

If the I&A officer cannot do a search and cannot contact the WCIRB directly, fill out a *Coverage Research Service Request* form to ask the WCIRB to search their records for information about your employer's workers' compensation insurance. Type or print neatly. You can copy the form in Appendix G or ask the I&A officer for the form. Fill out the form, listing all possible names that your employer uses. Sign the form. Mail the completed form to the WCIRB at the address shown on the form. No fee is charged to injured workers. Expect a reply in two to six weeks. If the WCIRB states that no insurance coverage was found, go to the next step.



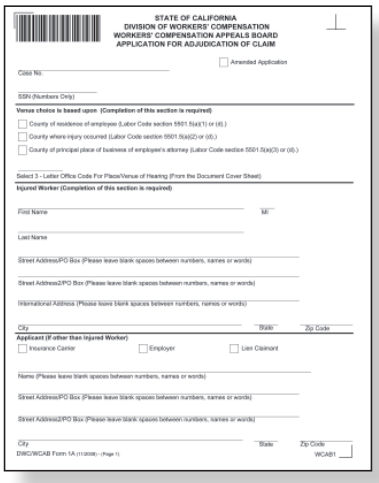
Coverage Research Service Request

STEP 5.

File an Application for Adjudication of Claim

Fill out and sign an *Application for Adjudication of Claim* form. You use this form to open a case and request a workers' compensation judge to decide what benefits you have a right to receive. You can fill out the form with the I&A officer. The form is shown in Appendix F.

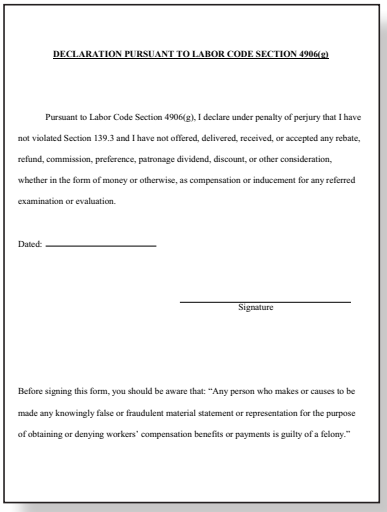
The form asks for your employer's name. Use the name(s) you wrote out in Step 3. If you could not find the true legal name of your employer even after asking for help from the I&A officer, write all the names you think the employer uses and the names of all the persons who appear to be in charge of the business. When you later learn the true legal name of your employer, you must amend (revise) the Application.



Application for Adjudication of Claim

Next, sign a ***Declaration Pursuant to Labor Code Section 4906(g)***. This declaration states that you do not have a financial interest in medical tests or examinations. You can do this with the I&A officer. A sample Declaration is shown in Appendix F.

With the I&A officer, file copies of the Application, the Declaration, and the Workers' Compensation Claim Form with the Workers' Compensation Appeals Board. The WCAB office will mail you a notice with your case number on it.



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."

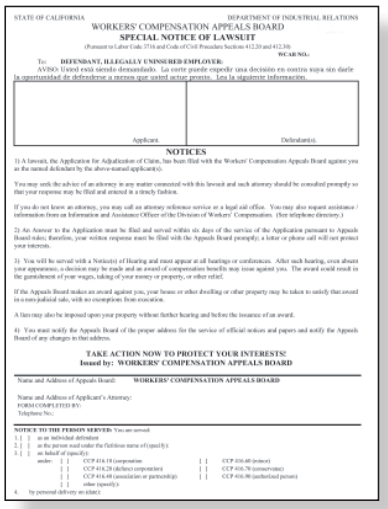
Declaration Pursuant to Labor Code Section 4906(g)

STEP 6.
File in Bankruptcy Court If Applicable

Bankruptcy means that a court decides what will happen when a company does not have enough money to pay its debts, including workers' compensation claims filed by employees. A bankruptcy court has the power to stop workers' compensation proceedings. Stopping workers' compensation proceedings is called a "stay."

If you have received a notice that your employer is filing for bankruptcy, file a "proof of claim" in the bankruptcy proceeding and request "relief" from the court's stay of your workers' compensation proceedings. You must do this to preserve, or protect, the right to obtain workers' compensation benefits from your employer or from the Uninsured Employers Benefits Trust Fund (UEBTF).

If possible, hire a bankruptcy attorney to take these actions to protect your rights, such as an attorney who is certified by the State Bar of California as a specialist in bankruptcy law. You can get names of certified specialists from the State Bar (website: **www.calbar.ca.gov**), a local bar association, a county legal aid society, or your union (if you have one). You can also contact the State Bar of California about lawyer referral services (phone toll-free in California: 1-866-442-2529; website: **www.calbar.ca.gov**), or check the yellow pages of a phone book and look under: Attorney Referral Service.



STATE OF CALIFORNIA — DEPARTMENT OF INDUSTRIAL RELATIONS

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 actue 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: [ ] CCP 416.10 (corporation) [ ] CCP 416.60 (minor)

[ ] CCP 416.20 (defunct corporation) [ ] CCP 416.70 (conservatee)

[ ] CCP 416.40 (association or partnership) [ ] CCP 416.90 (authorized person)

[ ] other (specify):

4. by personal delivery on (date):

Special Notice of Lawsuit

STEP 7.
Fill Out a Special Notice of Lawsuit Form

Fill out a *Special Notice of Lawsuit* form. You use this form to notify your employer about the application you filed with the WCAB. You can copy and use the form in Appendix G. Type or print neatly. In the "Applicant" space, type your full name. In the "Defendant(s)" space, use the name of your employer that you wrote out on the Application.

