LFL&M LAUGHLIN, FALBO LEVY & MORESI LLP

A Guidebook On

WORKERS' COMPENSATION LAW FOR PUBLIC AGENCIES

(2017 EDITION)

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As of its printing date, this guidebook presents the most accurate and up to date information. However, appellate court decisions and statutory amendments result in an ever changing picture. We call this a "guidebook" because that is what it is intended to be. It is not comprehensive enough to provide all the answers. What was true yesterday may not be true today or tomorrow.

FOREWORD

The law offices of Laughlin, Falbo, Levy & Moresi LLP represent employers, insurers, self-insured entities and Public Agencies defending disputed workers' compensation claims. We provide advice, perform discovery, negotiate resolution of claims, and offer representation before the Workers' Compensation Appeals Board. Over the years, Laughlin, Falbo, Levy & Moresi LLP has supplemented this emphasis with several complimentary practice areas, including insurance coverage, insurance litigation, and civil litigation.

Today, Laughlin, Falbo, Levy & Moresi LLP has offices in 11 California cities and a legal staff of more than 150 attorneys. We represent Public Agencies in all of our locations. Below is a list of our attorneys committed to servicing Public Agency clients.

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A special thanks to
all our Insurance Carriers, Administrators and Public Agencies
who have endeavored to manage the unique and important
risks of public agency work. This Guidebook reflects
a small part of the benefit of our teamwork.

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SECTION I

UNIQUE EMPLOYMENT RELATIONSHIPS

I.

UNIQUE EMPOYMENT RELATIONSHIPS

Pursuant to §3350 through §3371 of the California Labor Code, certain individuals who would not be normally considered employees under the usual definitions of the term are considered employees for purposes of workers' compensation claims. If you are presented with a claim in which the worker's employment status is not crystal clear, you may wish to consult these code sections for specific definitions. Some of the more common classes of workers whose claims you are likely to encounter are discussed below.

A. Volunteer Firefighters

There are several different groups of volunteer firefighters who are considered employees depending on their relationship to the public entity, as well as their own status. Pursuant to Labor Code §3361, all registered members of an officially recognized volunteer fire department are deemed employees of the entity for whom they are volunteering, such as a city, county, town or fire district. Further, with certain exceptions, individuals who are injured fighting fires at the request of a public officer or employee charged with the duty of fighting fires are deemed employees of the entity they are serving. Prisoners fighting fires are considered employees of the State Department of Corrections for purposes of workers' compensation. However, members of the Armed Services serving under military command are exempted from this coverage. Finally, pilots who do not furnish their own aircraft are also exempted under certain circumstances (Labor Code §3365).

Registry of volunteer firefighters is accomplished by a roster (Form N). There is no official form, so any document that identifies the individual, his status as an active firefighter, and the date of such service is sufficient. At a minimum a roster must be accomplished annually, but it is best to update it monthly. Be certain to remove persons from the active firefighter roster if their duties have changed to other volunteer work. A separate list of non-firefighter personnel (Form N) and fire cadets (Form N) should be kept in a similar fashion.

Volunteer firefighters disabled as a result of a work injury are compensated at the maximum rate for temporary disability, permanent disability, or death regardless of normal rate of earnings from their employment (Labor Code §4458).

B. Non-Firefighting Volunteers

In order to insulate public entities from civil liability for injuries, unsalaried volunteers for recreation and park districts are deemed employees for workers' compensation purposes if the governing board of such districts has adopted a resolution designating volunteers as employees (Labor Code §3361.5). Similarly, school district volunteers are covered if the County Superintendent or District Board adopts a resolution designating those volunteers as employees

(Labor Code §3364.5). There is a "catch all" provision in Labor Code §3363.5 allowing other public agencies to adopt resolutions specifically allowed for recreation and park districts, as well as school districts discussed above, designating volunteers as employees for purposes of workers' compensation benefits. Volunteers are defined as persons receiving no remuneration other than meals, transportation, lodging and reimbursement for incidental expenses.

C. Reserve/Auxiliary Peace Officers

Individuals properly deputized by sheriffs or city police, as well as by regional park and transit district peace officers are deemed employees when assigned specific police functions and when they sustain injuries while performing peace officer duties (Labor Code §3362.5). Reserve/auxiliary peace officers disabled as a result of a work injury are compensated at the maximum rate for temporary disability, permanent disability or death regardless of normal earnings from their employment (Labor Code §4458.2).

