How to file a claim with the Uninsured Employers Benefits Trust 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 Benefits Trust Fund (UEBTF) 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 UEBTF. 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. To look for insurance coverage for the past five years go to http://www.caworkcompcoverage.com.

Otherwise you can 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
1221 Broadway Ste 900
Oakland, CA 94612

The WCIRB will determine if your employer had workers' compensation insurance at the time of your injury. The name of your employer, business, or owner's name; address; and date of injury will help with coverage look up. The WCIRB waives its customary fees for injured workers. Keep a copy of the WCIRB response for your records.

Some employers are self-insured for their workers' compensation risk. Check this link for self-insured verification:
http://www.dir.ca.gov/osip/databases/sisr/default.aspx

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 UEBTF, 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(h) contained in guide 4. File the application, the 4906(h) 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 Benefits Trust 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) Application of Adjudication of Claim
b) Special notice of lawsuit
c) Declaration of readiness to proceed
d) DWC-1, employee's claim for workers' compensation benefits and registered mail return-receipt
e) Medical report(s)
f) Medical bill(s)
g) Proof of employment
h) WCIRB reply indicating employer did not have workers' compensation insurance coverage
i) Petition to join party defendant
j) Verification

7. 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 one copy of the packet at the WCAB district 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 UEBTF can decide to pay your benefits before a workers' compensation judge issues an "award" in your case. To request benefits from the UEBTF, send a letter requesting benefits and one copy of the packet to the UEBTF office nearest to you:

UEBTF claims
1515 Clay Street
17TH Floor
OAKLAND CA 94612

UEBTF claims
320 W. 4th Street
6th Floor
LOS ANGELES CA 90013

11. Keep one original 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 UEBTF 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 workers' 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. You can also sue your uninsured employers in a legal action apart from the workers' compensation case, in Superior Court.

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.

Information & Assistance Unit guide 16

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.

If you do not have the name and address of your insurance company 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.

WORKERS' COMPENSATION APPEALS BOARD DISTRICT OFFICES

ANAHEIM, 92806-2131 1065 North Link, Suite 170 Information & Assistance Unit **(714) 414-1801**	**SACRAMENTO, 95834-2962** 160 Promenade Circle, Suite 300 Information & Assistance Unit **(916) 928-3158**
BAKERSFIELD, 93301-1929 1800 30th Street, Suite 100 Information & Assistance Unit **(661) 395-2514**	**SALINAS, 93906-2204** 1880 N Main Street, Suites 100 & 200 Information & Assistance **(831) 443-3058**
FRESNO, 93721-2219 2550 Mariposa Street, Suite 4078 Information & Assistance Unit **(559) 445-5355**	**SAN BERNARDINO, 92401-1411** 464 W Fourth Street, Suite 239 Information & Assistance Unit **(909) 383-4522**
LODI, 95240-6936 3021 Reynolds Ranch Parkway, Suite 130 Information & Assistance Unit **(209) 948-7759**	**SAN DIEGO, 92108-4424** 7575 Metropolitan Drive, Suite 202 Information & Assistance Unit **(619) 767-2082**
LONG BEACH, 90810-1870 1500 Hughes Way, Suite C203 Information & Assistance Unit **(424) 450-2565**	**SAN FRANCISCO, 94102-7014** 455 Golden Gate Avenue, 2nd Floor Information & Assistance Unit **(415) 703-5020**
LOS ANGELES, 90013-1105 320 W 4th Street, 9th Floor Information & Assistance Unit **(213) 576-7389**	**SAN JOSE, 95110-3718** 224 Airport Parkway, Suite 600 Information & Assistance Unit **(408) 277-1292**
MARINA DEL REY, 90292-6902 4720 Lincoln Boulevard, 2nd and 3rd Floors Information & Assistance Unit **(310) 482-3820**	**SAN LUIS OBISPO, 93401-8736** 4740 Allene Way, Suite 100 Information & Assistance Unit **(805) 596-4159**
OAKLAND, 94612-1499 1515 Clay Street, 6th Floor Information & Assistance Unit **(510) 622-2861**	**SANTA ANA, 92707-7704** 2 MacArthur Place, Suite 600 Information & Assistance Unit **(714) 942-7576**
OXNARD, 93030-7912 1901 N Rice Avenue, Suite 100 Information & Assistance Unit **(805) 485-3528**	**SANTA BARBARA, 93101-7538** 130 E Ortega Street Information & Assistance Unit **(805) 568-1390**
POMONA, 91768-1653 732 Corporate Center Drive Information & Assistance Unit **(909) 623-8568**	**SANTA ROSA, 95404-4771** 50 "D" Street, Suite 420 Information & Assistance Unit **(707) 576-2452**
REDDING, 96002-0940 250 Hemsted Drive, 2nd Floor, Suite B Information & Assistance Unit **(530) 225-2047**	**VAN NUYS, 91401-3370** 6150 Van Nuys Boulevard, Suite 105 Information & Assistance Unit **(818) 901-5374**
RIVERSIDE, 92501-3337 3737 Main Street, Suite 300 Information & Assistance Unit **(951) 782-4347**	

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

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

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Use the attached form to file 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 you file a claim, the claims administrator, who is responsible for handling your claim, must notify you within 14 days whether your claim is accepted or whether additional investigation is needed.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Do this right away to avoid problems with your claim. In some cases, benefits will not start until you inform your employer about your injury by filing a claim form. Describe your injury completely. Include every part of your body affected by the injury. If you mail the form to your employer, use first-class or certified mail. If you buy a return receipt, you will be able to prove that the claim form was mailed and when it was delivered. Within one working day after you file the claim form, your employer must complete the "Employer" section, give you a dated copy, keep one copy, and send one to the claims administrator.

Medical Care: Your claims administrator will pay for all reasonable and necessary medical care for your work injury or illness. Medical benefits are subject to approval and may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, medicines, equipment and travel costs. Your claims administrator will pay the costs of approved medical services directly so you should never see a bill. There are limits on chiropractic, physical therapy, and other occupational therapy visits.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness.

- If you previously designated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
- If your employer is using a medical provider network (MPN) or Health Care Organization (HCO), in most cases, you will be treated in the MPN or HCO unless you predesignated your personal physician or a medical group. An MPN is a group of health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
- If your employer is not using an MPN or HCO, in most cases, the claims administrator can choose the doctor who first treats you unless you predesignated your personal physician or a medical group.
- If your employer has not put up a poster describing your rights to workers' compensation, you may be able to be treated by your personal physician right after you are injured.

Within one working day after you file a claim form, your employer or the claims administrator must authorize up to $10,000 in treatment for your injury, consistent with the applicable treating guidelines until the claim is accepted or rejected. If the employer or claims administrator does not authorize treatment right away, talk to your supervisor, someone else in management, or the claims administrator. Ask for treatment to be authorized right now, while waiting for a decision on your claim. If the employer or claims administrator will not authorize treatment, use your own health insurance to get medical care. Your health insurer will seek reimbursement from the claims administrator. If you do not have health insurance, there are doctors, clinics or hospitals that will treat you without immediate payment. They will seek reimbursement from the claims administrator.

Switching to a Different Doctor as Your PTP:

- If you are being treated in a Medical Provider Network (MPN), you may switch to other doctors within the MPN after the first visit.
- If you are being treated in a Health Care Organization (HCO), you may switch at least one time to another doctor within the HCO. You may switch to a doctor outside the HCO 90 or 180 days after your injury is reported to your employer (depending on whether you are covered by employer-provided health insurance).
- If you are not being treated in an MPN or HCO and did not predesignate, you may switch to a new doctor one time during the first 30 days after your injury is reported to your employer. Contact the claims administrator to switch doctors. After 30 days, you may switch to a doctor of your choice if

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Utilice el formulario adjunto para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran dependiendo de la índole de su reclamo. Si usted presenta un reclamo, l administrador de reclamos, quien es responsable por el manejo de su reclamo, debe notificarle dentro de 14 días si se acepta su reclamo o si se necesita investigación adicional.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Haga esto de inmediato para evitar problemas con su reclamo. En algunos casos, los beneficios no se iniciarán hasta que usted le informe a su empleador acerca de su lesión mediante la presentación de un formulario de reclamo. Describa su lesión por completo. Incluya cada parte de su cuerpo afectada por la lesión. Si usted le envía por correo el formulario a su empleador, utilice primera clase o correo certificado. Si usted compra un acuse de recibo, usted podrá demostrar que el formulario de reclamo fue enviado por correo y cuando fue entregado. Dentro de un día laboral después de presentar el formulario de reclamo, su empleador debe completar la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos.

