WORKERS' COMPENSATION COVERAGE

This coverage extends to all employees injured while working for a member entity. The coverage is also extended to police and fire reserves.

Volunteers are excluded from coverage pursuant to Section 3352(i) of the Labor Code unless the entity agrees to provide coverage pursuant the YCPARMIA policy on pages K-17.

CONTENTS

DEDUCTIBLE SELECTED AND COVERAGE AMOUNTS

WORKERS' COMPENSATION

DEDUCTIBLE SELECTED PER OCCURRENCE

YCPARMIA - 0
City of Davis - $1,000
City of Winters - $1,000
City of Woodland - $1,000
County of Yolo - $1,000
Esparto Unified School District - $1,000
City of West Sacramento - $1,000
Yolo Emergency Communications Agency - $1,000
Yolo-Solano Air Quality Management District - $1,000
In-Home Supportive Services Public Authority - $1,000
Capay Valley Fire Protection District - $1,000
Yolo County LAFCO - $1,000
Davis Cemetery District - $1,000
Madison Fire District - $1,000
Yolo County Habitat Conservation JPA - $1,000
Winters Cemetery District - $1,000
Dunnigan Fire Protection District - $1,000
Cottonwood Cemetery District - $1,000
Clarksburg Fire Protection District - $1,000
Madison Community Service District - $1,000
Sacramento-Yolo Port District - $1,000
Willow Oak Fire Protection District - $1,000 (effective 10/1/2016)
West Plainfield Fire Protection District - $1,000
Esparto Fire Protection District - $1,000

SELF INSURANCE FUND

Difference between entity deductible selected and excess insurance deductible of $500,000 (YCPARMIA SIR)

EXCESS INSURANCE

Excess Workers' Compensation –

CSAC-EIA - $4,500,000
in excess of $500,000 per occurrence (YCPARMIA retention)

Reinsured Layer – $45,000,000
in excess of CSAC-EIA $5,000,000 pooled retention

Excess Insurance Layer - Statutory
In excess of $50,000,000

YOLO COUNTY PUBLIC AGENCY
RISK MANAGEMENT INSURANCE AUTHORITY

CENTRAL POOL WORKERS' COMPENSATION COVERAGE

A. COVERAGE AGREEMENT

The Yolo County Public Agency Risk Management Insurance Authority, hereinafter called the Authority, effective July 1, 1994, will pay, per occurrence:

> All compensation and other benefits that each agency shall become legally obligated to pay on account of bodily injury by accident or disease to any participating agency's employee, arising out of and in the course of his or her employment which exceeds the entity's deductible and is required by the Workers' Compensation Laws of the State of California or any other State having jurisdiction.

All claims administration costs not included in the contract claims administrator's fee, i.e., "allocated costs," shall be paid. The Authority's pro rata share of "defense, settlement and supplementary payment" costs, as defined in the excess workers' compensation insurance policy, shall also be included.

Except where otherwise indicated, terms and conditions appearing in the excess workers' compensation policy will apply to this coverage.

The protection afforded by the Authority is self-insurance, and under no circumstances is it to be construed as any form of insurance.

B. EXCLUSIONS

Coverage shall not apply:

1) Under workers' compensation to any employee not subject to the Workers' Compensation Law of any state.

2) Under employer's liability to any employee not injured in the scope of employment.

3) Under workers' compensation or employer's liability to the job training program employees unless such employees are directly employed by or performing duties on behalf of a participating entity.

4) For defense or indemnification for any civil claim or civil lawsuit in any court brought by an employee against his/her employer.

5) To any exclusions described in the excess policy in effect at the time of the occurrence.

C. ENTITIES COVERED

Authority coverage shall apply to those entities identified in the excess workers' compensation insurance policy.

D. LIMITS

The Authority will pay all covered losses excess of each participating agency's deductible (if any), the total amount (deductible plus Authority payment) of which shall not exceed $500,000. Losses in excess of $500,000 will be paid by the excess insurance policy.

E. POLICY

The excess policy, in effect at the time of the occurrence, will be the prevailing document. That policy is maintained in the YCPARMIA office and is available to the entity upon written request.

F. FINES, PENALTIES, AND FEES

Any fines, penalties, or other statutorily ordered fees that result due to the entity's failure to properly process or handle a claim will be the sole responsibility of the entity and be billed to the entity by YCPARMIA.

INSTRUCTIONS FOR REPORTING WORKERS' COMPENSATION CLAIMS

Workers' compensation claims are adjusted by LWP Claims Solutions, Inc. An employer's report of employee's industrial injury should be sent to LWP Claims Solutions, Inc., with a copy to the Risk Manager, at the addresses listed below as soon as possible, but in no event longer than 5 days following the injury.

LWP Claims Solutions, Inc.
P.O. Box 349016
Sacramento, CA 95834-9016

Risk Manager
YCPARMIA
77 W. Lincoln Avenue
Woodland, CA 95695

Detailed instructions for completion of Employer's Report of Employee's Industrial Injury can be found on page C-8 and the Employee's Claim for Workers' Compensation Benefits on page C-11.

Employee's industrial injuries are those injuries or illnesses that result from the employee's occupation and involve time off from work and/or seeing a doctor. Lost time cases (injuries necessitating time off from employment) should be given high priority. If these cases are to be properly managed, it is vital that LWP be notified as soon as possible.

Do not prohibit or resist treatment by any of the above listed practitioners - let LWP manage each case. It is the responsibility of LWP to make the decision whether or not an employee's injury is covered under the workers' compensation laws of the State of California.

Periodically, the risk manager will arrange meetings with LWP and member agencies to advise them of the status of selected claims.

Any questions regarding Workers' Compensation claims should be directed to Jeffrey Tonks, Risk Manager, (530) 666-4456.

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS
FORM 5020 (Rev. 7) 2002

This form must be completed within five days of supervisor knowledge of the event. The numbered items below correspond with the information requested in the numbered boxes on the Form 5020.

1. Fill in the name of employer and Department
1A. Leave blank
2. Fill in the mailing address of employer
2A. Fill in the telephone number of the employer
3. Fill in the address of the department of the employee
3A. Fill in the Department code
4. Fill in appropriate nature
5. Leave blank
6. Check appropriate box
7. Fill in date as given by employee or supervisor
8. Fill in time as given by employee or supervisor
9. Fill in time employee began work on day of injury if known
10. Fill in date of death if applicable
11. Check appropriate box if unable to work at least one day after injury if known
12. Fill in date last worked prior to or including date of injury if known
13. Fill in first date employee returned to work after injury if known
14. Check box if applicable
15 Check "yes" if employee was paid as if worked full day on date of injury. If employee charged sick leave or docked for balance of day of injury, check "no" if known
16. Check yes if employee receiving full salary benefits if caused by job
17. Fill in date employer first had knowledge of injury/illness
18. Fill in date employee was provided with Claim Form (DWC-1)
19. Fill in part of body and diagnosis
20. Fill in street address of location where injury or illness occurred
20A. Fill in County
21. Check applicable box
22. Fill in specific location of accident
23. Check appropriate box
24. Fill in any known equipment, materials or chemicals employee was using at time of injury
25. Fill in description of work activity performed at time of injury, dumping trash, mopping floors
26. Fill in brief description as given by employee of how accident occurred
27. Fill in name and address of physician seen by employee if known
27A. Fill in physician telephone number if known
28. Fill in hospital name and address if “yes” is marked
28A. Fill in hospital telephone number if known
29. Check appropriate box
30. Fill in employee complete name
31. Fill in employee SSN#
32. Fill in employee date of birth
33. Fill in employee mailing address
33A. Fill in employee home telephone number
34. Check applicable box
35. Fill in employee regular job title (Rd. Wkr II - Wrong Road Worker II - Correct)
36. Fill in employee date of hire
37. Fill in each line with accurate information requested
37A. Check applicable status at time of injury
37B. Leave blank
38. Fill in gross wages and period, i.e. weekly, monthly, annual
39. Fill in if appropriate if known

Fill out bottom portion of form. The "completed by", "signature", etc. portion.

If any questions cannot be answered, please put "unknown" or N/A in the appropriate space.

Keep in mind that by completing this form you are not admitting liability but simply complying with the law. Send the original and one copy of the forms to LWP Claims Solutions, Inc. Send one copy to YCPARMIA and keep the number of copies for your file that is required by your entity's claim processing procedure.

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.

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, Street, City, Zip)
2a. Phone Number
3. LOCATION if different from Mailing Address (Number, Street, City and 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 ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)
8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM
9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy)
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)
20a. COUNTY
21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.
23. Other Workers injured or ill in this event? ☐ Yes ☐ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.
26. 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
27. Name and address of physician (number, street, city, zip)
27a. Phone Number
28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number
29. Employee treated in emergency room? ☐ Yes ☐ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, Street, City,Zip)
33a. PHONE NUMBER
34. SEX ☐ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED
38. GROSS WAGES/SALARY $ _____ per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Completed By (type or print)
Signature & Title
Date (mm/dd/yy)

• Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

FORM 5020 (Rev7) June 2002

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

Please do not use this column

CASE NUMBER

OWNERSHIP

INDUSTRY

OCCUPATION

SEX

AGE

DAILY HOURS

DAYS PER WEEK

WEEKLY HOURS

WEEKLY WAGE

COUNTY

NATURE OF INJURY

PART OF BODY

SOURCE

EVENT

SECONDARY SOURCE

EXTENT OF INJURY

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.

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: Yolo County – Sheriff-Coroner
1a. Policy Number
Please do not use this column
2. MAILING ADDRESS: (Number, Street, City, Zip): 41793 Gibson Rd. Woodland, CA 95776
2a. Phone Number: 668-5280
CASE NUMBER
3. LOCATION if different from Mailing Address (Number, Street, City and Zip): Same
3a. Location Code
OWNERSHIP
4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.: Government Services
5. State unemployment insurance acct.no
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☒ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____
INDUSTRY

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy): 7/1/2004
8. TIME INJURY/ILLNESS OCCURRED: _____ AM 3:30 PM
9. TIME EMPLOYEE BEGAN WORK: 8:00 AM _____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
OCCUPATION
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☒ No
12. DATE LAST WORKED (mm/dd/yy)
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy): 7/1/2004
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy): 7/1/2004
SEX
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning: Sprained Left Knee
AGE
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip): 41793 Gibson Rd. Woodland, CA 95776
20a. COUNTY: Yolo
21. ON EMPLOYER'S PREMISES? ☒ Yes ☐ No
DAILY HOURS
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.: Sheriff
23. Other Workers injured or ill in this event? ☐ Yes ☐ No
DAYS PER WEEK
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold: Rug
WEEKLY HOURS
26. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.: Walking and tripped on raised spot in rug
WEEKLY WAGE
26. 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: Was walking from the office to a meeting. The employee's foot caught on a raised part of the rug causing the employee to fall and twist his knee
COUNTY
27. Name and address of physician (number, street, city, zip): Dr. Jones - Fairchild Ct. Woodland, CA
27a. Phone Number: 666-0100
NATURE OF INJURY
28. Hospitalized as an inpatient overnight? ☒ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number
PART OF BODY
29. Employee treated in emergency room? ☐ Yes ☐ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.36(b)(2)(E)2*.
SOURCE

EMPLOYEE

30. EMPLOYEE NAME: William Smith
31. SOCIAL SECURITY NUMBER: 000-00-0000
32. DATE OF BIRTH (mm/dd/yy): 01/01/1940
EVENT
33. HOME ADDRESS (Number, Street, City,Zip): 123 First St. Woodland, CA 95695
33a. PHONE NUMBER: 666-0000
SECONDARY SOURCE
34. SEX ☒ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers): Sheriff
36. DATE OF HIRE (mm/dd/yy): 01/01/1970
37. EMPLOYEE USUALLY WORKS: 8 hours per day, 5 days per week, 40 total weekly hours
37a. EMPLOYMENT STATUS ☒ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED
EXTENT OF INJURY
38. GROSS WAGES/SALARY: $ 4,000 per month
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Completed By (type or print): Jane Doe
Signature & Title: Jane Doe secretary
Date (mm/dd/yy): 7/1/2004

+ Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

FORM 5020 (Rev7) June 2002

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS
DWC FORM 1 (REV. 1/94)

INSTRUCTIONS

Within 24 hours of being notified of an injury/illness that involves lost time and/or treatment at a medical facility, the injured employee needs to be provided with the "Employee's Claim for Workers' Compensation Benefits" form for completion.

