Reset Form | Print Form

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD

APPLICATION FOR SUBSEQUENT INJURIES FUND BENEFITS

Case Number 1 _____

Case Number 2 _____

Case Number 3 _____

Case Number 4 _____

Case Number 5 _____

Injured Worker

First Name _____ MI _____

Last Name _____

VS

Employer Name _____

Insurance Carrier Name _____

Third Party Administrator _____

APPLICATION FOR SUBSEQUENT INJURIES FUND BENEFITS

1. Applicant _____, born on _____ (MM/DD/YYYY)

was injured on _____ (MM/DD/YYYY), as a _____ at

_____ California, with earnings of $ _____ per _____

Applicant sustained injury arising out of and occurring in the course of his/her employment resulting in permanent and partial disability affecting the following parts of the body:

_____

The permanent disability, when considered alone and without regard to or adjustment for the applicant's occupation or age is equal to _____ percent or more of total disability.

2. Immediately prior to the injury, applicant was permanently disabled in the following respects

_____

The pre-existing disabilities occurred as a result of:

_____

3. Applicant has previously filed a workers' compensation claim with the Workers' Compensation Appeals Board

Case Number _____

4. Applicant filed for Social Security Disability benefits on _____

and is receiving $ _____ per month. Applicant's Social Security Number is _____

WHEREFORE, applicant requests benefits as provided by law

Attorney for Applicant Signature _____

Applicant Signature _____

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

_____ _____ _____
City State Zip Code