Notice and request for allowance of lien
OCR form sample packet

This packet contains instructions on how to fill in Optical Character Recognition (OCR) forms, examples of forms and is in the order in which forms / documents should be filed with the district office.

Use the table below to help identify the forms that you need to complete when filing a notice and request for allowance of lien. The table also shows the order in which the forms should be assembled. To help you find the correct document separator sheet, the product delivery unit, document type and document title are in brackets.

In this packet, you will see examples as filed by a medical company. If a claims administrator or law office is filing the forms, they do not file lien verification 10770.5.

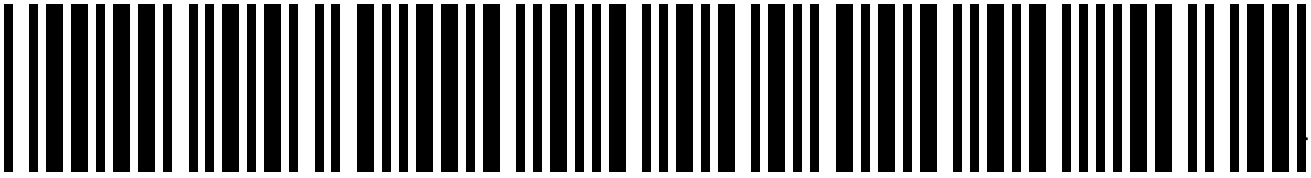
	Name of form
1	Document cover sheet
2	Document separator sheet **[ADJ-LIENS AND BILLS-NOTICE AND REQUEST FOR ALLOWANCE OF LIEN]**
3	Notice and request for allowance of lien
4	Document separator sheet for **medical bills**, use the following product delivery unit, document type and document title **[ADJ-LIENS AND BILLS-MEDICAL BILLS]** for **other bills**, use the following product delivery unit, document type and document title **[ADJ-LIENS AND BILLS – BILLS OTHER]**
5	Itemized billing statement
6	Document separator sheet for lien verification 10770.5 **when required** and proof of service **[ADJ-LEGAL DOCS-10770.5 VERIFICATION]**
7	Lien verification 10770.5 **when required**
8	Document separator sheet for proof of service **[ADJ-LEGAL DOCS-PROOF OF SERVICE]**
9	Proof of service

This packet is an example of how to fill in forms and the order in which they should be filed with the district office.

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET

This example shows documents submitted by a medical facility.



Is this a new case? Yes ☐ No ☑ Companion Cases Exist ☐ Walkthrough Yes ☐ No ☑

More than 15 Companion Cases ☐

03/04/2009
Date:(MM/DD/YYYY)

ENTER DATE YOU FILL IN DOCUMENT COVER SHEET.

SSN:

SOCIAL SECURITY NUMBER IS NOT REQUIRED.

☐ Specific Injury

ADJ987654321
Case Number 1

☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

NO OTHER INFORMATION IS NEEDED WHEN CORRECT CASE NUMBER IS LISTED.

Other Body Parts: _____

Please check unit to be filed on (check only one box)

☑ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ INT ☐ RSU

Companion Cases

☐ Specific Injury

_____
Case Number 2

☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

IF THERE ARE COMPANION CASES, ENTER THE CORRECT EAMS CASE NUMBER.

Other Body Parts: _____

Example

☐ Specific Injury

Case Number 3 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

☐ Specific Injury

Case Number 4 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

DO NOT PRINT OR SUBMIT BLANK PAGES.

☐ Specific Injury

Case Number 5 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

District office codes for place of venue

Legend	
Abbreviation	**Office**
AHM	Anaheim
ANA	Santa Ana
BAK	Bakersfield
EUR	Eureka
FRE	Fresno
GOL	Goleta
LAO	Los Angeles
LBO	Long Beach
MDR	Marina del Rey
OAK	Oakland
OXN	Oxnard
POM	Pomona
RDG	Redding
RIV	Riverside
SAC	Sacramento
SAL	Salinas
SBR	San Bernardino
SDO	San Diego
SFO	San Francisco
SJO	San Jose
SLO	San Luis Obispo
SRO	Santa Rosa
STK	Stockton
VNO	Van Nuys

Use this document to complete forms, but do not file this document with your forms.

DO NOT PRINT OR SUBMIT THIS PAGE.