Atención Médica: Su administrador de reclamos pagará por toda la atención médica razonable y necesaria para su lesión o enfermedad relacionada con el trabajo. Los beneficios médicos están sujetos a la aprobación y pueden incluir tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio, las medicinas, equipos y gastos de viaje. Su administrador de reclamos pagará directamente los costos de los servicios médicos aprobados de manera que usted nunca verá una factura. Hay límites en terapia quiropráctica, física y otras visitas de terapia ocupacional.

El Médico Primario que le Atiende *(Primary Treating Physician- PTP)* es el médico con la responsabilidad total para tratar su lesión o enfermedad.

- Si usted designó previamente a su médico personal o a un grupo médico, usted podrá ver a su médico personal o grupo médico después de lesionarse.
- Si su empleador está utilizando una red de proveedores médicos (*Medical Provider Network- MPN)* o una Organización de Cuidado Médico *(Health Care Organization- HCO)*, en la mayoría de los casos, usted será tratado en la *MPN* o *HCO* a menos que usted hizo una designación previa de su médico personal o grupo médico. Una *MPN* es un grupo de proveedores de asistencia médica quien da tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una *HCO* o una *MPN*. Hable con su empleador para más información.
- Si su empleador no está utilizando una *MPN* o *HCO*, en la mayoría de los casos, el administrador de reclamos puede elegir el médico que lo atiende primero a menos de que usted hizo una designación previa de su médico personal o grupo médico.
- Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede ser tratado por su médico personal inmediatamente después de lesionarse.

Dentro de un día laboral después de que Ud. Presente un formulario de reclamo, su empleador o el administrador de reclamos debe autorizar hasta $10000 en tratamiento para su lesión, de acuerdo con las pautas de tratamiento aplicables, hasta que el reclamo sea aceptado o rechazado. Si el empleador o administrador de reclamos no autoriza el tratamiento de inmediato, hable con su supervisor, alguien más en la gerencia, o con el administrador de reclamos. Pida que el tratamiento sea autorizado ya mismo, mientras espera una decisión sobre su reclamo. Si el empleador o administrador de reclamos no autoriza el tratamiento, utilice su propio seguro médico para recibir atención médica. Su compañía de seguro médico buscará reembolso del administrador de reclamos. Si usted no tiene seguro médico, hay médicos, clínicas u hospitales que lo tratarán sin pago inmediato. Ellos buscarán reembolso del administrador de reclamos.

Cambiando a otro Médico Primario o *PTP*:

- Si usted está recibiendo tratamiento en una Red de Proveedores Médicos

your employer or the claims administrator has not created or selected an MPN.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same level of privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Problems with Medical Care and Medical Reports: At some point during your claim, you might disagree with your PTP about what treatment is necessary. If this happens, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, the steps to take depend on whether you are receiving care in an MPN, HCO, or neither. For more information, see "Learn More About Workers' Compensation," below.

If the claims administrator denies treatment recommended by your PTP, you may request independent medical review (IMR) using the request form included with the claims administrator's written decision to deny treatment. The IMR process is similar to the group health IMR process, and takes approximately 40 (or fewer) days to arrive at a determination so that appropriate treatment can be given. Your attorney or your physician may assist you in the IMR process. IMR is not available to resolve disputes over matters other than the medical necessity of a particular treatment requested by your physician.

If you disagree with your PTP on matters other than treatment, such as the cause of your injury or how severe the injury is, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, notify the claims administrator in writing as soon as possible. In some cases, you risk losing the right to challenge your PTP's opinion unless you do this promptly. If you do not have an attorney, the claims administrator must send you instructions on how to be seen by a doctor called a qualified medical evaluator (QME) to help resolve the dispute. If you have an attorney, the claims administrator may try to reach agreement with your attorney on a doctor called an agreed medical evaluator (AME). If the claims administrator disagrees with your PTP on matters other than treatment, the claims administrator can require you to be seen by a QME or AME.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, you may receive temporary disability payments for a limited period. 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.

Stay at Work or Return to Work: Being injured does not mean you must stop working. If you can continue working, you should. If not, it is important to go back to work with your current employer as soon as you are medically able. Studies show that the longer you are off work, the harder it is to get back to your original job and wages. While you are recovering, your PTP, your employer (supervisors or others in management), the claims administrator, and your attorney (if you have one) will work with you to decide how you will stay at work or return to work and what work you will do. Actively communicate with your PTP, your employer, and the claims administrator about the work you did before you were injured, your medical condition and the kinds of work you can do now, and the kinds of work that your employer could make available to you.

Payment for Permanent Disability: If a doctor says you have not recovered completely from your injury and you will always be limited in the work you can do, you may receive additional payments. The amount will depend on the type of injury, extent of impairment, your age, occupation, date of injury, and your wages before you were injured.

Supplemental Job Displacement Benefit (SJDB): If you were injured on or after 1/1/04, and your injury results in a permanent disability and your employer does not offer regular, modified, or alternative work, you may qualify for a nontransferable voucher payable for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law.

Death Benefits: If the injury or illness causes death, payments may be made to a

(Medical Provider Network- MPN), usted puede cambiar a otros médicos dentro de la MPN después de la primera visita.

- Si usted está recibiendo tratamiento en un Organización de Cuidado Médico (Healthcare Organization- HCO), es posible cambiar al menos una vez a otro médico dentro de la HCO. Usted puede cambiar a un médico fuera de la HCO 90 o 180 días después de que su lesión es reportada a su empleador (dependiendo de si usted está cubierto por un seguro médico proporcionado por su empleador).
- Si usted no está recibiendo tratamiento en una MPN o HCO y no hizo una designación previa, usted puede cambiar a un nuevo médico una vez durante los primeros 30 días después de que su lesión es reportada a su empleador. Póngase en contacto con el administrador de reclamos para cambiar de médico. Después de 30 días, puede cambiar a un médico de su elección si su empleador o el administrador de reclamos no ha creado o seleccionado una MPN.

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes serán revelados. Si usted solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Problemas con la Atención Médica y los Informes Médicos: En algún momento durante su reclamo, podría estar en desacuerdo con su *PTP* sobre qué tratamiento es necesario. Si esto sucede, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, los pasos a seguir dependen de si usted está recibiendo atención en una *MPN*, *HCO* o ninguna de las dos. Para más información, consulte la sección "Aprenda Más Sobre la Compensación de Trabajadores," a continuación.

Si el administrador de reclamos niega el tratamiento recomendado por su *PTP*, puede solicitar una revisión médica independiente *(Independent Medical Review-IMR)*, utilizando el formulario de solicitud que se incluye con la decisión por escrito del administrador de reclamos negando el tratamiento. El proceso de la *IMR* es parecido al proceso de la *IMR* de un seguro médico colectivo, y tarda aproximadamente 40 (o menos) días para llegar a una determinación de manera que se pueda dar un tratamiento apropiado. Su abogado o su médico le pueden ayudar en el proceso de la *IMR*. La *IMR* no está disponible para resolver disputas sobre cuestiones aparte de la necesidad médica de un tratamiento particular solicitado por su médico.

Si no está de acuerdo con su *PTP* en cuestiones aparte del tratamiento, como la causa de su lesión o la gravedad de la lesión, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, notifique al administrador de reclamos por escrito tan pronto como sea posible. En algunos casos, usted arriesg perder el derecho a objetar a la opinión de su *PTP* a menos que hace esto de inmediato. Si usted no tiene un abogado, el administrador de reclamos debe enviarle instrucciones para ser evaluado por un médico llamado un evaluador médico calificado *(Qualified Medical Evaluator-QME)* para ayudar a resolver la disputa. Si usted tiene un abogado, el administrador de reclamos puede tratar de llegar a un acuerdo con su abogado sobre un médico llamado un evaluador médico acordado *(Agreed Medical Evaluator- AME)*. Si el administrador de reclamos no está de acuerdo con su *PTP* sobre asuntos aparte del tratamiento, el administrador de reclamos puede exigirle que sea atendido por un *QME* o *AME*.

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. puede recibir pagos por incapacidad temporal por un periodo limitado. Estos pagos pueden cambiar o parar cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no puede trabajar durante más de 14 días.

Permanezca en el Trabajo o Regreso al Trabajo: Estar lesionado no significa que usted debe dejar de trabajar. Si usted puede seguir trabajando, usted debe hacerlo. Si no es así, es importante regresar a trabajar con su empleador actual tan

spouse and other 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.

Resolving Problems or Disputes: You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your employer or 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) or unemployment insurance (UI) benefits. Call the state Employment Development Department at (800) 480-3287 or (866) 333-4606, or go to their website at www.edd.ca.gov.

You Can Contact an Information & Assistance (I&A) Officer: State I&A officers answer questions, help injured workers, provide forms, and help resolve problems. Some I&A officers hold workshops for injured workers. To obtain important information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an I&A officer of the state Division of Workers' Compensation. You can also hear recorded information and a list of local I&A offices by calling (800) 736-7401.

