

## Information & Assistance Unit guide 21

### How to file a petition for penalties

This petition may be filed when payment of compensation has been unreasonably delayed or refused either prior to or subsequent to the issuance of an award.

A petition for penalty can only be filed if you have a pending Workers' Compensation Appeals Board (WCAB) case. To open a WCAB case, you must file an application for adjudication of claim (see I&A guide 4). When you are ready to have a WCAB hearing, you must also file a declaration of readiness to proceed (see I&A guide 5).

A Petition for Penalties is attached for your convenience.

Send the original to your local WCAB office and copies to all the parties.

Submit the following documents with your form filing in the order shown:

- ✓ [Document Cover Sheet](#)
- ✓ [Document Separator Sheet](#) (*for Petition for Penalties*)
- ✓ [Petition for Penalties](#)
- ✓ [Verification](#)
- ✓ [Document Separator Sheet](#) (*for Proof Of Service By Mail*)
- ✓ [Proof Of Service By Mail](#)

Keep copies of your filings for your records.

Please note no action may be brought to recover penalties that may be awarded under this section more than two years from the date of the payment of compensation was due.

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

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

## Information & Assistance Unit guide 21

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

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

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

*E&A*

# WORKERS' COMPENSATION APPEALS BOARD DISTRICT OFFICES

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**ANAHEIM, 92806-2131**

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

**BAKERSFIELD, 93301-1929**

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

**EUREKA, 95501-0481 \* Satellite office \***

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

**FRESNO, 93721-2219**

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

**LONG BEACH, 90802-4339**

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

**LOS ANGELES, 90013-1105**

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

**MARINA DEL REY, 90292-6902**

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

**OAKLAND, 94612-1499**

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

**OXNARD, 93030-7912**

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

**POMONA, 91768-1653**

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

**REDDING, 96002-0940**

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

**RIVERSIDE, 92501-3337**

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

**SACRAMENTO, 95834-2962**

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

**SALINAS, 93906-2204**

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

**SAN BERNARDINO, 92401-1411**

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

**SAN DIEGO, 92108-4424**

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

**SAN FRANCISCO, 94102-7014**

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

**SAN JOSE, 95113-1402**

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

**SAN LUIS OBISPO, 93401-8736**

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

**SANTA ANA, 92701-4070**

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

**SANTA BARBARA, 93101-7538 \* Satellite office \***

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

**SANTA ROSA, 95404-4771**

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

**STOCKTON, 95202-2314**

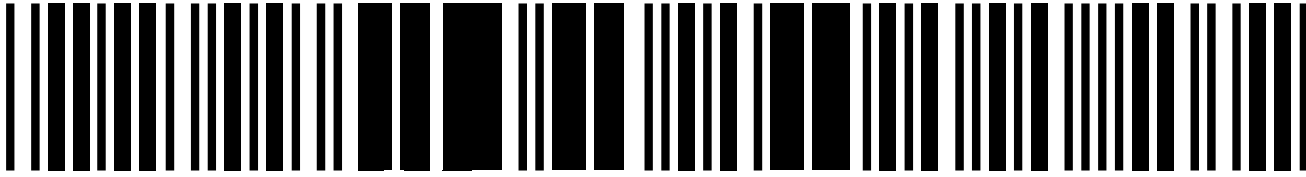
31 E Channel Street, Suite 344  
Information & Assistance Unit (209) 948-7980

**VAN NUYS, 91401-3370**

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

STATE OF CALIFORNIA  
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET



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

More than 15 Companion Cases

Date:(MM/DD/YYYY)

SSN: \_\_\_\_\_

Specific Injury

Case Number 1

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

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

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

ADJ  DEU  SIF  UEF  SAU  INT  RSU

**Companion Cases**

Specific Injury

Case Number 2

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

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

Specific Injury

Case Number 3

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

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

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

Specific Injury

Case Number 4

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

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

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_



Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

Specific Injury

Case Number 5

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

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

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_



Specific Injury

Case Number 6

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

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

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

Specific Injury

Case Number 7

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

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

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

Specific Injury

Case Number 8

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

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

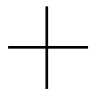
Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_



