How to file a claim with the Uninsured Employers Fund

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

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

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

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

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

Workers' Compensation Insurance Rating Bureau (WCIRB)
Customer Service, Attn: Coverage Department
525 Market Street Ste 800
San Francisco CA 94105

The WCIRB will determine if your employer had workers' compensation insurance at the time of your injury. The WCIRB can use your employer's business name, the owner's name and the address(s) to check for coverage, so put as much information as you can on the form. The WCIRB generally waives its $8 fee for injured workers. You should receive a response from the WCIRB in the mail. Keep this for your records.

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

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

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

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

6. Once you have your documentation and have completed all the forms, put the original documents in a package in the following order (top to bottom) for service on your employer:
   a. Special notice of lawsuit
   b. Declaration of readiness to proceed
   c. DWC-1, employee's claim for workers' compensation benefits and registered mail return-receipt
   d. Medical report(s)
   e. Medical bill(s)
   f. Proof of employment
   g. WCIRB reply indicating employer did not have workers' compensation insurance coverage
   h. Petition to join party defendant

7. This will be the "original" packet. Make three (3) copies of this packet. If your employer is a partnership, make additional copies for each partner.

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

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

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

UEF claims	UEF claims	UEF claims
1515 Clay Street, 17th floor	320 W. 4th Street, 6th floor	2424 Arden Way, #355
OAKLAND CA 94612	**LOS ANGELES** CA 90013	**SACRAMENTO** CA 95825

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

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

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

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

WORKERS' COMPENSATION APPEALS BOARD
DISTRICT OFFICES

ANAHEIM, 92801-1162
1661 N. Raymond Ave., Suite 202
Information & Assistance Unit **(714) 738-4038**

BAKERSFIELD, 93301-1929
1800 30th Street, Suite 100
Information & Assistance Unit **(661) 395-2514**

EUREKA, 95501-0481
100 "H" Street, Suite 202
Information & Assistance Unit **(707) 441-5723**

FRESNO, 93721-2280
2550 Mariposa Street, Suite 4078
Information & Assistance Unit **(559) 445-5355**

GOLETA, 93117-3018
6755 Hollister Avenue, Suite 100
Information & Assistance Unit **(805) 968-4158**

GROVER BEACH, 93433-2261
1562 Grand Avenue
Information & Assistance Unit **(805) 481-3380**

LONG BEACH, 90802-4339
300 Oceangate Street, Suite 200
Information & Assistance Unit **(562) 590-5240**

LOS ANGELES, 90013-1105
320 West 4th Street, 9th Floor
Information & Assistance Unit **(213) 576-7389**

OAKLAND, 94612-1402
1515 Clay Street, 6th Floor
Information & Assistance Unit **(510) 622-2861**

OXNARD, 93030
2220 East Gonzales Road, Suite 100
Information & Assistance Unit **(805) 485-3528**

POMONA, 91768-1601
732 Corporate Center Drive
Information & Assistance Unit **(909) 623-8568**

REDDING, 96001-2796
2115 Civic Center Drive, Suite 15
Information & Assistance Unit **(530) 225-2047**

RIVERSIDE, 92501-3337
3737 Main Street, Suite 300
Information & Assistance Unit **(951) 782-4347**

SACRAMENTO, 95825-2403
2424 Arden Way, Suite 230
Information & Assistance Unit **(916) 263-2741**

SALINAS, 93906-2204
1880 North Main Street, Suites 100 & 200
Information & Assistance **(831) 443-3058**

SAN BERNARDINO, 92401-1411
464 West Fourth Street, Suite 239
Information & Assistance Unit **(909) 383-4522**

SAN DIEGO, 92108
7575 Metropolitan Drive, Suite 202
Information & Assistance Unit **(619) 767-2170**

SAN FRANCISCO, 94102-7002
455 Golden Gate Avenue, 2nd Floor
Information & Assistance Unit **(415) 703-5020**

SAN JOSE, 95113-1482
100 Paseo de San Antonio, Suite 241
Information & Assistance Unit **(408) 277-1292**

SANTA ANA, 92701-4070
28 Civic Center Plaza, Suite 451
Information & Assistance Unit **(714) 558-4597**

SANTA MONICA, 90405-5219
2701 Ocean Park Blvd., Suite 220
Information & Assistance Unit **(310) 452-1188**

SANTA ROSA, 95404-4760
50 "D" Street, Suite 420
Information & Assistance Unit **(707) 576-2452**

STOCKTON, 94202
31 East Channel Street, Suite 344
Information & Assistance Unit **(209) 948-7980**

VAN NUYS, 91401-3373
6150 Van Nuys Blvd., Suite 105
Information & Assistance Unit **(818) 901-5374**

Rev. 06/05

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

Formulario de Reclamo de Compensación para 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. For injuries occurring on or after 1/1/04, 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. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Special rules apply if your employer offers a Health Care Organization (HCO) or after 1/1/05, has a medical provider network. 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 an employee files a claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars ($10,000).

