

Information & Assistance Unit guide 4

How to file an application for adjudication of claim

Complete this form if you have a disagreement with your employer or its insurance company about your case and you want it resolved by your local Workers' Compensation Appeals Board (WCAB). Filing this form opens a case with the WCAB.

You can also complete this form if you think you may need the WCAB to resolve a dispute in the future and the time allowed for you to file the application could run out. If you have questions about whether time limits apply in your case, contact your local Information and Assistance office. You can get information on contacting a local I&A office on the Web at www.dwc.ca.gov.

Complete the form and follow the instructions attached. This form can also be completed at <http://www.dir.ca.gov/dwc/FORMS/EAMS%20Forms/ADJ/DWC1.pdf>.

Please note that a hearing in your case will not be scheduled until a declaration of readiness to proceed is filed (see I&A guide 5).

The following papers must be included with your completed application:

1. A copy of your claim for workers' compensation benefits (required only for injuries that happened between 1-1-90 and 12-31-93). See I&A guide 1.
2. Declaration required by law (Labor Code section 4906 (g) -- see attached). A proof of service is recommended. See attached.

Send the originals to your local WCAB office and a copy to the insurance company. Submit the following documents with your form filing in the order shown:

- ✓ [Document Cover Sheet](#)
- ✓ [Document Separator Sheet](#) (*for Application for Adjudication of Claim*)
- ✓ [Application for Adjudication of Claim](#)
- ✓ [Document Separator Sheet](#) (*for Proof Of Service By Mail*)
- ✓ [Proof Of Service By Mail](#)
- ✓ [Document Separator Sheet](#) (*for Declaration Pursuant to Labor Code Section 4906 (g)*)
- ✓ [Declaration Pursuant to Labor Code Section 4906\(g\)](#)

Keep a copy for your records.

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

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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.

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 claims administrator to complete a form, please link to <http://www.dir.ca.gov/DWC/EAMS/EAMS-LC/EAMSClaimsAdmins.asp>.

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

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

WORKERS' COMPENSATION APPEALS BOARD DISTRICT OFFICES

ANAHEIM, 92806

1065 N. PacifiCenter Dr., Suite 202
Information & Assistance Unit (714) 414-7401

BAKERSFIELD, 93301-1929

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

EUREKA, 95501-0481

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

FRESNO, 93721-2280

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

GOLETA, 93117-3018

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

GROVER BEACH, 93433-2261

1562 W. Grand Avenue
Information & Assistance Unit (805) 481-3380

LONG BEACH, 90802-4339

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

LOS ANGELES, 90013-1105

320 West 4th Street, 9th Floor
Information & Assistance Unit (213) 576-7389

MARINA DEL REY, CA 90292

4720 Lincoln Blvd. 2nd and 3rd floors
Information & Assistance Unit (310) 482-3858

OAKLAND, 94612-1402

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

OXNARD, 93030

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

POMONA, 91766-1601

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

REDDING, 96001-2796

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

RIVERSIDE, 92501-3337

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

SACRAMENTO, 95034

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

SALINAS, 93906-2204

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

SAN BERNARDINO, 92401-1411

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

SAN DIEGO, 92108

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

SAN FRANCISCO, 94102-7002

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

SAN JOSE, 95113-1482

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

SANTA ANA, 92701-4070

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

SANTA ROSA, 95404-4760

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

STOCKTON, 94202

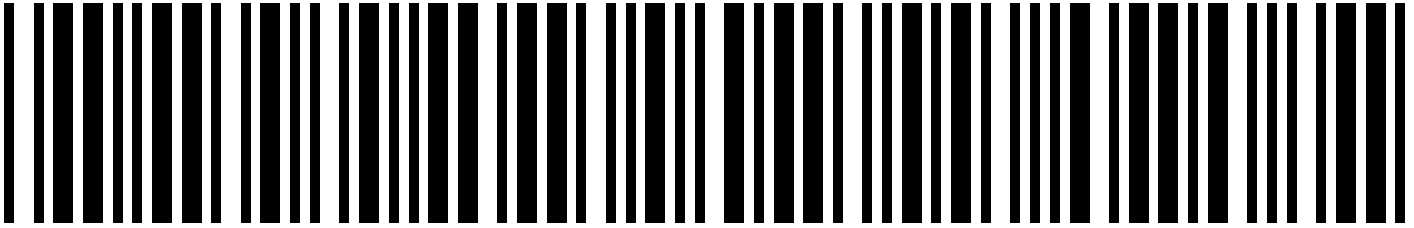
31 East Channel Street, Suite 344
Information & Assistance Unit (209) 948-7980

VAN NUYS, 91401-3373

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

DOCUMENT SEPARATOR SHEET

SAMPLE



Product Delivery Unit ADJ

Document Type LEGAL DOCS

Document Title APPLICATION FOR ADJUDICATION

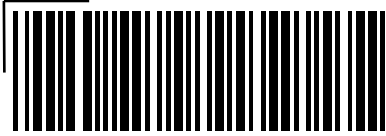
Document Date DATE YOU FILLED OUT THE FORM
MM/DD/YYYY

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**

SAMPLE

LEAVE BLANK

Amended Application

Case No. _____

YOUR SSN

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 _____

Employer Information (Completion of this section is required)

SAMPLE

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**, while employed as a(n) **YOUR JOB TITLE WHEN INJURED**
(DATE OF BIRTH: MM/DD/YYYY) (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)

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

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 End Date DATE RETURNED TO WORK
MM/DD/YYYY MM/DD/YYYY

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

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:

- | | |
|--|---|
| <input type="checkbox"/> Temporary disability indemnity | <input type="checkbox"/> Permanent disability indemnity |
| <input type="checkbox"/> Reimbursement for medical expense | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Medical treatment | <input type="checkbox"/> Supplemental Job Displacement/Return to Work |
| <input type="checkbox"/> Compensation at proper rate | <input type="checkbox"/> 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

YOUR SIGNATURE

Applicant Attorney/Representative 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.

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

INSURANCE COMPANY 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

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

Proof Of Service By Mail

I declare that:

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

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

_____ addressed as follows _____

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

(date) _____, at _____ California.

Type or print name _____

Signature _____

DECLARATION PURSUANT TO LABOR CODE SECTION 4906(g)

Pursuant to Labor Code Section 4906(g), I declare under penalty of perjury that I have not violated Section 139.3 and I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

Dated: _____

Signature

Before signing this form, you should be aware that: “Any person who makes or causes to be made any knowingly false or fraudulent material statement or representation for the purpose of obtaining or denying workers’ compensation benefits or payments is guilty of a felony.”