If you cannot find the true legal name of your employer even after asking for help from the I&A officer, write the names you think the employer uses and the names of the persons who appear to be in charge of the business. When you later learn the true legal name of your employer, you must amend (revise) the *Application* and *Special Notice of Lawsuit.* **NOTE: The Application and Special Notice of Lawsuit must contain the same employer's name.**

STEP 8.
Establish Personal Jurisdiction Over Your Employer

The WCAB must establish "personal jurisdiction" over your employer to have the legal power to decide whether your employer is required to pay workers' compensation benefits for your injury. Below are two different ways to establish personal jurisdiction. Option B is the traditional method. Option A is easier than Option B. However, if Option A does not work, you must do Option B. Discuss with the I&A officer whether the local office of the WCAB can do Option A.

OPTION A: REQUEST A HEARING

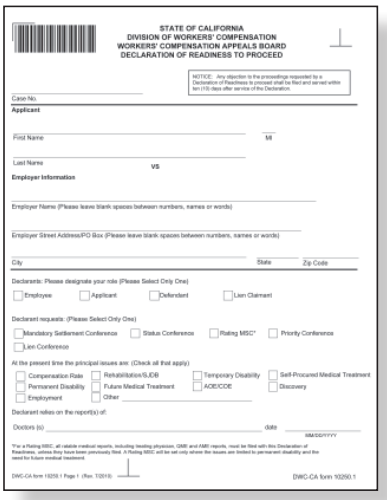
The WCAB may be able to establish personal jurisdiction over your employer if your employer attends and participates in a hearing. This option can work only if you know your employer's address and include it on the papers described below. This will allow the WCAB to notify your employer about the hearing.

Ask for help to find your employer's address if necessary

If you cannot find your employer's address, you can ask the I&A officer for help to request information from OD Legal. See the instructions in the box on page 9.

Prepare papers for a hearing

Fill out and sign a ***Declaration of Readiness to Proceed*** form to request a hearing before a workers' compensation judge. You can do this with the I&A officer. This form is shown in Appendix F.



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

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

DWC-CA form 10250.1

Declaration of Readiness to Proceed

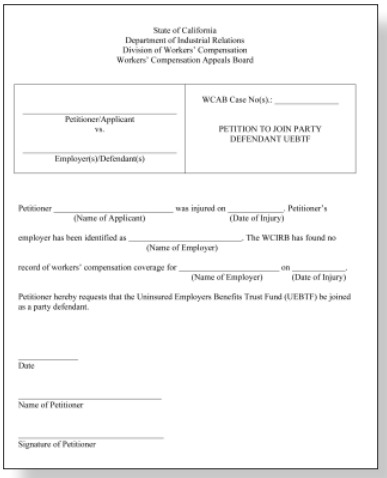
Request that the UEBTF be included in your case

Fill out and sign a ***Petition to Join Party Defendant UEBTF*** form to ask that the UEBTF be included in your case. You can copy and use the form in Appendix G. Type or print neatly.

Gather papers

Create a packet of the original documents listed below, and keep them together. Make a copy of the packet to file with the WCAB. Keep the original packet for your records.

- Special Notice of Lawsuit
- Application for Adjudication of Claim
- Declaration of Readiness to Proceed
- Workers' Compensation Claim Form (or a copy)
- WCIRB reply that no insurance coverage was found
- Petition to Join Party Defendant UEBTF



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

Petitioner/Applicant
vs.
Employer(s)/Defendant(s)

WCAB Case No(s).:

PETITION TO JOIN PARTY DEFENDANT UEBTF

Petitioner _____ was injured on _____, Petitioner's
(Name of Applicant) (Date of Injury)
employer has been identified as _____. The WCIRB has found no
(Name of Employer)
record of workers' compensation coverage for _____ on _____,
(Name of Employer) (Date of Injury)
Petitioner hereby requests that the Uninsured Employers Benefits Trust Fund (UEBTF) be joined as a party defendant.

Date

Name of Petitioner

Signature of Petitioner

Petition to Join Party Defendant UEBTF

File with the WCAB

With the I&A officer, file the copy you made of the packet described above with the WCAB.

Participate in the hearing

The WCAB will schedule a hearing before a workers' compensation judge and send a notice to all parties about the hearing date. At the hearing, be prepared to describe who you worked for when you

were injured on the job. If your employer attends and participates in the hearing, go to Step 9. If your employer does not participate in the hearing, go to Option B.

OPTION B: SERVE PROCESS AND REQUEST A HEARING

If you did not do Option A, or you tried but your employer did not appear, you must "serve process" to establish jurisdiction over your employer. Serving process means delivering papers to make sure that your employer is adequately informed about your claim. Someone besides yourself must deliver the papers.

Decide who should be served

If your employer is an individual who is the sole owner of his or her business, he or she is the person who must be served with your papers. If your employer is another type of business, see Appendix C for information on who may be served on behalf of the business.

Locate the person to be served

Use the resources in Step 3 to find the workplace of the person to be served or the place where the person receives mail. If your employer is an individual person, you may also find his or her home. If you cannot find any of this information, you can ask the I&A officer to help you request information from OD Legal. See the instructions in the box on page 9.

