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: _____