Body Part Code List

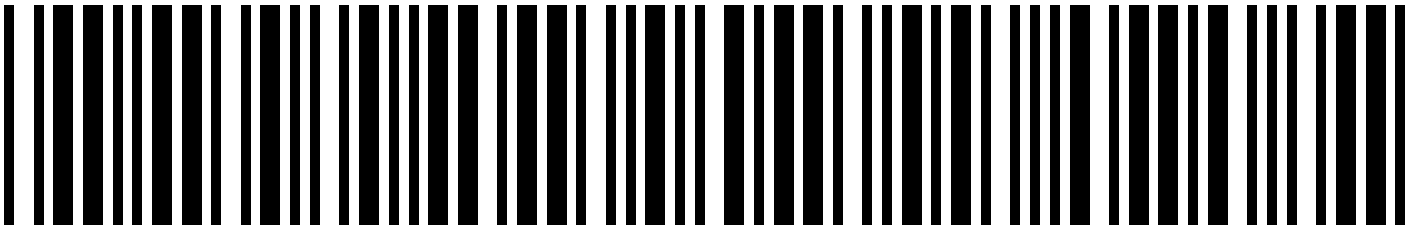
The body part codes listed below are used to complete forms that require the listing of the part of the body that is in issue. Please do not file this document with your forms.

100	Head - not specified
110	Brain
120	Ear - not specified
121	Ear - external
124	Ear - internal including hearing
130	Eye - including optic nerves and vision
140	Face - not specified
141	Jaw - including chin and mandible
144	Mouth - including lips, tongue, throat and taste
145	Teeth
146	Nose - including nasal passages, sinus and smell
148	Face - multiple parts any combination of above parts
149	Face - forehead, cheeks, eyelids
150	Scalp
160	Skull
198	Head - multiple injury any combination of above parts
200	Neck
300	Upper extremities - not specified
310	Arm - above wrist not specified
311	Arm - upper arm humerus
313	Arm - elbow head of radius
315	Arm -forearm radius and ulna
318	Arm - multiple parts any combination of above parts
319	Arm - not specified
320	Wrist
330	Hand - not wrist or fingers
340	Fingers
398	Upper extremities - multiple parts any combination of above parts
400	Trunk - not specified
410	Abdomen - including internal organs and groin
411	Hernia
420	Back - including back muscles, spine and spinal cord
430	Chest - including ribs, breast bone and internal organs of the chest
440	Hips - including pelvis, pelvic organs, tailbone, coccyx and buttocks
450	Shoulders - scapula and clavicle
498	Trunk - use for side; multiple parts any combination of above parts
500	Lower extremities - not specified
510	Legs - above ankles, not specified
511	Thigh femur
513	Knee Patella
515	Lower leg tibia and fibula
518	Leg - multiple parts any combination of above parts
519	Leg - not specified
520	Ankle malleolus
530	Foot not ankle or toe
540	Toes
598	Lower extremities - multiple parts any combination of above parts
700	Multiple parts more than five major parts use only in fifth position of listing of body parts
800	Body system - not specific
801	Circulatory system - heart -other than heart attack, blood, arteries,veins, etc.
802	Circulatory system - Heart attack
810	Digestive system - stomach
820	Excretory system - kidneys, bladder, intestines, etc.
830	Musculo-skeletal system - bones, joints, tendons, muscles, etc.
840	Nervous system - not specified
841	Nervous system - stress
842	Nervous system - Psychiatric/psych
850	Respiratory system - lungs, trachea, etc.
860	Skin dermatitis, etc.
870	Reproductive systems
880	Other body systems
999	Unclassified - insufficient information to identify body parts

DO NOT PRINT OR SUBMIT THIS PAGE.

Use this document to complete forms, but do not file this document with your forms.

DOCUMENT SEPARATOR SHEET



Product Delivery Unit: ADJ

Document Type: LIENS AND BILLS

Document Title: NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

Document Date: 03/04/2009 (MM/DD/YYYY)

ENTER DATE OF DOCUMENT FOLLOWING DOCUMENT SEPARATOR SHEET.

Author: XYZ MEDICAL COMPANY

IF YOU ARE A CLAIMS ADMINISTRATOR, HEARING REPRESENTATIVE OR LAW FIRM USE YOUR UNIFORM ASSIGNED NAME. IF PARTY PREPARING THE DOCUMENT IS NEITHER A CLAIMS ADMINISTRATOR'S OR REPRESENTATIVE'S OFFICE, ENTER THE ENTITY'S OR INDIVIDUAL'S NAME.