NOTE OF CAUTION: If an injured employee requests this form, you are required to provide it to the employee even if the injury did not involve lost time or treatment at a medical facility.

If the Employee's Claim for Workers' Compensation Benefits form cannot be handed to the injured employee within 24 hours, it must be **mailed** within 24 hours to the injured employee at home, in the hospital, or where the employee is most likely to receive it. If the form is mailed, indicate this action on the Employee's Claim form on line 12.

1. The supervisor must complete lines 9, 10, 11, 12, 14 and 15, and put his/her initials at the end of line 12 **PRIOR** to handing/mailing the employee the form.

2. The goldenrod copy of the Employee's Claim form is to be retained in the department in a file where it can be retrieved at a later date.

3. The remaining four copies are to be kept together and given to the employee with the pamphlet "Facts for Injured Workers".

4. The injured employee should complete lines 1 through 8 of the "Employee Claim Form" and return all four copies to the designated departmental employee. **However, the employee is not required to complete and return this form**.

5. Upon receiving the "Employee Claim Form" back from the employee, the designated departmental representative **must** complete lines 13, 16, 17, and 18. Additionally, at the end of line 16, the departmental designated representative must include the date he/she signed the form.

6. **Do not hold up** sending the Employer's Report to LWP and YCPARMIA if you have not received the Employee's Claim form back. Send the Employer's Report and a copy of the Employee's form, with as much filled in as possible, to LWP and YCPARMIA within 5 days of notice of injury.

7. Distribute to the injured employee the completed pink and green copies.

8. Distribute the completed canary copy to LWP.

9. Distribute a photocopy of the form to YCPARMIA.

10. The original (white) form **must** be retained by the department.

Failure to provide this form within 24 hours of knowledge of an injury or within 24 hours of a request of the form could result in a $100 or $5,000 (respectfully) fine. As noted on the bottom of the form, receipt and signature of this form, by the supervisor, does not constitute liability in any form.

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

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

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included as the cover sheet of this form.

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

Empleado: *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 firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabajador.*

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

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.

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 "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

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 see note below. ***Empleador—complete esta sección y note la notación abajo.***

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 adminstradora de seguros.*
    LWP Claims Solutions, Inc. PO Box 349016, Sacramento, Ca 95834-9016
15. Insurance Policy Number. *El número de la póliza de 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 claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

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.*

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

❑ Employer copy/*Copia del Empleador* ❑ Employee copy/ *Copia del Empleado* ❑ Claims Administrator/*Administrador de Reclamos* ❑ Temporary Receipt/*Recibo del Empleado*

7/1/04 Rev.

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

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

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included as the cover sheet of this form.

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

Empleado: *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 firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabjador.*

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

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.

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 "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* WILLIAM SMITH Today's Date. *Fecha de Hoy.* 7/1/2004
2. Home Address. *Dirección Residencial.* 123 FIRST STREET
3. City. *Ciudad.* WOODLAND State. *Estado.* CA Zip. *Código Postal.* 95695
4. Date of Injury. *Fecha de la lesión (accidente).* 7/1/2004 Time of Injury. *Hora en que ocurrió.* a.m. 3:30 p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* SHERIFF'S OFFICE - 41793 GIBSON RD. WOODLAND, CA
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* Walking from office to meeting and tripped on rug and twisted knee
7. Social Security Number. *Número de Seguro Social del Empleado.* 000-00-0000
8. Signature of employee. *Firma del empleado.*

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* Yolo County Sheriff / Coroner
10. Address. *Dirección.* 41793 GIBSON RD. WOODLAND, CA 95776
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* 7/1/2004
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* 7/1/2004
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* 7/1/2004
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* **LWP Claims Solutions, Inc.** PO Box 349016, Sacramento, Ca 95834-9016
15. Insurance Policy Number. *El número de la póliza de Seguro.*
16. Signature of employer representative. *Firma del representante del empleador.* Jane Doe
17. Title. *Título.* Secretary 18. Telephone. *Teléfono.* 668-5280

Employer: You are required to date this form and provide copies to your insurer or claims 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

☐ Employer copy/*Copia del Empleador* ☐ Employee copy/ *Copia del Empleado* ☐ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

7/1/04 Rev.

CLAIMS HANDLING OVERVIEW

A. HISTORY OF WORKERS' COMPENSATION

Workers' compensation involves a fundamental legislative trade-off between the liability of employers and the rights of employees. Employers became liable for compensation "without regard to negligence" of either the employer or employee if an employee is injured on the job, and employees gave up the right to sue their employers for civil damages as a result of on-the-job injuries in exchange for certain, though limited, benefits.

Under California law, workers' compensation benefits, with some exceptions, are an injured employee's "exclusive" remedy against the employer.

Before the emergence of this "no fault" insurance program, an employee injured on the job had to prove that the employer was "negligent" before he or she could recover the cost of medical treatment and damages for any physical limitations and "pain and suffering". The negligence suits were descriptive for businesses and damaging to industrially injured employees.

In general terms, this "no fault" insurance program provides several socially desirable protections:

- It ensures that the injured worker will receive necessary medical care, at no cost to the employee, to "cure" and "relieve" them of the effects of the injury.
- It ensures that the disabled workers' loss of income will be offset by tax-free cash benefits, which are paid during periods of inability to earn income because of temporary incapacity and for some period of time after the worker returns to the labor market with a diminished earning capacity as a result of the permanent nature of the injury.
- It ensures that permanently disabled workers will receive vocational rehabilitation services to help them return to suitable gainful employment.

The Boynton Act of 1913 gave rise to California's first compulsory workers' compensation system. After substantially revising the Boynton Act, the Legislature, in 1917, finally adopted the comprehensive workers' compensation system as it is more or less known today.

Workers' compensation claims in California over the years have not been administered promptly or inexpensively or without administrative impediments. This led to the Reform Act of 1989 and the Clean-up Act of 1990 to provide new legal standards, procedures, time frames and limitations, which collectively are designed to help finance the benefit increases and improve the efficiency of the system.

B. WORKERS' COMPENSATION BENEFITS

BACKGROUND

Employees who are injured on the job are entitled to receive various benefits under the workers' compensation systems, which are described below. Under narrowly drawn circumstances, they also may pursue remedies in the civil justice system, including punitive damages, if the employer has acted in an irresponsible manner. These civil remedies are highlighted below as well.

Workers' compensation benefits fall into two categories. The first of these is the payment made on behalf of, or reimbursement paid to, the injured employee. The other benefit category is direct, tax-free cash payments to the injured employee or dependents in the event of death.

COST EMPLOYERS PAY

Physician bills, hospital expenses and other medical expenses are paid for by the employer through workers' compensation insurance. This benefit includes all medical treatment costs "reasonably required to cure or relieve [the injured employee] from the effects of the injury". No limits are set on dollar amounts of duration. There is no waiting period. There are no deductibles or co-payments requiring a contribution by the employee, if the employer is unable to accommodate permanent restrictions.

If the injured employee is unable to return to his or her usual occupation, then the employer may be liable for the vocational rehabilitation costs of evaluation, counseling, training and job placement assistance.

The injured employee also is entitled to a mileage allowance for all reasonable transportation expenses including mileage fees and budget tools when he or she submits to a physician's exam at the employer's or workers' compensation judge's request, or when he or she participates in a state-approved vocational rehabilitation plan.

CASH BENEFITS PAID TO EMPLOYEES

Six types of tax-free cash benefits can be paid to an injured employee:

1) Temporary Total Disability Benefits This benefit is paid to a disabled worker whose injury temporarily prevents him or her from performing the regular job duties.

   The amount of this benefit is calculated by taking two-thirds of the employees' gross earnings, subject to a maximum weekly benefit limit of $1,074.64 for injuries.

   This benefit is paid every two weeks during the healing period, up until the time when the employee either has reached maximum medical improvement from the effects of the injury or has been released by the treating physician to return to work.

The benefit can continue for a maximum of 104 weeks within a 5-year period after the date of injury.

When dealing with Active Law Enforcement or Fire Fighting employees including Police, Sheriffs, and District Attorneys' Investigators, the employee is eligible for salary continuation in the form of 4850 pay. This continues for up to 52 weeks from the date of injury.

2) Permanent Partial Disability Benefit. This benefit is paid to a disabled worker whose injury permanently and adversely affects his or her ability to compete for employment in the open labor market. A worker's permanent disability is rated between 1.0 percent and 99.75 percent.

   Depending on the permanent disability rating, the aggregate amount of this benefit ranges from less than $500 to as much as $159,677.50. The percentage rating is based on the nature and severity of the injury and the employee's age and occupation at the time of injury. The permanent disability rating determines the number of weeks for which this benefit is paid.

   This benefit is frequently paid in a lump sum through a settlement agreement, but it is supposed to be paid every two weeks at a weekly rate of $160 to $290 after the last temporary disability benefit payment is made.

3) Life Pension. This benefit is paid to a seriously disabled worker whose permanent disability rating is between 70 percent and 99.75 percent.

   Depending on the permanent disability rating, this benefit is paid every two weeks at a rate of $16.50 to $64.21, after the last permanent partial disability benefit payment is made and up until the employee's death.

4) Supplemental Job Displacement Voucher. It should indicate that any employee found to have permanent disability and the employer is unable to offer them their regular, modified or alternative job within 60 days of the notice of permanent disability and restrictions can be offered a voucher for retaining costs. The amount of the voucher is set on the amount of the permanent disability except in injuries occurring on or after 1/1/2014, they are all eligible for a $6,000 voucher.

5) Permanent Total Disability Benefit. This benefit is paid to a disabled worker whose permanent disability rating is 100 percent (i.e., the employee's injury precludes him or her from competing against non-disabled job applicants for any type of occupation).

   Disabilities are "conclusively presumed" to be permanent and stationary and total under four circumstances:

   - Loss of both eyes or sight in both eyes;

- ♦ Loss of both hands or use of both hands;
- ♦ Total or practically total paralysis; and
- ♦ Brain damage resulting in incurable imbecility or insanity.

In all other instances, permanent total disability is determined by the facts of the particular case.

The amount of this benefit is the claimant's temporary total disability rate.

This benefit is paid every two weeks for the remainder of the employee's life.

6) Death Benefit. This benefit is paid to the dependents of employees who are fatally injured on the job.

For fatal injuries, the current benefit rates are outlined below:

- $250,000 for 1 total dependent or no dependents found which is then paid to the State, or to the employee's estate.
- 2 or more dependents are found, the benefit is $290,000
- 3 or more dependents receive $320,000
- 1 total plus 1 or more partial dependents is to receive $250,000 plus four times the annual support for partial dependents not to exceed $290,000
- 1 or more partial dependents receive 8 times annual support not to exceed $250,000.

This benefit is usually paid to the surviving spouse or dependents bi-weekly at the temporary disability rate.

Employers also are liable for "reasonable expenses of the employee's burial" up to a maximum amount of $5,000 prior to January 1, 2013 and $10,000 for injuries on or after 1/1/2013.

C. TEMPORARY DISABILITY

QUALIFYING CRITERIA

1) The employee must have a medical disability, which precludes the employee from working (LC 3209.3);
2) The disability must be temporary rather than permanent in nature;
3) The medical disability must be a result of a compensable industrial injury (LC 3600)
4) The injured employee must sustain a wage loss.

TERMINATION OF TD PAYMENTS

1) Employee has no loss of earnings;
2) Employee refuses available employment;
3) Employee no longer medically disabled;
4) Disability not a result of an industrial injury;
5) Employee unreasonably refuses medical treatment or examinations;
6) The disability becomes permanent and stationary;
7) Employee dies.