D. Fire Cadets

The term "fire cadet" is imprecise, and in our experience can refer to several different types of potential employees. As such, if you are presented with a claim from a fire cadet, information concerning that individual's status in relation to the public agency should be gathered immediately. In some instances, cadets are really volunteers, discussed previously in part A above. Other cadets who are full-time paid employees may be entitled to Labor Code §4850 benefits depending on their duties. Finally, other cadet programs may be organized under certain public or private programs such as the Boy Scouts of America. Accordingly, cases involving fire cadets need to be analyzed on a case by case basis. Nevertheless all fire cadets should be placed on a separate list and have a job description that accurately describes the limited duty to which they may be assigned. (Form N.)

Where a cadet program permits minors under 18 years of age special precautions must be taken to ensure such minors are not exposed to any dangerous, heavy or potentially detrimental activity as Labor Code §§1294, 1294.1, 1299 preclude such activity whether as employment or volunteer work. Attending fire scenes, operation of firefighting equipment, or emergency medical response are each likely illegal under state and federal law. Additionally even "safe" volunteer work should be established upon parental consent and not involve any activity for which the department may be liable such as operation of an automobile. The best course is to avoid any employment until the individual is over 18 years old. Volunteers under 18 years of age should be restricted in their activities such as clerical/office work, promotional fund raiser activities, or strictly academic training. For this reason, these individuals should be placed on a general volunteer list (Form N). Minors must avoid all active firefighting and response work.

E. Disaster Service Workers

Disaster service workers are specifically addressed by Labor Code §3600.6. To be covered, such workers must be registered by a disaster council, and injured while performing services under the

general direction of the council. Unregistered persons pressed into service during some enumerated types of emergencies are also covered.

F. Independent Contractors

Notwithstanding the above sections, individuals who are found to be independent contractors while performing their duties when injured are not deemed employees. An independent contractor is defined by Labor Code §3353 as:

> …any person who renders service for a specified recompense for a specified result, under the control of his principal as to the result of his work only, and not as to the means by which such result is accomplished.

The "burden of proof" (discussed in Section II, part C of this guidebook) as to establishing an individual as an independent contractor rests with the employer, and cases interpreting this section often seem inconsistent. While the primary test is said to be who has "control" over the methods by which the actual work is performed, whether the individual is actually licensed by the state in a particular occupation, such as a building contractor, is often the determinative issue. Even in instances where the individuals are licensed, such as court reporters, employment relationships are occasionally found. This is a difficult determination, and you may well wish to seek legal advice before denying a claim based on an individual's alleged status as an independent contractor.

G. Employment by Contract, Shared Employment and Mutual Aid Agreement

Public agencies must take great care when contracting for work with third parties who legally are not independent contractors (discussed in Section F, above) or when contracting between agencies to avoid creating unintended employment relationships. This usually will occur when employees are loaned or shared under the terms of a contract. Also, these situations can convert a private employee to a public agency safety member entitling him or her to all manner of special and costly benefits. You should always obtain a legal analysis of contracts or unwritten agreements that in any way involve employees or the use of any so called independent contractors who are unlicensed or work by the hour. It is always best to address clearly in any agreement which party has the obligation to provide workers' compensation coverage and to require proof of insurance, or naming an additional insured.

Public agencies may contract to share employees to save money or to fully utilize personnel. Shared employment agreements between public agencies are especially difficult to administer because the contractual terms may not create joint employment for all the participating public agencies. If so, the exclusive remedy provision which protects an employer from civil lawsuits in most instances may not apply to some agencies in the agreement.

In the case of *Brassinga v. City of Mountain View* (1998) 66 Cal. App. 4th 195, several Bay Area cities formed a Regional SWAT Team. During a joint practice a Palo Alto member was killed in a mock exercise when a Mountain View member failed to unload his weapon. The deceased Palo Alto member received workers' compensation benefits and his dependents sued Mountain View for wrongful death. The Court allowed the wrongful death case to proceed because it did not find Mountain View and the deceased in an employment relationship. The exclusive remedy defense was unavailable. This is an extremely complex area in which it is very difficult to create a joint employment relationship without careful legal advice, and most likely requires forming a new "joint agency" to limit liability. We recommend public agencies be aware of the risks for both workers' compensation and general liability when considering a shared employment or interdepartmental contract. Expert legal advice is a must. This unfortunate legal exposure for team member injuries, adds costly risks to mutual aid and/or regional response teams especially in this time of limited financial resources. We would welcome new legislation to further protect public agencies from civil liability resulting from mutual aid and/or regional response team member injuries.