Prepare papers for a hearing

Fill out and sign a ***Declaration of Readiness to Proceed*** form to request a hearing before a workers' compensation judge. You can do this with the I&A officer. This form is shown in Appendix F.

Request that the UEBTF be included in your case

Fill out and sign a ***Petition to Join Party Defendant UEBTF*** form to ask that the UEBTF be included in your case. You can copy and use the form in Appendix G. Type or print neatly.

Gather papers

Create a packet of the original documents listed below, and keep them together. Make three copies of the packet: one for your employer, one for OD Legal, and one to file with the WCAB. Keep the original packet for your records.

- Special Notice of Lawsuit
- Application for Adjudication of Claim
- Declaration of Readiness to Proceed
- Workers' Compensation Claim Form (or a copy)
- WCIRB reply that no insurance coverage was found
- Petition to Join Party Defendant UEBTF

Find a process server

You must find someone besides yourself to deliver one copy of the packet to the person to be served. It is best to use the sheriff or marshal or to hire a professional process server. To find the sheriff or marshal, look in the County Government pages of your phone book. To find a professional process server, look in the Yellow Pages of your phone book. Expect to pay a fee to the sheriff, marshal, or professional process server. Keep the receipt so you can request reimbursement later from your employer or the UEBTF. The process server will deliver the packet by one of the following methods:

- Personal service, which means handing the papers directly to the person to be served
- Substituted service, which means delivering the packet to a different person and mailing a copy of the packet to the person to be served

Instruct the process server

The process server will give you forms asking for the names and addresses of the person(s) to be served and other instructions. Provide the numbers of copies of documents required by the process server. Also give the process server a ***Proof of Service of Special Notice of Lawsuit*** form to fill out and return to you after delivering the packet. The proof of service shows that the process server successfully served the ***Special Notice of Lawsuit***. You can copy and use the form in Appendix G. The process server should

PROOF OF SERVICE – SPECIAL NOTICE OF LAWSUIT

1) I served the (check all that apply):
a. [ ] Special Notice of Lawsuit [ ] Application for Adjudication of Claim [ ] Claim Form
[ ] Order Joining Party Defendant [ ] Medical Records [ ] Other (specify):
b. on defendant (name):

c. Person served: [ ] Party in 1(b) [ ] Other (specify name and relationship to defendant):

d. Address where the party was served:
e. by delivery [ ] at home [ ] at business [ ] other (specify):
(a) date:
(b) time:
(c) address:
f. by mailing
(1) date:
(2) place:

2) Manner of service (check proper box):
a. [ ] Personal service. By personally delivering copies (CCP 415.10)
b. [ ] **Substituted service on corporation, unincorporated association (including partnership), or public** entity. By leaving, during usual office hours, copies in the office of the person served with the person who apparently was in charge and thereafter mailing (by first-class mail, postage prepaid) copies to the person served at the place where the copies were left. [CCP 415.20(a)]
c. [ ] Substituted service on natural person, minor, conservatee, or candidate. By leaving copies at the dwelling house, usual place of abode, or usual place of business of the person served in the presence of a competent member of the household or a person apparently in charge of the office or place of business, at least 18 years of age, who was informed on the general nature of the papers, and thereafter mailing on (date): _____ from (city): _____ or [ ] declaration of mailing attached (by first-class mail, postage prepaid) copies to the person served at the place where the copies were left. [CCP 415.20(b)] ***(Attach separate declaration or affidavit stating acts relied on to establish reasonable diligence in first attempting personal service.)***
d. [ ] **Mail and acknowledgment service.** By mailing (by first class mail or airmail, postage prepaid) copies to the person served, together with two copies of the form of notice and acknowledgment and a return envelope, postage prepaid, addressed to the sender. (CCP 415.30) ***(Attach completed acknowledgment of receipt.)***
e. [ ] **Certified or registered mail service.** By mailing to an address outside California (by first-class mail, postage prepaid, requiring a return receipt) copies to the person served. (CCP 415.40) ***(Attach signed return receipt or other evidence of actual delivery to the person served.)***
f. [ ] **Other** *(specify code section):*
g. [ ] Additional page describing service is attached.
3) The "Notice to the Person Served" (on the Notice) was completed as follows (CCP 412.30, 415.0 and 474):
a. [ ] on an individual defendant.
b. [ ] as the person sued under the fictitious name of *(specify)*:
c. [ ] on behalf of (specify):
under: [ ] CCP 416.10 (corporation [ ] CCP 416.60 (minor)
[ ] CCP 416.20 (defunct corporation) [ ] CCP 416.70 (conservatee)
[ ] CCP 416.40 (association or partnership) [ ] CCP 416.90 (authorized person)
[ ] other (specify):
4) At the time of service I was at least 18 years of age and not a party to this action.
5) Fee for service: $
6) Person serving: Name:
Address:
Telephone no.:
a. [ ] Not a registered California process server.
b. [ ] Exempt from registration under Bus. & Prof. Code 22350(b).
c. [ ] Registered California process server:
(i) [ ] Owner [ ] Employee [ ] Independent contractor
(ii) Registration no.:
(iii) County:
d. [ ] California sheriff, marshal or constable.

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

(For California sheriff, marshal or constable use only)
I certify that the foregoing is true and correct.