Office Use Only

Received Date: _____ (MM/DD/YYYY)

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

Date Of Original Lien: 03/04/2009 (MM/DD/YYYY)

☑ Original Lien ☐ Amended Lien

ADJ987654321
Case No.

(Choose only one)

☑ a specific injury on 01/15/2008
(DATE OF INJURY: MM/DD/YYYY)

☐ a cumulative injury which began on _____ and ended on _____
(START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

SOCIAL SECURITY NUMBER IS NOT REQUIRED.
SSN (Numbers Only)

09/10/1960
(DATE OF BIRTH: MM/DD/YYYY)

Injured Worker:

JANE
First Name

MI

SMITH
Last Name

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

ARCADIA
City

CA
State

91007
Zip Code

Attorney/Representative for Injured Worker:

ENTER UNIFORM ASSIGNED NAME OF LAW FIRM IF INJURED WORKER IS REPRESENTED.

UNIFORM ASSIGNED NAME
Name

ENTER ADDRESS IN THE UNIFORM ASSIGNED NAME DATABASE.

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

City

State

Zip Code

Lien Claimant (Completion of this section is required):

IF YOU ARE A CLAIMS ADMINISTRATOR, HEARING REPRESENTATIVE OR LAW FIRM ENTER UNIFORM ASSIGNED NAME. IF PARTY PREPARING THE DOCUMENT IS NEITHER A CLAIMS ADMINISTRATOR'S OR REPRESENTATIVE'S OFFICE, ENTER THE ENTITY'S OR INDIVIDUAL'S NAME.

XYZ MEDICAL COMPANY
Name of Organization filing lien (for individual lien claimants, leave blank)

First Name of Individual filing lien(organizational lien claimants, leave blank)

Last Name of Individual filing lien(organizational lien claimants, leave blank)

43342 VENTURA BLVD STE 110
Address/PO Box (Please leave blank spaces between numbers, names or words)

ENCINO
City

CA
State

91436
Zip Code

(818) 555-1212
Phone

Lien Claimant's Attorney/Representative, if any

☐ Law Firm/Attorney ☐ Non-Attorney Representative ☐ Lien Claimant not represented

ENTER UNIFORM ASSIGNED NAME OF LAW FIRM.

Lien Claimant Law Firm/Representative

First Name

Last Name

ENTER ADDRESS IN THE UNIFORM ASSIGNED NAME DATABASE.

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

City State Zip Code

Phone

Employer

ABC INC
Name

1498 ATLANTA AVE
Address/PO Box (Please leave blank spaces between numbers, names or words)

EL MONTE CA 91731
City State Zip Code

Insurance Carrier or Claims Administrator

ENTER UNIFORM ASSIGNED NAME OF CLAIMS ADMINISTRATOR.

Name

ENTER ADDRESS IN THE UNIFORM ASSIGNED NAME DATABASE.

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

City State Zip Code

Employer or Claims Administrator Attorney/Representative (if known)

Name

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

City State Zip Code

The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of $ 7,323.20 (Total Lien Amount) against any amount now due or which may hereafter become payable as compensation to the above-named employee on account of the above-claimed injury.

This request and claim for lien is for (mark appropriate box):

- ☐ A reasonable attorney's fee for legal services pertaining to any claim for compensation either before the appeals board or before any of the appellate courts, and the reasonable disbursements in connection therewith. (Labor Code § 4903 (a).)
- ☑ The reasonable expense incurred by or on behalf of the injured employee, as provided by Labor Code § 4600. (Labor Code § 4903 (b).)
- ☐ Reasonable expense incurred by or on behalf of the injured employee for medical-legal expenses. (Labor Code § 4903 (b).)
- ☐ The reasonable value of the living expenses of an injured employee or of his or her dependents, subsequent to the injury. (Labor Code § 4903 (c).)
- ☐ The reasonable burial expenses of the deceased employee. (Labor Code § 4903 (d).)
- ☐ The reasonable living expenses of the spouse or minor children of the injured employee, or both, subsequent to the date of the injury, where the employee has deserted or is neglecting his or her family. (Labor Code § 4903 (e).)
- ☐ The reasonable fee for interpreter's services performed on _____ 20 ___ . (Labor Code § 4600 (f).)
- ☐ The amount of indemnification granted by the California Victims of Crime Program. (Labor Code § 4903 (i).)
- ☐ The amount of compensation, including expenses of medical treatment, and recoverable costs that have been paid by the Asbestos Workers' Account. (Labor Code § 4903 (j).)