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 website at **www.californiaspecialist.org**.

Learn More About Workers' Compensation: For more information about the workers' compensation claims process, go to www.dwc.ca.gov. At the website, you can access a useful booklet, "Workers' Compensation in California: A Guidebook for Injured Workers." You can also contact an Information & Assistance Officer (above), or hear recorded information by calling 1-800-736-7401.

pronto como usted pueda medicamente hacerlo. Los estudios demuestran que entre más tiempo esté fuera del trabajo, más difícil es regresar a su trabajo original y a sus salarios. Mientras se está recuperando, su *PTP*, su empleador (supervisores u otras personas en la gerencia), el administrador de reclamos, y su abogado (si tiene uno) trabajarán con usted para decidir cómo va a permanecer en el trabajo o regresar al trabajo y qué trabajo hará. Comuníquese de manera activa con su *PTP*, su empleador y el administrador de reclamos sobre el trabajo que hizo antes de lesionarse, su condición médica y los tipos de trabajo que usted puede hacer ahora y los tipos de trabajo que su empleador podría poner a su disposición.

Pago por Incapacidad Permanente: Si un médico dice que no se ha recuperado completamente de su lesión y siempre será limitado en el trabajo que puede hacer, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, grado de deterioro, su edad, ocupación, fecha de la lesión y sus salarios antes de lesionarse.

Beneficio Suplementario por Desplazamiento de Trabajo *(Supplemental Job Displacement Benefit- SJDB)*: Si Ud. se lesionó en o después del 1/1/04, y su lesión resulta en una incapacidad permanente y su empleador no ofrece un trabajo regular, modificado, o alternativo, usted podría cumplir los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo un curso de reentrenamiento y/o mejorar su habilidad. Si Ud. cumple los requisios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales.

Beneficios por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a un cónyuge y otros parientes o a las personas que viven en el hogar que dependían económicamente del trabajador difunto.

Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad laboral, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (Código Laboral, sección 132a.) De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

Resolviendo problemas o disputas: Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su empleador o administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatalde Incapacidad *(State Disability Insurance- SDI)* o beneficios del desempleo *(Unemployment Insurance- UI)*. Llame al Departamento del Desarrollo del Empleo estatal al (800) 480-3287 o (866) 333-4606, o visite su página Web en www.edd.ca.gov.

Puede Contactar a un Oficial de Información y Asistencia *(Information & Assistance- I&A)*: Los Oficiales de Información y Asistencia *(I&A)* estatal contestan preguntas, ayudan a los trabajadores lesionados, proporcionan formularios y ayudan a resolver problemas. Algunos oficiales de *I&A* tienen talleres para trabajadores lesionados. Para obtener información importante sobre el proceso de la compensación de trabajadores y sus derechos y obligaciones, vaya a www.dwc.ca.gov o comuníquese con un oficial de información y asistencia de la División Estatal de Compensación de Trabajadores. También puede escuchar información grabada y una lista de las oficinas de *I&A* locales llamando al (800) 736-7401.

Ud. puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, o consulte su página Web en www.californiaspecialist.org.

Aprenda Más Sobre la Compensación de Trabajadores: Para obtener más información sobre el proceso de reclamos del programa de compensación de trabajadores, vaya a www.dwc.ca.gov. En la página Web, podrá acceder a un folleto útil, "Compensación del Trabajador de California: Una Guía para Trabajadores Lesionados." También puede contactar a un oficial de Información y Asistencia (arriba), o escuchar información grabada llamando al 1-800-736-7401.

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 in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

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. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

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. ☐ Check if you agree to receive notices about your claim by email only. ❑ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. _____ *Correo electrónico del empleado.* _____.
You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*
9. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

10. Name of employer. *Nombre del empleador.* _____
11. Address. *Dirección.* _____
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.*_____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* _____
_____
16. Insurance Policy Number. *El número de la póliza de Seguro.*_____
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* _____ 19. 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
– for Injured Worker Use Only
Form 811ES (03/2022)

Instructions

Purpose of Form
An injured worker requesting coverage research services in connection with a pending workers' compensation claim must complete and submit this request form to the WCIRB. This service is free to all injured workers. Coverage information is only available from 1958 to the present.

Note: The *California Workers' Compensation Coverage Inquiry* website located at caworkcompcoverage.com provides free coverage information for a specific employer on a specific date within the last five years.

Authorization
To obtain coverage information you must certify that:

1. you are an injured worker and are entitled to receive the requested coverage information;
2. the requested coverage information will be used solely in connection with a pending workers' compensation claim; and
3. the requested coverage 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.

Information Requirements
All sections of the Request Form must be completed or the request will not be processed.

Form Completion
- Print or type all information.
- Under Coverage Information Requested, list both the physical address and the P.O. Box address, if applicable.

Form Submission
Submit completed Request Form:

By email: customerservice@wcirb.com or

By mail: WCIRB California
Customer Service
Attn: Coverage Requests
1901 Harrison Street, 17th Floor
Oakland, CA 94612

Delivery of Coverage Research Results
By email: Email delivery is preferred
(provide email address on the Request Form).

By mail: Coverage research results are mailed if no email address is provided.

Questions
Call WCIRB Customer Service toll free
888.CA.WCIRB (229.2472)
7:30 AM – 4:45 PM Pacific

Solicitud de Servicio de Investigación de Cobertura
– para Uso del Trabajador Lesionado Solamente
Formulario 811ES (03/2022)

Instrucciones

Propósito de Formulario
Para el trabajador lesionado que solicita servicios de investigación de cobertura de seguros en relación con un reclamo pendiente de Compensación del Trabajador debe completar y enviar este formulario a WCIRB. Este servicio es gratis para trabajadores lesionados. La información sobre coberturas solo está disponible desde 1958 hasta el presente.

Nota: El sitio web de *Consulta Sobre Cobertura de Compensación del Trabajador de California* (*California Workers' Compensation Coverage Inquiry*) ubicado en caworkcompcoverage.com tiene información de cobertura de pólizas de seguro de Compensación del Trabajador en California para el empleador con fecha específica dentro de los últimos 5 años.

Autorización

Para obtener información sobre una cobertura, usted debe certificar que:

1. usted es un trabajador lesionado y tiene derecho a recibir la información solicitada sobre la cobertura de seguros de Compensación del Trabajador;
2. la información de cobertura solicitada se utilizará únicamente en conexión con un reclamo pendiente de Compensación del Trabajador; y
3. la información de cobertura de seguros solicitada no se publicará de otra manera, distribuida o divulgada ni comunicada a ningún tercer partido, excepto aquellos que estén relacionados con la administración y / o llitigación de un reclamo pendiente de Compensación del Trabajador.

Información Obligatoria
Todas las secciones del formulario de solicitud deben completarse o la solicitud no será procesada.

Cómo Completar el Formulario
- Imprimir o escribir toda la información que se pide.
- En la sección "Información de Cobertura Solicitada", indique la dirección física y la dirección de su casilla postal, si corresponde.

Entrego de Formulario
Envíe el formulario de solicitud completado a una de las siguiente direcciones:

Por correo electrónico: customerservice@wcirb.com

Por correo postal: WCIRB California
Customer Service
Attn: Coverage Requests
1901 Harrison Street, 17th Floor
Oakland, CA 94612

Entrega de Resultados de Investigación de Cobertura
Por correo electrónico: Esta es la forma que se prefiere (indique su dirección de correo electrónico en el formulario de solicitud).

Por correo postal: Si no indica una dirección de correo electrónico, recibirá los resultados de la investigación de cobertura por correo postal.

Preguntas
Llame gratis al Servicio del Cliente de WCIRB
888.CA.WCIRB (229.2472)
de 7:30 AM -- 4:45 PM (Pacífico)

WCIRB California™
Objective. Trusted. Integral.

1901 Harrison Street, 17th Floor
Oakland, CA 94612

Voice 888.229.2472 customerservice@wcirb.com
Fax 415.778.7272 wcirb.com

Workers' Compensation Insurance Rating Bureau of California®

Coverage Research Service Request
– for Injured Worker Use Only
Form 811ES (03/2022)

Solicitud de Servicio de Investigación de Cobertura
– para Uso del Trabajador Lesionado Solamente **Formulario 811ES (03/2022)**

Injured Worker Information. *Información del Trabajador Lesionado.*

Print Name of Injured Worker. *Imprimir el nombre del trabajador lesionado.* Telephone. *Teléfono.*

Address. *Dirección.*

City. *Ciudad.* State. *Estado.* Zip. *Código Postal.*

Email Address for delivery of coverage information.
By providing an email address here you are authorizing the WCIRB to email the coverage research results to you rather than sending the research results by mail.