(Signature) (Date) (Signature) (Date)

Proof of Service of Special Notice of Lawsuit

type or print neatly, and should list on the form all the documents in the packet.

If delivery by personal service to an individual who is the sole owner of his or her business is not possible and delivery is made by substituted service, the process server will also prepare a ***Declaration of Due Diligence***, which is a statement describing how the process server tried to deliver by personal service. Make two copies of the proof of service form: one for OD Legal and one to file with the WCAB. Do the same with the declaration (if one was prepared). Keep the originals for your records.

(You may also ask a friend or relative to deliver the packet, but this is not recommended unless you know that delivery will be easy and straightforward. The person who delivers the packet must be at least 18 and not listed in your claim. For instructions on how to deliver the packet by personal service or substituted service, see Appendix D.)

Ask for help if the packet cannot be delivered

If delivery by personal service or substituted service is not possible, you can ask for help from the I&A officer to do service by mail with acknowledgment of receipt, service by publication in a newspaper, or service of the Secretary of State (if your employer is a corporation).

Notify OD Legal

Ask the I&A officer for the address of the appropriate office of OD Legal, which represents the UEBTF. Mail a copy of the packet to that office. Use first-class or certified mail, and purchase a return receipt.

File with the WCAB

With the I&A officer, file a copy of the packet listed above with the WCAB, along with a copy of the ***Proof of Service of Special Notice of Lawsuit*** and a copy of the ***Declaration of Due Diligence*** (if one was prepared).

Participate in the hearing scheduled by the WCAB

Go to the hearing and be prepared to describe who you worked for when injured on the job.

STEP 9.
Receive an Order Joining the UEBTF

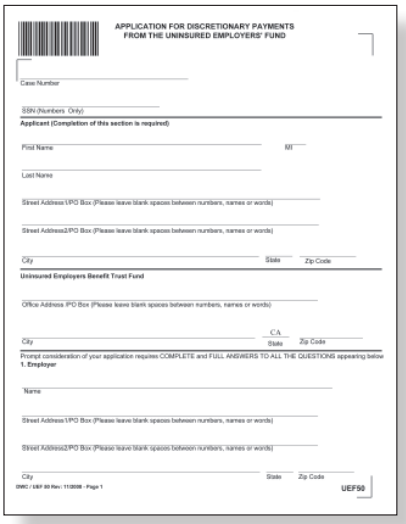
If there are no problems with the steps you took to name, notify, and establish personal jurisdiction over your employer, you will receive an order from the WCAB joining the Uninsured Employers Benefits Trust Fund (UEBTF) as a defendant in your claim. After you receive this order, give copies of important documents in your claim to the UEBTF if the WCAB asks you to do so.

STEP 10.
Request Benefits

Go to and participate in any medical examinations, meetings, and hearings required by the workers' compensation judge. The judge will review the medical reports and other information in your case to decide whether you have the right to receive workers' compensation benefits. The process could take some time, depending on how complicated your case is.

In the meantime, fill out and sign an ***Application for Discretionary Payments from the Uninsured Employers Fund***. You can do this with the I&A officer. This form is shown in Appendix F. With the I&A officer, file the application with the UEBTF. The UEBTF may provide you with benefits before the workers' compensation judge makes a decision, but is not required to do so.

If the judge decides that you should receive workers' compensation benefits, he or she will issue an award requiring your employer to pay the benefits. If you do not begin receiving benefits from your employer within 10 days after learning about your award, you can ask the I&A officer for help to obtain benefits from the UEBTF.


APPLICATION FOR DISCRETIONARY PAYMENTS
FROM THE UNINSURED EMPLOYERS' FUND

Case Number

SSN (Numbers Only)

Applicant (Completion of this section is required)

First Name MI

Last Name

Street Address1/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

Uninsured Employers Benefit Trust Fund

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

City CA State Zip Code

Prompt consideration of your application requires COMPLETE and FULL ANSWERS TO ALL THE QUESTIONS appearing below

1. Employer

Name

Street Address1/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

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UEF00

Application for Discretionary Payments from the Uninsured Employers Fund

APPENDIX A

State Information & Assistance (I&A) Services

Information & Assistance (I&A) officers answer questions and help injured workers. They may provide information and forms and help resolve problems. Their services are free. They cannot actively prepare your case, argue on your behalf, or speak as your representative (unlike an attorney).

The I&A numbers listed below were effective as of April 2024.

Toll-Free: 1-800-736-7401
Call this number to hear recorded messages.

District Offices: For addresses, check the Government Pages at the front of the white pages of your phone book. Look under: State Government Offices/Industrial Relations/Workers' Compensation. Also see the website of the state Division of Workers' Compensation (DWC): **www.dir.ca.gov/dwc**.