D. WHAT IS AN INJURY?

An injury or illness may be “physical” or “mental” in nature. Such an injury may be an occupational disease.

An injury is “specific” if there is one incident or exposure in the workplace that causes a physical or mental injury.

An injury is “cumulative” if there are repetitive traumatic activities in the workplace, which, extending over a period of time, cause injury.

Thus, there are four types of injuries covered by workers’ compensation law:

- A specific, physical injury
- A cumulative, physical injury
- A specific, mental injury
- A cumulative, mental injury

Any one of these injuries is covered under workers’ compensation law, whether only first-aid treatment is required or surgery has to be performed, or if the injury is work disabling, even if no medical treatment is required.

Another question that the supervisor faces is whether the claimed injury or illness is a new or old problem.

- ♦ Exacerbation: Flare up of a prior injury without substantial new contributing factors. WC benefits provided in accordance with statutes in effect at time of original injury. Usually involves ongoing medical treatment through date of exacerbation. Severity of activity being performed at time of exacerbation is evaluated with activities of a normal and non traumatic nature the determining factors. The balance of unused 60 day Ed Code benefits would be due pursuant to the original injury.
- ♦ Aggravation: Flare up of prior injury with substantial new contributing factors. WC benefits provided in accordance with statutes in effect at time of aggravation injury date. Usually involves a brief (3 months +) period of time with no medical treatment prior to the aggravating incident. Severity of activity performed at time of aggravation indicates a moderate traumatic event causing the current disability and need for treatment. LC §4663 requires compensation only for disability due to aggravation but 60 day Ed Code benefits would be initiated with the full 60 days available.
- ♦ Example of Exacerbation: Employee has prior back injury with ongoing care. Employee reaches across desk to pick up pencil causing increased pain and immediate need for treatment and disability.
- ♦ Example of Aggravation: Employee has prior back injury but hasn't seen a doctor for four months. Employee lifts a box of books causing increased pain and immediate need for treatment and disability.

In all instances the supervisor should report the injury and let the claims examiner investigate to make a determination.

E. UNDER WHAT CIRCUMSTANCES IS AN INJURY COVERED?

For purposes of workers' compensation, an injury is deemed to be job-related when it arises out of employment (AOE) and when it occurs in the course of employment (COE). In other words, an injury is not covered unless it is AOE-COE.

In simple terms, an injury is AOE-COE if the job has played an "active" role or has been a "positive" factor in the development of the injury, and if the activity resulting in an injury was required or reasonably contemplated by the employer.

Effective January 1, 1990, the law establishes a higher threshold of compensability for all psychiatric injuries (including those caused by on-the-job stress). This new threshold requires the employee claiming to be mentally or emotionally disabled to prove that "actual events of employment were responsible for the total causation from all sources contributing to the psychiatric injury", the preponderance and at least 35-40% of all factors. Claimant must have been employed at least 6 months or experienced a sudden and extraordinary condition.

The employer has seven affirmative defenses, which would disqualify the employee from receiving workers' compensation benefits, even if the employee was injured on the job. An injury is not covered under workers' compensation law (not AOE-COE), if:

- The employee was intoxicated on alcohol or drugs.
- The employee intentionally inflicted the injury or committed suicide.
- The employee was engaged in an "altercation" in which he or she was the initial physical aggressor.
- The employee was engaged in the commission of a felonious act, for which he or she has been convicted.
- The employee was engaged in "horseplay" or "skylarking" on the employer's premises or during a period when the employee is being compensated.
- The employee was engaged in an off-duty recreational, social or athletic activity not constituting his or her work-related duties.
- The employee was going to or coming from work, unless the employer exercises control over the employee's route, the employee's activities during the commute or the employee's mode of transportation.

F. SUPERVISOR PROCEDURES FOR PROCESSING WORKERS' COMPENSATION CLAIMS

FIRST AID

Should an employee report a work injury or illness that is minor and does not require treatment with a doctor or any time off from work, the supervisor should refer the employee to any first aid treatment available at the site. No report forms are required to be completed at this time. Should the employee request an Employee Claim Form please proceed to Step 2 below.

PROCEDURES

1) If the injury is serious, call 911 immediately for assistance!
2) Complete items #1, #9, #10, #11 and #12 on the "Employee's Claim for Workers' Compensation Benefits, Form DWC-1". Tear off the fifth copy of the DWC-1 and give the form to the employee. Should the employee fill out their portion of the form immediately, complete the remaining sections in the employer box and follow the directions on the bottom of the form for dispersal of copies making sure to send the white copy to the Risk Management Office. Should the employee not be available to hand deliver the DWC-1 to, mail the form to the employee at their home address.

This procedure **must** be completed within one working day of employer knowledge of the injury.

You must give a claim form to any employee who requests one within 24 hours regardless of whether you believe a job related injury has occurred.

3) Give employee red “Facts For Injured Workers” pamphlet.
4) Investigate circumstances of injury/illness and complete “Employer’s Report of Occupational Injury or Illness, Form 5020”, and mail original to LWP Claims Solutions Inc. and a copy to YCPARMIA. Should there be lost time for the injury by the employee, immediately FAX a copy of the 5020 to LWP Claims Solutions, Inc. at (408) 715-0395.
5) Should you subsequently receive a DWC-1 from the employee, complete the form and follow directions at the bottom of the form for dispersal of copies.

§ 5402. EMPLOYER’S KNOWLEDGE EQUIVALENT TO NOTICE; EMPLOYER’S NOTICE TO EMPLOYEE OR EMPLOYEE’S DEPENDENTS.

Knowledge of an injury, obtained from any source, on the part of an employer, his or her managing agent, superintendent, foreman, or other person in authority, or knowledge of the assertion of a claim of injury sufficient to afford opportunity to the employer to make an investigation into the facts, is equivalent to service under Section 5400. If liability is not rejected within 90 days after the date the claim form is filed under Section 5401, the injury shall be presumed compensable under this division.

The presumption is rebuttable only by evidence discovered subsequent to the 90-day period.

G. RETURN TO WORK

Whenever an injured employee is losing time from work there needs to be a coordinated effort between LWP Claims Solutions, Inc. staff and the employer in confirming disability and return to work.

Every workers' compensation absence from work must be excused in writing by the treating physician. These written excuses must be sent to LWP Claims Solutions, Inc. in order for industrial leave to be approved.

Any new periods of disability should be telephoned into LWP Claims Solutions, Inc. to ensure proper investigation and disability determination. This includes additional time off after a return to work.

The employer should review any return to work slip very carefully to evaluate if there are any restrictions or preclusions.

While the injured employee is off on industrial leave LWP will be making regular contact with the treating doctor and injured worker. When written information is slow in coming from the doctor, LWP staff will send out "Work Status Report" forms to be completed by the doctor's office (form RU-90). It is imperative that each and every period of disability be accompanied by written verification from a doctor.

If an injured worker is off 76 calendar days or more, LWP staff shall initiate the development of a physical job description with the employer and to be reviewed by the injured worker. This form must be completed by all parties by the 90^{th} day of disability. The form is then sent to the treating doctor for comment on prognosis for eventual return to work.

LWP Claims Solutions, Inc. is very supportive of Light or Modified Duty programs. LWP staff will work with each employer to develop custom designed programs to return injured workers to work. These programs can be addressed on a case by case basis or pre-developed job descriptions and assignments.

SAMPLE

State of California
Division of Workers' Compensation

DESCRIPTION OF EMPLOYEE'S JOB DUTIES
DWC - AD 10133.33

INSTRUCTIONS: This form shall be developed jointly by the employer and employee and is intended to describe the employee's job duties. The completed form will be reviewed to determine whether the employee is able to return to work.

Employee Last Name _____ Employee First Name _____ MI ___ Claim #: _____

Employer Name _____ Job Address _____

Job Title: _____ Hrs. Worked Per Day _____ Hrs. Worked Per Week _____

Description of Job Responsibilities: (Describe All Job Duties):

Please check one: Regular Duty ☐ Modified Duty ☐ Alternative Work ☐

1. Check the frequency of activity required of the employee to perform the job.

ACTIVITY (Hours per day)	NEVER 0 HOURS	OCCASIONALLY UP TO 3 HOURS	FREQUENTLY 3-6 HOURS	CONSTANTLY 6-8+ hours
Sitting	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Bending (neck)	☐	☐	☐	☐
Bending (waist)	☐	☐	☐	☐
Squatting	☐	☐	☐	☐
Climbing	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Twisting (neck)	☐	☐	☐	☐
Twisting (waist)	☐	☐	☐	☐
Hand Use: Dominant hand: ○ Right ○ Left	☐	☐	☐	☐
Is repetitive use of hand	☐	☐	☐	☐
Simple Grasping (right hand)	☐	☐	☐	☐
Simple Grasping (left hand)	☐	☐	☐	☐
Power Grasping (right hand)	☐	☐	☐	☐
Power Grasping left hand)	☐	☐	☐	☐
Fine Manipulation (right hand)	☐	☐	☐	☐
Fine Manipulation (left hand)	☐	☐	☐	☐
Pushing & Pulling (right hand)	☐	☐	☐	☐
Pushing & Pulling (left hand)	☐	☐	☐	☐
Reaching (above shoulder level)	☐	☐	☐	☐
Reaching (below shoulder level)	☐	☐	☐	☐
Keyboarding with both hands	☐	☐	☐	☐

SAMPLE

2. Please indicate the daily Lifting and Carrying requirements of the job: Indicate the height the object is lifted from floor, table or overhead location and the distance the object is carried.

	LIFTING					CARRYING				
	Never 0 hrs	Occasionally up to 3 hrs	Frequently 3-6 hrs	Constantly 6-8+	Height	Never 0 hrs.	Occasionally up to 3 hrs.	Frequently 3-6 hrs.	Constantly 6-8+ hrs.	Distance
0 - 10 lbs	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____
11 - 25 lbs.	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____
26 - 50 lbs.	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____
51 - 75 lbs.	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____
76 - 100 lbs.	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____
100+ lbs.	☐	☐	☐	☐	_____	☐	☐	☐	☐	_____

Describe the heaviest item required to carry and the distance to be carried:

3. Please indicate if your job requires:

	YES	NO	(IF YES, PLEASE BRIEFLY DESCRIBE)
a. Driving cars, trucks, forklifts and other equipment?	○	○	_____
b. Working around equipment and machinery?	○	○	_____
c. Walking on uneven ground?	○	○	_____
d. Exposure to excessive noise?	○	○	_____
e. Exposure to extremes in temperature, humidity or wetness?	○	○	_____
f. Exposure to dust, gas, fumes, or chemicals?	○	○	_____
g. Working at heights?	○	○	_____
h. Operation of foot controls or repetitive foot movement?	○	○	_____
i. Use of special visual or auditory protective equipment?	○	○	_____
j. Working with bio-hazards such as: blood borne pathogens, sewage, hospital waste, etc.?	○	○	_____

Employee Comments

Employer Comments:

Employer Contact Name: Employer Contact Title:

Employer Representative Signature: _____ Date: _____

Employee's Signature: _____ Date: _____

DWC AD 10133.33 (SJDB) Eff: 1/1/14 Page 2 of 2

H. PERMANENT DISABILITY AND AMERICANS WITH DISABILITIES ACT

Whenever LWP receives a medical report that indicates the injured employee is permanently disabled from their usual and customary work, LWP staff is required to ask the employer if they can provide permanent modified or alternate work. The employer has up to 30 days to review the case and make a determination. A copy of the letter and form are on the following pages.

The employer should also be very aware of the ADA and their responsibility to provide reasonable accommodation.

SAMPLE

Physician's Return-to-Work & Voucher Report

FOR INJURIES OCCURRING ON OR AFTER 1/1/13

☐ The Employee is P&S from all conditions and the injury has caused permanent partial disability

Employee Last Name | Employee First Name | MI | Date of Injury

Claims Administrator | Claims Representative

Employer Name | Employer Street Address

Employer City | State | Zip Code | Claim No.