Dirección de correo electrónico para recibir la información de cobertura.
Al proporcionar una dirección de correo electrónico aquí, usted está autorizando WCIRB a enviar por correo electrónico los resultados de la investigación de cobertura en lugar de enviar los resultados por correo postal.

Coverage Information Requested — for additional employers, attach separate sheet(s).
Información de Cobertura Solicitada — para empleadores adicionales, adjunte hojas separadas.

The WCIRB is unable to supply coverage information prior to 1958. *El WCIRB no puede proporcionar información de cobertura antes de 1958.*

List the physical address and if the employer has a P.O. Box, the P.O. Box must also be included.
Indique la dirección física y, si el empleador tiene una casilla postal, indique también.

(1)

Employer. *Empleador.*

DBA (If known). *Nombre comercial (DBA, por sus siglas en inglés - si lo conoce).*

Coverage Year(s) Requested. *Año(s) de la cobertura que solicita.*

Physical Address. *Dirección física.*

Physical Address City. *Ciudad de la dirección física.*

Physical Address State. *Estado de la dirección física.* Zip. *Código Postal.*

P.O Box Address. *Dirección de la Casilla Postal (P.O. Box).*

P.O. Box City. Ciudad *de la Casilla Postal (P.O. Box).*

P.O. Box State. *Estado de la Casilla Postal (P.O. Box).* Zip. *Código Postal.*

(2)

Employer. *Empleador.*

DBA (If known). *Nombre comercial (DBA, por sus siglas en inglés - si lo conoce).*

Coverage Year(s) Requested. *Año(s) de la cobertura que solicita.*

Physical Address. *Dirección física.*

Physical Address City. *Ciudad de la dirección física.*

Physical Address State. *Estado de la dirección física.* Zip. *Código Postal.*

P.O Box Address. *Dirección de la Casilla Postal (P.O. Box).*

P.O. Box City. Ciudad *de la Casilla Postal (P.O. Box).*

P.O. Box State. *Estado de la Casilla Postal (P.O. Box).* Zip. *Código Postal.*

Certification and Restricted Use of Information
Certificación y Uso Limitado de Información

By signing below, I (1) certify that I am an injured worker in a pending workers' compensation claim, (2) agree that the coverage information provided shall be used solely in connection with the administration and/or litigation of a pending workers' compensation claim and for no other purpose, (3) 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 a pending workers' compensation claim, and (4) affirm that all information provided on this form is true and correct.

Al firmar a continuación, yo (1) certifico que soy un trabajador lesionado en un reclamo pendiente de Compensación del Trabajador, (2) acepto que la información de cobertura presentada se utilizará únicamente en conexión con la administración y / o el litigio de un reclamo pendiente de Compensación del Trabajador y para ningún otro propósito, (3) entiendo que la información proporcionada a WCIRB de cobertura de seguros solicitada no se publicará de otra manera, distribuida o divulgada ni comunicada a ningún tercer partido, excepto aquellos que estén relacionados con la administración y / o litigación de un reclamo pendiente de Compensación del Trabajador (4) confirmo que toda la información proporcionada en este formulario es verdadera y correcta.

Name. *Nombre.* Date. *Fecha.*

WCIRB California
Objective. Trusted. Integral.

1901 Harrison Street, 17th Floor
Oakland, CA 94612

Voice 888.229.2472 customerservice@wcirb.com
Fax 415.778.7272 wcirb.com

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

Legend Abbreviation	Office
AHM	Anaheim
ANA	Santa Ana
BAK	Bakersfield
FRE	Fresno
LAO	Los Angeles
LBO	Long Beach
LOD	Lodi
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
VNO	Van Nuys

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.

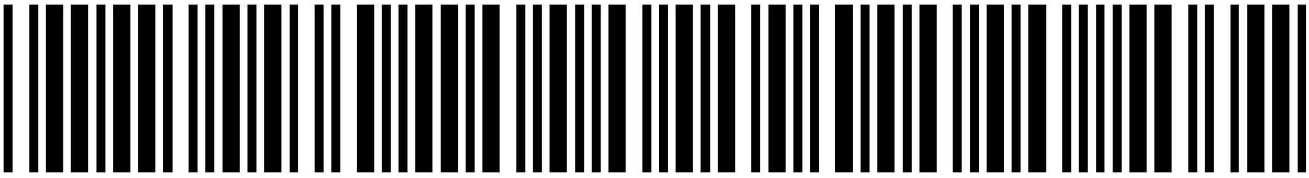
100	Head - not specified
110	Brain
120	Ear - not specified
121	Ear - external
124	Ear - internal including hearing
130	Eye - including optic nerves and vision
140	Face - not specified
141	Jaw - including chin and mandible
144	Mouth - including lips, tongue, throat and taste
145	Teeth
146	Nose - including 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
900	COVID-19
999	Unclassified - insufficient information to identify body 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)

SSN: **YOUR SOCIAL SECURITY NUMBER**

EAMS CASE NUMBER

Case Number 1

☐ Specific Injury

☐ Cumulative Injury

DATE OF 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

Body Part 1: _____ **USE CODE FROM BODY PART CODE LIST -- SEE PAGE 8**

Body Part 2: _____ 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 ☐ SAU ☐ INT ☐ RSU

Companion Cases

Case Number 2

☐ Specific Injury

☐ Cumulative Injury

(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

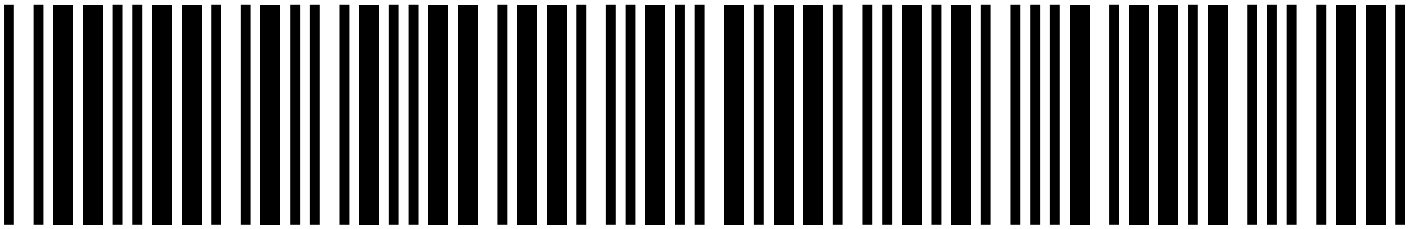
(If Specific Injury, use the start date as the specific date of injury)

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

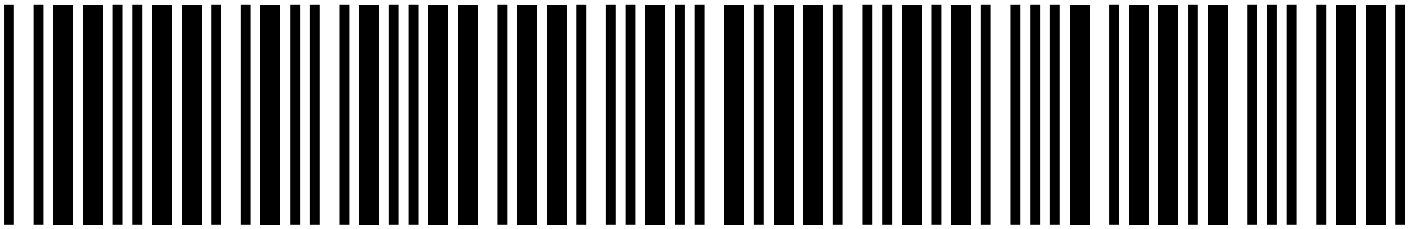
Author _____

Office Use Only

Received Date _____
MM/DD/YYYY

SAMPLE

DOCUMENT SEPARATOR SHEET



Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: APPLICATION FOR ADJUDICATION

Document Date: DATE YOU FILLED OUT THE FORM
MM/DD/YYYY

Author: 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

☐ Amended Application

Case No.

SSN (Numbers Only)

Venue choice is based upon (Completion of this section is required)

☐ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

☐ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

☐ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

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

Injured Worker (Completion of this section is required)

First Name MI

Last Name

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

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

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

City State Zip Code

Applicant (If other than Injured Worker)

☐ Insurance Carrier ☐ Employer ☐ Lien Claimant

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

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

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

City State Zip Code

Employer Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

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

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

City State Zip Code

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

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

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

City State Zip Code

Claims Administrator Information (If known and if applicable)

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

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

City State Zip Code

IT IS CLAIMED THAT (Complete all relevant information):

1. The injured worker, born _____ (DATE OF BIRTH: MM/DD/YYYY), while employed as a(n) _____ (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)

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

suffered a :

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

The injury occurred at _____

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

City , State Zip Code .

