Application for Adjudication of Claim
OCR form sample packet

This packet contains instructions on how to fill in Optical Character Recognition (OCR) forms, examples of forms and is in the order in which they should be filed with the district office.

Use the table below to help identify the forms that you need to complete when filing an application for adjudication of claim. The table also shows the order in which the forms should be assembled. To help you find the correct document separator sheet, the product delivery unit, document type and document title are in brackets.

In this packet, you will see examples as filed by the applicant attorney for injured worker. If a lien claimant is filing the forms, then complete and submit the documents identified in this reference table.

	Name of form	Applicant attorney for injured worker	Claims administrator and/or defense attorney	Lien claimant
1	Document cover sheet	x	x	x
2	Document separator sheet	x	x	x
3	Application for adjudication of claim	x	x	x
4	Document separator sheet for labor code section 4906(g) **[ADJ-LEGAL DOCS-4906(g) DECLARATION]**	x	x	x
5	All declarations pursuant to labor code section 4906(g)	x	x	x
6	Document separator sheet for fee disclosure statement **[ADJ-LEGAL DOCS-FEE DISCLOSURE STATEMENT]**	x		
7	Fee disclosure statement	x		
8	Document separator sheet for venue authorization **[ADJ-LEGAL DOCS-VENUE VERIFICATION]**	x		
9	Venue authorization	x		
10	Document separator sheet for lien verification **[ADJ-LEGAL DOCS-10770.5 VERIFICATION]**			x
11	Lien verification §10770.5			x
12	Document separator sheet for proof of service **[ADJ-LEGAL DOCS-PROOF OF SERVICE]**	x	x	x
13	Proof of service	x	x	x

This packet is an example of how to fill in forms and the order in which they should be filed with the district office.

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET

This example shows documents submitted by a represented injured worker.

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

CHECK "YES" BOX ONLY

DO NOT CHECK THIS BOX

DO NOT CHECK BOXES

More than 15 Companion Cases ☐

09/10/2008 DATE YOU FILL OUT DOCUMENT COVER SHEET

Date:(MM/DD/YYYY)

SSN: SOCIAL SECURITY NUMBER IS NOT REQUIRED.

THERE IS NO CASE NUMBER FOR APPLICATION FOR ADJUDICATION LEAVE BLANK.

Case Number 1

☐ Specific Injury

☐ Cumulative Injury 11/02/2007 (Start Date: MM/DD/YYYY) _____ (End Date: MM/DD/YYYY)

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

IF CUMULATIVE INJURY MUST ENTER START AND END DATE USING MM/DD/YYYY.

SEE BODY PART NUMBER LIST ON PAGE 8

Body Part 1: 420

Body Part 2: 100

Body Part 3: _____

Body Part 4: _____

Other Body Parts: WHEN MORE THAN 5 BODY PARTS USE BODY PART NUMBER 700 IN THIS FIELD

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

☐ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ INT ☐ RSU

Companion Cases

☐ Specific Injury

Case Number 2

☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

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

Body Part 1: _____

Body Part 2: _____

Body Part 3: _____

Body Part 4: _____

Other Body Parts: _____

☐ Specific Injury

Case Number 3 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

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

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

☐ Specific Injury

Case Number 4 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

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

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

Do NOT print or submit blank page(s).

☐ Specific Injury

Case Number 5 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

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

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

District office codes for place of venue

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

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

DO NOT PRINT OR SUBMIT THIS PAGE.

Body Part Code List

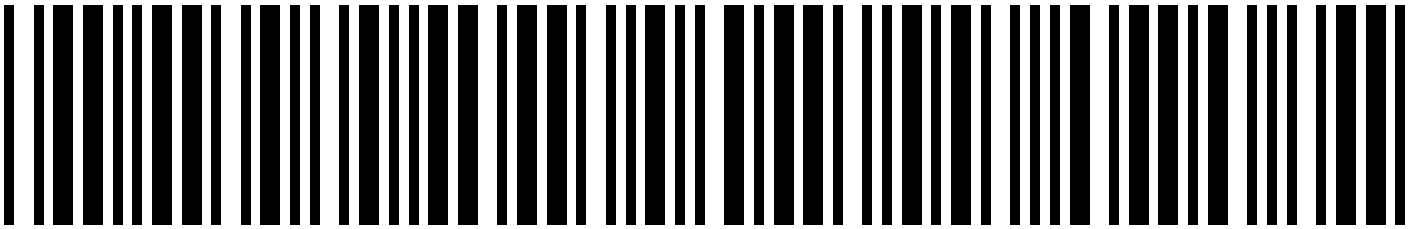
The body part codes listed below are used to complete forms that require the listing of the part of the body that is in issue. Please do not file this document with your forms.