☐ The Employee can return to regular work

☐ The Employee can work with the following restrictions:

	hours: 1-2	2-4	4-6	6-8	None
Standing	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐
Forward Bending	☐	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	☐
Crawling	☐	☐	☐	☐	☐
Twisting	☐	☐	☐	☐	☐
Keyboarding	☐	☐	☐	☐	☐
R/L/Bilat Hand(s) (circle): *Grasping*	☐	☐	☐	☐	☐
R/L/Bilat Hand(s) (circle): *Pushing/ Pulling*	☐	☐	☐	☐	☐
Other: _____ (See below)	☐	☐	☐	☐	☐

Lift/Carry Restrictions: May not lift/carry at a height of _____ more than _____ lbs. for more than _____ hours per day.

Describe in what ways the impaired activities are limited:

If a Job Description has been provided, please complete: ☐ *Regular* ☐ *Modified* ☐ *Alternative Work*

Job Title: _____ *Work Location*: _____

Are the work capacities and activity restrictions compatible with the *physical requirements* set forth in the provided job description? ☐ *Yes* ☐ *No, explain below*

Physician's Name _____ Role of Doctor (PTP, QME, AME) _____

Physician's Signature _____ Date _____

DWC AD Form 10133.36 (SJDB) Eff: 1/1/14

SAMPLE

State of California
Division of Workers' Compensation

Physician's Return-to-Work & Voucher Report Instructions
FOR INJURIES OCCURRING ON OR AFTER 1/1/13
DWC - AD 10133.36

Who is responsible for filling out this form? The first physician (primary treating physician, Agreed Medical Evaluator, or Qualified Medical Evaluator) who finds that the disability from all conditions for which compensation is claimed has become permanent and stationary (or has reached maximum medical improvement) and finds that the injury has caused permanent partial disability.

What is the purpose of this form? The purpose of the form is to fully inform the employer of the work capacities and activity restrictions resulting from the injury that are relevant to potential regular work, modified work, or alternative work. The information contained on the form is for voucher purposes and is not considered in any permanent impairment rating or any permanent disability indemnity.

Is this a mandatory form? This is a mandatory attachment to the first medical report finding that the disability from all conditions for which compensation is claimed has become permanent and stationary and that the injury has caused permanent partial disability. This form should be attached to a comprehensive medical-legal evaluation and does not replace such comprehensive medical-legal evaluations.

When does the form need to be completed? This form does not need to be completed until all conditions for which compensation is claimed have become permanent and stationary.

If the employer or claims administrator has provided the physician with a job description providing physical requirements of the employee's regular work, proposed modified work, or proposed alternative work, the physician will evaluate and describe in the form whether the work capacities and activity restrictions are compatible with the physical requirements set forth in that job description. The bottom portion of the form does not need to be completed if the physician has not been provided with a job description.

Completing the employee's work restrictions: The physician should indicate work restrictions in terms of how many hours a particular activity is restricted during an 8-hour work day. For hand restrictions, the physician should indicate whether the restrictions are for the right hand, left hand, or both.

Other restrictions can include psychiatric restrictions, chemical exposure, use of equipment, or any other restrictions.

How does the employer receive the form? The claims administrator will forward the form to the employer.

DWC AD Form 10133.36 (SJDB) Eff: 1/1/14

SAMPLE

Bringing Your Risk Management Programs Full Circle

02/21/2014

Employer name and address

Employee: Employee name
Employer Name: City of West Sacramento
Claim Number: SAC0000155810
Date of Injury: 11/27/2013
Insuring Company: Self Insured

SENT VIA FAX OR EMAIL

NOTICE TO EMPLOYER - SUPPLEMENTAL JOB DISPLACEMENT BENEFIT

{GREETING}:

We have received notice that the above captioned employee has permanent, partial permanent disability as result of their industrial injury. Now that the permanent restrictions have been identified we must have you determine, within 30 days from the termination of temporary disability benefits, if there is permanent modified or alternative work available. The position must meet the following criteria in order to be a valid offer of permanent modified or alternative work:

- Offer is for modified work which accommodates your work restrictions and lasts at least 12 months

or

- Offer is for alternative work meeting all of the following conditions: (1) You have the ability to perform the essential functions of the job provided; (2) the job provided is in a regular position lasting at least 12 months; (3) the job provided offers wages and compensation that are within 15 percent of those paid to you at the time of the injury; and (4) the job is located within reasonable commuting distance of your residence at the time of injury.

The employee's permanent restrictions, as defined by {POPUP 1 - Doctor's name} are {POPUP 2 - Insert restrictions}.

If you have a permanent modified or alternative position available for the employee please present the attached form (DWC-AD 10133.53 Notice of Offer of Modified or Alternative Work - For Injuries occurring on or after 1/1/04) either in person or by certified mail to the employee no later than 30 days from the date temporary disability benefits are terminated, which is {POPUP 3 - Date - 30 days from last TD}.

Please advise us availability of a permanent modified or alternative position no later than {POPUP 4 - Insert date} by returning the attached reply form.

ENCLOSURE: Employer Reply Form

LWP Claims Solutions, Inc.
PO Box 349016, Sacramento, CA 95834
Phone: (916) 609-3600
Fax: (408) 725-0395

SAMPLE

Sincerely,

-

Senior Examiner
(916) 609-3666

LWP

SAMPLE

Bringing Your Risk Management Programs Full Circle

02/21/2014

Employer name and address

EMPLOYER REPLY FORM

RE: Employee: Employee name
Employer: City of West Sacramento
Claim Number: SAC0000155810
Date of Injury: 11/27/2013
Insuring Company: Self Insured

____ We have a permanent modified or alternative position for the injured employee that meets the criteria set forth by the DWC.

____ We do not have a permanent modified or alternative position for the injured employee that meets the criteria set forth by the DWC.

_____
Print Name

_____
Date

_____
Signature of Employer Representative

Sincerely,

Senior Examiner
(916) 609-3666

LWP Claims Solutions, Inc.
PO Box 349016, Sacramento, CA 95834
Phone: (916) 609-3600
Fax: (408) 725-0395

SAMPLE

Bringing Your Risk Management Programs Full Circle

02/21/2014

Employee name and address

RE: Employer Name: City of West Sacramento
Date of Injury: 11/27/2013
Claim Number: SAC0000155810
Insuring Co. Self Insured

Dear Employees name:

It appears that your injury has caused permanent partial disability. Per the report of Dr. {POPUP 1 - doctor name}, your injury does not prevent you from returning to your regular work. Regular work is defined as the usual occupation in which you were engaged at the time of injury and which offers wages and compensation equivalent to those paid to you at the time of injury, and located within a reasonable commuting distance of your residence.

Enclosed you will find form DWC-AD 10118 "Notice of Offer of Regular Work". Please complete the portion of the form marked "This section to be completed by Employee" and return the completed form to your employer or to our office.

Please note that whether you accept or reject this offer, your remaining permanent disability payments may be decreased by 15%.

If either party has a dispute regarding the offer of regular work, that party may file a Declaration of Readiness to Proceed with the local district office of the Workers' Compensation Appeals Board.

If you have a question or need more information, you can contact your employer or the claims administrator listed below. You can also contact a State Division of Workers' Compensation Information and Assistance Officer at 1-800-736-7401 or call you local Information and Assistance Officer at 916-928-3158. You may also consult with and be represented by an attorney.

Sincerely,

.

Senior Examiner
(916) 609-3666

cc: cc Employer

LWP Claims Solutions, Inc.
PO Box 349016, Sacramento, CA 95834

Phone: (916) 609-3600
Fax: (408) 725-0395

SAMPLE

State of California
Division of Workers' Compensation

NOTICE OF OFFER OF REGULAR, MODIFIED, OR ALTERNATIVE WORK
FOR INJURIES OCCURRING ON OR AFTER 1/1/13
DWC - AD 10133.35

THIS SECTION COMPLETED BY CLAIMS ADMINISTRATOR (All information in this section must be completed):

Claims Administrator Type: (Please Choose One)

☐ Insurance Company ☐ Third Party Administrator ☐ Employer

_____ is offering you _____
Employer Name (Employee Name)

the position of a _____
Name of Job

This offer is for: ☐ Regular Work ☐ Modified Work ☐ Alternative Work

You may contact _____ concerning this offer. Phone No.: _____

Date of offer: _____ Date job starts: _____
MM/DD/YYYY MM/DD/YYYY

_____
Claims Administrator

_____
Claims Representative Claim Phone Number

_____
Claims Address Claim Number:

(Choose only one)

☐ a specific injury on _____
MM/DD/YYYY

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

Date of Birth: _____
MM/DD/YYYY

You have 30 calendar days from receipt to accept or reject the attached offer of work. However, if you fail to respond in 30 days or reject this job offer, you will not be entitled to the supplemental job displacement benefit unless the offer is for modified work or alternative work and:

A. You cannot perform the essential functions of the job; or
B. The job is not a regular position lasting at least 12 months; or
C. Wages and compensation offered are less than 85% paid at the time of injury; or
D. The job is beyond a reasonable commuting distance from residence at time of injury.

SAMPLE

POSITION REQUIREMENTS

Actual job title: _____

Wages: $ _____ Per hour ☐ Week ☐ Month ☐ Year ☐

Is salary of regular/modified/alternative work the same as pre-injury job? Yes ☐ No ☐

Is salary of regular/modified/alternative work at least 85% of pre-injury job? Yes ☐ No ☐

Is job expected to last at least 12 months? Yes ☐ No ☐

Is the job a regular position required by the employer's business? Yes ☐ No ☐

Work location: _____ ☐ Same as Pre-Injury Position

If the job offered is at a different location than the job you held at the time of your injury, and you believe the commuting distance to this job from the residence where you lived at the time of your injury is not reasonable, you may object to the job offer as not being within a reasonable commuting distance.

You may also waive this commuting distance requirement. You will be considered to have waived this requirement if you accept the above offer of work or do not reject the offer within twenty calendar days of receipt of this notice. The employee should keep a copy of this form for his or her records.

☐ I accept the offer and waive any right to object to the job location or shift as not being within a reasonable commuting distance from the residence where I lived at the time of my injury.

☐ Position is for a different shift. The shift time is _____ (Start Time) - _____ (End Time)

Duties required of the position:

Description of activities to be performed (if not stated in job description):

SAMPLE

Physical requirements for performing work activities (include modifications to usual and customary job):

Name of doctor who approved job restrictions (optional): ☐ PTP ☐ QME ☐ AME

Date of report: _____
MM/DD/YYYY

Proof of Service by Mail
(To Be Completed By the Employer or Claims Administrator)

I declare that: On _____ ,

I served the attached on:

☐ by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United States mail.

☐ by personal service.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was exectuted on: _____ at _____ , CA.

Signature: _____

Print Name: _____

SAMPLE

THIS SECTION TO BE COMPLETED BY EMPLOYEE (All information in this section must be completed)

☐ I accept this offer of Regular, Modified, or Alternative work.

☐ I reject this offer of Regular, Modified, or Alternative work and understand that I may not be entitled to the Supplemental Job Displacement Benefit.

☐ I object to this offer because the job location that has been offered is different than the job location I held at the time of my injury, and I do not believe this job allows a reasonable commute from my residence.

I understand that this offer is expected to last at least 12 months. If seasonal work is being offered, I understand that the 12 months may be satisfied by cumulative periods of seasonal work. In the event this position ends or I am laid off prior to working 12 months, I understand that I may be entitled to the Supplemental Job Displacement Benefit.

I understand that if I voluntarily quit prior to working in this position for 12 months, I may not be entitled to the Supplemental Job Displacement Benefit.

I feel I cannot accept this offer because:

Signature: _____ Date: _____
MM/DD/YYYY

NOTICE TO THE PARTIES

If the offer is not accepted or rejected within 30 days of receipt of the offer, the offer is deemed to be rejected by the employee.

