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APPLICATION FOR DISCRETIONARY PAYMENTS FROM THE UNINSURED EMPLOYERS' FUND

Case Number

SSN (Numbers Only)

Applicant (Completion of this section is required)

First Name MI

Last Name

Street Address1/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

Uninsured Employers Benefit Trust Fund

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

City CA State Zip Code

Prompt consideration of your application requires COMPLETE and FULL ANSWERS TO ALL THE QUESTIONS appearing below

1. Employer

Name

Street Address1/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

2. Please specify a specific injury date or specify if it was a cumulative trauma injury:

(Choose only one)

☐ as specific Injury on _____
(DATE OF INJURY: MM/DD/YYYY)

☐ a cumulative trauma which began on _____ and ended on _____
(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

3. List the names and address of doctors and hospitals that have treated you for this injury:

4. Have you returned to work ? ☐ Yes ☐ No

If Yes, give date _____
(MM/DD/YYYY)

5. Have you received payments from anyone for this injury ? ☐ Yes ☐ No

If Yes, how much were you paid ? $ _____

Who paid you ? _____

I, the undersigned, hereby apply for discretionary payments of compensation from the Uninsured Employers Fund under Laber Code section 4903.3 and declare under penalty of perjury that the information furnished above is true and correct to the best of my knowledge and belief. I hereby authorize any doctors or hospitals that have treated me for this injury to furnish and disclose all facts concerning my medical condition that are within their knowledge, and to allow inspection of and provide copies of any records concerning my medical condition that are under their control.

Executed on _____ ,at _____ , California
(MM/DD/YYYY)

_____
(Signature of Applicant)