Anaheim
1-714-414-1801

Bakersfield
1-661-395-2514

Eureka
*Virtual office
1-707-441-5723

Fresno
1-559-445-5355

Lodi
1-209-948-7759

Long Beach
1-424-450-2565

Los Angeles
1-213-576-7389

Marina del Rey
1-310-482-3820

Oakland
1-510-622-2861

Oxnard
1-805-485-3528

Pomona
1-909-623-8568

Redding
1-530-225-2047

Riverside
1-951-782-4347

Sacramento
1-916-928-3158

Salinas
1-831-443-3058

San Bernardino
1-909-383-4522

San Diego
1-619-767-2082

San Francisco
1-415-703-5020

San Jose
1-408-277-1292

San Luis Obispo
1-805-596-4159

Santa Ana
1-714-942-7576

Santa Barbara
1-805-568-1295

Santa Rosa
1-707-576-2452

Van Nuys
1-818-901-5367

APPENDIX B

Workers' Compensation Applicants' Attorneys

Lawyers who represent injured workers in their workers' compensation cases are called applicants' attorneys. Their job is to protect your rights, plan a strategy for your case, be your advocate, gather information to support your claim, keep track of deadlines, represent you in hearings before a workers' compensation judge, and tell you about additional claims and benefits that may be available.

Most applicants' attorneys provide one free consultation. If you hire an attorney, you do not pay right away. Instead, the attorney's fee is taken out of some of your benefits later. The fee is usually 9% to 15% of your final permanent disability settlement or award. A workers' compensation judge must approve the fee. Note: Often applicants' attorneys will not take cases where the worker does not have a permanent disability or where the employer is illegally uninsured.

You can get names of applicants' attorneys from an I&A officer, the State Bar of California (website: **www.calbar.ca.gov**), a certified lawyer referral service, a local bar association, the California Applicants' Attorneys Association (toll-free within California: 1-800-648-3132; website: **www.caaa.org**), a county legal aid society, your union (if you have one), or other injured workers.

APPENDIX C

Persons Who May Be Notified About a Claim on Behalf of a Business

IF THE BUSINESS IS:	THE PERSON TO BE SERVED IS:
A sole proprietorship (only one owner)	The owner
A partnership	One of the partners
A corporation or association	Agent for service listed with the California Secretary of State: **www.sos.ca.gov** (link to "Business Entities," then link to "Business Search") – or – Any corporate officer (president, vice president, secretary, treasurer), chief executive officer (CEO), controller, chief financial officer, or general manager
A limited liability company (LLC), limited liability partnership (LLP), or limited partnership (LP)	Agent for service listed with the California Secretary of State: **www.sos.ca.gov** (link to "Business Entities," then link to "Business Search") – or – The general partner if the business is a limited partnership
An unknown business type	Someone who seems to be in charge of the business during normal business hours

Source: Judicial Council of California, **www.courtinfo.ca.gov**, "How to Serve a Business or Public Entity (Small Claims)," Form SC-104C, July 1, 2007.

APPENDIX D

How to Deliver by Personal Service or Substituted Service

It is best to use the sheriff or marshal or to hire a professional process server to deliver by personal or substituted service, unless you know that delivery will be easy and straightforward. The person who delivers the packet must be at least 18 years old and not listed in your claim. If you ask a friend or relative to deliver the packet, show this person the following instructions:

"Personal" service if the person to be served can be found:

- Walk up to the person.
- Say, "These are legal papers."
- Give the person the packet. If the person will not take the packet, just leave it near the person. It does not matter if he or she tears it up or throws it away.
- Fill out and sign the ***Proof of Service of Special Notice of Lawsuit*** form.

"Substituted" service if the person to be served cannot be found:

If your employer is an individual who is the sole owner of his or her business, the process server must make a reasonable, genuine effort to deliver the packet to that person. Ordinarily this means trying to deliver the packet two or three different times at a location where the person is likely to be found. If the person cannot be found after reasonable attempts, the process server may use substituted service, as follows:

Deliver the packet using one of the following methods:

- At the home of the person to be served, give the packet to a competent member of the household, who is at least 18 years old.
- At the usual place of business of the person to be served, give the packet to a person who seems to be in charge of the place of business, who is at least 18 years old.
- At the usual mailing address of the person to be served (can be a private mailbox but not a U.S. post office box), give the packet to a person who seems to be in charge of the mailing address, who is at least 18 years old.

Tell the person who is given the packet that the packet contains legal papers and ask him or her to give it to the person to be served. If the person will not take the packet, just leave it near the person.

Write down the name of the person who is given the packet. If the person will not give his or her name, write down a physical description of the person.

After delivering the packet, mail a copy of the packet by first-class mail, postage prepaid, to the person to be served at the place where the packet was left.

Fill out and sign the ***Proof of Service of Special Notice of Lawsuit*** form. Also prepare and sign a ***Declaration of Due Diligence*** stating the actions taken to attempt delivery by personal service. Finally, complete a ***Declaration of Mailing*** if the Proof of Service does not include one.

If your employer is another type of business, the process server may use substituted service as follows:

Deliver the packet using one of the following methods:

- In the office of the person to be served during usual business hours, give the packet to a person who seems to be in charge of the office.
- At the usual mailing address of the person to be served (can be a private mailbox but not a U.S. post office box), give the packet to a person who seems to be in charge of the mailing address, who is at least 18 years old. If the packet is left at a commercial mail receiving agency (CMRA), you must obtain from the CMRA a declaration of service by mail, given under penalty of perjury, along with a certificate of mailing. Attach those to your Proof of Service.

Tell the person who is given the packet that the packet contains legal papers and ask him or her to give it to the person to be served. If the person will not take the packet, just leave it near the person.

Write down the name of the person who is given the packet. If the person will not give his or her name, write down a physical description of the person.

After delivering the packet, mail a copy of the packet by first-class mail, postage prepaid to the person to be served at the place where the packet was left.