Fire Districts and local departments all participate in the Cooperative Agreement with the State of California Office of Emergency Services. The agreement provides reimbursement for personnel and equipment use, but liability for workers' compensation benefits is not covered by the State. Similarly, local mutual aid agreements generally provide that each signatory retains its own liability for workers' compensation benefits. On the local level, however, you may agree to other terms and you should seek legal advice in preparing these agreements to either understand the liability you will assume or to shift it to the other party.

H. Minors and Workfare Recipients

Juvenile court wards and probationers, and juvenile traffic offenders doing rehabilitative work without pay are deemed employees when the governing Board of Supervisors adopts a resolution declaring them to be so. You should be aware that there are particular differences in calculating indemnity rates in these cases; for example, juveniles are not entitled to temporary disability indemnity, and permanent disability is computed at the statutory minimum rate. In such instances the specific Labor Code Sections should be consulted (Labor Code §§3364.55 - 3364.7). In addition to the above statutory provisions, the California Supreme Court has decided that an adult performing community service work in lieu of paying a fine is the employee of both the public entity assigning the work, as well as the entity directing it (*Arriaga v. County of Alameda* (1991) 28 C.A.4th 1685, 59 CCC 188). Individuals performing services in lieu of serving a sentence are generally deemed "volunteers" of the county which imposed the sanction.

I. Inmates, Probationers and Community Service

As a public agency you may be offered the services of inmates or probationers who are in custody under a County administered sentence. While these services are offered "free", there may well be a workers' compensation obligation that attaches. Certainly if you pay any wages on a daily rate, your public agency will be responsible for workers' compensation coverage unless you have a

coverage agreement. In any case, we recommend you have a clear agreement that all workers' compensation coverage will be provided by the custodial agency or County before you accept any community service workers.

J. Non-Profit Workers

You may receive offers for free or subsidized workers from a non-profit agency. Often the hope is to enhance the workers' training and eventual employability after gaining some job experience. Green Thumb, Inc. for example provides this service for senior citizens. Often there is an option for the non-profit to cover the worker. If so, we recommend you opt for such coverage to keep these workers who have not gone through your hiring process from affecting your own Workers' Compensation experience. We recommend you have a clear agreement that all workers' compensation coverage will be provided by the non-profit before you accept any services. In summary you should carefully consider the terms of the agreement and whether the workers' compensation and general liability exposures fit your agency's risk management protocols.

SECTION II

INJURIES ARISING OUT OF EMPLOYMENT & IN THE COURSE OF EMPLOYMENT (AOE/COE)

II.

INJURIES ARISING OUT OF EMPLOYMENT & IN THE COURSE OF EMPLOYMENT (AOE/COE)

A. The Definition of an Industrial Injury

In order for the conditions of compensation to exist (in other words, the employer pays), an industrial injury must occur. Only industrial injuries are compensated under California workers' compensation laws. An "industrial injury" is an injury or illness which arises out of a worker's employment, although in most circumstances it need only be shown that the worker's employment contributed to the condition - not that it was the sole cause. Additionally the injury must occur in the "course of employment" which requires to the time, place and manner if the event be industrially related.

There are three ways in which an industrial injury can occur. The simplest is a "specific injury", i.e., a specific event such as a fall or other such occurrence that results in a physical or mental condition.

The second variety is called an occupational disease. A contagious air borne disease for instance is compensable if it is contracted as a result of an exposure that is peculiar to an employment or encountered because of the employment. Examples of an occupational disease might be hospital workers encountering and contracting a disease such as hepatitis, a commercial traveler sent into an area where a disease is epidemic or endemic, etc. Occupational diseases may also result from continuous exposure to deleterious substances in the work environment. Common examples are asbestosis, lead poisoning, and cancer from exposure to certain carcinogens.

Closely akin to and frequently indistinguishable from occupational diseases are the third type of industrial event - cumulative injuries. By statute, these types of injuries are defined as "repetitive mentally or physically traumatic activities", the combined effect of which causes disability or need for medical treatment. (Labor Code §3208.1)

Examples of cumulative injuries include back or upper extremity disabilities resulting from the stress and strain of repetitive movements or acoustical trauma resulting in hearing loss. It is not the one individual act by itself that causes the damage/injury, but rather in the aggregate, the activities over an extended period of time (the cumulative effect), produce a gradual onset and deterioration to the point where the condition becomes symptomatic and medical care becomes necessary.

