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

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)

Reset Form | Print Form

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)

suffered a :

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

☐ 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 2

_____ Case Number 3

_____ 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