Fill out and sign the ***Proof of Service of Special Notice of Lawsuit*** form.

APPENDIX E

Important Laws, Regulations, and Cases

Laws, regulations, and cases that govern the rights and duties discussed in this booklet are listed below. The laws and regulations are listed by section number (§).

How to Use This Booklet

Injured worker's right to sue illegally uninsured employer in civil court for personal injury: Labor Code §§ 3706-3709.5

Authority of the California Department of Industrial Relations over illegally uninsured employers: Labor Code §§ 3710-3732

Notice to an illegally uninsured employer about an injured worker's claim must be in the same manner that a summons is written and issued in a civil court action, as governed by the Code of Civil Procedure: Labor Code § 3716(d)

Summons in civil court cases: Code of Civil Procedure §§ 412.20-412.30

Party serving a summons must be at least 18 and not a party to the action: Code of Civil Procedure § 414.10

Persons upon whom summons may be served: Code of Civil Procedure §§ 416.10-416.90

Manner in which summons may be served: Code of Civil Procedure §§ 415.10-415.95

Use of fictitious name is permitted if plaintiff does not know defendant's name: Code of Civil Procedure § 474; Rea v. WCAB (2005) 127 Cal. App. 4th 625

Step 1. Report the Injury

Notice of injury within 30 days of injury; date of injury: Labor Code §§ 5400, 5411, 5412

Employer's knowledge equivalent to notice: Labor Code § 5402

Failure to give proper notice not a bar to recovery if employer was not misled or prejudiced by such failure: Labor Code § 5403

Step 2. File a Claim Form

Employer must provide claim form: Labor Code § 5401(a)

Claim form is filed when personally delivered or mailed by first-class or certified mail: Labor Code § 5401(d)

Step 3. Identify and Correctly Name Your Employer

Injured worker must identify a legal person or entity as the employer: Labor Code § 3716(d)

Corporation, limited liability company, or limited partnership must file papers with the California Secretary of State showing its true legal name: Corporations Code §§ 200-213, 15621-15628, 17050-17062

Any for-profit business operating in California under a "fictitious business name" must file a statement in the county where the business is located, showing both its fictitious business name and its true legal name: Business and Professions Code §§ 17900-17930

Director of Industrial Relations must furnish information on the identities, legal capacities, and addresses of uninsured employers known to the Director upon a showing of good cause: Labor Code § 3716(d)(4)

Step 4. Request Coverage Information

Workers' Compensation Insurance Rating Bureau, which is an association of all companies that are licensed to provide insurance in the California workers' compensation system, collects statistics and other information from its members and develops advisory pure premium rates: Insurance Code §§ 11750-11759.2

Step 5. File an Application for Adjudication of Claim

Filing of the Application establishes subject matter jurisdiction of the WCAB for injuries occurring after 1993: Labor Code § 5500

Names of the parties must be included on a summons in a civil court case: Code of Civil Procedure § 412.20

The injured worker, employer, insurance company, and attorneys in a case must each sign a Declaration Pursuant to Labor Code Section 4906(g), stating they have no financial conflict of interest involving medical tests and exams: Labor Code § 4906(g

Step 6. File in Bankruptcy Court If Applicable

To preserve the right to claim benefits from the UEBTF, injured worker must file a proof of claim in the employer's bankruptcy proceeding and request relief from the court's stay of the workers' compensation proceedings: Ortiz v. WCAB and UEF (1992) 4 Cal. App. 4th 392

Step 7. Fill Out a Special Notice of Lawsuit Form

Special Notice of Lawsuit must identify person(s) and/or entity being served and the date of service: Labor Code § 3716(d); Code of Civil Procedure §§ 412.20, 412.30

Step 8. Establish Personal Jurisdiction

If employer makes a general appearance at the WCAB by participating in a case in some manner that recognizes the authority of the WCAB to proceed, personal jurisdiction over the employer will be established and the employee will not be required to effect service of process on the employer: Code of Civil Procedure §§ 410.50, 1014; Dial 800 v. Fesbinder (2004) 118 Cal. App. 4th 32

Director of Industrial Relations must furnish information on the identities, legal capacities, and addresses of uninsured employers known to the Director upon a showing of good cause: Labor Code § 3716(d)(4)

Any party filing documents with the WCAB must serve copies of the documents on all parties and file proof of service: California Code of Regulations, title 8, § 10410 and 10625

WCAB must notify all parties and their attorneys of the time and place of a hearing: California Code of Regulations, title 8, § 10750

If employer is illegally uninsured, the injured worker must serve the employer with the Application for Adjudication of Claim and the Special Notice of Lawsuit in the manner provided for service of summons in the Code of Civil Procedures: Labor Code § 3716(d); Rea v. WCAB (2005) 127 Cal. App. 4th 625 (citing Yant v. Snyder & Dickenson, 47 Cal. Comp. Cases 254 (1982))

Persons upon whom summons may be served: Code of Civil Procedure §§ 416.10-416.90

Manner in which summons may be served: Code of Civil Procedure §§ 415.10-415.95

Service of the Secretary of State if employer is a corporation: Code of Civil Procedure § 416.10(d) (citing Corporations Code § 1702)

Proof of Service must be provided to the Director of Industrial Relations: Labor Code § 5502(f)

Step 9. Receive an Order Joining the UEBTF

WCAB may designate the injured worker to notify the UEBTF and send copies of all relevant documents: California Code of Regulations, title 8, § 10382