(State which parts of the body were injured)

Body Part 1: _____

Body Part 2: _____

Body Part 3: _____

Body Part 4: _____

Other Body Parts: _____

2. The injury occurred as follows:

(EXPLAIN WHAT THE WORKER WAS DOING AT THE TIME OF INJURY AND HOW THE INJURY OCCURED)

3. Actual earnings at the time of injury:

Rate of Pay $ _____ ☐ Monthly ☐ Weekly ☐ Hourly

State value of tips, meals, lodging, or other advantages, regularly received $ _____ ☐ Monthly ☐ Weekly ☐ Hourly

Number of hours worked per week _____

4. The injury caused disability as follows:

Last day off work due to injury: _____ MM/DD/YYYY

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

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

5. Compensation:

Compensation was paid: ☐ Yes ☐ No

Total paid: _____

Weekly rate(s): _____

Date of last payment: _____ MM/DD/YYYY

6. Has the worker received any unemployment insurance benefits and/or any unemployment compensation disability benefits (state disability) since the date of injury? ☐ Yes ☐ No

7. Medical treatment:

Medical treatment was received: ☐ Yes ☐ No

All treatment was furnished by the Employer or Insurance Carrier: ☐ Yes ☐ No

Date of last treatment: _____
MM/DD/YYYY

Other treatment was provided/paid by: _____
(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)

Did Medi-Cal pay for any health care related to this claim? ☐ Yes ☐ No

Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or examined for this injury, but that were not provided or paid for by the employer or insurance carrier:

_____
Name of Doctor/Hospital/Clinic 1 (Please leave blank spaces between numbers, names or words)

_____
Name of Doctor/Hospital/Clinic 2 (Please leave blank spaces between numbers, names or words)

8. Other cases have been filed for industrial injuries by this worker as follows:

_____ _____
Case Number 1 Case Number 3

_____ _____
Case Number 2 Case Number 4

9. This application is filed because of a disagreement regarding liability for:

☐ Temporary disability indemnity
☐ Permanent disability indemnity
☐ Reimbursement for medical expense
☐ Rehabilitation
☐ Medical treatment
☐ Supplemental Job Displacement/Return to Work
☐ Compensation at proper rate
☐ Other (Specify) _____

Is the Applicant Represented? ☐ Yes ☐ No **If "No", applicant is to sign and date below.**

If "Yes", applicant's representative is to complete the following and is to sign and date below.

☐ Law Firm/Attorney ☐ Non-Attorney Representative

Law Firm or Company Name (If Applicable)

Law Firm Number (If Applicable)

Attorney/Representative First Name MI

Attorney/Representative Last Name

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

City State Zip Code

Applicant Attorney/Representative Signature

Applicant Signature

Dated at _____, California
City

Date _____
MM/DD/YYYY

INSTRUCTIONS

FILING AND SERVICE OF A DECLARATION OF READINESS IS A PREREQUISITE TO THE SETTING OF A CASE FOR HEARING.

Effect of Filing Application

Filing of this application begins formal proceedings against the defendant(s) named in your application.

Assistance in Filling Out Application

You may request the assistance of an information and assistance officer of the Division of Workers' Compensation.

Right to Attorney

You may be represented by an attorney or agent, or you may represent yourself. The attorney's fee will be set by the Workers' Compensation Appeals Board at the time the case is decided and is ordinarily payable out of your award.

Filling Out Application

For "amended" applications, the venue choice must be the same as that specified on the original application, unless an order changing venue has issued. A street or P.O. Box address within the United States must be entered for the place where the injury occurred. Therefore, if the injury did not occur at a fixed or identifiable location (such as a field, a highway,or on water), or if the injury occurred outside of the United States, the employer's business address or another appropriate address must be specified; however, a short explanation regarding the place of injury may be appended to the application. If medical treatment has been paid for by Medi-Cal, Medicare, group health insurance, or a private carrier, please specify.

Service of Documents

Your attorney or agent will serve all documents in accordance with Labor Code section 5501 and the Workers' Compensation Appeals Board's Rules of Practice and Procedure.

If you have no attorney or agent, copies of this application will be served by the Workers' Compensation Appeals Board on all parties. If you file any other document, you must mail or deliver a copy of the document to all parties in the case.

IMPORTANT!

If any applicant is under 18 years of age, it will be necessary to file a Petition for Appointment of Guardian ad Litem. Forms for this purpose may be obtained at the district office of the Workers' Compensation Appeals Board, or by calling the district office and requesting this form.

SAMPLE

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

LEAVE BLANK

Case No.

☐ Amended Application

YOUR SOCIAL SECURITY NUMBER

SSN (Numbers Only)

Venue choice is based upon (Completion of this section is required)

☐ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

☐ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

☐ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

← SELECT ONE

USE 3 LETTER OFFICE CODE FROM DOCUMENT COVER SHEET

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

Injured Worker (Completion of this section is required)

YOUR FIRST NAME

First Name MI

YOUR LAST NAME

Last Name

YOUR MAILING ADDRESS

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)

YOUR CITY

City State Zip Code

Applicant (If other than Injured Worker)

☐ Insurance Carrier ☐ Employer ☐ Lien Claimant

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

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

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

City State Zip Code

SAMPLE

Employer Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

NAME OF COMPANY YOU WERE WORKING FOR AT TIME OF INJURY

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

COMPANY ADDRESS

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

COMPANY CITY

City State Zip Code

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

NAME OF COMPANY INSURANCE CARRIER

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

INSURANCE CARRIER ADDRESS

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

INSURANCE CARRIER CITY

City State Zip Code

Claims Administrator Information (If known and if applicable)

NAME OF CLAIMS ADMINISTRATOR

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

CLAIMS ADMINISTRATOR ADDRESS

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

CLAIMS ADMINISTRATOR CITY

City State Zip Code

IT IS CLAIMED THAT (Complete all relevant information):

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

(Choose only one)

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

suffered a :

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

The injury occurred at ADDRESS WHERE ACCIDENT TOOK PLACE

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

_____ , _____ _____ .

City State Zip Code

(State which parts of the body were injured)

SAMPLE

Body Part 1: PART OF BODY THAT WAS INJURED, USE LIST FROM DOCUMENT COVER SHEET

Body Part 2: _____

Body Part 3: _____

Body Part 4: _____

Other Body Parts: _____

2. The injury occurred as follows:

(EXPLAIN WHAT THE WORKER WAS DOING AT THE TIME OF INJURY AND HOW THE INJURY OCCURED)

INDICATE WHAT YOU WERE DOING AT THE TIME OF INJURY

3. Actual earnings at the time of injury:

Rate of Pay $ _____ ☐ Monthly ☐ Weekly ☐ Hourly

State value of tips, meals, lodging, or other advantages, regularly received $ _____ ☐ Monthly ☐ Weekly ☐ Hourly

Number of hours worked per week _____

4. The injury caused disability as follows:

Last day off work due to injury: LAST DAY WORKED (MM/DD/YYYY)

First Period of Disability: Start Date FIRST DAY OFF WORK (MM/DD/YYYY) End Date DATE RETURNED TO WORK (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): FROM CLAIMS ADMINISTRATOR

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

SAMPLE

All treatment was furnished by the Employer or Insurance Carrier: ☐ Yes ☐ No

Date of last treatment: _____ MM/DD/YYYY

IF YOU OR PRIVATE INSURANCE PAID FOR MEDICAL TREATMENT

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:

LIST ANY OTHER CASES FILED WITH DWC

Case Number 1 _____ Case Number 3 _____

Case Number 2 _____ Case Number 4 _____

9. This application is filed because of a disagreement regarding liability for:

☐ Temporary disability indemnity
☐ Permanent disability indemnity
☐ Reimbursement for medical expense
☐ Rehabilitation
☐ Medical treatment
☐ Supplemental Job Displacement/Return to Work
☐ Compensation at proper rate
☐ Other (Specify) _____

Is the Applicant Represented? ☐ Yes ☐ No **If "No", applicant is to sign and date below.**

If "Yes", applicant's representative is to complete the following and is to sign and date below.

SAMPLE

☐ Law Firm/Attorney ☐ Non-Attorney Representative

Law Firm or Company Name (If Applicable)

Law Firm Number (If Applicable)

Attorney/Representative First Name MI

Attorney/Representative Last Name

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

City State Zip Code

Applicant Attorney/Representative Signature

YOUR SIGNATURE

Applicant Signature

Dated at _____, California
City

Date TODAY'S DATE
MM/DD/YYYY

INSTRUCTIONS

FILING AND SERVICE OF A DECLARATION OF READINESS IS A PREREQUISITE TO THE SETTING OF A CASE FOR HEARING.

Effect of Filing Application

Filing of this application begins formal proceedings against the defendant(s) named in your application.