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

Do NOT print or submit this page

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

DOCUMENT SEPARATOR SHEET



Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: APPLICATION FOR ADJUDICATION

Document Date: 04/16/2008 (DATE OF DOCUMENT FOLLOWING DOCUMENT SEPARATOR SHEET)

MM/DD/YYYY

Author: UNIFORM ASSIGNED NAME

IF YOU ARE A CLAIMS ADMINISTRATOR, HEARING REPRESENTATIVE OFFICE OR LAW FIRM, USE YOUR OFFICE'S UNIFORM ASSIGNED NAME. FOR ALL OTHERS ENTER YOUR NAME.

Office Use Only

Received Date

MM/DD/YYYY

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

NO CASE NUMBER - LEAVE BLANK

Case No.

☐ Amended Application

SSN (Numbers Only)

SEE PAGE 6 FOR ADDITIONAL INSTRUCTIONS ON COMPLETING THIS FORM.

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).)

VNO

3 DIGIT OFFICE CODE MUST BE IN COUNTY OF BOX CHECKED ABOVE

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

Injured Worker (Completion of this section is required)

JOHN

First Name

MI

MILLER

Last Name

1234 WILLOW ROAD

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)

VAN NUYS

City

CA

State

91401

Zip Code

Applicant (If other than Injured Worker)

☐ Insurance Carrier ☐ Employer ☐ Lien Claimant

Name (Please leave

USE THE UNIFORM ASSIGNED NAME AND ADDRESS FOR THE CLAIMS ADMINISTRATOR, IF YOU ARE AN INSURANCE CARRIER. USE YOUR NAME AND ADDRESS, IF YOU ARE AN EMPLOYER OR A LIEN CLAIMANT.

Street Address/PO

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

City

State

Zip Code

WCAB1

Employer Information (Completion of this section is required) MUST CHECK ONE BOX

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

COMPANY INJURED EMPLOYEE WORKED FOR AT TIME OF INJURY

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

COMPANY ADDRESS - MUST INCLUDE STREET ADDRESS OR PO BOX NUMBER

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

MUST INCLUDE CITY, STATE AND ZIP CODE

City State Zip Code

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

NAME OF EMPLOYER'S INSURANCE CARRIER

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

INSURANCE CARRIER'S ADDRESS - MUST INCLUDE STREET ADDRESS OR PO BOX NUMBER

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

MUST INCLUDE CITY, STATE AND ZIP CODE

City State Zip Code

Claims Administrator Information (If known and if applicable)

UNIFORM ASSIGNED NAME OF CLAIMS ADMINISTRATOR

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

CLAIMS ADMINISTRATOR MEANS A SELF-ADMINISTERED INSURER, A SELF ADMINISTERED SELF-INSURED EMPLOYER, A SELF-ADMINISTERED JOINT POWERS AUTHORITY, A SELF-ADMINISTERED LEGALLY UNINSURED OR A THIRD PARTY ADMINISTRATOR.

CLAIMS ADMINISTRATOR ADDRESS - MUST USE THE ONE IN UAN DATABASE.

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

MUST INCLUDE CITY, STATE AND ZIP CODE

City State Zip Code

IT IS CLAIMED THAT (Complete all relevant information):

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

(Choose only one)

☐ specific injury DATE OF ACCIDENT (Date of injury: MM/DD/YYYY)

INJURY DATE/S MUST MATCH DATE/S INDICATED ON DOCUMENT COVER SHEET.

suffered a :

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

The injury occurred at MAY PUT "INJURED ON JOB SITE" OR COMPLETE ADDRESS WHERE INJURY OCCURED.

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

MUST INCLUDE CITY AND ZIPCODE. USE "CA" FOR STATE.

City , CA State Zip Code .

WCAB1

(State which parts of the body were injured)

Body Part 1: 420 BACK

BODY PARTS MUST MATCH THE BODY PARTS INDICATED ON THE DOCUMENT COVER SHEET

Body Part 2: 100 HEAD

Body Part 3:

Body Part 4:

IF MORE THAN 5 INJURED BODY PARTS, MAY ENTER 700 MULTIPLE IN OTHER BODY PARTS FIELD AND INCLUDE ADDITIONAL BODY PARTS IN SECTION 2.

