Reset Form | Print Form

# STATE OF CALIFORNIA
# DIVISION OF WORKERS' COMPENSATION
# WORKERS' COMPENSATION APPEALS BOARD

## APPLICATION FOR SUBSEQUENT INJURIES FUND BENEFITS

Case Number 1

Case Number 2

Case Number 3

Case Number 4

Case Number 5

**Injured Worker**

First Name

MI

Last Name

**VS**

Employer Name

Insurance Carrier Name

Third Party Administrator

## APPLICATION FOR SUBSEQUENT INJURIES FUND BENEFITS

1. Applicant _____ , born on _____ (MM/DD/YYYY)

was injured on _____ (MM/DD/YYYY) , as a _____ at

_____ California, with earnings of $ _____ per _____

Applicant sustained injury arising out of and occurring in the course of his/her employment resulting in permanent and partial disability affecting the following parts of the body:

_____

The permanent disability, when considered alone and without regard to or adjustment for the applicant's occupation or age is equal to _____ percent or more of total disability.

2. Immediately prior to the injury, applicant was permanently disabled in the following respects

The pre-existing disabilities occurred as a result of:

3. Applicant has previously filed a workers' compensation claim with the Workers' Compensation Appeals Board

Case Number _____

4. Applicant filed for Social Security Disability benefits on _____

and is receiving $ _____ per month. Applicant's Social Security Number is _____

WHEREFORE, applicant requests benefits as provided by law

Attorney for Applicant Signature _____

Applicant Signature _____

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

City | State | Zip Code