☐ Other Lien(s): Specify nature and statutory basis.

NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED

☑ A copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.

THIS FORM IS SIGNED BY EITHER THE ATTORNEY/REPESENTATIVE OR THE LIEN CLAIMANT.

DATE MUST MATCH THE DOCUMENT COVER SHEET.

(Signature of Attorney/Representative for Lien Claimant) (Signature of Lien Claimant) Date (MM/DD/YYYY)

DOCUMENT SEPARATOR SHEET

IN THIS EXAMPLE, DOCUMENTS FOLLOWING THE SEPARATOR SHEET IS AUTHORED BY A MEDICAL FACILITY.
IF DOCUMENTS FOLLOWING THE SEPARATOR SHEET IS FROM A LAW OFFICE, CLAIMS ADMINISTRATOR OR OTHERS,
USE PRODUCT DELIVERY UNIT: ADJ,
DOCUMENT TYPE: LIENS AND BILLS
DOCUMENT TITLE: BILLS OTHER.

Product Delivery Unit: ADJ

Document Type: LIENS AND BILLS

Document Title: MEDICAL BILLS

ENTER DATE OF DOCUMENT FOLLOWING DOCUMENT SEPARATOR SHEET.

Document Date: 03/04/2009
MM/DD/YYYY

IF YOU ARE A CLAIMS ADMINISTRATOR, HEARING REPRESENTATIVE OR LAW FIRM USE UNIFORM ASSIGNED NAME. IF PARTY PREPARING THE DOCUMENT IS NEITHER A CLAIMS ADMINISTRATOR'S OR REPRESENTATIVE'S OFFICE, ENTER THE ENTITY'S OR INDIVIDUAL'S NAME.

Author: XYZ MEDICAL COMPANY

Office Use Only

Received Date: _____
MM/DD/YYYY

Example

[redacted] MD, QME

Patient Ledger

Sorted By: Case Number

Entry	Date	POS	Description	Case	Procedure	Document	Provider	Amount
[redacted]								
	Last Payment: -209.15		On: 2/13/2009					
53362	2/1/2008		Carrier: [redacted] was billed	3752	NOTE	0802010000	0002	0.00
53387	1/16/2008	11		3752	99205	0802010000	0002	250.00
53388	1/16/2008	11		3752	99080	0802010000	0002	250.00
53389	1/16/2008	11		3752	99354	0802010000	0002	200.00
53390	1/16/2008	11		3752	99070	0802010000	0002	125.00
53391	1/16/2008	11		3752	99070	0802010000	0002	142.00
53392	1/16/2008	11		3752	99070	0802010000	0002	105.00
53393	2/1/2008		Carrier: [redacted] was billed	3752	NOTE	0802010000	0002	0.00
53980	2/27/2008	11		3752	99214	0802290000	0002	100.00
53981	2/27/2008	11		3752	99081	0802290000	0002	50.00
53982	2/29/2008		Carrier: [redacted] was billed	3752	NOTE	0802290000	0002	0.00
54502	3/5/2008	11		3752	INS	0803140000	0002	-205.40
55251	4/10/2008	11		3752	99214	0804140000	0002	100.00
55252	4/10/2008	11		3752	99081	0804140000	0002	50.00
55253	4/14/2008		Carrier: [redacted] was billed	3752	NOTE	0804140000	0002	0.00
55357	4/8/2008	11	2/27/08	3752	INS	0804210000	0002	-101.26
55804	5/7/2008	11		3752	95861	0805090000	0002	250.00
55805	5/7/2008	11		3752	95903	0805090000	0002	600.00
55806	5/7/2008	11		3752	95904	0805090000	0002	540.00
55807	5/7/2008	11		3752	99070	0805090000	0002	60.00
55808	5/7/2008	11		3752	99081	0805090000	0002	50.00
55809	5/9/2008		Carrier: [redacted] was billed	3752	NOTE	0805090000	0002	0.00
56031	5/15/2008	11		3752	99214	0805190000	0002	100.00
56032	5/15/2008	11		3752	99081	0805190000	0002	50.00
56033	5/15/2008	11		3752	99070	0805190000	0002	120.00
56034	5/15/2008	11		3752	99070	0805190000	0002	220.00
56035	5/19/2008		Carrier: [redacted] was billed	3752	NOTE	0805190000	0002	0.00
56623	6/2/2008	11	4/10/08	3752	INS	0806060000	0002	-110.22
56951	6/19/2008	11		3752	99214	0806200000	0002	100.00
56952	6/19/2008	11		3752	99081	0806200000	0002	50.00
56953	6/19/2008	11		3752	99070	0806200000	0002	120.00
56954	6/19/2008	11		3752	99070	0806200000	0002	120.00
56955	6/20/2008		Carrier: [redacted] was billed	3752	NOTE	0806200000	0002	0.00
57281	6/23/2008	11	5/15/08	3752	INS	0806270000	0002	-193.77
57757	7/18/2008	11		3752	INS	0807230000	0002	-162.69
58063	7/31/2008	11		3752	99214	0808060000	0002	100.00
58064	7/31/2008	11		3752	99081	0808060000	0002	50.00
58065	7/31/2008	11		3752	99070	0808060000	0002	125.00
58066	7/31/2008	11		3752	99070	0808060000	0002	120.00
58067	7/31/2008	11		3752	99070	0808060000	0002	220.00
58068	8/6/2008		Carrier: [redacted] was billed	3752	NOTE	0808060000	0002	0.00
59151	9/11/2008	11		3752	99214	0809120000	0002	100.00
59152	9/11/2008	11		3752	99081	0809120000	0002	50.00
59153	9/11/2008	11		3752	99070	0809120000	0002	220.00
59154	9/11/2008	11		3752	99070	0809120000	0002	180.00