Assistance in Filling Out Application

You may request the assistance of an information and assistance officer of the Division of Workers' Compensation.

Right to Attorney

You may be represented by an attorney or agent, or you may represent yourself. The attorney's fee will be set by the Workers' Compensation Appeals Board at the time the case is decided and is ordinarily payable out of your award.

Filling Out Application

For "amended" applications, the venue choice must be the same as that specified on the original application, unless an order changing venue has issued. A street or P.O. Box address within the United States must be entered for the place where the injury occurred. Therefore, if the injury did not occur at a fixed or identifiable location (such as a field, a highway,or on water), or if the injury occurred outside of the United States, the employer's business address or another appropriate address must be specified; however, a short explanation regarding the place of injury may be appended to the application. If medical treatment has been paid for by Medi-Cal, Medicare, group health insurance, or a private carrier, please specify.

Service of Documents

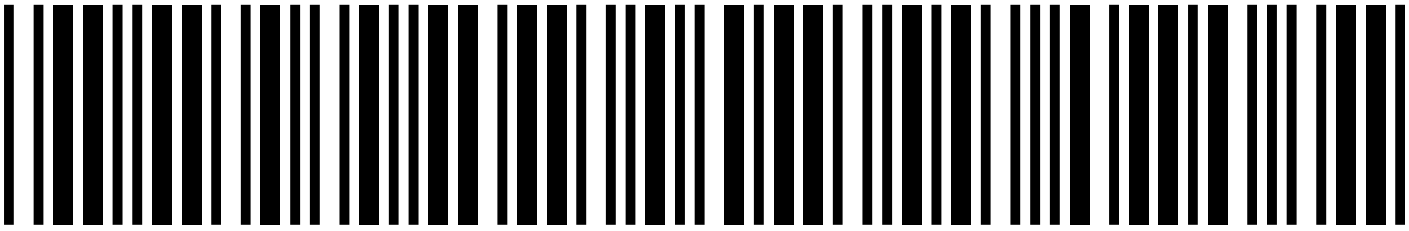
Your attorney or agent will serve all documents in accordance with Labor Code section 5501 and the Workers' Compensation Appeals Board's Rules of Practice and Procedure.

If you have no attorney or agent, copies of this application will be served by the Workers' Compensation Appeals Board on all parties. If you file any other document, you must mail or deliver a copy of the document to all parties in the case.

IMPORTANT!

If any applicant is under 18 years of age, it will be necessary to file a Petition for Appointment of Guardian ad Litem. Forms for this purpose may be obtained at the district office of the Workers' Compensation Appeals Board, or by calling the district office and requesting this form.

DOCUMENT SEPARATOR SHEET



Product Delivery Unit _____

Document Type _____

Document Title _____

Document Date _____
MM/DD/YYYY

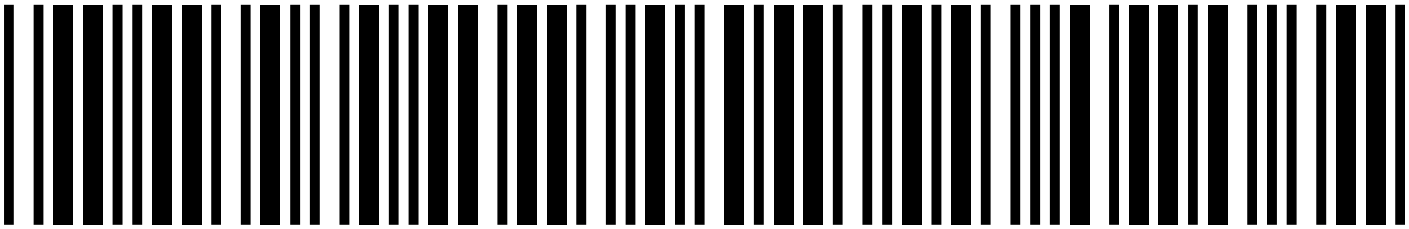
Author _____

Office Use Only

Received Date _____
MM/DD/YYYY

SAMPLE

DOCUMENT SEPARATOR SHEET



Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: 4906(h) DECLARATION

Document Date: DATE YOU FILLED OUT THE FORM
MM/DD/YYYY

Author: YOUR NAME

Office Use Only

Received Date: _____
MM/DD/YYYY

DECLARATION PURSUANT TO LABOR CODE SECTION 4906(h)

Pursuant to Labor Code Section 4906(h), 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.

Date: _____

_____
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

DECLARATION PURSUANT TO LABOR CODE SECTION 4906(h)

Pursuant to Labor Code Section 4906(h), 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.

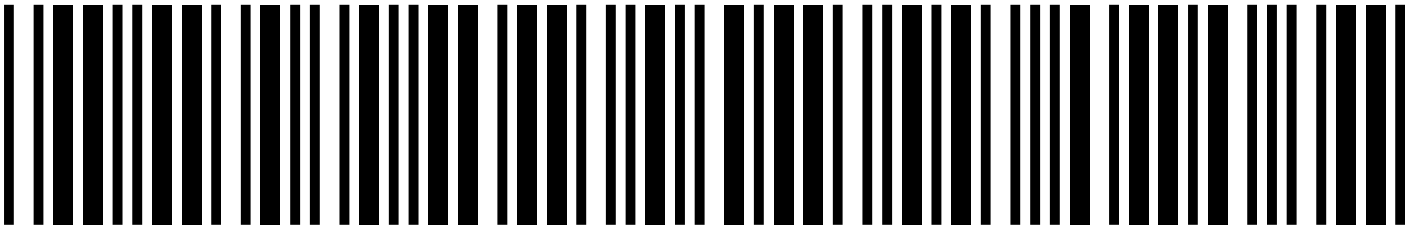
Date: TODAY'S DATE

YOUR SIGNATURE

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."

DOCUMENT SEPARATOR SHEET



Product Delivery Unit _____

Document Type _____

Document Title _____

Document Date _____
MM/DD/YYYY

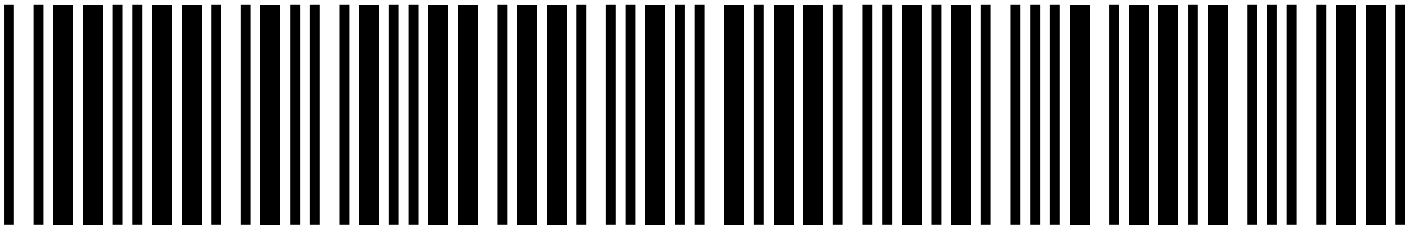
Author _____

Office Use Only

Received Date _____
MM/DD/YYYY

SAMPLE

DOCUMENT SEPARATOR SHEET



Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: DECLARATION OF READINESS TO PROCEED

Document Date: DATE YOU FILLED OUT THE FORM
MM/DD/YYYY

Author: YOUR NAME

Office Use Only

Received Date
MM/DD/YYYY

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

NOTICE: Any objection to the proceedings requested by a Declaration of Readiness to proceed shall be filed and served within ten (10) days after service of the Declaration.

Case No.

Applicant

First Name MI

Last Name

VS

Employer Information

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

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

City State Zip Code

Declarants: Please designate your role (Please Select Only One)

☐ Employee ☐ Applicant ☐ Defendant ☐ Lien Claimant

Declarant requests: (Please Select Only One)

☐ Mandatory Settlement Conference ☐ Status Conference ☐ Rating MSC* ☐ Priority Conference

☐ Lien Conference

At the present time the principal issues are: (Check all that apply)

☐ Compensation Rate ☐ Rehabilitation/SJDB ☐ Temporary Disability ☐ Self-Procured Medical Treatment

☐ Permanent Disability ☐ Future Medical Treatment ☐ AOE/COE ☐ Discovery

☐ Employment ☐ Other

Declarant relies on the report(s) of:

Doctors (s) date

MM/DD/YYYY

*For a Rating MSC, all ratable medical reports, including treating physician, QME and AME reports, must be filed with this Declaration of Readiness, unless they have been previously filed. A Rating MSC will be set only where the issues are limited to permanent disability and the need for future medical treatment.