If a dispute occurs regarding the above offer or agreement, either party may request the Administrative Director to resolve the dispute by filing a Request for Dispute Resolution (Form DWC-AD 10133.55) with the Administrative Director, Division of Workers' Compensation, P.O. Box 420603, San Francisco, CA 94142-0603.

SAMPLE

State of California
Division of Workers' Compensation

NOTICE OF OFFER OF REGULAR WORK
FOR INJURIES OCCURRING BETWEEN 1/1/05 - 12/31/12, INCLUSIVE
DWC - AD 10118

THIS SECTION TO BE COMPLETED BY EMPLOYER OR CLAIMS ADMINISTRATOR (All information in this section must be completed):

Claims Administrator Type

☐ Insurance Company ☐ Third Party Administrator ☐ Employer _____ Case Number

Claim Number _____

Claims Administrator _____ (Name of Claims Administrator)

_____ _____
Employee First Name MI

_____ _____
Employee Last Name Date of Birth: MM/DD/YYYY

Based on the opinion of: ☐ Treating Physician ☐ QME ☐ AME

_____ (Name of Physician)

you are able to return to your usual occupation or the position you held at the time of your injury on

(Choose only one)

☐ a specific injury on _____ MM/DD/YYYY

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

Date you are eligible to return to your job _____ MM/DD/YYYY (as stated in the above physician's report),

Employer _____ (Name of Firm)

Job Title _____ Starting Date _____ MM/DD/YYYY.

SAMPLE

☐ This position is at the same location and shift as your pre-injury position.

☐ This position is at a different location than your pre-injury position. The location is:

_____

☐ This position is for a different shift than your pre-injury position. The shift time is _____ (Start Time) — _____ (End Time)

You may contact _____ (Name of contact person) at _____ Phone Number concerning this position.

You must return the completed form to the employer or claims administrator listed here:

Claims Administrator (To Be Completed By The Employer or Claims Administrator) (All information in this section must be completed)

_____
Name

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

_____ _____ _____
City State Zip Code

_____ _____
Claims Representative Phone

This position provides wages and compensation of $ _____, that are equivalent to or more than
Weekly Wages

the wages and compensation paid to you at the time of your injury.

This position is expected to last for a total of at least 12 months of work. If this position does not last for a total of at least 12 months of work, you may be entitled to an increase in your permanent disability benefit payments.

I, _____
(Name of Claims Administrator)
have obtained the above job offer information from your employer.

SAMPLE

THIS SECTION TO BE COMPLETED BY EMPLOYEE:

The employee must accept, reject, or object to this offer for regular work and return this form to the employer or claims administrator listed on the form within 20 calendar days of receipt of the offer or it will be deemed that the employee has waived the right to object to the location or shift.

If the job offered is at a different location than the job you held at the time of your injury, and you believe the commuting distance to this job from the residence where you lived at the time of your injury is not reasonable, you may object to the job offer as not being within a reasonable commuting distance.

You may also waive this commuting distance requirement. You will be considered to have waived this requirement if you accept the above offer of work or do not reject the offer within twenty calendar days of receipt of this notice. The employee should keep a copy of this form for his or her records.

First Name _____ MI _____

Last Name _____

Claim Number _____

Date Offer Received _____ MM/DD/YYYY

I understand that if my disability is permanent and stationary and the employer has fulfilled its legal obligations related to this offer, my remaining permanent disability payments will be decreased by 15% whether I accept or reject this offer.

Offer of Regular Work at Same Location and/or Shift

☐ I accept this offer of regular work.

☐ I reject this offer of work. Reason: _____

SAMPLE

THIS SECTION TO BE COMPLETED BY EMPLOYEE:

Offer of Regular Work at a Different Location and/or Shift

I understand that I have the right to object to a work offer when the location or shift is different than what I had at the time of my injury.

☐ I accept the offer and waive any right to object to the job location or shift as not being within a reasonable commuting distance from the residence where I lived at the time of my injury.

☐ I reject this offer of work. Reason:

☐ I object to this offer because the job location that has been offered is different than the job location I held at the time of my injury, and I do not believe this job allows a reasonable commute from my residence. I understand if the claims administrator does not agree with this objection, my remaining permanent disability weekly benefit payment may be decreased by 15%.

☐ I object to this offer because the job shift that has been offered is different than the job shift I held at the time of my injury. I understand if the claims administrator does not agree with this objection, my remaining permanent disability weekly benefit payment may be decreased by 15%.

If a dispute occurs regarding the above offer or agreement, either party may request the Administrative Director to resolve the dispute by filing a Request for Dispute Resolution (Form DWC-AD 10133.55) with the Administrative Director, Division of Workers' Compensation, P.O. Box 420603, San Francisco, CA 94142-0603.

_____ Date _____

(Signature) MM/DD/YYYY

SAMPLE

State of California
Division of Workers' Compensation

NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK
FOR INJURIES OCCURRING BETWEEN 1/1/04 - 12/31/12, INCLUSIVE
DWC - AD 10133.53

THIS SECTION COMPLETED BY CLAIMS ADMINISTRATOR (All information in this section must be completed):

Claims Administrator Type: (Please Choose One)

☐ Insurance Company ☐ Third Party Administrator ☐ Employer

_____
Employer Name

is offering you _____
(Employee Name)

the position of a _____.
Job Title

You may contact _____

concerning this offer. Phone No.:_____ Date of offer: _____ Date job starts: _____
MM/DD/YYYY MM/DD/YYYY

_____
Claims Administrator

_____
Claim Number :

NOTICE TO EMPLOYEE (All information in this section must be completed)

Name of employee:

_____ _____
First Name Last Name

(Choose only one)

☐ a specific injury on _____
MM/DD/YYYY

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

Date offer received: _____ Date of Birth: _____
MM/DD/YYYY MM/DD/YYYY

You have 30 calendar days from receipt to accept or reject the attached offer of modified or alternative work. Regardless of whether you accept or reject this offer, the remainder of your permanent disability payments may be decreased by 15%. However, if you fail to respond in 30 days or reject this job offer, you will not be entitled to the supplemental job displacement benefit unless:

Modified Work ☐ or Alternative Work ☐

A. You cannot perform the essential functions of the job; or
B. The job is not a regular position lasting at least 12 months; or
C. Wages and compensation offered are less than 85% paid at the time of injury; or
D. The job is beyond a reasonable commuting distance from residence at time of injury.

SAMPLE

POSITION REQUIREMENTS (All information in this section must be completed)

Actual job title: _____

Wages: $ _____ Per hour ☐ Week ☐ Month ☐ Year ☐

Is salary of modified/alternative work the same as pre-injury job?	Yes ☐	No ☐
Is salary of modified/alternative work at least 85% of pre-injury job?	Yes ☐	No ☐
Will job last at least 12 months?	Yes ☐	No ☐
Is the job a regular position required by the employer's business?	Yes ☐	No ☐

Work location: _____

Duties required of the position:

Description of activities to be performed (if not stated in job description):

SAMPLE

Physical requirements for performing work activities (include modifications to usual and customary job):

Name of doctor who approved job restrictions (optional):

Date of report: _____
MM/DD/YYYY

Date of last payment of Temporary Total Disability: _____
MM/DD/YYYY

Preparer's Name: _____

Preparer's Signature: _____

Date: _____
MM/DD/YYYY

THIS SECTION TO BE COMPLETED BY EMPLOYEE (All information in this section must be completed)

☐ I accept this offer of Modified or Alternative work.

☐ I reject this offer of Modified or Alternative work and understand that I am not entitled to the Supplemental Job Displacement Benefit.

I understand that if I voluntarily quit prior to working in this position for 12 months, I may not be entitled to the Supplemental Job Displacement Benefit.

Signature: _____ Date: _____
MM/DD/YYYY

I feel I cannot accept this offer because:

SAMPLE

NOTICE TO THE PARTIES

If the offer is not accepted or rejected within 30 days of receipt of the offer, the offer is deemed to be rejected by the employee.

If a dispute occurs regarding the above offer or agreement, either party may request the Administrative Director to resolve the dispute by filing a Request for Dispute Resolution (Form DWC-AD 10133.55) with the Administrative Director, Division of Workers' Compensation, P.O. Box 420603, San Francisco, CA 94142-0603.

H. MEDICAL MANAGEMENT

Medical management of a workers' compensation claim play a key role in reducing the exposure of a claim by maintaining control over an injured worker's medical care. This results in a substantial economic savings with a reduction in lost workdays and medical payments. The following are some procedures used in the medical management of a claim:

- Direct injured worker to employer designated clinics
- Call doctor every two weeks to determine the injured worker's ability to return to work and to push for an early return to work date
- Early identification of potential problems
- Refer cases to on staff nurse case manager when warranted
- Secure second opinions on care and disability
- Control medication
- Control durable medical equipment
- Use of the Managed Care Network (PPO)
- Litigation Review
- Pre-screen hospitals for utilization, continued stay and post discharge planning
- Perform reviews for proposed surgeries
- Ongoing development of preferred providers and facilities to accommodate our clients at the local work site
- Provide hospital audits and negotiate payments
- Maintain constant flow of medical information and reports
- Early return to work dates
- Monitor all medical treatment for the following:
    - ✓ Maintain medical control in order to control costs of the treatment
    - ✓ Referrals to specialists at the appropriate time
    - ✓ Identification of abuse of medical treatment by the physician
    - ✓ Identification of abuse by the injured worker in order to increase both temporary and permanent disability
- Payment of medical billings within the time limits of the Labor Code (60 days)

Medical control can be won or lost following the first 30 days from the injury. It is essential that we work closely with the employer to educate and encourage the referral of injured workers to the appropriate physicians and clinics for quality care. Economic savings will be recognized when the employer plays an active role in treating industrial injuries.

I. SETTLEMENTS

Many workers' compensation claims result in some permanent disability benefits due to the injured employee. If they are not represented by counsel their claim is resolved by getting medical opinion on the extent of their disability and a disability rating that determines how

much permanent disability benefits are payable. This is then all formalized by signing papers called “Stipulations with Request for Award”.

If there is a dispute over causation or complicated legal issues and the employee has retained counsel, another form of settlement may be used where no claim is admitted but the parties want to settle by payment of one lump sum. This type of settlement is called a “Compromise and Release”.

All settlements are sent to YCPARMIA for approval and may also require additional approvals.

On the following pages are Samples of related forms.

SAMPLE

Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION
OFFICE OF BENEFIT DETERMINATION
DISAIBLITY EVALUATION UNIT
1550 Mariposa Street, Room 2005
Fresno, CA 93721-2280
209 / 445-6427

STATE OF CALIFORNIA
PETE WILSON, Governor

CONSULTATIVE RATING DETERMINATION

Arthur
Our File No: 8967
Occupation: DOCK PERSON

WCAB #.....: 0171354
Age at DOI: 30

MACMORRAN M.D. 10-21-98
Work restrictions rate:

21.4 - 15%- 1G- 17- 15:2

Hector Torres

January 4, 1999

Disability Evaluator
DEU Form 230 (Rev 1-91) 525494

Date

SAMPLE

WORKERS' COMPENSATION APPEALS BOARD
STATE OF CALIFORNIA

Department of Industrial Relations
Division of Workers' Compensation
Disability Evaluation Unit

State of California
Gray Davis, Governor

NOTICE OF OPTIONS FOLLOWING PERMANENT DISABILITY RATING

This is a permanent disability rating determination (Rating) prepared by the State of California Disability Evaluation Unit within the Division of Workers' Compensation. It describes your percentage of permanent disability. This percentage is based on your limitations as reported by the doctor, your age, and the type of work you were doing at the time of your injury. If the rating indicates that you have some permanent disability, you should automatically begin to receive permanent disability payments. Payments are made in installments, every two weeks, for the number of weeks shown on the rating, less any permanent disability payments made to you prior to the rating.