Disability resulting from aggravation of a pre-existing condition or disease by employment activities (such as stress) also entitles the worker to compensation. Heart attacks precipitated by mental or physical stress are examples of this type of injury. It is not necessary that the work

precipitating the disability be of an unusual nature; there need only be a causal connection between the strain and the disabling event.

Damage to artificial limbs, dentures, hearing aids, eye glasses and medical braces is an injury, however physical damage to eye glasses and hearing aids will not be compensated "unless injury to them is incident to an injury causing disability" (Labor Code §3208). Damage to clothing and other personal property is not covered under workers' compensation, but may be compensated under the employer's statutory obligation to indemnify the employee for a loss in direct consequence of the discharge of employment duties (Labor Code §2802).

B. Special Situations

1. Personal Comfort and Convenience

During the work day, a worker is likely to pause for a drink of water, get some fresh air, visit the lavatory, or to engage in other acts of comfort and convenience. Although none of these activities are the services for which the employee was hired, they are incidental to the employment and impliedly within its contemplation. Injuries sustained while engaged in such acts arise out of and in the course of the employment.

2. Lunch and Coffee Breaks

Lunch and coffee breaks on the employer's premises are in the course of employment. Injuries that occur away from the employer's premises during a lunch break generally do not require payment of compensation. (See Section II, part B-13, Going and Coming Rule) There are many exceptions to this rule, such that off premises coffee breaks can be in the course of employment if they have become customary and have the implied approval of the employer.

3. Bunkhouse Rule

The employer's premises include living quarters furnished to the employee if the employment contract contemplates, or the nature of the work requires the employee to live on the premises. Pursuant to what is known as the "Bunkhouse Rule", the worker is considered to be performing services incidental to the employment whenever making reasonable use of the premises.

4. Proximate Cause

Compensation is payable if the injury has been proximately caused by the employment. Proximate cause exists when the employment brings the worker within the range of the danger which causes the injury. The employment need not be the sole cause of the danger which causes the injury; it need only be a substantial contributing cause. Examples of compensable injuries or conditions include: an injury sustained in a vehicle collision on the way to treatment for an industrial injury; an injury incurred while delivering a return to work slip to the employer after recovery from an industrial injury; drug addiction from pain medication prescribed for the industrial injury; a new injury caused by pain and weakness from the industrial injury.

5. Intoxication

No compensation is payable if the injury has been caused by the employee's intoxication. The employer must prove that the intoxication was the proximate cause of the injury. An employer who condones or encourages the drinking may be stopped from asserting the intoxication defense (i.e., office parties where the alcohol is provided or condoned).

6. Self-Inflicted Injury

An intentionally self-inflicted injury is not compensable.

7. Suicide

Compensation paid in the form of statutory death benefits is not payable if the death was willfully and deliberately caused by the employee. The employer must, however, show that the employee voluntarily committed suicide and also that he could have resisted the impulse to commit the act. If expert testimony shows that without the industrial injury, there would have been no suicide, the injury is a proximate cause of the death. A death by suicide is also compensable when the pain resulting from an industrial injury has caused the employee to feel that death would afford the only relief unless it appears that the employee could have resisted the impulse to act.

8. Initial Physical Aggressor

Work puts employees under strains and fatigue that create frictions and sometimes cause altercations. An injury sustained in a fight that grows out of a dispute over the employment may be compensable, whether inflicted by a supervisor, fellow employee or a subordinate. Conversely, an injury sustained in an altercation engendered by personal animosity wholly unrelated to the employment does not arise out of the employment. There is no recovery if the worker who claims benefits for an injury sustained in an altercation was the initial physical aggressor. The person making the first physical contact is not necessarily the initial physical aggressor. A worker who approaches a fellow worker in such a manner that the fellow worker is placed in reasonable fear of bodily harm is the initial physical aggressor even though he does not strike the first blow. Thus, the initial physical aggressor is the first person engaging in conduct amounting to the legal definition of an "assault".