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 _____

DO NOT ENTER NONE, UNKNOWN OR N/A. IF YOU DON'T HAVE INFORMATION, LEAVE BLANK.

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: MUST SELECT AT LEAST ONE.

☐ 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

UNIFORM ASSIGNED NAME OF ATTORNEY FOR CLAIMS ADMINISTRATOR, INJURED WORKER OR LIEN CLAIMANT

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

MUST INCLUDE SIGNATURE WHEN APPLICANT IS REPRESENTED

Applicant Attorney/Representative Signature

APPLICANT MUST SIGN WHEN NOT REPRESENTED

Applicant Signature

Dated at _____, California
City

Date 04/16/2008
MM/DD/YYYY

DOCUMENT DATE ON DOCUMENT SEPARATOR SHEET

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.

DOCUMENT SEPARATOR SHEET

Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: 4906(g) DECLARATION

Document Date: 04/16/2008 (MM/DD/YYYY)

ENTER DATE OF DOCUMENT FOLLOWING DOCUMENT SEPARATOR SHEET

Author: UNIFORM ASSIGNED NAME

IF YOU ARE A CLAIMS ADMINISTRATOR, REPRESENTATIVE OR LAW FIRM, USE YOUR OFFICE'S UNIFORM ASSIGNED NAME. FOR ALL OTHERS, ENTER YOUR NAME.

Office Use Only

Received Date: _____ (MM/DD/YYYY)

[redacted]

[redacted]

A PROFESSIONAL CORPORATION

[redacted]

COMPLIANCE WITH LABOR CODE § 4906(g)

EMPLOYEE: [redacted]

EMPLOYER: [redacted]

CASE NO/DATE OF INJURY: [redacted]

Pursuant to the requirements set forth in Labor Code §4906(g), I declare as follows:

I have not violated Labor Code §139.3.

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.

A photostatic copy of this declaration shall be as valid as the original.

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

DATED: 4/16/21

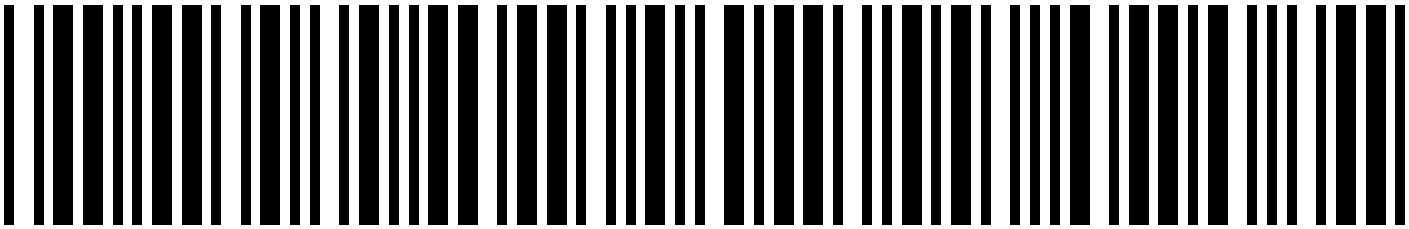
X [redacted]

DATED: _____

[redacted]

APPLICANT'S ATTORNEY

DOCUMENT SEPARATOR SHEET



Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: FEE DISCLOSURE

Document Date: 04/16/2008 — DATE OF DOCUMENT FOLLOWING DOCUMENT SEPARATOR SHEET

MM/DD/YYYY

Author: UNIFORM ASSIGNED NAME — LAW FIRM ONLY - USE YOUR UNIFORM ASSIGNED NAME

Office Use Only

Received Date

MM/DD/YYYY

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

FEE DISCLOSURE STATEMENT

If you choose to be represented by an attorney, your attorney's fees will be deducted from your benefits. The fee will be approved by the Workers' Compensation Appeals Board, with consideration given to the: (1) responsibility assumed by the attorney; (2) care exercised in representing you; (3) time involved; and, (4) results obtained.

Attorney's fees normally range from 9% to 12% of the benefits awarded. However a fee of 15% may be charged if the case is complicated and time consuming. If your attorney has also represented you before the Rehabilitation Unit, there may also be a fee allowed for this representation.

