Gregory B. Bragg and Associates, Inc.
P.O. Box 5072, Walnut Creek, CA 94696, tel (925) 933-2992, fax (925) 933-2994
P.O. Box 1406, Roseville, CA 95678, tel (916) 783-0100, fax (916) 783-0335
P.O. Box 13315-325, Oakland, CA 94661, tel (510) 530-3697, fax (510) 530-3699

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

If you are injured or become ill because of your job, you may be entitled to workers' compensation benefits.

Complete the **"Employee"** section and give the form to your employer. Keep the copy marked **"Employee's Temporary Receipt"** until you receive the dated copy from your employer. You may call the Division of Workers' Compensation at **1-800-736-7401** if you need help in filling out this form or in obtaining your benefits. An explanation of workers' compensation benefits is included on the back of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

PETICION DEL EMPLEADO PARA BENEFICIOS DE COMPENSACIÓN DEL TRABAJADOR

*Si Ud. se ha lesionado o se ha enfermado a causa de su trabajo, Ud. tiene derecho a recibir beneficios de compensación al trabajador. Complete la sección "**Empleado**" y entregue la forma a su empleador. Quédese con la copia designada "**Recibo Temporal del Empleado**" hasta que Ud. reciba la copia fechada de su empleador. Si Ud. necesita ayuda para completar esta forma o para obtener sus beneficios, Ud. puede hablar con la Division de Compensación al Trabajador llamando al **1-800-736-7401**. En la parte de atrás de esta forma se encuentra una explicación de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonía".

Employee: ***Empleado:***

1. Name. *Nombre.* _____ Today's Date. *Fecha de hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.* _____

Employer - complete this section and give the employee a copy immediately as a receipt.
Empleador - complete esta sección y déle inmediatamente una copia al empleado como recibo.

9. Name of employer. *Nombre del empleador.* _____
10. Address. *Dirección.* _____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* _____
15. Insurance Policy Number. *El número de la póliza del Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claim administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de **un día hábil** desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type, if possible). Mail two copies to:

OSHA Case No.

☐ Fatality

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

NOTICE: California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident ***OR*** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury/illness, or death must be reported **immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME
1A. POLICY NUMBER
2. MAILING ADDRESS (Number and Street, City, ZIP)
2A. PHONE NUMBER
3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, ZIP)
3A. LOCATION CODE
4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.
5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.
6. TYPE OF EMPLOYER
☐ PRIVATE ☐ STATE ☐ CITY ☐ COUNTY ☐ SCHOOL DIST. ☐ OTHER GOVERNMENT - SPECIFY _____

EMPLOYEE

7. EMPLOYEE NAME
8. SOCIAL SECURITY NUMBER
9. DATE OF BIRTH (mm/dd/yy)
10. HOME ADDRESS (Number and Street, City, ZIP)
10A. PHONE NUMBER
11. SEX ☐ MALE ☐ FEMALE
12. OCCUPATION (Regular job title - NO initials, abbreviations or numbers)
13. DATE OF HIRE (mm/dd/yy)
14. EMPLOYEE USUALLY WORKS _____ hours per day _____ days per week _____ total weekly hours
14A. EMPLOYMENT STATUS (check applicable status at time of injury) _____ regular full-time _____ part-time _____ temporary _____ seasonal
14B. Under what class code of your policy were wages assigned?
15. GROSS WAGES/SALARY $_____ per _____
16. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc.)? ☐ YES, $_____ per _____ ☐ NO

INJURY OR ILLNESS

17. DATE OF INJURY OR ONSET OF ILLNESS (mm/dd/yy)
18. TIME INJURY/ILLNESS OCCURRED _____ A.M. _____ P.M.
19. TIME EMPLOYEE BEGAN WORK _____ A.M. _____ P.M.
20. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ YES ☐ NO
22. DATE LAST WORKED (mm/dd/yy)
23. DATE RETURNED TO WORK (mm/dd/yy)
24. IF STILL OFF WORK CHECK THIS BOX ☐
25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? ☐ YES ☐ NO
26. SALARY BEING CONTINUED? ☐ YES ☐ NO
27. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yy)
28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm/dd/yy)
29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED. MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tendonitis of left elbow, lead poisoning.
30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)
30A. COUNTY
30B. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO
31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop.
32. OTHER WORKERS INJURED/ILL IN THIS EVENT? ☐ YES ☐ NO
33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.
34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck.
35. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.
36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)
36A. PHONE NUMBER
37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)
37A. PHONE NUMBER

DO NOT USE THIS COLUMN

Case No.
Ownership
Industry
Occupation
Sex
Age
Daily hours
Days per week
Weekly hours
Weekly wage
County
Nature of injury
Part of body
Source
Event
Sec. Source
Extent of injury

Completed by (type or print) | Signature | Title | Date

FORM 5020 (REV. 6)