9. Recreational, Social and Athletic Activities

There is no recovery for injuries arising out of voluntary participation in off-duty recreational, social or athletic activity that is not a part of the employee's work related duties, unless the activity is a reasonable expectation of employment or is expressly or impliedly required by the employment. However, activities of a worker who is hired to engage in recreational or athletic activities are in the course of employment. Some commentators have suggested that when an employee furnishes equipment for the activity, or has an interest in the activity, for example in relation to advertising the business, a compensable injury is more likely to be found. In any instance, an employer should post notice pursuant to Title 8, regulation 9881 that "your employer or its insurance carrier may not be liable for payment of workers' compensation benefits for

any injury which arises out of an employee's voluntary participation in any off-duty recreational, social or athletic activity which is not a part of the employee's work-related duties."

10. Felonies

Injuries sustained while in the commission of a felony do not result in payment of compensation by the employer.

11. Injuries After a Firing or Lay-Off

Injuries claimed after a notice of termination or lay-off (including a voluntary lay-off) may or may not be entitled to compensation depending upon when the notice of termination or lay-off was issued, and a number of other criteria [Labor Code §3600a(10)]. There are additional elements of proof that the employee must produce if the claimed injury is of a psychiatric nature (see Labor Code §3208.3 - discussion following in part 12). It is good practice to provide written notice of termination or lay-off to the employee, and to keep a copy of the notice in the employee's personnel file for easy documentation. The effective date of the termination or lay-off must be within 60 days of the notice to insure this potential defense.

12. Psychiatric Injuries

Sweeping and drastic changes were implemented by the Legislature in 1993 with respect to compensation payable for psychiatric injuries. To be compensable, a psychiatric injury must: a) cause disability or need for medical treatment; b) be diagnosed pursuant to procedures promulgated by the Industrial Medical Council; c) have been caused by actual events of employment which are predominant (more than 50%) as to all causes combined of the psychiatric injury; d) not have been substantially caused by a lawful non-discriminatory good faith personnel action. If, however, the injured worker was the victim of a violent act or was directly exposed to a significant violent act, the actual events of the employment need only be a substantial cause (i.e., 35% to 40%). There is also a requirement that the worker must have been employed for six months before the injury, unless it was caused by a sudden and extraordinary condition. Additional criteria for the payment of compensation exist if the psychiatric claim is filed after a notice of termination or lay-off. (See Section II, part B-11).

13. Commute Injuries (Going and Coming Rule)

The "Going and Coming Rule" precludes compensation for injuries sustained en route to and from work, in other words, during a normal commute. The rule has numerous complex exceptions. Two examples of exception are a) the employer provides or contributes to the cost of the transportation, or b) the employee is on a special mission for the employer. A basic statement of the rule is as follows: "travel to and from work is deemed to be in the course of employment unless it is an ordinary commute to a fixed place at a fixed time." Injuries suffered during a commute are compensable if the employment subjected the worker to a special risk or there are special circumstances. For

example if a worker is required to participate in off-site training an injury during such travel is compensable as this is a "special mission" even if the travel is uncompensated.

C. Presumptions

1. Burden of Proof

In a normal case of industrial injury, the employee has the burden of proof to show that an injury/disability arose out of and in the course of employment (Labor Code §§3600, 3202.5):

a. The employee must meet his burden by a "preponderance of the evidence."

b. "Preponderance of the evidence" is defined as evidence which weighed with that opposed to it, has more convincing force and the greater probability of truth.

2. Safety Officers Entitled to Certain Presumptions

Certain safety officers, such as police officers, firefighters, deputy sheriffs, jailers, state prison guards, campus police, district attorney investigators, and other law enforcement personnel have the benefit of a presumption of work injury respecting certain medical conditions. These medical conditions are outlined in several statutes, Labor Code §3212 through §3213 (see Table I – Page 32). More detail about these medical conditions will be covered in part C-5 of this section.

a. These presumptions do not apply to all public safety officers - the safety job title must be specifically covered in a statute.

3. What is a Presumption?

a. Simply put, a presumption is an assumption of fact the law requires to be made from another fact or group of facts formed in the case (Evidence Code §600 (a)). These statutorily enacted facts can either be "conclusive", meaning that you cannot dispute them, or they are "rebuttable", which means that you can produce evidence to overcome what you are told you must assume to be true.

b. The presumptions we are dealing with in these statutes are rebuttable.

