PROOF OF SERVICE FOR WORKERS' COMPENSATION APPEAL
(DECLARATION OF SERVICE)

Case Name/No.: In the Matter of the Appeal of:

____
Case name

File No. AHB-WCA-____-____

I, ________________________________, declare that:
Your name

I am employed in the County of ______________________, California. I am over the age of 18 years and not a party to this action. My business address is ____.

I am readily familiar with the business practices of _________________________________ for the collection and
Name of your company
processing of correspondences of mailing with the United States Postal Service. Said ordinary business practice is that correspondence is deposited with the United States Postal Service that same day in ____________________, California.
City

☐ On _____________________, following ordinary business practices, I caused a true and correct copy of
Date
the following documents(s):

to be placed for collection and mailing at the office of ____,
Business address
California with proper postage prepaid, in a sealed envelope(s) addressed as follows: **(See attached Party Service List)**

☐ In addition, on _____________________, I also faxed a copy of said document to all parties where
Date
indicated the to the fax number which is printed under each address on this Declaration.

I declare under penalty of perjury that the foregoing is true and correct, and that this declaration was executed at San Francisco, California, on _____________________.
Date

__________________________ __________________________________
Date Name of person mailing document

PROOF OF SERVICE FOR WORKERS' COMPENSATION APPEAL
(PARTY SERVICE LIST)
AHB-WCA-____-____

Kristin L. Rosi Chief Administrative Law Judge **Administrative Hearing Bureau** **Department of Insurance** 1901 Harrison Street, 3rd Floor Oakland, CA 94612 Tel. No.: (415) 538-4243 or (415) 538-4127 Fax No.: (510) 238-7828	
Brenda J. Keys, Esq. Senior Vice President – Legal **WORKERS' COMPENSATION INSURANCE RATING BUREAU** 1901 Harrison Street, 17th Floor Oakland, CA 94612 Tel. No.: (415) 778-7000 Fax No.: (415) 371-5202 Email: legal@wcirb.com	Attorney(s) for Workers' Compensation Insurance Rating Bureau
______________________ Contact Person ______________________ Insurance Company ______________________ Address ______________________ City, State, Zip ______________________ Telephone ______________________ Fax	Insurer

PROOF OF SERVICE FOR WORKERS' COMEPSATION APPEAL
(PARTY SERVICE LIST)
AHB-WCA-____-____