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same 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, you will receive temporary disability payments. 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.

Si Ud. se lesiona o se enferma, ya sea física 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 para trabajadores. Se adjunta el formulario para presentar un reclamo de compensación para 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/la administrador(a) de reclamos, quien es responsable del manejo de su reclamo, le notificará a usted, lo referente a su elegibilidad para beneficios.

Para presentar un reclamo, complete 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/a la administrador(a) de reclamos. Los beneficios no pueden comenzar hasta, que el/la administrador(a) de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

Atención Médica: Su administrador(a) 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(a) de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Para lesiones que ocurren en o después de 1/1/04, hay un límite de visitas para ciertos servicios médicos.

El Médico Primario que le Atiende-*Primary Treating Physician PTP* es el médico con toda la responsabilidad para dar el tratamiento para 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 pre-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 especiales que son aplicables cuando su empleador ofrece una Organización del Cuidado Médico (HCO) o depués de 1/1/05 tiene un Sistema de Proveedores de Atención Médica. Hable con su empleador para más información. Si su empleador no ha colocado un poster describiendo sus derechos para la compensación para trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

El empleador autorizará todo tratamiento médico consistente con las directivas de tratamiento applicables a la lesión o enfermedad, durante el primer día laboral después que el empleado efectúa un reclamo para beneficios de compensación, y continuará proveyendo este tratamiento hasta la fecha en que el reclamo sea aceptado o rechazado. Hasta la fecha en que el reclamo sea aceptado o rechazado, el tratamiento médico será limitado a diez mil dólares ($10,000).

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

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

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

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 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.

Vocational Rehabilitation (VR): If a doctor says your injury or illness prevents you from returning to the same type of job and your employer doesn't offer modified or alternative work, you may qualify for VR. If you qualify, your claims administrator will pay the costs, up to a maximum set by state law. VR is a benefit for injuries that occurred prior to 2004.

Supplemental Job Displacement Benefit (SJDB): If you do not return 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. SJDB is a benefit for injuries occurring on or after 1/1/04.

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, or you can hear recorded information and a list of local offices by calling **(800) 736-7401**. You may also go to the DWC web site at **www.dir.ca.gov.** Link to Workers' Compensation.

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**.

impuestos. Los pagos 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(a) de 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/la administrador(a) 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 extenderse o no temporalmente, 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.

Rehabilitación Vocacional: Si el doctor dice que su lesión o enfermedad no le permite regresar a la misma clase de trabajo, y su empleador no le ofrece trabajo modificado o alterno, es posible que usted reúna los requisitos para rehabilitación vocacional. Si Ud. reúne los requisitos, su administrador(a) de reclamos pagará los costos, hasta un máximo establecido por las leyes estatales. Este es un beneficio para lesiones que ocurrieron antes de 2004.

Beneficio Suplementario por Desplazamiento de Trabajo: Si Ud. no vuelve al trabajo en un plazo de 60 días después que los pagos por incapcidad temporal terminan, y su empleador no ofrece un trabajo modificado o alterno, es posible que usted reúne 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(a) de reclamos pagará los costos hasta un máximo establecido por las leyes estatales basado en su porcentaje del incapicidad permanente. Este es un beneficio para lesiones que ocurren en o después de 1/1/04.

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 vivan en el hogar, que dependían económicamente del/de la trabajador(a) difunto(a).

Es ilegal que su empleador le castigue o despida, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por atestiguar en el caso de compensación para trabajadores de otra persona. (El Codigo Laboral sección 132a). Si es probado, puede ser que usted reciba pagos por perdida de sueldos, reposición del trabajo, aumento de beneficios, y gastos hasta un límite establecido por el estado.

Ud. tiene derecho a estar en desacuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador(a) de reclamos, para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios de 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 al Trabajador *(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 ir al sitio electrónico en el Internet de la DWC en **www.dir.ca.gov.** Enlácese a la sección de Compensación para Trabajadores.