Step 10. Request Benefits

Injured worker may request discretionary benefits from the UEBTF: Labor Code § 4903.3

Workers' compensation judge may issue an award against the employer: Labor Code § 3715

If employer does not begin payments or post a bond within 10 days after receiving notice of the award, the injured worker may apply to the UEBTF and the UEBTF shall pay the benefits: Labor Code §§ 3716(a), 3716.2

UEBTF may file an action in civil court to collect the award that was issued against the employer: Labor Code § 3717

Appendix D. How to Deliver by Personal Service or Substituted Service

Persons upon whom summons may be served: Code of Civil Procedure §§ 416.10-416.90

Manner in which summons may be served: Code of Civil Procedure §§ 415.10-415.95

Reasonable diligence in attempting personal service on an individual as a sole owner: Hearn v. Howard (2009) 177 Cal. App. 4th 1193 (quoting Espindola v. Nunez (1988) 199 Cal. App. 3d 1389); Ellard v. Conway (2001) 94 Cal. App. 4th 540

Declaration of Due Diligence required by Proof of Service of Summons, Form POS-010, January 1, 2007, adopted by the Judicial Council of California, **www.courtinfo.ca.gov**

APPENDIX F

Forms to Fill Out with an I&A Officer or Attorney

You can work with an I&A officer or attorney to fill out the forms in this appendix, as discussed in this booklet. These forms are to be filed with the WCAB.

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 _____ (DATE OF BIRTH: MM/DD/YYYY), while employed as a(n) _____ (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)

suffered a :

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

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

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

☐ Temporary disability indemnity
☐ Permanent disability indemnity
☐ Reimbursement for medical expense
☐ Rehabilitation
☐ Medical treatment
☐ Supplemental Job Displacement/Return to Work
☐ Compensation at proper rate
☐ 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.

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."

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)

_____ Date _____
Phone Number 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, or a priority conference hearing.

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 lien conference or 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.**

2. 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.**

3. 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.

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

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

6. The WCJ, upon the receipt of the Declaration of Readiness, may set the case for a type of proceeding other than the one requested (Section 10417).

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

APPLICATION FOR DISCRETIONARY PAYMENTS FROM THE UNINSURED EMPLOYERS' FUND

Case Number

SSN (Numbers Only)

Applicant (Completion of this section is required)

First Name MI

Last Name

Street Address1/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

Uninsured Employers Benefit Trust Fund

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

City CA State Zip Code

Prompt consideration of your application requires COMPLETE and FULL ANSWERS TO ALL THE QUESTIONS appearing below

1. Employer

Name

Street Address1/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

2. Please specify a specific injury date or specify if it was a cumulative trauma injury:

(Choose only one)

☐ as specific Injury on _____
(DATE OF INJURY: MM/DD/YYYY)

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

3. List the names and address of doctors and hospitals that have treated you for this injury:

4. Have you returned to work ? ☐ Yes ☐ No

If Yes, give date _____
(MM/DD/YYYY)

5. Have you received payments from anyone for this injury ? ☐ Yes ☐ No

If Yes, how much were you paid ? $ _____

Who paid you ? _____

I, the undersigned, hereby apply for discretionary payments of compensation from the Uninsured Employers Fund under Laber Code section 4903.3 and declare under penalty of perjury that the information furnished above is true and correct to the best of my knowledge and belief. I hereby authorize any doctors or hospitals that have treated me for this injury to furnish and disclose all facts concerning my medical condition that are within their knowledge, and to allow inspection of and provide copies of any records concerning my medical condition that are under their control.

Executed on _____ ,at _____ , California
(MM/DD/YYYY)

_____
(Signature of Applicant)

APPENDIX G

Forms to Copy and Use

You can copy and use the forms in this appendix, as discussed in this booklet. Type or print neatly.

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 differentes 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 lesions por un period 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

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 atienda, 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 requisitios, 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 despida, 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 Codigo 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 pagína 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 pagína Web en **www.californiaspecialist.org**.

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

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.

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 Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabajador.*

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

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.

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 occurió el accidente.* _____
   _____
6. Describe injury and part of body affected. *Describa 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 adminstradora 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

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

○ Employer copy/*Copia del Empleador* ○ Employee copy/ *Copia del Empleado* ○ Claims Administrator/*Administrador de Reclamos* ○ Temporary Receipt/*Recibo del Empleado*

6/10 Rev.

Coverage Research Service Request
Form 807 (Rev. 06/2010)

Instructions

Purpose of Form
Completion of this form is required for coverage requests made in connection with a pending workers' compensation claim.

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
2006–2007	2	$20
1/1/06–1/1/07	1	$10
1/1/06–1/31/07	2	$20
2006–3/1/09	4	$40
2005–2009	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
525 Market Street, Suite 800
San Francisco, CA 94105-2767

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

Coverage Research Service Request
Form 807 (Rev. 06/2010)

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 Zip	Physical Address State Zip
P.O Box Address	**P.O. Box Address**
P.O Box City	P.O. Box City
P.O Box State Zip	P.O. Box State Zip

WCIRB Customer Service | 525 Market Street, Suite 800, San Francisco, CA 94105-2767 | Voice 888.229.2472 | Fax 415.778.7272 | customerservice@wcirbonline.org | www.wcirbonline.org

Coverage Research Service Request

Form 807 (Rev. 06/2010)

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.