[redacted] MD, QME

Patient Ledger

Sorted By: Case Number

Entry	Date	POS	Description	Case	Procedure	Document	Provider	Amount
59155	9/11/2008	11		3752	99070	0809120000	0002	120.00
59156	9/12/2008		Carrier: [redacted] was billed	3752	NOTE	0809120000	0002	0.00
59336	9/12/2008	11		3752	INS	0809180000	0002	-241.05
59899	9/30/2008	11		3752	95861	0810100000	0002	250.00
59900	9/30/2008	11		3752	95934	0810100000	0002	210.00
59901	9/30/2008	11		3752	95903	0810100000	0002	600.00
59902	9/30/2008	11		3752	95904	0810100000	0002	360.00
59903	9/30/2008	11		3752	99070	0810100000	0002	60.00
59904	9/30/2008	11		3752	99081	0810100000	0002	50.00
59905	10/10/2008		Carrier: [redacted] was billed	3752	NOTE	0810100000	0002	0.00
60089	10/16/2008	11		3752	99214	0810150000	0002	100.00
60090	10/16/2008	11		3752	99081	0810150000	0002	50.00
60091	10/16/2008	11		3752	99070	0810150000	0002	160.00
60092	10/16/2008	11		3752	99070	0810150000	0002	115.00
60093	10/16/2008	11		3752	99070	0810150000	0002	130.00
60094	10/17/2008		Carrier: [redacted] was billed	3752	NOTE	0810150000	0002	0.00
60182	10/22/2008	11	PAYMENT	3752	INS	0810220000	0002	-185.70
60891	11/20/2008	11		3752	99214	0811210000	0002	100.00
60892	11/20/2008	11		3752	99081	0811210000	0002	50.00
60893	11/20/2008	11		3752	99070	0811210000	0002	130.00
60894	11/20/2008	11		3752	99070	0811210000	0002	150.00
60895	11/20/2008	11		3752	99070	0811210000	0002	160.00
60896	11/21/2008		Carrier: [redacted] was billed	3752	NOTE	0811210000	0002	0.00
61273	12/10/2008	11	PAYMENT 10/16/08	3752	INS	0812100000	0002	-330.41
61564	12/18/2008	11		3752	99214	0812190000	0002	100.00
61565	12/18/2008	11		3752	99081	0812190000	0002	50.00
61566	12/18/2008	11		3752	99070	0812190000	0002	160.00
61567	12/18/2008	11		3752	99070	0812190000	0002	150.00
61568	12/19/2008		Carrier: [redacted] was billed	3752	NOTE	0812190000	0002	0.00
61808	12/30/2008	11	PAYMENT	3752	INS	0812300000	0002	-209.15
62873	1/29/2009	11		3752	ML 103	0902130000	0002	950.00
62874	1/29/2009	11		3752	99070	0902130000	0002	150.00
62875	2/13/2009		Carrier: [redacted] was billed	3752	NOTE	0902130000	0002	0.00
62888	2/13/2009	11	12/18/08	3752	INS	0902130000	0002	-209.15
							Patient Total	$7,323.20

DOCUMENT SEPARATOR SHEET

Product Delivery Unit: ADJ

THIS IS AN EXAMPLE OF THE DOCUMENT SEPARATOR SHEET FOR LIEN VERIFICATION.