Ud. puede consultar con un(a) abogado(a). La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un(a) abogado(a), sus honorarios se tomarán de sus beneficios. Para obtener nombres de abogados de compensación para trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, ó vaya a su sitio electrónico en el Internet en **www.californiaspecialist.org**.

PRINT CLEAR

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 trabjador.*

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*

Coverage Research Service Request
Form 807

Instructions

Who Can Use the Coverage Research Service

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. 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.

Requirements

Completion of the Coverage Research Service Request Form is required for coverage requests made in connection with a pending workers' compensation claim.

The WCIRB will not process your coverage research service request unless all five 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

- Please print or type
- This form can be completed electronically but requires a signature and must be mailed to the WCIRB
- Please complete all necessary information on page 1 and page 2
- If you need additional information, please call WCIRB Customer Service

To Request Coverage Research

Mail WCIRB Customer Service
Attn: Coverage Department
525 Market Street, Suite 800
San Francisco, CA 94105-2767

Fees

The fee for coverage research is $8.00 **per coverage year per employer**. For example, the fee for a research request for one employer for one year is $8.00. The fee for a research request for one employer for policy years 1998-1999 is $16.00. The fee for a research request for ABC Corp., XYZ Corp. and OPQ Corp. for the 2001 policy year is $24.00.

Payment

Payment must be received before your request can be processed.

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. Please include your payment when submitting the Coverage Research Service Request Form.

Shipping

Mail Coverage research requests will be mailed.

Email If you want to receive the information by email, please be sure to check the designated box on the order form.

Questions

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

WCIRB California™

WCIRB Customer Service
ATTN: Coverage Department
525 Market Street, Suite 800
San Francisco, CA 94105-2767
Voice 888.229.2472
customerservice@wcirbonline.org
www.wcirbonline.org

Coverage Research Service Request

Form 807 Electronic Form

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)*

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, director, or owner of, and has the authority to bind:

☐ a licensed workers' compensation insurance insurer in the pending workers' compensation claim;
☐ an employer, as defined by Labor Code Section 3300, in the pending workers' compensation claim;
☐ a licensed health care provider in the pending workers' compensation claim;
☐ a Third Party Entity (TPE) that is authorized by a member insurer to obtain coverage information;

TPE Name | Member Insurer Name ; **OR**

☐ an attorney representing any of the above individuals or entities in the pending workers' compensation claim.

Coverage Information Requested

For additional employers, attach a separate sheet. The WCIRB is unable to supply coverage information prior to 1958.

(1)	(2)
Employer	Employer
Address	Address
City/State/Zip Code	City/State/Zip Code
Coverage Year(s) Requested	Coverage Year(s) Requested

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

WCIRB USE ONLY: CONTROL #

Coverage Research Service Request

Form 807

Signature required. This form must be mailed.

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

Delivery

☐ Check this box for email delivery.

Payment (See instructions.)

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

☐ Fee enclosed (nonrefundable) $ _____

☐ Bill My Company
(WCIRB member insurers and authorized TPEs only. See instructions.)

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

WCIRB USE ONLY: CONTROL #

STATE OF CALIFORNIA

DEPARTMENT OF INDUSTRIAL RELATIONS

WORKERS' COMPENSATION APPEALS BOARD

SEE REVERSE SIDE FOR INSTRUCTIONS

APPLICATION FOR ADJUDICATION OF CLAIM

CASE No. _____

(PRINT OR TYPE NAMES AND ADDRESSES)

M _____

_____ (INJURED EMPLOYEE'S ADDRESS AND ZIP CODE)

Social Security No.: _____

_____

_____ (APPLICANT, IF OTHER THAN INJURED EMPLOYEE

VS.