There are certain circumstances where your employer (or his/her insurer) may be liable to pay your attorneys' fees. For example, if employer disputes a permanent disability evaluation obtained when you were not represented by an attorney, your employer may, be liable for any attorney fees you incur because of the dispute.

If at anytime you no longer wish to be represented by the attorney, you may withdraw from representation by notifying the attorney. If you withdraw from representation, the fee amount found by a workers' compensation judge to be the fair value of any work the attorney did in your case will be deducted from your award.

An Information and Assistance Officer may be able to answer your questions concerning your workers' compensation benefits at no charge to you. He/She may be able to resolve your problems without the need for litigation.

Call this toll-free number: 1-800-736-7401

Employee's Signature [redacted] Date: 9/16/08

Employee's Name [redacted]

Attorney's Signature [redacted] Date: _____

Attorney's Name [redacted]

Address [redacted]

Phone No. [redacted]

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 felony.

Example

DOCUMENT SEPARATOR SHEET

THIS IS AN EXAMPLE OF THE DOCUMENT SEPARATOR SHEET FOR VENUE AUTHORIZATION

Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title VENUE VERIFICATION

ENTER THE DATE OF THE VENUE AUTHORIZATION

Document Date 04/16/2008
MM/DD/YYYY

ON VENUE AUTHORIZATION DOCUMENT SEPARATOR SHEET, LIST INJURED WORKER AS THE AUTHOR.

Author JOHN SMITH

Office Use Only

Received Date
MM/DD/YYYY

VENUE AUTHORIZATION

I HEREBY AUTHORIZE MY WORKERS' COMPENSATION CASE(S) FOR INJURY(IES)

DATED [redacted] TO BE

FILED AT THE VAN NUYS

WORKERS' COMPENSATION APPEALS BOARD.

DATED: 4/16/2008 X [redacted]

APPLICANT

Applicant's Attorney:

[redacted]

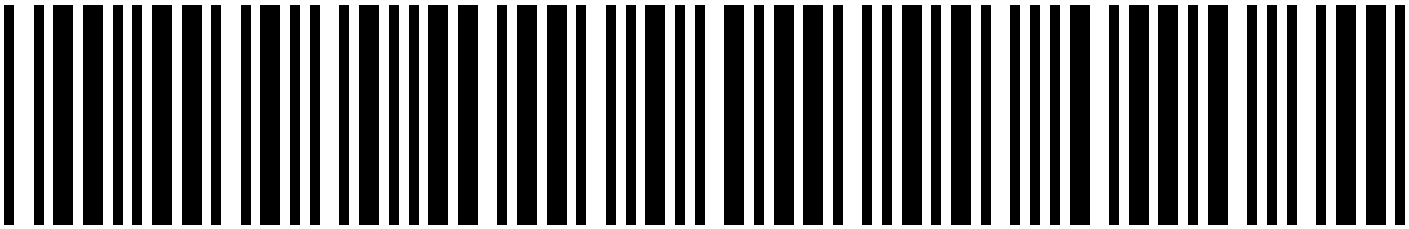
[redacted] Drive, Suite [redacted]

[redacted], CA [redacted]

TEL: ([redacted]) [redacted]

FAX: ([redacted]) [redacted]

DOCUMENT SEPARATOR SHEET



Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: PROOF OF SERVICE

Document Date: 04/16/2008 — DATE OF DOCUMENT FOLLOWING DOCUMENT SEPARATOR SHEET

MM/DD/YYYY

Author: UNIFORM ASSIGNED NAME — IF YOU ARE A CLAIMS ADMINISTRATOR, REPRESENTATIVE OR LAW FIRM, USE YOUR OFFICE'S UNIFORM ASSIGNED NAME. FOR ALL OTHERS, ENTER YOUR NAME.

Office Use Only

Received Date

MM/DD/YYYY

[redacted]

Proof of Service

I am at least 18 years of age, not a party to this action, and I am a resident of or employed in the county where the mailing took place.

My business address is: [redacted]

On 04/16/2008 served a true copy of the following documents, along with supporting documents, described as: Application of adjudication of claim, 4906(g), fee disclosure statement and venue authorization by enclosing them in a sealed envelope addressed to each of the parties named and at the addresses set forth in the Party List, and placing each envelope for collection and mailing at the business address herein following our ordinary business practices, with postage fully prepaid, or by other previously agreed-upon method of electronic service.

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

Dated: 04/16/2008

Declarant Signature [redacted]

Party List

[redacted]