Document Type: LEGAL DOCS

Document Title: 10770.5 VERIFICATION

Document Date: 03/04/2009
MM/DD/YYYY

ENTER THE DATE OF THE LIEN VERIFICATION.

Author: XYZ MEDICAL COMPANY

ENTER THE NAME OF LIEN CLAIMANT OR LIEN REPRESENTATIVE WHO SIGNED THE LIEN VERIFICATION.

Office Use Only

Received Date
MM/DD/YYYY

§10770.5. Verification to Filing of Lien Claim

A lien claim is being filed because: CHECK ALL BOXES THAT APPLY.

☐ Sixty days have elapsed since the date of acceptance or rejection of liability for the claim, or the time provided for investigation of liability pursuant to Labor Code section 5402(b) has elapsed, whichever is earlier.

☐ Time provided for payment of medical treatment bills pursuant to LC 4603.2 has elapsed.

☐ The time provided for payment of medical-legal expenses pursuant to Labor Code section 4622 has elapsed.

I declare under penalty of perjury under the laws of the State of California that one of the time periods set forth in Rule 10770.5(a) has elapsed and, if an application for adjudication is being filed, that venue is proper as set forth in Rule 10770.5(b) and that I have made a diligent search and have determined that no adjudication case number exists for the same injured worker and the same date of injury. In determining that no adjudication case number exists for the same injured worker and the same date of injury, I have made a diligent search consisting of the following efforts (specify):

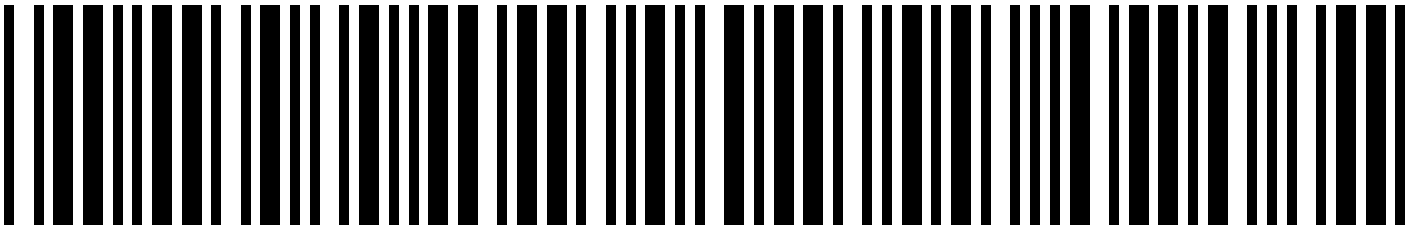
I have sent numerous billing statements to parties involved for the past two years and have not received any payment.

_____ _____

Signature Date (MM/DD/YYYY)

Injured worker name: JANE SMITH

DOCUMENT SEPARATOR SHEET



Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: PROOF OF SERVICE

Document Date: 03/04/2009 (MM/DD/YYYY)

ENTER DATE OF DOCUMENT FOLLOWING DOCUMENT SEPARATOR SHEET.

Author: XYZ MEDICAL COMPANY

IF YOU ARE A CLAIMS ADMINISTRATOR, HEARING REPRESENTATIVE OR LAW FIRM USE YOUR UNIFORM ASSIGNED NAME. IF PARTY PREPARING THE DOCUMENT IS NEITHER A CLAIMS ADMINISTRATOR'S OR REPRESENTATIVE'S OFFICE, ENTER THE ENTITY'S OR INDIVIDUAL'S NAME.

Office Use Only

Received Date: _____ (MM/DD/YYYY)

Example

[redacted]

Proof of Service

I am at least 18 years of age, not a party to this action, and I am a resident of or employed in the county where the mailing took place.

My business address is: [redacted]

On 03/04/2009, I served a true copy of the following documents, along with supporting documents, described as: LIEN FORM AND ITEMIZED STATEMENT
by enclosing them in a sealed envelope addressed to each of the parties named and at the addresses set forth in the Party List, and placing each envelope for collection and mailing at the business address herein following our ordinary business practices, with postage fully prepaid, or by other previously agreed-upon method of electronic service.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated: **03/04/2009**

Declarant Signature [redacted]

Party List

[redacted]