Specific Injury

Case Number 9

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

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

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

Specific Injury

Case Number 10

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

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

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_



Other Body Parts: \_\_\_\_\_

Specific Injury

Case Number 11

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

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

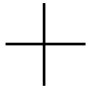
Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_



Specific Injury

Case Number 12

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

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

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

Specific Injury

Case Number 13

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

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

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_



Other Body Parts: \_\_\_\_\_

Specific Injury

Case Number 14

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

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

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_





Specific Injury

Case Number 15

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

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

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_



Specific Injury

Case Number 16

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

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

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_



## District office codes for place of venue

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

\* Eureka is a satellite office of Santa Rosa district office. \*\* Santa Barbara is a satellite office of the Oxnard district office.

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

## Body Part Code List

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

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

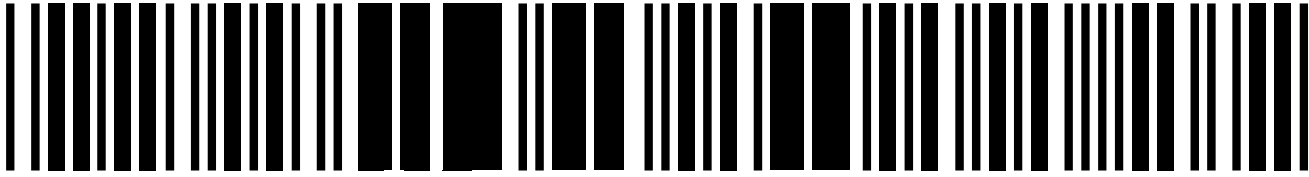
**Use this document to complete forms, but do not file this document with your forms.**



STATE OF CALIFORNIA  
DWC DISTRICT OFFICE

**SAMPLE**

DOCUMENT COVER SHEET



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

More than 15 Companion Cases

**TODAY'S DATE**

Date:(MM/DD/YYYY)

**YOUR SOCIAL SECURITY NUMBER**

SSN:

**EAMS CASE NUMBER**

Case Number 1

Specific Injury

**DATE OF INJURY**

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

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

**IF NEW CASE LEAVE BLANK**

**USE CODE FROM BODY PART CODE LIST, SEE PAGE 8**

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

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     SAU     INT     RSU

**Companion Cases**

Specific Injury

Case Number 2 \_\_\_\_\_

Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

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

Body Part 1: \_\_\_\_\_

Body Part 3: \_\_\_\_\_

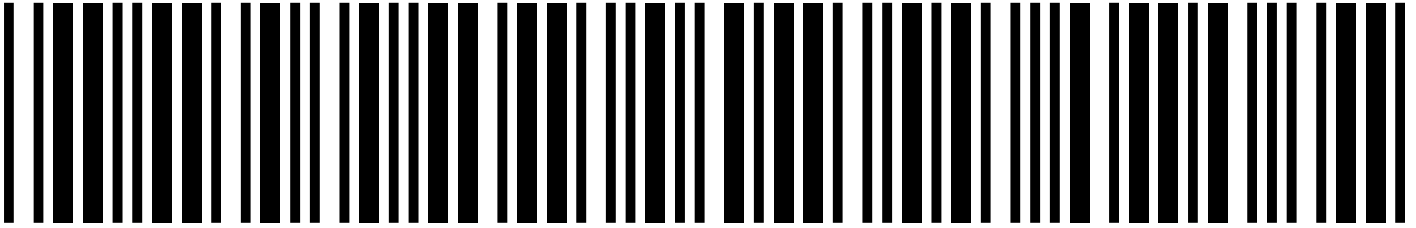
Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_