If the rating is not disputed by you or your employer, you do not have to take any action to receive your benefits. We do want you to know that you may have two options you may want to consider. They are:

1) Stipulated Findings and Award;
2) Compromise and Release

1) STIPULATED FINDINGS AND AWARD

If you and the employer, carrier or agent accepts the rating, written agreements may be submitted to the Workers' Compensation Appeals Board (WCAB) requesting that an Award be made without the need for a hearing. We recommend this option when the rating is not disputed, and you have a need for future medical care. A Workers' Compensation Judge will review the stipulations and issue an award.

ADVANTAGES

- A stipulated award is a quick, easy way to settle your case while protecting your rights;
- There is no need to take time off work to go to a hearing;
- The Division of Workers' Compensation will review the settlement to protect your rights at no cost to you; there is no need to hire a lawyer;
- If your condition worsens, you can apply for additional payments anytime within five years from the date of your injury;
- If you need additional medical care or you are to receive a life pension (rating of 70% or more),
- Your rights to future benefits can be fully protected and a judge can enforce the award if there later becomes a problem.
- You may request a lump sum payment of all or part of your permanent disability if you can show a financial need or hardship. However, a Workers' Compensation Judge must first be convinced that it would be in your best interest.

DISADVANTAGES

- You normally will not receive a lump sum payment, but will receive your benefits in payments every two weeks.

2) COMPROMISE AND RELEASE

A Compromise and Release Agreement is a settlement which usually permanently closes all aspects of a workers' compensation claim except for vocational rehabilitation benefits, including any provision for future medical care.

The Compromise and Release is paid in one lump sum to you. It must be reviewed and approved by a

SAMPLE

WORKERS' COMPENSATION APPEALS BOARD
STATE OF CALIFORNIA

Workers' Compensation Judge.

ADVANTAGES

- You may receive more money than you would receive under a Stipulated Findings and Award because you are giving up your future rights in exchange for money.
- If the employer or insurance company disputes the rating, a Compromise and Release will assure you receive an agreed amount of money now rather than risk getting nothing or a lesser amount later.
- You will receive your benefits in one lump sum.

DISADVANTAGES

- A Compromise and Release usually permanently releases the employer from all future responsibilities. After your case has been resolved by a Compromise and Release Agreement, you cannot ask for more medical treatment at your employer's expense, nor can you claim additional benefits if your disability or condition becomes worse. Also, if you later die as a result of the injury, your dependents would not be entitled to death benefits.
- Once a Workers' Compensation Judge has approved your Compromise and Release, the settlement is final and it cannot be set aside except in very rare circumstances

If you would like more information, you can receive recorded information free of charge, by calling 1-800-736-7401 or you may contact your local Information and Assistance officer (listed in the state government section of your telephone book under Department of Industrial Relations, Division of Workers' Compensation). You may also consult an attorney of your choice.

SPECIAL NOTICE TO UNREPRESENTED INJURED WORKERS

If you disagree with the rating because the doctor failed to address any or all issues or failed to follow the procedures of the Industrial Medical Council, you may request reconsideration of the rating from the Administrative Director of the Division of Workers' Compensation. In some cases, you may be entitled to an additional medical evaluation or a different medical specialist.

Your request should include a copy of the rating and a copy of the report from the doctor. A copy of the request must be sent to your claims adjustor.

If you have questions about whether to request reconsideration of your rating or whether another medical evaluation is appropriate, you should contact the local Information and Assistance Officer listed in the state government section of your telephone book under Department of Industrial Relations, Division of Workers' Compensation. They can tell you how to file the request if you decide to do so.

DEU FORM 110 (Rev. 1/94)

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF INDUSTRIAL ACCIDENTS
DWC WCAB FORM 3 (REV. 9-1990) (Page 1 of 4)

C-36

90 90634

WCAB-3

SAMPLE

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
STIPULATIONS WITH REQUEST FOR AWARD

Case No. _____ Date of Injury _____ MM/DD/YYYY

SSN (Numbers Only) _____

Venue Choice is based upon: (Completion of this section is required)

☐ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

☐ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

☐ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

Select 3 Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet) _____

Applicant (Completion of this section is required)

First Name _____ MI _____

Last Name _____

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

City _____ State _____ Zip Code _____

Employer #1 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words) _____

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

City _____ State _____ Zip Code _____

SAMPLE

Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

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

City State Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

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

City State Zip Code

Employer #2 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

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

City State Zip Code

Insurance Carrier Information
(if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

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

City State Zip Code

DWC-CA form 10214 (a) Page 2 (Rev 11/2008)

SAMPLE

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

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

City State Zip Code

Employer #3 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

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

City State Zip Code

Insurance Carrier Information
(if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

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

City State Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

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

City State Zip Code

SAMPLE

Employer #4 Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words)

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

City State Zip Code

Insurance Carrier Information
(if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

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

City State Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

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

City State Zip Code

The parties hereto stipulate to the issuance of an Award and/or Order, based upon the following facts, and waive the requirements of Labor Code section 5313:

1. _____
Employees First Name

_____ ,
Employees Last Name

birth date _____ , MM/DD/YYYY

while employed at _____ , _____ State

as a(n) _____ Occupation , _____ Group in

SAMPLE

☐ More than 4 Companion Cases

Case Number 1 ☐ Specific Injury ☐ 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 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

Case Number 2 ☐ Specific Injury ☐ 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 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

Case Number 3 ☐ Specific Injury ☐ 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 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

Case Number 4 ☐ Specific Injury ☐ 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 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

by the employer(s) and their insurer(s) listed above and who sustained injury(ies) arising out of and in the course of employment to

(Please list all body parts injured)

SAMPLE

2. The injury (ies) caused temporary disability for the period _____ (MM/DD/YYYY) through _____ (MM/DD/YYYY) for which indemnity has been paid at $ _____ (Indemnity Paid) per week.

2(a). The injury(ies) caused additional temporary disability for the period _____ (MM/DD/YYYY) through _____ (MM/DD/YYYY) at the rate of $ _____ (Rate) in the amount of $ _____ (Indemnity Paid)

3. The injury(ies) caused permanent disability of _____ % for which indemnity is payable at $ _____ (Indemnity Rate) per week beginning _____ (MM/DD/YYYY) in the sum of $ _____, less credit for such payments previously made. ☐ And a life pension of $_____ (Life Pension) per week thereafter.

Labor Code §4658(d) adjustment:

☐ Increase rate to $ _____ as of _____ (MM/DD/YYYY)

☐ Decrease rate to $ _____ as of _____ (MM/DD/YYYY)

☐ Not Applicable

An informal rating ☐ has / ☐ has not (Select one) been previously issued in case no(s) _____.

4. There ☐ is ☐ is Not a need for medical treatment to cure or relieve from the effects of said injury (ies).

5. Medical-legal expenses and/or liens are payable by defendant as follows:

6. Applicant's attorney requests a fee of $ _____

☐ Fees to be commuted as follows:

7. Liens Against compensation are payable as follows:

DWC-CA form 10214 (a) Page 6 (Rev 11/2008)

SAMPLE

8.Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

9.Other stipulations:

Dated _____ MM/DD/YYYY

_____ Applicant

Applicant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm name

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

City State Zip Code

Dated _____ MM/DD/YYYY

_____ Applicant Attorney Signature

DWC-CA form 10214 (a) Page 7 (Rev 11/2008)

SAMPLE

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

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

City State Zip Code

Dated MM/DD/YYYY

Defense Attorney Signature

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

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

City State Zip Code

Dated MM/DD/YYYY

Defense Attorney Signature

DWC-CA form 10214 (a) Page 8 (Rev 11/2008)

SAMPLE

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

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

City State Zip Code

Dated MM/DD/YYYY

Defense Attorney Signature

Interpreter Licence Number:

Interpreter Name

Interpreter License Number

SAMPLE

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
STIPULATIONS WITH REQUEST FOR AWARD
(Death Case)

Case Number 1

Case Number 2

Venue Choice is based upon: (Completion of this section is required)

☐ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

☐ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

☐ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

Select 3 Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

Adult Dependent #1 Information

First Name MI

Last Name

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

City State Zip Code

Adult Dependent #2 Information

First Name MI

Last Name

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

City State Zip Code

DWC-CA form 10214 (b) (Page 1) (REV. 11/2008) DWC-CA form 10214 (b)

SAMPLE

Adult Dependent #3 Information

First Name _____ MI _____

Last Name _____

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

City _____ State _____ Zip Code _____

Employer Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words) _____

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

City _____ State _____ Zip Code _____

Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words) _____

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

City _____ State _____ Zip Code _____

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words) _____

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

City _____ State _____ Zip Code _____

DWC-CA form 10214 (b) (Page 2) (REV. 11/2008) DWC-CA form 10214 (b)

SAMPLE

The parties to the above-entitled action hereby enter into the following stipulations and request the Division of Workers' Compensation to issue Findings and Award forthwith, without further proceedings.

IT IS HEREBY STIPULATED AS FOLLOWS:

1. That _____ (First Name) _____ (Last Name), age _____ (Years),

while employed at _____ (Place of injury)

as a _____ (Occupation)

by _____ (Name of employer; an individual, co-partnership or corporation) on _____ (Date of injury: MM/DD/YYYY)

sustained injury arising out of and occurring in the course of his/her employment, proximately resulting in the death of

said employee on _____ (Date of Death: MM/DD/YYYY). That at said time, employer's workers' compensation insurance carrier

covering said injury was _____, and both the employer

and the employee were subject to the provisions of the Labor Code of the State of California.

2. That said employee left surviving him/her, wholly dependent/partially dependent, dependents listed herein: (Give name and if a minor, date of birth and relationship to the employee. Adult dependents are listed above and minor dependents are listed below.)

Minor dependents

☐ Minor dependents?

Minor Dependent # 4 Information

_____
Name

_____ ☐ Minor _____
Relation Date of Birth: MM/DD/YYYY

Minor Dependent # 5 Information

_____
Name

_____ ☐ Minor _____
Relation Date of Birth: MM/DD/YYYY

Minor Dependent # 6 Information

_____
Name

_____ ☐ Minor _____
Relation Date of Birth: MM/DD/YYYY

SAMPLE

3. That the said dependents are entitled to a death benefit of $ _____

based upon earnings of $ _____ , payable at $ _____ a week.
(State weekly or monthly wages)

4. That the sum of $ _____ is payable to _____
Total Sum Paid

on account of the burial expense. The sum of $ _____ has previously been paid to

_____

5. That all necessary medical, surgical and hospital expenses on account of said injury has been paid by defendants. (If not paid, explain):

☐ Yes

☐ No

6. That defendants have heretofore paid the sum of $ _____
Total Death Benefits Paid
on account of death benefit, for which they request credit.

7. It is necessary that a guardian ad litem and trustee be appointed for the minors, and the parties request that

_____
First name

_____
Last Name

be appointed such guardian ad litem and trustee.

The Workers' Compensation Administrative Law Judge may assume that no attorney fee is involved in the above-entitled matter and should the facts be otherwise a detailed explanation shall be attached to these stipulations.

_____
Dependent or guardian signature (Date)

_____
Dependent or guardian signature (Date)

_____
Dependent or guardian signature (Date)

SAMPLE

Applicant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Law Firm Number

Law Firm Name

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

City State Zip Code

Dated MM/DD/YYYY

Applicant Attorney Signature

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Law Firm Number

Law Firm Name

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

City State Zip Code

Dated MM/DD/YYYY

Defense Attorney Signature

SAMPLE

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
COMPROMISE AND RELEASE

Case Number 1 _____ Case Number 4 _____

Case Number 2 _____ Case Number 5 _____

Case Number 3 _____ SSN (Numbers Only) _____

Venue Choice is based upon: (Completion of this section is required)

☐ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

☐ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

☐ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

_____
Select 3 Letter Office Code For Place/Venue of Hearing (From Document Cover Sheet)

Employee(Completion of this section is required)

First Name _____ MI _____

Last Name _____

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

City _____ State _____ Zip Code _____

Employer Information (Completion of this section is required)

☐ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

Employer Name (Please leave blank spaces between numbers, names or words) _____

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

City _____ State _____ Zip Code _____

SAMPLE

Applicant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Law Firm Number

Law Firm Name

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

City State Zip Code

Defendant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Law Firm Number

Law Firm Name

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

City State Zip Code

Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

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

City State Zip Code

SAMPLE

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

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

City State Zip Code

IT IS CLAIMED THAT:

1. The injured employee, born _____ (DATE OF BIRTH: MM/DD/YYYY), alleges that while employed as a(n) _____ (OCCUPATION AT THE TIME OF INJURY), sustained injury arising out of and in the course of employment at the locations and during the dates listed below:

(State with specificity the date(s) of injury(ies) and what part(s) of body, conditions or systems are being settled.)

