



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



**APPLICATION FOR SUBSEQUENT INJURIES FUND BENEFITS**

Case Number 1 \_\_\_\_\_

Case Number 4 \_\_\_\_\_

Case Number 2 \_\_\_\_\_

Case Number 5 \_\_\_\_\_

Case Number 3 \_\_\_\_\_

**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 \_\_\_\_\_, as a \_\_\_\_\_ at  
MM/DD/YYYY

\_\_\_\_\_ 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)

\_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_