Declarant states under penalty perjury that he or she is presently ready to proceed to hearing on the issues below and has made the following specific, genuine, good faith efforts to resolve the dispute(s) listed below:

Unless a status or priority conference is requested, I have completed discovery on the issues listed above, and that all medical reports in my possession or control have been filed and served as required by the rules promulgated by the Court Administrator.

Copies of this Declaration have been served this date as shown on the attached proof of service.

Declarant's Signature _____

_____
Name of declarant or name of the law firm of the declarant (Print or Type)

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

_____ Date _____
Phone Number MM/DD/YYYY

INSTRUCTIONS

1. This Declaration must be completed and filed before any case will be set for hearing at the request of any party. A party may request a mandatory settlement conference hearing, status conference hearing, rating mandatory settlement conference hearing, priority conference hearing or a lien conference.

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 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.**

A lien conference is a proceeding for which judicial attention is required to resolve disputes on liens. 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.

2. A lien claimant may file a declaration of readiness to proceed only after the underlying case has been resolved or where the applicant chooses not to proceed with his or her case. (Labor Code § 4903.6 (b).) A declaration of readiness filed by a lien claimant shall be accompanied by the verification required by section 10770.6 of title 8 of the California Code of Regulation. The failure to attach the verification or an incorrect verification may be a basis for sanctions.

3. 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.**

4. 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.

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

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

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

SAMPLE

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

NOTICE: Any objection to the proceedings requested by a Declaration of Readiness to proceed shall be filed and served within ten (10) days after service of the Declaration.

EAMS CASE NUMBER

Case No.

Applicant

YOUR FIRST NAME

First Name MI

YOUR LAST NAME

Last Name

VS

Employer Information

NAME OF COMPANY YOU WERE WORKING FOR AT TIME OF INJURY

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

COMPANY ADDRESS

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

COMPANY CITY

City State Zip Code

Declarants: Please designate your role (Please Select Only One)

☐ Employee ☐ Applicant ☐ Defendant ☐ Lien Claimant

Declarant requests: (Please Select Only One)

SELECT THE TYPE OF HEARING YOU WANT (SEE PAGE 3, INSTRUCTION SHEET FOR DEFINITIONS)

☐ Mandatory Settlement Conference ☐ Status Conference ☐ Rating MSC* ☐ Priority Conference

☐ Lien Conference

At the present time the principal issues are: (Check all that apply)

☐ Compensation Rate ☐ Rehabilitation/SJDB ☐ Temporary Disability ☐ Self-Procured Medical Treatment

☐ Permanent Disability ☐ Future Medical Treatment ☐ AOE/COE ☐ Discovery

☐ Employment ☐ Other _____

Declarant relies on the report(s) of:

Doctors (s) NAME OF THE DOCTOR'S REPORT YOU ARE USING date DATE OF REPORT

MM/DD/YYYY

*For a Rating MSC, all ratable medical reports, including treating physician, QME and AME reports, must be filed with this Declaration of Readiness, unless they have been previously filed. A Rating MSC will be set only where the issues are limited to permanent disability and the need for future medical treatment.

Declarant states under penalty perjury that he or she is presently ready to proceed to hearing on the issues below and has made the following specific, genuine, good faith efforts to resolve the dispute(s) listed below:

LIST THE EFFORTS YOU HAVE MADE TO RESOLVE THE DISUPUTE

Unless a status or priority conference is requested, I have completed discovery on the issues listed above, and that all medical reports in my possession or control have been filed and served as required by the rules promulgated by the Court Administrator.

Copies of this Declaration have been served this date as shown on the attached proof of service.

Declarant's Signature YOUR SIGNATURE

IF YOU DO NOT HAVE AN ATTORNEY, PRINT YOUR NAME

Name of declarant or name of the law firm of the declarant (Print or Type)

YOUR MAILING ADDRESS

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

YOUR PHONE

Phone Number

Date TODAY'S DATE

MM/DD/YYYY

INSTRUCTIONS

1. This Declaration must be completed and filed before any case will be set for hearing at the request of any party. A party may request a mandatory settlement conference hearing, status conference hearing, rating mandatory settlement conference hearing, priority conference hearing or a lien conference.

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 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.**

A lien conference is a proceeding for which judicial attention is required to resolve disputes on liens. 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.

2. A lien claimant may file a declaration of readiness to proceed only after the underlying case has been resolved or where the applicant chooses not to proceed with his or her case. (Labor Code § 4903.6 (b).) A declaration of readiness filed by a lien claimant shall be accompanied by the verification required by section 10770.6 of title 8 of the California Code of Regulation. The failure to attach the verification or an incorrect verification may be a basis for sanctions.

3. 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.**

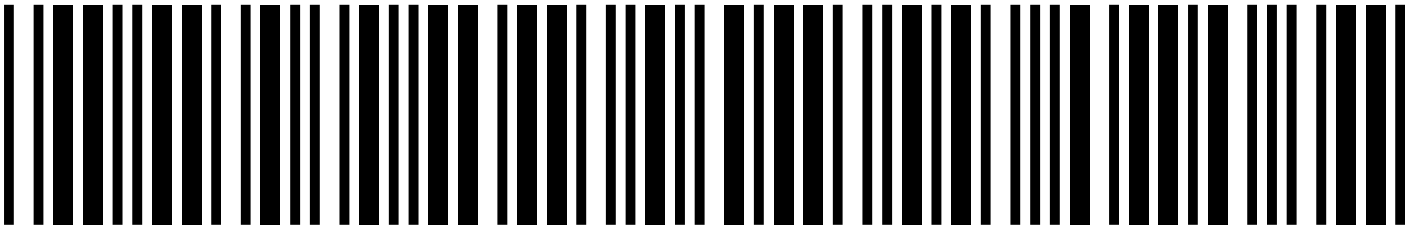
4. The party requiring an interpreter must arrange for the presence of an interpreter, except that the defendant(s) must arrange for the presence of the interpreter if the injured worker is not represented by an attorney.

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

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

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

DOCUMENT SEPARATOR SHEET



Product Delivery Unit _____

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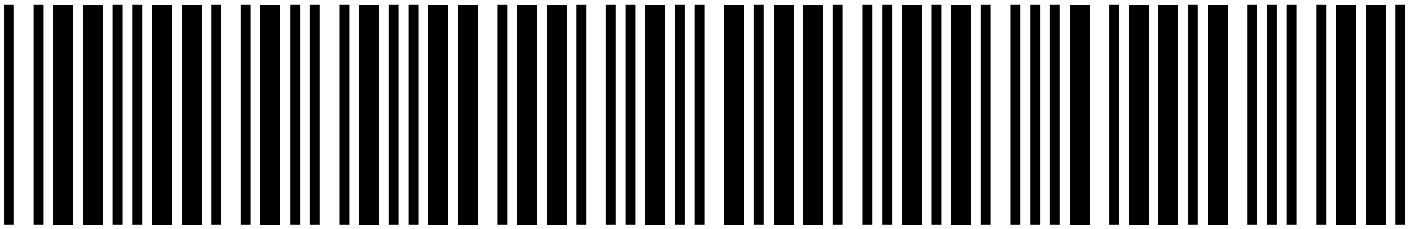


Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: SPECIAL NOTICE OF LAWSUIT

Document Date: DATE YOU FILLED OUT THE FORM
MM/DD/YYYY

Author: YOUR NAME

Office Use Only

Received Date
MM/DD/YYYY

STATE OF CALIFORNIA DEPARTMENT OF INDUSTRIAL RELATIONS

WORKERS' COMPENSATION APPEALS BOARD

PRINT CLEAR

SPECIAL NOTICE OF LAWSUIT

(Pursuant to Labor Code 3716 and Code of Civil Procedure Sections 412.20 and 412.30)

WCAB NO.:

To: **DEFENDANT, ILLEGALLY UNINSURED EMPLOYER:**

AVISO: Usted está siendo demandado. La corte puede expedir una decisión en contra suya sin darle la oportunidad de defenderse a menos que usted actue pronto. Lea la siguiente información.

Applicant.	Defendant(s).

NOTICES

1) A lawsuit, the Application for Adjudication of Claim, has been filed with the Workers' Compensation Appeals Board against you as the named defendant by the above-named applicant(s).

You may seek the advice of an attorney in any matter connected with this lawsuit and such attorney should be consulted promptly so that your response may be filed and entered in a timely fashion.

If you do not know an attorney, you may call an attorney reference service or a legal aid office. You may also request assistance / information from an Information and Assistance Officer of the Division of Workers' Compensation. (See telephone directory.)

2) An Answer to the Application must be filed and served within six days of the service of the Application pursuant to Appeals Board rules; therefore, your written response must be filed with the Appeals Board promptly; a letter or phone call will not protect your interests.

