City of Arts & Innovation

Human Resources Department
Workers' Compensation Division

REQUEST TO WITHDRAW CLAIM FOR BENEFIT

CLAIMANT NAME: _____

ADDRESS: _____

SOCIAL SECURITY #:_____

DATE OF BIRTH: _____

EMPLOYER: _____

I hereby request to withdraw any claim for Workers' Compensation benefits as a result of a work-related injury claim filed on _____, and alleging to have occurred on or about _____, and claiming the following injuries:

By requesting this claim be dismissed, I agree to hold _____harmless from any liability related to this claim.

I hear by swear under penalty of perjury of the laws of the State of California that this waiver is of my request and no threats or promises have been made to induce me to sign this waiver. The facts outlined are true and to the best of my knowledge and belief.

Signature: _____

Signed this ____ day of _____, 20____, at _____, California.

Witness: _____