_____ (APPLICANT'S ADDRESS AND ZIP CODE)

_____ (EMPLOYER--STATE IF SELF-INSURED)

_____ (EMPLOYER'S ADDRESS AND ZIP CODE)

_____ (EMPLOYER'S INSURANCE CARRIER OR, IF SELF-INSURED, ADJUSTING AGENCY)

_____ (INSURANCE CARRIER OR ADJUSTING AGENCY'S ADDRESS)

IT IS CLAIMED THAT:

1. The injured employee, born _____ (DATE OF BIRTH), while employed as a _____ (OCCUPATION AT TIME OF INJURY) on _____ (DATE OF INJURY) at _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP CODE)
   By the employer sustained injury arising out of and in the course of employment to
   _____ (STATE WHAT PARTS OF THE BODY WERE INJURED)
2. The injury occurred as follows: _____ (EXPLAIN WHAT EMPLOYEE WAS DOING AT THE TIME OF INJURY AND HOW INJURY WAS RECEIVED)
3. Actual earnings at the time of injury were: _____ (GIVE WEEKLY OR MONTHLY SALARY OR HOURLY RATE AND NUMBER OF HOURS WORKED PER WEEK)
   _____ (SEPARATELY STATE VALUE PER WEEK OR MONTH OF TIPS, MEALS, LODGING OR OTHER ADVANTAGES REGULARLY RECEIVED)
4. The injury caused disability as follows: _____ (SPECIFY LAST DAY OFF WORK DUE TO THIS INJURY AND BEGINNING AND ENDING DATES OF ALL PERIODS OFF DUE TO THIS INJURY)
5. Compensation was paid _____ (YES) _____ (NO) $_____ (TOTAL PAID) $_____ (WEEKLY RATE) _____ (DATE OF LAST PAYMENT)
6. Unemployment insurance or unemployment compensation disability benefits have been received since the date of injury
   _____ (YES) _____ (NO)
7. Medical treatment was received _____ (YES) _____ (NO) _____ (DATE OF LAST TREATMENT) All treatment was furnished by the Employer or Insurance Company _____ (YES) _____ (NO) Other treatment was provided or 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) doctors not provided or paid for by employer or insurance company who treated or examined for this injury are _____ (STATE NAMES AND ADDRESSES OF SUCH DOCTORS AND NAMES OF HOSPITALS TO WHICH SUCH DOCTORS ADMITTED INJURED)
8. Other cases have been filed for industrial injuries by this employee as follows: _____
   _____ (SPECIFY CASE NUMBER AND CITY WHERE FILED)
9. This application is filed because of a disagreement regarding liability for: Temporary disability indemnity _____
   Permanent disability indemnity _____ Reimbursement for medical expense _____ Medical treatment _____
   Compensation at proper rate _____ Rehabilitation _____ Other (Specify) _____ AND APPLICANT REQUESTS A HEARING AND
   _____ AWARD OF THE SAME, AND FOR ALL OTHER APPROPRIATE BENEFITS PROVIDED BY LAW.

Dated at _____ (CITY), California _____ (DATE)

_____ (APPLICANT'S ATTORNEY)

_____ (APPLICANT'S SIGNATURE)

_____ (ADDRESS AND TELEPHONE NUMBER OF ATTORNEY)

STATE OF CALIFORNIA

SAMPLE

WORKERS' COMPENSATION APPEALS BOARD

Your Name *Applicant* vs. Your Employer and Insurance Company *Defendants*	**Case No.** Your WCAB case number

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. (Rule 10416)

The [ ] Employee or Applicant
[ ] Defendant
[ ] Lien Claimant

requests that this case be set for hearing at WCAB Office where you want hearing held
(Place)

and Declarant states under penalty of perjury that he or she is presently ready to proceed to hearing on the issues below and has made the following efforts to resolve these issues: _____

List efforts you have made to resolve dispute

Select the type of hearing you want

Declarant requests: [ ] Mandatory Settlement Conference [ ] Status Conference [ ] Rating MSC* [ ] Priority Conference (L.C. §5502(c))

At the present time the principal issues are:

[ ] Compensation Rate
[ ] Temporary Disability
[ ] Permanent Disability
[ ] Rehabilitation
[ ] Self-procured Treatment
[ ] Future Medical Treatment
[ ] Other _____

Declarant relies on the report(s) of Doctor(s) _____ dated _____

Unless a status or priority conference is requested, I have completed discovery on the issues listed above, and all medical reports in my possession or control have been filed and served as required by WCAB Rules of Practice and Procedure.

Copies of this Declaration have been served this date as shown below.

Declarant's Signature X Your signature

Name and Law Firm (Print or Type) If you do not have an attorney, just print your name.

Address Your mailing address Phone Your phone number

Date Today's Date

SERVICE

Names and addresses of parties, including law firms and representatives, and lien claimants served with a copy of this Declaration.

1. WCAB
2. insurance company
3. insurance company's attorney

*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.