# DOCUMENT SEPARATOR SHEET



Product Delivery Unit

\_\_\_\_\_

Document Type

\_\_\_\_\_

Document Title

\_\_\_\_\_

Document Date

\_\_\_\_\_

MM/DD/YYYY

Author

\_\_\_\_\_

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## Office Use Only

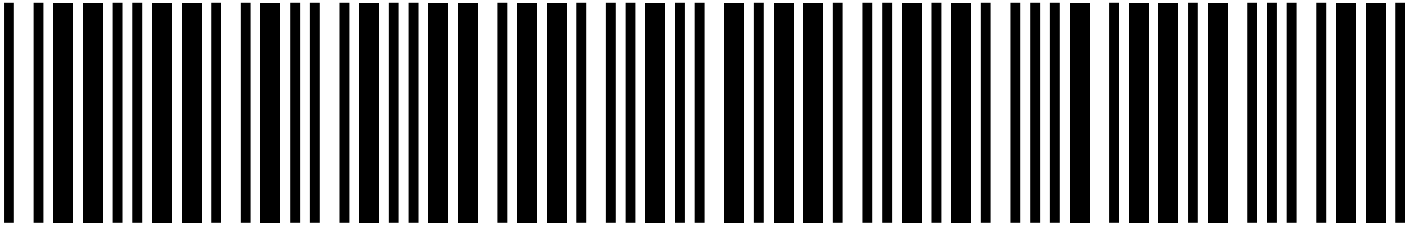
Received Date

\_\_\_\_\_

MM/DD/YYYY



# DOCUMENT SEPARATOR SHEET



Product Delivery Unit

ADJ

Document Type

LEGAL DOCS

Document Title

PETITION FOR PENALTIES

Document Date

DATE YOU FILLED OUT THE FORM

MM/DD/YYYY

Author

YOUR NAME

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**Office Use Only**

Received Date

MM/DD/YYYY

NAME:  
STREET:  
CITY, STATE, ZIP CODE:  
TELEPHONE #:

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

vs.	Applicant,  Defendants.
-----	-------------------------------

WCAB #:

PETITION FOR PENALTIES

Comes Now Applicant and Petitions for Penalties for unreasonable delay in furnishing of benefits per Labor Code Section 5814 as follows (check one or more):

- (A)  Temporary Disability
- (B)  Permanent Disability
- (C)  Medical Treatment
- (D)  Reimbursement of Medical (prescriptions, mileage, treatment, etc.)
- (E)  Supplemental Job Displacement Benefits

Describe the events/acts of the unreasonable delay in benefits below.

\_\_\_\_\_  
your signature

\_\_\_\_\_  
date mailed

NAME: ***your name***  
STREET: ***your address***  
CITY, STATE, ZIP CODE:  
TELEPHONE #: ***your telephone number***

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

<b><i>your name</i></b>	Applicant,	WCAB #: <b><i>EAMS/WCAB</i></b>
vs.		PETITION FOR PENALTIES
<b><i>your employer</i></b>	Defendants.	

Comes Now Applicant and Petitions for Penalties for unreasonable delay in furnishing of benefits per Labor Code Section 5814 as follows (check one or more):

- (A)  Temporary Disability
- (B)  Permanent Disability
- (C)  Medical Treatment
- (D)  Reimbursement of Medical (prescriptions, mileage, treatment, etc.)
- (E)  Supplemental Job Displacement Benefits

Describe the events/acts of the unreasonable delay in benefits below.

\_\_\_\_\_  
***your signature***

\_\_\_\_\_  
***date mailed***



# VERIFICATION

**STATE OF CALIFORNIA**

County of \_\_\_\_\_

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

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

Executed on \_\_\_\_\_ at \_\_\_\_\_, California.