Case Number 1

☐ Specific Injury

☐ 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 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

The injury occurred at _____
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

_____ City, _____ State _____ Zip Code.

Body parts, conditions and systems may not be incorporated by reference to medical reports.

SAMPLE

☐ 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 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

The injury occurred at _____
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

_____ , _____ _____ .
City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ 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 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

The injury occurred at _____
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

_____ , _____ _____ .
City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ 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 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

The injury occurred at _____
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

_____ , _____ _____ .
City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

SAMPLE

☐ 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 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

The injury occurred at _____

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

_____ City , _____ State _____ Zip Code .

Body parts, conditions and systems may not be incorporated by reference to medical reports.

2. Upon approval of this compromise agreement by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge and payment in accordance with the provisions hereof, the employee releases and forever discharges the above-named employer(s) and insurance carrier(s) from all claims and causes of action, whether now known or ascertained or which may hereafter arise or develop as a result of the above-referenced injury(ies), including any and all liability of the employer(s) and the insurance carrier(s) and each of them to the dependents, heirs, executors, representatives, administrators or assigns of the employee. Execution of this form has no effect on claims that are not within the scope of the workers' compensation law or claims that are not subject to the exclusivity provisions of the workers' compensation law, unless otherwise expressly stated.

3. This agreement is limited to settlement of the body parts, conditions, or systems and for the dates of injury set forth in Paragraph No. 1 and further explained in Paragraph No. 9 despite any language to the contrary elsewhere in this document or any addendum.

4. Unless otherwise expressly stated, approval of this agreement RELEASES ANY AND ALL CLAIMS OF APPLICANT'S DEPENDENTS TO DEATH BENEFITS RELATING TO THE INJURY OR INJURIES COVERED BY THIS COMPROMISE AGREEMENT. The parties have considered the release of these benefits in arriving at the sum in Paragraph 7. Any addendum duplicating this language pursuant to Sumner v WCAB (1983) 48 CCC 369 is unnecessary and shall not be attached.

5. Unless otherwise expressly ordered by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge, approval of this agreement does not release any claim applicant may have for vocational rehabilitation benefits or supplemental job displacement benefits.

6. The parties represent that the following facts are true: (If facts are disputed, state what each party contends under Paragraph No. 9.)

EARNINGS AT TIME OF INJURY $ _____

TEMPORARY DISABILITY INDEMNITY PAID _____ Weekly Rate $ _____

Period(s) Paid _____ (Start Date: MM/DD/YYYY) _____ (End Date: MM/DD/YYYY)

PERMANENT DISABILITY INDEMNITY PAID _____ Weekly Rate $ _____

Period(s) Paid _____ (Start Date: MM/DD/YYYY) End date _____ (End Date: MM/DD/YYYY)

TOTAL MEDICAL BILLS PAID $ _____ Total Unpaid Medical Expense to be Paid By: _____

Unless otherwise specified herein, the employer will pay no medical expenses incurred after approval of this agreement.

SAMPLE

7. The parties agree to settle the above claim(s) on account of the injury(ies) by the payment of the SUM OF

$ _____
Settlement Amount

The following amounts are to be deducted from the settlement amount:

$ _____ for permanent disability advances through _____

$ _____ for temporary disability indemnity overpayment, if any.

$ _____ payable to _____

$ _____ payable to _____

$ _____ payable to _____

$ _____ payable to _____

$ _____ requested as applicant's attorney's fee.

LEAVING A BALANCE OF $ _____, after deducting the amounts set forth above and less further permanent disability advances made after the date set forth above. Interest under Labor Code section 5800 is included if the sums set forth herein are paid within 30 days after the date of approval of this agreement.

8. Liens not mentioned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary):

SAMPLE

9. The parties wish to settle these matters to avoid the costs, hazards and delays of further litigation, and agree that a serious dispute exists as to the following issues (initial only those that apply). ONLY ISSUES INITIALED BY THE APPLICANT OR HIS/HER REPRESENTATIVE AND DEFENDANTS OR THEIR REPRESENTATIVES ARE INCLUDED WITHIN THIS SETTLEMENT.

Applicant	Defendant	
_____	_____	earnings
_____	_____	temporary disability
_____	_____	jurisdiction
_____	_____	apportionment
_____	_____	employment
_____	_____	injury AOE/COE
_____	_____	serious and willful misconduct
_____	_____	discrimination (Labor Code §132a)
_____	_____	statute of limitations
_____	_____	future medical treatment
_____	_____	other _____
_____	_____	permanent disability _____
_____	_____	self-procured medical treatment, except as provided in Paragraph 7
_____	_____	vocational rehabilitation benefits/supplemental job displacement benefits

COMMENTS:

Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

10. It is agreed by all parties hereto that the filing of this document is the filing of an application, and that the workers' compensation administrative law judge may in its discretion set the matter for hearing as a regular application, reserving to the parties the right to put in issue any of the facts admitted herein and that if hearing is held with this document used as an application, the defendants shall have available to them all defenses that were available as of the date of filing of this document, and that the workers' compensation administrative law judge may thereafter either approve this Compromise and Release or disapprove it and issue Findings and Award after hearing has been held and the matter regularly submitted for decision.

SAMPLE

11. WARNING TO EMPLOYEE: SETTLEMENT OF YOUR WORKERS' COMPENSATION CLAIM BY COMPROMISE AND RELEASE MAY AFFECT OTHER BENEFITS YOU ARE RECEIVING TO WHICH YOU BECOME ENTITLED TO RECEIVE IN THE FUTURE FROM SOURCES OTHER THAN WORKERS' COMPENSATION, INCLUDING BUT NOT LIMITED TO SOCIAL SECURITY, MEDICARE AND LONG-TERM DISABILITY BENEFITS.

THE APPLICANT'S (EMPLOYEE'S) SIGNATURE MUST BE ATTESTED TO BY TWO DISINTERESTED PERSONS OR ACKNOWLEDGED BEFORE A NOTARY PUBLIC

By signing this agreement, applicant (employee) acknowledges that he/she has read and understands this agreement and has had any questions he/she may have had about this agreement answered to his/her satisfaction.

Witness the signature hereof this _____ day of _____, _____ at _____

Witness 1	(Date)	Applicant (Employee)	(Date)
Witness 2	(Date)	Attorney for Applicant	(Date)
Interpreter	(Date)	Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)

SAMPLE

ACKNOWLEDGMENT

State of California
County of _____)

On _____ before me, _____
(insert name and title of the officer)

personally appeared _____,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ **(Seal)**

DWC-CA form 10214 (c) (Rev. 11/2008) (Page 9 of 9)

SAMPLE

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
COMPROMISE AND RELEASE
(Dependency claim)

Case Number 1 _____ Case Number 4 _____

Case Number 2 _____ Case Number 5 _____

Case Number 3 _____ SSN (Numbers Only) _____

Venue Choice is based upon: (Completion of this section is required)

☐ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

☐ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

☐ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

_____

Select 3 Letter Office Code For Place/Venue of Hearing (From Document Cover Sheet)

Employee (Completion of this section is required)

First Name _____ MI ____

Last Name _____

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

City _____ State ____ Zip Code _____

Employer (Completion of this section is required)

Name (Please leave blank spaces between numbers, names or words) _____

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

City _____ State ____ Zip Code _____

DWC-CA form 10214 (d) (PAGE 1) (REV. 11/2008)

SAMPLE

Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

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

City State Zip Code

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

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

City State Zip Code

1. The below - named dependent(s) claims that _____ (NAME OF EMPLOYEE)

while employed at _____ on _____ by Date of Injury: MM/DD/YYYY

_____ (NAME OF EMPLOYER) , then insured as to worker's compensation

liability by _____ (STATE NAME OF CARRIER OR WHETHER SELF - INSURED)

sustained injury arising out of and in the course of such employment as follows:

2. The death of the said employee occurred on _____ Date of Employee Death: MM/DD/YYYY , as a result of the claimed injury.

3. The actual weekly wages of the employee at the time of claimed injury were, _____ , while average weekly wages (statutory) were _____ .

4. Payments of compensation to the employee in his lifetime on the account of the claimed injury were _____ .

DWC-CA form 10214 (d) (PAGE 2) (REV. 11/2008)

SAMPLE

5. The applicant(s) herein claims to have been dependent upon said employee at the time of the claimed injury and states the name(s), age(s), relationship to, and the extent of dependency upon the deceased employee to have been as follows:

Dependent # 1 of Employee

First Name _____ MI ____

Last Name _____

Age _____ Relationship _____ Extent of dependency ☐ Partial ☐ Total

Dependent # 2 of Employee

First Name _____ MI ____

Last Name _____

Age _____ Relationship _____ Extent of dependency ☐ Partial ☐ Total

Dependent # 3 of Employee

First Name _____ MI ____

Last Name _____

Age _____ Relationship _____ Extent of dependency ☐ Partial ☐ Total

6. The parties hereby agree to settle any and all claims of said dependent(s) on account of the claimed injury and the death of said employee by the payment of sum of $ _____ , payable as follows to:

7. The parties hereby agree (if such items of expense be claimed) that medical, hospital and burial expense required by reason of alleged injury and death of employee shall be borne as follows:

DWC-CA form 10214 (d) (PAGE 3) (REV. 11/2008)

SAMPLE

8. Is the Applicant Represented?: ☐ Yes ☐ No **if "No", applicant is to sign and date below.**
if "Yes", applicant's representative is to complete the following and is to sign and date below.

☐ Law Firm/Attorney ☐ Non-Attorney Representative

Law firm or Company Name (If applicable)

Law Firm Number (If Applicable)

Attorney/Rep First Name MI

Attorney/Rep Last Name

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

City State Zip Code

who requested a fee of $ _____ , having been previously paid $ _____

9. Reason for compromise

10. The undersigned request that this compromise agreement and release be approved.

11. Upon the approval of this compromise agreement as provided by law, and payment in accordance with the provision of the said order of approval, said applicants and each of them do hereby release and forever discharge said employer and said insurance company of and from all claims, demands, actions or causes of action, of every kind or nature whatsoever on account of, or by reason of injury and death sustained as aforesaid by the employee, and in particular of any, all and every claim or cause of action which the undersigned, heirs, executors, representatives, and administrators may have had, now have, or shall hereafter have against said employer, said insurance carrier, and each of them under Division 4 of the Labor Code of the State of California.

DWC-CA form 10214 (d) (PAGE 4) (REV. 11/2008)

SAMPLE

12. It is agreed by all parties hereto that the filing of this document is filing of an application on behalf of the applicant and that it may be set for hearing as a regular application, reserving to the parties the right to put in issue any of the facts admitted herein, and that if hearing is held with this document used as an application the defendants shall have available to them all defenses that were available as of date of filing this document, and that it may thereafter be approved, disapproved, or a decision issued after a hearing has been held and the matter regularly submitted.

13. For the purpose of determining the lien claim filed herein for the unemployment compensation disability and / or unemployment compensation benefits which have been paid under or pursuant to California Unemployment Insurance Code, the parties propose the following division of sum agreed upon for settlement and release of this case:

$ _____ for temporary disability covering the period _____ to _____.

$ _____ for accrued medical expense paid or incurred by the employee.

$ _____ for future medical care.

$ _____ for permanent disability.

(The above segregation must be fair and reasonable and must be based on the real facts of the case. There should be no attempt made to deprive the lien claimant of a reasonable recovery consistent with all amounts involved.)