4. Why do we have Presumptions?

a. To provide additional compensation to certain public employees who provide vital and hazardous services by easing their burden of proof - it's a benefit to them, conferred by the legislature, to which other employees are not entitled.

b. This additional compensation is delivered by easing the burden of proof that the employee has to show and, in fact, actually shifts this burden of proof to the employer to disprove the statutorily enacted fact.

5. Types of Presumptions (see Table I – Page 32)

a. The presumption for certain illnesses is such that the specified illness set forth in the statutes arose out of the employment relationship if it **developed** or **manifested itself** during the **employment period**.

1) Litigation over the terms "developed", "manifested itself" and "employment period" abound.

2) The following illnesses are presumed to have been attributable to the employment for certain specifically enumerated employees.

a) Heart trouble

This has a rather expansive term. In general, it encompasses any affliction to, or additional exertion of, the heart caused directly by that organ or the system to which it belongs, or to it through interaction with other afflicted areas of the body, which might be produced by the stress and strain of the covered employment.

(1) Examples: the presumption has been applied to a fire-fighter's aortic valve disease, to acute and chronic arteriosclerotic occlusive disease in the iliac arteries, to a heart attack caused by valvular lesions due to rheumatic fever, to atherosclerotic heart disease, to cardiomyopathy, and to coronary insufficiency.

(2) For purposes of the presumption, **hypertension** is not deemed the equivalent of "heart trouble" even though this condition is frequently the precursor of other cardiac conditions that may be so characterized - such as cardiomyopathy, etc.

(3) Stroke (CVA's): **no presumption**.

(4) Labor Code §3212.5 indicates that for California highway patrol, peace officers and district attorney investigators to enjoy the presumption for heart trouble, they must have worked full time for five years. Firefighters (even volunteers) are covered immediately.

b) Pneumonia

c) Hernia

d) Tuberculosis

e) Cancer

(1) This presumption applies when the cancer develops or manifests itself during a period while the member is in the service of the department. For injuries filed after 1-1-97, this statute provides that cancer or leukemia is a

presumed injury that may only be controverted by evidence showing the primary site of cancer has been established, and the carcinogen to which the claimant has demonstrated exposure is not reasonably linked to the disabling cancer. Specifically included as a cancer condition is leukemia. This provision shifts the burden of proof to the defendants to disprove a presumed injury once the firefighter/peace officer establishes the presence of a cancer and an exposure to a known carcinogen. In the case of *Joy v. WCAB* (2009) 74 CCC 871, the WCAB held that a reserve police officer's thyroid cancer, having a latency of 10 years, manifested when the applicant was a Penal Code §830.6 "reserve officer" not covered by the presumption. Peace officers covered by the cancer presumption only include those engaging in active law enforcement and sworn under Penal Code §§830.1, 830.2 (a), and 830.37 (a). Based upon a latency finding defendants proved the presumption did not apply, and further the latency proved the absence of a reasonable link between his later employment exposure as a regular City police officer and the thyroid cancer. In the same case however, Joy suffered a separate unrelated cancer in the form of Hodgkin's disease during a period when he was a regular City police officer under Penal Code §830.1, and therefore he was entitled to the presumption, and found the Hodgkin's disease compensable.

f) Low back where a police “duty belt” is a condition of employment
g) Blood borne diseases
h) Meningitis
i) Biochemical exposure
j) Lyme Disease
k) Methicillin-resistant staphyloccusaureus skin infection (MRSA)

6. UC & CSU Personnel

For statutory reference applicable to University of California Firefighters and Law Enforcement Officers, see Table I – Page 32. For statutory reference applicable to California State University Police Officers, see Table I – Page 32.

7. Duration of Presumptions (Labor Code §3212, et. seq.)

a. Toward the beginning of this section, the statement is made that the presumption applies if the disease manifests itself during the employment period - what is the employment period?

1) It can extend beyond the **last date worked** in the covered capacity as opposed to the effective date of retirement.

2) If the safety job title is specifically enumerated by statute, the presumption is extended post-active service up to a maximum of 60 months (120 months for cancer, Labor Code §3212.1 amended in 2010) from the last day actually worked. The extension is for each full year of service a three month extension is granted. In order to get the maximum 60 months (120 months for cancer), the officer must have 20 years of safety service (40 years for the cancer maximum). Less than 20 years service provides three months for every year of safety service; so as an example, five years service permits a post-service extension of 15 months, 10 years service provides 30 months and 15 years service provides 45 months.

Exception: Under Labor Code §3212.8 the MRSA presumption extends only 90 days from the last day actually worked.