Restricted Use of Information

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.

WCIRB Customer Service | 525 Market Street, Suite 800, San Francisco, CA 94105-2767 | Voice 888.229.2472 | Fax 415.778.7272 | customerservice@wcirbonline.org | www.wcirbonline.org

Coverage Research Service Request
Form 807 (Rev. 06/2010)

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.

WCIRB Customer Service | 525 Market Street, Suite 800, San Francisco, CA 94105-2767 | Voice 888.229.2472 | Fax 415.778.7272 | customerservice@wcirbonline.org | www.wcirbonline.org

Form CS807.10-0614

STATE OF CALIFORNIA DEPARTMENT OF INDUSTRIAL RELATIONS

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 actue 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:
- [ ] CCP 416.10 (corporation)
- [ ] CCP 416.20 (defunct corporation)
- [ ] CCP 416.40 (association or partnership)
- [ ] other (specify):
- [ ] CCP 416.60 (minor)
- [ ] CCP 416.70 (conservatee)
- [ ] CCP 416.90 (authorized person)

4. by personal delivery on (date):

PROOF OF SERVICE -- SPECIAL NOTICE OF LAWSUIT

1) I served the (check all that apply):

a. [ ] Special Notice of Lawsuit [ ] Application for Adjudication of Claim [ ] Claim Form
[ ] Order Joining Party Defendant [ ] Medical Records [ ] Other (specify):

b. on defendant (name):

c. Person served: [ ] Party in 1(b) [ ] Other (specify name and relationship to defendant):

d. Address where the party was served:

e. by delivery [ ] at home [ ] at business [ ] other (specify):
(a) date:
(b) time:
(c) address:

f. by mailing
(1) date:
(2) place:

2) Manner of service (check proper box)

a. [ ] Personal service. By personally delivering copies (CCP 415.10)

b. [ ] **Substituted service on corporation, unincorporated association (including partnership), or public** entity. By leaving, during usual office hours, copies in the office of the person served with the person who apparently was in charge and thereafter mailing (by first class mail, postage prepaid) copies to the person served at the place where the copies were left. [CCP 415.20(a)]

c. [ ] Substituted service on natural person, minor, conservatee, or candidate. By leaving copies at the dwelling house, usual place of above, or usual place of business of the person served in the presence of a competent member of the household or a person apparently in charge of the office or place of business, at least 18 years of age, who was informed on the general nature of the papers, and thereafter mailing on (date)_____from (city)_____or [ ] declaration of mailing attached (by first-class mail, postage prepaid) copies to the person served at the place where the copies were left. [CCP 415.20(b)] ***(Attach separate declaration or affidavit stating acts relied on to establish reasonable diligence in first attempting personal service.)***

d. [ ] **Mail and acknowledgment service.** By mailing (by first class mail or airmail, postage prepaid) copies to the person served, together with two copies of the form of notice and acknowledgment and a return envelope, postage prepaid, addressed to the sender. (CCP 415.30) ***(Attach completed acknowledgment of receipt.)***

e. [ ] **Certified or registered mail service.** By mailing to an address outside California (by first-class mail, postage prepaid, requiring a return receipt) copies to the person served. (CCP 415.40) ***(Attach signed return receipt or other evidence of actual delivery to the person served.)***

f. [ ] **Other** (*specify code section):*

g. [ ] Additional page describing service is attached.

3) The "Notice to the Person Served" (on the Notice) was completed as follows (CCP 412.30, 415.0 and 474):

a. [ ] as an individual defendant.

b. [ ] as the person sued under the fictitious name of *(specify):*

c. [ ] on behalf of (specify):

under:
- [ ] CCP 416.10 (corporation
- [ ] CCP 416.20 (defunct corporation)
- [ ] CCP 416.40 (association or partnership)
- [ ] other (specify):
- [ ] CCP 416.60 (minor)
- [ ] CCP 416.70 (conservatee)
- [ ] CCP 416.90 (authorized person)

4) At the time of service I was at least 18 years of age and not a party to this action.

5) Fee for service: $

6) Person serving: Name:
Address:
Telephone no.:

a. [ ] Not a registered California process server.

b. [ ] Exempt from registration under Bus. & Prof. Code 22350(b).

c. [ ] Registered California process server:
(i) [ ] Owner [ ] Employee [ ] Independent contractor
(ii) Registration no.:
(iii) County:

d. [ ] California sheriff, marshal or constable.

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

_____
(Signature) (Date)

(For California sheriff, marshal or constable use only)
I certify that the foregoing is true and correct.

_____
Signature) (Date)

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

_____ Petitioner/Applicant vs. _____ Employer(s)/Defendant(s)	WCAB Case No(s).: _____ PETITION TO JOIN PARTY DEFENDANT UEBTF

Petitioner _____ was injured on _____. Petitioner's
(Name of Applicant) (Date of Injury)

employer has been identified as _____. The WCIRB has found no
(Name of Employer)

record of workers' compensation coverage for _____ on _____.
(Name of Employer) (Date of Injury)

Petitioner hereby requests that the Uninsured Employers Benefits Trust Fund (UEBTF) be joined as a party defendant.

_____
Date

_____
Name of Petitioner

_____
Signature of Petitioner

State of California
Department of Industrial Relations