Witness the signature hereof this _____ day of _____, _____ at _____

Witness 1	(Date)	Applicant (Employee)	(Date)
Witness 2	(Date)	Attorney for Applicant	(Date)
Interpreter	(Date)	Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)

SAMPLE

ACKNOWLEDGMENT

State of California
County of _____)

On _____ before me, _____
(insert name and title of the officer)

personally appeared _____,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ **(Seal)**

DWC-CA form 10214 (d) (PAGE 6) (REV. 11/2008)

SAMPLE

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

FORWARD TO

P.O. BOX 422400
SAN FRANCISCO CA 94142

NOTICE OF EMPLOYEE DEATH

EACH EMPLOYER SHALL NOTIFY THE ADMINISTRATIVE DIRECTOR OF THE DEATH OF EVERY EMPLOYEE REGARDLESS OF THE CAUSE OF DEATH EXCEPT WHERE THE EMPLOYER HAS ACTUAL KNOWLEDGE OR NOTICE THAT THE DECEASED EMPLOYEE LEFT A SURVIVING MINOR CHILD (TITLE 8, CHAPTER 4.5, SECTION 9900).

DECEASED EMPLOYEE:

NAME: _____ AGE: _____ SOCIAL SECURITY NUMBER: _____

LAST KNOWN ADDRESS: _____

NAME, RELATIONSHIP AND LAST KNOWN ADDRESS OF NEXT OF KIN: _____

_____

JOB TITLE AND NATURE OF DUTIES: _____

_____

DATE, TIME AND PLACE OF ACCIDENT: _____

DATE, TIME AND PLACE OF DEATH: _____

CIRCUMSTANCES OF DEATH (DESCRIBE FULLY THE EVENTS WHICH RESULTED IN DEATH. TELL WHAT HAPPENED. USE ADDITIONAL SHEET IF NECESSARY):

_____

CAUSE OF DEATH (ATTACH COPY OF DEATH CERTIFICATE OR CORONER'S REPORT):

_____

HAVE ANY WORKERS' COMPENSATION DEATH BENEFITS BEEN PROVIDED IN CONNECTION WITH THIS DEATH? ____YES ____NO

IF YES, TO WHOM: _____

ATTACH A COPY OF THE FORM 5020, "EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS," IF ONE WAS FILED.

PLEASE NOTE:

IF THE DEATH IS WORK-RELATED, THE EMPLOYER ALSO IS REQUIRED TO REPORT THE DEATH TO HIS OR HER WORKERS' COMPENSATION INSURANCE CARRIER AND TO THE NEAREST OFFICE OF THE DIVISION OF INDUSTRIAL SAFETY IMMEDIATELY BY TELEPHONE OR TELEGRAPH. AN EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS SHOULD ALSO BE FILED WITH THE WORKERS' COMPENSATION INSURANCE CARRIER.

( ) INSURED ( ) SELF-INSURED ( ) LEGALLY UNINSURED

EMPLOYER: _____

STREET: _____

CITY/STATE: _____ ZIP: _____

TELEPHONE: _____
(INCLUDE AREA CODE)

INSURANCE CARRIER
OR ADJUSTING AGENT: _____

STREET: _____

CITY/STATE: _____ ZIP: _____

TELEPHONE: _____
(INCLUDE AREA CODE)

BY: _____

TITLE: _____

DATE: _____

DIA 510 (REV. 9/84)

QUESTIONS AND ANSWERS

The following is a brief discussion of the workers' compensation system as it applies to employees in California. This presentation is set up in a question and answer format. These are typically asked about the workers' comp process by employees and supervisors. If the employee or supervisor has questions about a specific case, he or she should call YCPARMIA for an answer.

Our experience shows that over 95% of the claims filed are legitimate. We find that most workers' comp injuries/illnesses are minor and the employee very quickly returns to work. We also find the rate of litigation, which drives up costs, can be reduced if a concerned employee can get his/her questions answered quickly by the supervisor or claims examiner. If you have specific questions about the workers' comp process that are not covered by the following information, please call YCPARMIA.

A. How does the workers' comp process begin?

The process begins when the employer is made aware of an injury, illness, or death of an employee that is the result of the employee's work.

B. What constitutes notice of a workers' comp claim?

A claim is created when an employee suffers a work-related injury, illness, or death and the employer is notified by one of the following:

- Employee tells supervisor of the incident;
- Employee tells another employee of the incident;
- Another employee observes injury and tells supervisor of the incident;
- Employee's supervisor observes an incident;
- The employee's legal representative files a claim with the employer.

C. When knowledge of injury/illness is received, what are the paperwork steps?

1. If there is no lost time and no doctor visit:
   - Employer's internal accident/incident report should be completed within 48 hours of knowledge, to be kept in the supervisor's personnel file.
   - If requested by the injured employee, the workers' comp Employee Claim Form (DWC-1) should be provided to the employee within 24 hours of the request (provided by mail or in person) with verification this has been done through a "Proof of Service" form or other formal verification process.

2. If there is lost time and/or a doctor's visit:
   - Employer's accident/incident report should be completed within 48 hours of knowledge.
   - Employee Claim Form should be provided to injured employee within 24 hours of knowledge of injury (provided by mail or in person) with

- ♦ verification this has been done through a “Proof of Service” form or other formal verification process.
- ♦ Employer’s First Report of Injury (5020) should be completed within (5) five calendar days of knowledge of injury.
- ♦ The Employer’s First Report and Employee’s Claim Form should be sent to LWP and YCPARMIA immediately upon completion.

D. Where does the employee receive medical treatment?

1. In the case of serious life-threatening injury or illness, the nearest emergency room medical facility.
2. In the case of an ambulatory, non-life-threatening injury or illness, the nearest employer designated occupational medical facility.
3. If there is a chance of causing more serious injury or illness due to staff moving the injured employee, an ambulance should be called and notified that this is a workers’ compensation injury.

E. Can an employee use his/her own medical doctor for treatment of an injury or illness?

1. For preliminary treatment, only if the employee has signed a request **prior** to the injury/illness and that request is in the employee’s personnel file.
2. Thirty (30) days after the initial injury/illness the employee may request a change of treating physicians within the medical provider network through the claims examiner.

F. When can the employee return to work?

1. Following the receipt of treatment by the doctor, the doctor should provide the employee with a return-to-work slip, which will tell the supervisor if the employee can return to work and under what conditions.
2. If the return-to-work slip is unclear as to the conditions under which an employee can return, the supervisor should call the claims examiner for clarification. The employee **should not** be returned to work until clarification is received.

G. Does the employer have to take an employee back for limited duty?

The employer can review the conditions of return to work from the doctor. If the employer can’t accommodate those conditions without further aggravating the injury/illness, the employer does not have to bring the employee back until work is available that would not aggravate the injury/illness. If a limited duty program is created, it must be offered equally to all workers’ comp injured workers in the specific job classification.

H. Who pays for any doctor bill, hospitalization charges, ambulance fees, and/or medication that result from the injury/illness?

1. If the injury/illness is accepted as a legitimate workers' comp claim, then the employer, through the claims administrator, pays these expenses for the employee.
2. If the claim is accepted and the employee receives a bill for the above services, the supervisor should obtain the bill and send it to the claims examiner for payment.

I. When does an employee begin to receive his workers' comp disability payments?

1. If an employee is off more than three calendar days due to a workers' comp injury/illness, he/she will begin receiving workers' comp temporary disability payments with his/her normal paycheck or from LWP directly. The employee will receive up to $1,074.64 per week, tax free, based on a percentage of his/her actual wages. These payments may be supplemented with an employee's accrued sick leave and vacation to provide a full paycheck. The supplemental payments are not tax-free.
2. Police officers and firemen receive full pay, tax-free from the first day of disability for up to one year.
3. If an employee runs out of supplements, he/she will continue to receive the temporary disability payments as long as he/she is off work and eligible for the benefits.

J. Are workers' comp injuries always accepted as job related and benefits provided to the employee?

No. There are three notices that can be sent to an employee regarding their workers' comp claim. The first notice is that the claim is accepted. The second notice states that acceptance or denial is delayed for up to 90 days pending the receipt of more information to determine whether or not the claim is accepted. The third notice states that the claim is rejected as not being work related and no benefits will be provided. If the acceptance of a claim is delayed and later accepted, then all benefits due to the employee, from the date of injury, will be provided.

K. If I know that the employee is faking or was injured off the job, what can I do?

If you are aware of the possibility that this is not a work-related injury, contact the claims examiner and provide him/her with the information you have. An investigation will be conducted and the claim will be reviewed to see if it is a valid claim.

L. If the employee is off work, what can I do to get him/her back?

Once a doctor takes an employee off work for a workers' comp injury/illness, it takes a doctor's statement to bring the employee back to full or limited duty. If you have knowledge that the employee is doing similar work while off, contact the claims examiner and he/she will investigate the matter, including talking to the doctor about returning the employee to duty.

M. Does the employee have the right to an attorney in workers' comp cases?

Yes. The benefits are very specific in the law; however, some employees want an attorney to represent them. Once a settlement is reached in the case, the attorney gets a certain percentage of the employee's settlement. If you know an employee has an attorney, you should not discuss the details of the case with the employee. You can discuss how the employee is feeling and when the doctor may allow them back to work and/or whether they have future medical appointments.

N. What can I do about follow-up treatment or evaluations for accepted workers' comp claims?

The employee has the right to any follow-up treatment or evaluation ordered by a physician. They will be paid mileage to and from the doctor's office. If the employee has returned to work and has treatment or an evaluation, you can request that he/she schedule the treatment at the beginning or ending of a shift to reduce disruption to the work site. The employee will not receive a temporary disability payment for treatment or a follow-up evaluation unless his/her treating physician indicated that they were not able to physically work during that entire normal work shift.

O. When can I replace an employee if he/she cannot return to work because of the workers' comp injury?

1. Generally, once a doctor has declared the employee's condition to be permanent and stationary (P&S) and has defined the conditions of work which preclude the employee from returning to work, you can replace the employee. However, before taking any action, you should check with your personnel department and LWP.
2. Under recent federal law established through the Americans with Disabilities Act (PL 101-336), an employer is required to try and make "reasonable accommodations" for an injured employee trying to return to work. Reasonable accommodation should be explored and documented before making a final decision to release/replace an employee.

P. What are some of the benefits due an employee who is injured at work?

1. If the claim is accepted as legitimate, the following are some of the benefits:
   - ♦ The employee's injury/illness-related medical bills and transportation will be paid.

- If the employee misses work, he/she will receive tax-free temporary disability payments until the employee returns to work, is retired, or the case is closed.
- If the employee cannot return to his/her normal job they may be eligible for a Supplemental Job Displacement Voucher
- The employee may be eligible for a cash payment for permanent disability if it is found that the employee has suffered some percentage of permanent disability due to the injury. The amount of the payment is determined by medical statements about the degree of permanent disability by a physician, and the use of a state mandated rating system.
- If the employee dies due to a work-related injury, there are specific burial and death benefits provided to his/her dependents.

Q. How are cases closed in the workers' comp system?

1. There are three ways in which a case can be closed:
   - The injury/illness is resolved with no permanent disability, the employee returns to work, the matter is closed.
   - The case can be closed with a Stipulation. This means everyone agrees to the nature of the injury/illness, the level of benefits (i.e. return to work, PD, etc.), and future medical care if any.
   - If there is no agreement or compromise on the injury, its severity, and/or level of benefits, the matter goes before a Workers' Compensation Appeals Board judge who hears the case and then determines the type or level of injury and benefits, if any are to be awarded.
   - The third type of closure is in between. There may be a dispute on injury level of benefits or other case-related benefits. Rather than go before the judge, the matter is Compromised and Released (C&R) to avoid the cost of litigation. This usually represents some form of compromise with neither side admitting to any guilt or responsibility in the case and provides a specific amount of benefits with no future medical benefits provided.

RESERVED FOR FUTURE ADDITIONS