8. Rebutting Presumptions

a. Must a claim be accepted when the treating physician makes a diagnosis of one of the presumed compensable illnesses? No.

b. Should a medical opinion be obtained? Yes, not so much for causation, although it must be addressed to a certain degree to rebut the presumption, but also to confirm the diagnosis because only the specifically identifiable illnesses are presumed to be compensable.

1) Is an opinion from a medical expert (PQME/AME) that "heart trouble" was not caused by the employee's work as a safety officer sufficient to rebut presumption? No. The opinions of the expert must establish a cause other than work to rebut presumption, that is, medical opinion that heart trouble such as a heart attack is of unknown cause does not rebut the presumption. However, a medical opinion that cardiomyopathy (enlargement of the heart muscle) was heart trouble but was caused by non-industrial alcoholism may rebut the presumption.

c. Failure to properly rebut presumption can result in penalties being assessed.

d. "Anti-attribution clause"

1) No hernia, heart trouble, pneumonia, or blood borne infectious disease that develops or manifests itself during the period the member is in service may be attributed to any disease existing prior to that development or manifestation (Labor Code §3212) - however, a contemporaneous non-work related event or set of circumstances can sufficiently rebut this presumption. This presumption is called the anti-attribution clause.

2) By comparison other presumptions like the cancer presumption do not include an anti-attribution clause allowing rebuttal by a broader scope of evidence, which includes prior diseases or medical conditions that generally are not admissible evidence in presumptions which do include the anti-attribution clause such as "heart trouble". Evidence that may rebut the cancer presumption includes the lack of reasonable link between the latency period of the specific cancer and the "development or manifestation" of the cancer.

3) The presumptions discussed above and found in Table I have been expanded to disallow apportionment of permanent disability beginning 1-1-07 (Labor Code §4663(e)) (See also, Section III Benefits Apportionment of permanent Disability).

9. Off Duty Injuries

a. Are safety officers' off duty injuries compensable?

1) Off duty peace officers' (peace officers are defined in Penal Code §830, et seq.) injuries are compensable if:

a) The employer must require the officer to be on call,

b) The injury must occur within the jurisdiction of the employer,

c) The activity producing the injury must be one the officer is required to perform when on duty (Labor Code §3600.3).

b. Injury producing activities while the off duty officer is acting as an employee of another entity or independent contractor in any capacity other than as a peace officer are not within the course of the employment (Labor Code §3600.3).

c. Firefighters not under immediate direction are covered if:

1) Proceeding or engaging in fire suppression, rescue operation, or preserving property **except** when:

a) Paid by a non-firefighting agency at the time of injury; OR

b) The activity is prohibited by law, ordinance or department regulation (Labor Code §3600.4).

SECTION III

BENEFITS

III.

BENEFITS

A. Workers' Compensation Benefits

Typical benefits under California Workers' Compensation laws generally fall into five categories. These categories are:

- Medical benefits
- Temporary disability indemnity benefits
- Permanent disability indemnity benefits
- Supplemental Job Displacement Benefits (for injuries after 1-1-04)
- Dependency (death) benefits.

There is a separate category of benefits called penalties which will be dealt with in another section (see Section IV).

1. Medical Treatment

California law provides that an employee who is injured on the job is entitled to all the medical treatment which is reasonably required to cure or relieve from the effects of the injury. Determination of the reasonableness and necessity of medical treatment is subject to Utilization Review (UR) (Labor Code §4610), which is mandatory for all employers and effective for all dates of injury. UR standards must be consistent with the schedule for medical treatment utilization adopted pursuant to Labor Code §5307.27 and the Medical Treatment Utilization Schedule (MTUS).

Labor Code §4604.5(b) states that medical treatment is determined by the MTUS. Effective July 18, 2009 the Administrative Director's (AD) changes to the MTUS include Acupuncture Guidelines, Chronic Pain Medical Treatment Guidelines, and post Surgical MT Guidelines (see Cal Code of Regulations §9792.24 1- 3). The ACOEM based guidelines and MTUS (including new guidelines) adopted pursuant to Labor Code §5307.27 shall be presumptively correct on the issue of the extent and scope of medical treatment. This presumption may be rebutted by a preponderance of scientific medical evidence based on other scientifically based, nationally recognized and peer reviewed guidelines. Medical care is not limited in terms of time or money and is provided entirely by the employer without co-payments or deductibles from the employee.

a. MPN Medical Treatment

Utilization Review determinations are now effective for 12 months unless there is a documented change in the injured worker's condition. Labor Code §§4616, et seq. allow the employer on or after 1/1/05 to establish a medical provider network (MPN) for provision of medical treatment to injured employees. The

framework for provision of medical treatment differs depending on whether it is within or outside of an MPN.