\_\_\_\_\_  
Petitioner

April 2014

*Sample*

## VERIFICATION

STATE OF CALIFORNIA

County of your county

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

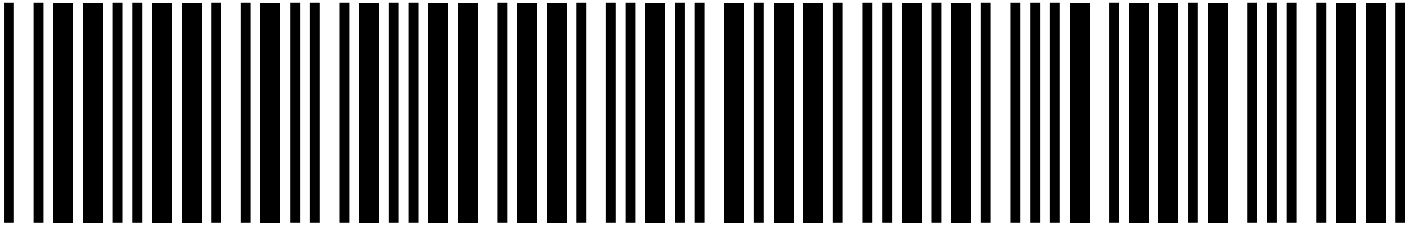
I declare under penalty of perjury that the foregoing is true and correct.

Executed on date mailed at your city, California.

your signature  
\_\_\_\_\_  
Petitioner

April 2014

# DOCUMENT SEPARATOR SHEET



Product Delivery Unit

\_\_\_\_\_

Document Type

\_\_\_\_\_

Document Title

\_\_\_\_\_

Document Date

\_\_\_\_\_

MM/DD/YYYY

Author

\_\_\_\_\_

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## Office Use Only

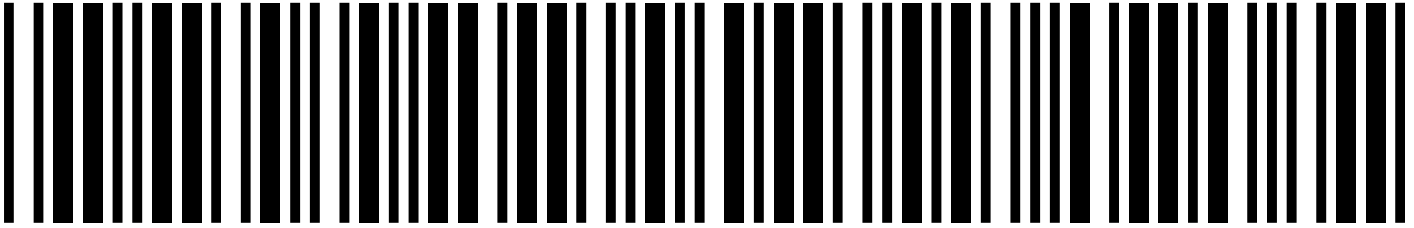
Received Date

\_\_\_\_\_

MM/DD/YYYY



# DOCUMENT SEPARATOR SHEET



Product Delivery Unit

Document Type

Document Title

Document Date   
MM/DD/YYYY

Author

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**Office Use Only**

Received Date \_\_\_\_\_  
MM/DD/YYYY



Proof of Service by Mail

I declare that:

I am (resident of / employed in) the county of \_\_\_\_\_, California.

I am over the age of eighteen years, my (business / residence) address is:

On \_\_\_\_\_, I served the attached \_\_\_\_\_  
on the parties listed below 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 \_\_\_\_\_

Proof of Service by Mail

I declare that:

I am (resident of / employed in) the county of YOUR COUNTY, California.

I am over the age of eighteen years, my (business / residence) address is:

PUT YOUR HOME ADDRESS HERE

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

on the parties listed below 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:

1) WORKERS' COMPENSATION APPEALS BOARD: ADDRESS  
2) INSURANCE COMPANY: NAME, ADDRESS AND CLAIM NUMBER  
3) DEFENSE ATTORNEY (IF KNOWN): NAME AND ADDRESS  
4) ALL OTHER PARTIES INVOLVED IN YOUR CASE: NAME AND ADDRESS

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

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

Type or print name PRINT YOUR NAME

Signature SIGN YOUR NAME