(SEE REVERSE SIDE FOR INSTRUCTIONS)

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 Board, upon the receipt of the Declaration of Readiness, may set the case for a type of proceeding other than the one requested (Rule 10417).

PRINT CLEAR

STATE OF CALIFORNIA

WORKERS' COMPENSATION APPEALS BOARD

Applicant vs. *Defendants*	**Case No.** _____

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. (Rule 10416)

The [ ] Employee or Applicant
[ ] Defendant
[ ] Lien Claimant

requests that this case be set for hearing at _____
(Place)

and Declarant states under penalty of perjury that he or she is presently ready to proceed to hearing on the issues below and has made the following efforts to resolve these issues: _____

_____

_____

Declarant requests: [ ] Mandatory Settlement Conference [ ] Status Conference [ ] Rating MSC* [ ] Priority Conference (L.C. §5502(c))

At the present time the principal issues are:

[ ] Compensation Rate
[ ] Temporary Disability
[ ] Permanent Disability
[ ] Rehabilitation
[ ] Self-procured Treatment
[ ] Future Medical Treatment
[ ] Other _____

Declarant relies on the report(s) of Doctor(s) _____ dated _____

Unless a status or priority conference is requested, I have completed discovery on the issues listed above, and all medical reports in my possession or control have been filed and served as required by WCAB Rules of Practice and Procedure.

Copies of this Declaration have been served this date as shown below.

Declarant's Signature _____

Name and Law Firm (Print or Type) _____

Address _____ Phone _____

Date _____

SERVICE

Names and addresses of parties, including law firms and representatives, and lien claimants served with a copy of this Declaration.

_____ _____

_____ _____

_____ _____

*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.

(SEE REVERSE SIDE FOR INSTRUCTIONS)

PRINT CLEAR

State of California | Department of Industrial Relations

Workers' Compensation Appeals Board

Special Notice of Lawsuit

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

WCAB No. _____

To: DEFENDANT, ILLEGALLY UNINSURED EMPLOYER:
AVISO: A ud le estan demandando. Le corte puede expedir una decision que le afecte sin que se le eschuche a menos que ad actue pronto. Lea la siguiente informacion.

DEFENDANT:	APPLICANT:

NOTICES

1. A lawsuit, the attached 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 (see telephone directory).

   You may also request assistance/information from an Information and Assistant Office 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			
Address	**City, State, ZIP Code**		
COMPLETED BY:			
Name	**Address**	**City, State, ZIP Code**	**Telephone No.**

SAMPLE

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

YOUR NAME Applicant vs. YOUR EMPLOYER'S NAME Defendant(s)	**WCAB Case No(s)**: YOUR WCAB CASE NO. **PETITION TO JOIN PARTY DEFENDANT**

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

(Select office nearest your residence)

_____Uninsured Employers Fund, 1515 Clay Street, 17th Floor, Oakland, CA, 94612

_____Uninsured Employers Fund, 2424 Arden Way, Ste. 355, Sacramento, CA, 95825

_____Uninsured Employers Fund, 320 West 4th Street, 6th Floor, Los Angeles, CA, 90013-1105

Proof of Service:

On__DATE_____ at____CITY, STATE_____ _____PRINT YOUR NAME_____
(date) (place) Petitioner (block letters)

Copies mailed to following addressees:

1.__WCAB_____

2.__YOUR EMPLOYER_____

3._____

X____YOUR SIGNATURE_____
(Signature of Petitioner)

PRINT CLEAR

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

WCAB Case No(s):.

Applicant

vs.

Defendant(s)

PETITION TO JOIN PARTY DEFENDANT

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

(Select office nearest your residence)

_____Uninsured Employers Fund, 1515 Clay Street, 17th Floor, Oakland, CA, 94612

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Proof of Service:

On_____ at_____ _____
(date) (place) Petitioner (block letters)

Copies mailed to following addressees:

1._____

2._____

3._____

X_____
(Signature of Petitioner)

PRINT CLEAR

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."

SAMPLE

Proof Of Service By Mail

I declare that:

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

Put your home address

On *today's date*, I served the attached *Documents* on the *your employer* in said case, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United State mail at *city where you mailed this* addressed as follows _____

your employer's name and address here

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

(date) *Today's Date*, at *City* California.

Type or print name *Type or print name*

Signature _____

PRINT CLEAR

Proof Of Service By Mail

I declare that:

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

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

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

(date) _____, at _____ California.

Type or print name _____

Signature _____