

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
WORKERS COMPENSATION APPEALS BOARD

SEE REVERSE SIDE
FOR INSTRUCTIONS

APPLICATION FOR ADJUDICATION OF CLAIM (DEATH CASE) CASE NUMBER: _____
(FOR INJURIES OCCURRING ON OR AFTER JANUARY 1, 1990)

(READ INSTRUCTIONS BEFORE FILLING OUT APPLICATION--PRINT OR TYPE NAMES AND ADDRESSES)

_____ (DECEASED WORKER)	_____ (ADDRESS)	
_____ (DATE OF CLAIMED INJURY)	_____ (SOCIAL SECURITY NUMBER)	_____ (DATE OF BIRTH)
_____ (APPLICANT)	_____ (ADDRESS)	
_____ (ATTORNEY FOR INJURED WORKER)	_____ (ADDRESS)	
_____ (EMPLOYER--STATE IF SELF-INSURED)	_____ (ADDRESS)	
_____ (INSURANCE CARRIER)	_____ (ADDRESS WHERE CLAIM ADMINISTERED)	
_____ (ADJUSTING AGENCY, IF AGENCY ADMINISTERED)	_____ (ADDRESS)	

(ATTORNEY FOR EMPLOYER/CARRIER) _____ (ADDRESS) _____
Venue selection based on: Labor Code Section 5501.5(a)(1) 5501.5(a)(2) 5501.5(a)(3) 5501.5(d)

THIS APPLICATION IS BEING FILED BECAUSE A BONA FIDE DISPUTE EXISTS ON THE FOLLOWING ISSUE(S):

*MANDATORY ARBITRATION	
Contribution	<input type="checkbox"/>
Insurance Coverage	<input type="checkbox"/>

Death Benefit	<input type="checkbox"/>	_____
Burial Expense	<input type="checkbox"/>	_____
Compensation Accrued and Unpaid	<input type="checkbox"/>	_____
Death Benefit	<input type="checkbox"/>	_____

*(See Instructions--Parties may voluntarily agree to arbitration of any other issue(s).)

Describe Nature of Bona Fide Dispute (See Instructions): _____

IT IS CLAIMED THAT:

1. The deceased employee, born _____, while employed as a _____ on _____
(date of birth) (occupation at time of injury) (date of injury)
at _____
(address) (city) (state) (zip code)
by the employer sustained injury arising out of and in the course of employment to _____
(State what parts of body were injured)
resulting in death on _____

2. The injury occurred as follows: _____
(Explain what deceased was doing at the time of injury and how injury was received)

3. Actual earnings at time of injury: \$ _____ 4. The injury caused disability as follows: _____

(Specify last day off work due to this injury and beginning and ending dates of all periods off due to this injury)

5. Compensation was paid Yes No \$ _____ \$ _____ _____
(Total paid) (Weekly rate) (Date of last payment)

6. Unemployment insurance or unemployment compensation disability benefits have been received since the date of injury Yes No

7. Defendants have paid burial expenses: Yes No Total Paid \$ _____

8. The employees surviving him the following dependents:

NAME	DATE OF BIRTH (if under 18)	RELATIONSHIP TO THE EMPLOYEE	ADDRESS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

9. Medical treatment was received Yes No _____ (Date of last treatment) Furnished by employer or carrier Yes No

List physicians or hospitals not provided or paid for by employer: _____

(Name of person or entity providing or paying for medical care)

10. Reports or records of the following physicians will be offered in evidence and are attached: _____

(List by name and date)

List all other medical reports: _____

(List by name and date)

11. The following other documents will be offered in evidence and are attached: _____

12. List other claims for industrial injury or applications filed by this worker: _____

(If no application filed, attach copy or copies of Employee's Claim for Workers' Compensation Benefits (Form DWC-1)
If application filed, give case number and location filed.)

NOTE: If additional space is needed to answer items 1 through 12, attach additional pages to Application.

DECLARATION UNDER PENALTY OF PERJURY—

I _____, the applicant, applicant's attorney or representative declare under penalty of perjury that applicant has completed discovery; that all the medical reports in my possession or control have been filed and served as required by the WCAB Rules of Practice and Procedure; that a copy of this application together with all supporting documents has been served on opposing parties (proof of service attached); that applicant is ready to proceed to hearing mandatory arbitration voluntary arbitration on the issues indicated above; that the following efforts to resolve the issues have been made _____

and that applicant expects to present _____ witnesses and I estimate the time required for the hearing will be _____ hours.

(If arbitration selected, Arbitration Submittal Form must be attached.)

Dated at _____, California
(city)

(applicant's attorney or representative signature)

(date)

(applicant's signature)

(applicant's attorney)

(applicant's telephone number)

(address and telephone number of attorney)

This Application cannot be filed without a dated and completed Employee's Claim for Workers' Compensation Benefits form provided by the employer describing this claim of injury or disability. Attach copy of Employee's Claim for Workers' Compensation Benefits form. (See Instruction #1)