State of California
Division of Workers' Compensation
Workers' Compensation Appeals Board
Arbitration Submittal Form

Employee First Name: ______________________________ Middle Initial: ____

Last Name: ______________________________

Address/P.O. Box: ______________________________

City: ____________________ State: ____ Zip Code: ____________

Employee Representative ☐ Law Firm /Attorney ☐ Non attorney Representative

Law Firm or Company Name (If applicable): ______________________________

First Name: ______________________________ Middle Initial: ____

Last Name: ______________________________

Address/P.O.Box: ______________________________

City: ____________________ State: ____ Zip Code: ____________

Is the injured worker requesting arbitration or is the injured worker a party to the arbitration? ____________

List all the parties to this request for arbitration in the spaces provided below.

Party Requesting Arbitration (If applicable)

☐ Insurance Co. ☐ Self-insured ☐ Legally Uninsured ☐ Uninsured ☐ Lien Claimant Case number: ____________

Party Name: ______________________________

Address: ______________________________

City: ____________________ State: ____ Zip Code: ____________

Party Representative

Law Firm or Company Name (If applicable) ______________________________

First Name: ______________________________ Middle Initial ____

Last Name: ______________________________

Address/P.O.Box: ______________________________

City: ____________________ State: ____ Zip Code: ____________

Party to the Arbitration

☐ Insurance Co. ☐ Self-insured ☐ Legally Uninsured ☐ Uninsured ☐ Lien Claimant Case Number: ________________

Party Name: ____

Address: ____

City: ______________________ State: ____ Zip Code: ____________

Party Representative ☐ Law Firm /Attorney ☐ Non attorney Representative

Law Firm or Company Name (If applicable): ______________________________

First Name: ______________________________ Middle Initial: ____

Last Name: ____

Address/P.O.Box: ____

City: ______________________ State: ____ Zip Code: ____________

Party to the Arbitration

☐ Insurance Co. ☐ Self-insured ☐ Legally Uninsured ☐ Uninsured ☐ Lien Claimant Case Number: ________________

Party Name: ____

Address: ____

City: ______________________ State: ____ Zip Code: ____________

Party Representative ☐ Law Firm /Attorney ☐ Non attorney Representative

Law Firm or Company Name (If applicable) ______________________________

First Name: ______________________________ Middle Initial: ____

Last Name: ____

Address/P.O.Box: ____

City: ______________________ State: ____ Zip Code: ____________

Party to the Arbitration

☐ Insurance Co. ☐ Self-insured ☐ Legally Uninsured ☐ Uninsured ☐ Lien Claimant Case Number: ________________

Party Name: ____

Address: ____

City: ______________________ State: ____ Zip Code: ______________

Party Representative ☐ Law Firm /Attorney ☐ Non attorney Representative

Law Firm or Company Name (If applicable): ______________________________

First Name: ______________________________ Middle Initial: ____

Last Name: ____

Address/P.O.Box: ____

City: ______________________ State: ____ Zip Code: ______________

Party to the Arbitration

☐ Insurance Co. ☐ Self-insured ☐ Legally Uninsured ☐ Uninsured ☐ Lien Claimant Case Number: ________________

Party Name: ____

Address: ____

City: ______________________ State: ____ Zip Code: ______________

Party Representative ☐ Law Firm /Attorney ☐ Non attorney Representative

Law Firm or Company Name (If applicable): ______________________________

First Name: ______________________________ Middle Initial: ____

Last Name: ____

Address/P.O.Box: ____

City: ______________________ State: ____ Zip Code: ______________

The issues below are hereby submitted for arbitration pursuant to Labor Code section 5275:

☐ Mandatory arbitration under Labor Code section 5275 (a)

- ☐ Insurance Coverage
- ☐ Contribution

☐ Voluntary arbitration under Labor Code section 5275 (b)

Explanation of issues submitted for arbitration

☐ The parties have agreed to have this case heard before:

Arbitrator Name ______________________________

Address: ______________________________

City: ______________ State: ______ Zip Code: ______________

Phone Number: ______________

☐ The parties have unsuccessfully attempted to agree on a arbitrator and request a list of arbitrators pursuant to Labor Code section 5271(b).

The parties to the arbitration must sign this form in the spaces provides below.

Dated: ______________ at ______________________________ , California on ______________

Party or party representative: ______________________________

Party or party representative: ______________________________

Party or party representative: ______________________________

Party or party representative: ______________________________

Party or party representative: ______________________________