3) You will be served with a Notice(s) of Hearing and must appear at all hearings or conferences. After such hearing, even absent your appearance, a decision may be made and an award of compensation benefits may issue against you. The award could result in the garnishment of your wages, taking of your money or property, or other relief.

If the Appeals Board makes an award against you, your house or other dwelling or other property may be taken to satisfy that award in a non-judicial sale, with no exemptions from execution.

A lien may also be imposed upon your property without further hearing and before the issuance of an award.

4) You must notify the Appeals Board of the proper address for the service of official notices and papers and notify the Appeals Board of any changes in that address.

TAKE ACTION NOW TO PROTECT YOUR INTERESTS!
Issued by: WORKERS' COMPENSATION APPEALS BOARD

Name and Address of Appeals Board: **WORKERS' COMPENSATION APPEALS BOARD**

Name and Address of Applicant's Attorney:
FORM COMPLETED BY:
Telephone No.:

NOTICE TO THE PERSON SERVED: You are served:

1. [ ] as an individual defendant
2. [ ] as the person sued under the fictitious name of (specify):
3. [ ] on behalf of (specify):
   under:
   - [ ] CCP 416.10 (corporation
   - [ ] CCP 416.20 (defunct corporation)
   - [ ] CCP 416.40 (association or partnership)
   - [ ] other (specify):
   - [ ] CCP 416.60 (minor)
   - [ ] CCP 416.70 (conservatee)
   - [ ] CCP 416.90 (authorized person)
4. by personal delivery on (date):

PROOF OF SERVICE -- SPECIAL NOTICE OF LAWSUIT

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

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

b. on defendant (name):

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

d. Address where the party was served:

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

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

2) Manner of service (check proper box)

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

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

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

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

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

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

g. [ ] Additional page describing service is attached.

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

a. [ ] as an individual defendant.

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

c. [ ] on behalf of (specify):

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

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

5) Fee for service: $

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

a. [ ] Not a registered California process server.

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

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

d. [ ] California sheriff, marshal or constable.

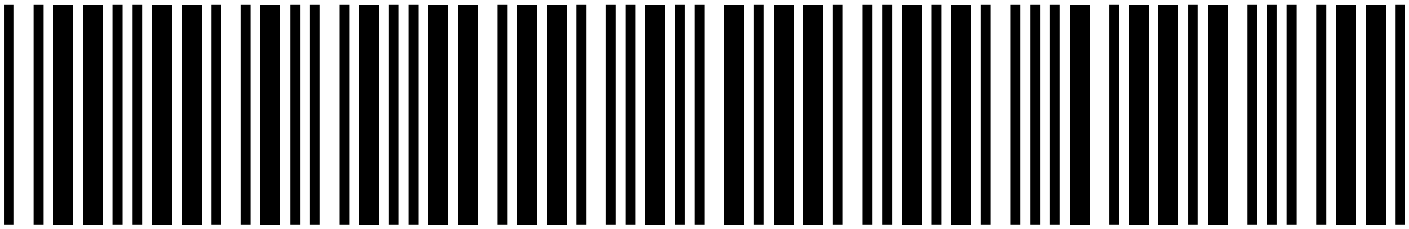
I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____
(Signature) (Date)

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

_____
Signature) (Date)

DOCUMENT SEPARATOR SHEET



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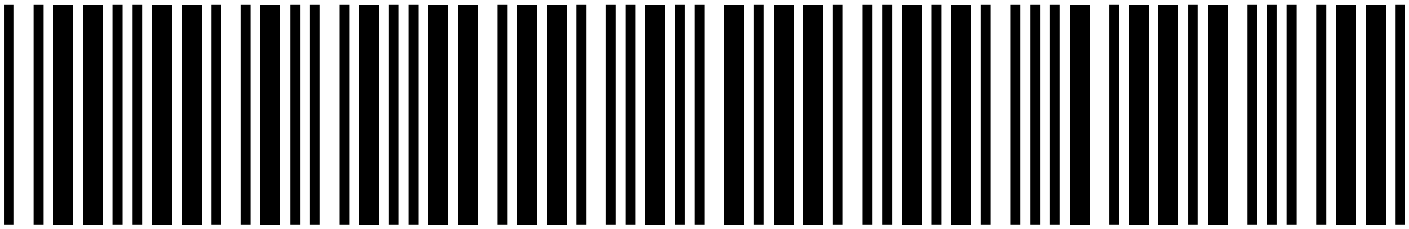

Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: PETITION TO JOIN UEBTF

Document Date: DATE YOU FILLED OUT THE FORM
MM/DD/YYYY

Author: YOUR NAME

Office Use Only

Received Date: _____
MM/DD/YYYY

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

Applicant

EAMS Case No:

Vs.

PETITION TO JOIN PARTY DEFENDANT

Defendant(s)

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

(Select office nearest your residence)

☐ Uninsured Employers Benefits Trust Fund, 1515 Clay Street, 17th Floor, Oakland, CA 94612

☐ Uninsured Employers Benefits Trust Fund, 320 West 4th Street, 6th Floor, Los Angeles, CA 90013

Proof of Service:

On_____at_____ _____
(Date) (Place) Petitioner (print name)

Copies mailed to following addresses:

1._____

2._____

3._____

X_____
Signature of Petitioner

SAMPLE

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

YOUR NAME
Applicant

EAMS Case No: YOUR EAMS NUMBER

Vs.

PETITION TO JOIN PARTY DEFENDANT

YOUR EMPLOYER'S NAME
Defendant(s)

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

(Select office nearest your residence)

_____ Uninsured Employers Benefits Trust Fund, 1515 Clay Street, 17th Floor, Oakland, CA 94612

_____ Uninsured Employers Benefits Trust Fund, 320 West 4th Street, 6th Floor, Los Angeles, CA 90013

Proof of Service:

On DATE (Date) at CITY, STATE (Place)

PRINT YOUR NAME
Petitioner (print name)

Copies mailed to following addresses:

1. WCAB
2. YOUR EMPLOYER
3. _____

X YOUR SIGNATURE
Signature of Petitioner

PRINT CLEAR

VERIFICATION

STATE OF CALIFORNIA

County of _____

I, the undersigned, say that I am _____, a party to this action. I have read the foregoing **Petition to Join UEBTF** and know the contents thereof, and that the same is true of my own knowledge, except as to the maters 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

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 to Join UEBTF** and know the contents thereof, and that the same is true of my own knowledge, except as to the maters 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

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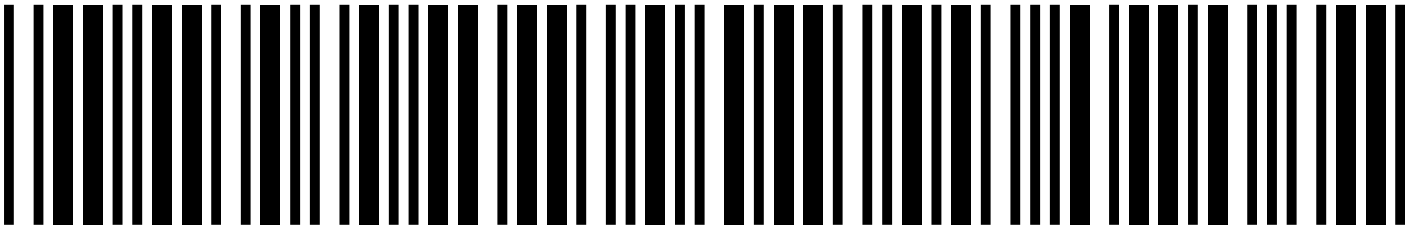

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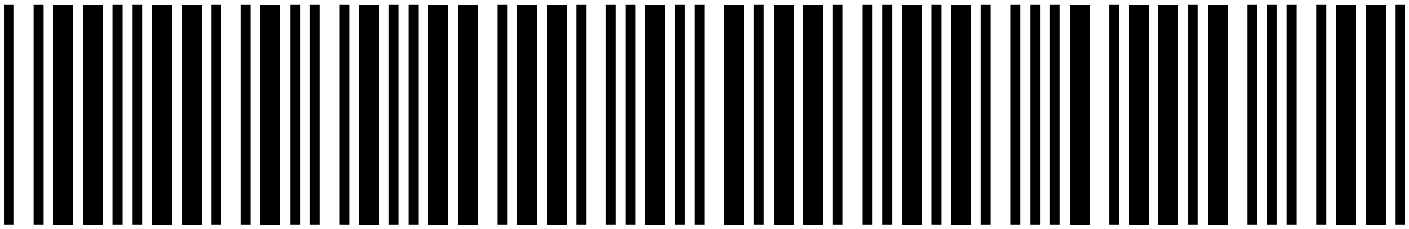

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Document Date: DATE YOU FILLED OUT THE FORM
MM/DD/YYYY

Author: YOUR NAME

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 _____

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 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