Once an injury has been reported to the employer, it is the employer's obligation to make an offer of medical care on a timely basis. If the employer does so, the employer and/or its administrator/insurance company has the right to control the provision of medical care for the first 30 days after the injury is reported. Thereafter, the employee may select his own treating physician at a facility of his choice within a reasonable geographic area. A chiropractor shall not be a treating physician after an employee has received a maximum number (24) of chiropractic visits (Labor Code §4600(c)). If the employer fails to make an offer of medical care on a timely basis, the injured worker has the right to obtain medical care with a physician or medical facility of his choice at the employer's expense. It is therefore extremely important that the employer, when an injury is reported, makes a timely offer of medical care in order to maintain the right to direct medical care for at least the first 30 days and up until the point where the employee designates his own physician to provide further medical care.

Labor Code §4600 allows an employee to pre-designate his personal physician as the medical provider in the event of an industrial injury. Under these circumstances, the injured worker may then go to his own pre-designated personal physician immediately. In order for an employee to pre-designate his physician, the following five requirements must be met:

1) The employee must have health care coverage for non-occupational injuries or illnesses on the date of injury;
2) Written notice must be given to the employer setting forth the physician's name prior to the date of injury;
3) The medical provider must be a physician as defined in the Business and Professions Code (may not be a chiropractor) who has previously directed the employee's medical treatment; and
4) The named physician must retain the employee's medical records, including medical history, in the physician's office;
5) The physician must agree to be pre-designated.

The medical care to be provided to injured employees is defined in broad terms. Medical treatment includes medical, surgical, chiropractic and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches and apparatus including orthotic and prosthetic devices and services. Also included may be reasonably needed psychological counseling provided by a psychiatrist, psychologist or other mental health practitioners (with certain restrictions for monitoring by a medical physician). Medical treatment also includes reasonable transportation expense to and from offices of physicians; travel to hospitals and for obtaining prescriptions authorized by the treating physician and temporary

disability benefits in the event the employee loses wages while obtaining medical care.

While the employer has the right to control medical care for the first 30 days (in the absence of pre-designation of the personal physician or failure to offer medical care), employees have the right to request the employer to provide a change of treating physician at any time including during the first 30 days. Any such request must be responded to within five working days, or thereafter employees may select any physician they choose to provide care. Employees are also entitled, in a serious case, upon request to the services of a consulting physician or chiropractor of their choice at the expense of the employer. Contrary to common belief, an employee may change physicians more than once, so long as the changes are reasonable.

The MPN established by the employer **on or after 1/1/13** must meet the statutory requirements set forth in Labor Code §4616 and the employer must secure approval of the proposed MPN from the AD. MPN approval by the AD is valid for four years. (Commencing 1/1/14 existing and approved MPNs shall likewise be valid and approved for four years.) Moreover, if the AD does not act on a submitted MPN, within 60 days it shall be deemed approved. Once approved, there shall be a conclusive presumption by the Appeals Board that the MPN is valid.

If an employee disputes either the diagnosis or treatment prescribed by the MPN physician, the employee may seek the opinion of another physician within the MPN. If the injured employee disputes the diagnosis or treatment prescribed by the second MPN physician, the employee may seek an opinion from a third MPN physician.

Noteworthy is that **commencing 1/1/14**, every MPN must provide one or more individuals within the United States to serve as medical access assistants to help the injured employee find an available physician.

b. Medical Treatment Disputes

Pursuant to Labor Code §4610.5(d), for all dates of injury, if a treatment recommendation is denied, modified, or delayed pursuant to Utilization Review, the employee's remedy for appeal is to request an Independent Medical Review (IMR) within 30 days of service of the adverse determination.

The request must be made on the form prescribed by the AD to initiate the IMR process. Within 10 days of notice of assignment to an IMR organization (the identity of the IMR physician remains confidential) the employer must provide all requisite medical records and correspondence as set forth in Labor Code §4610.5(l), including the following:

All medical records regarding current medical condition, medical treatment, disputed medical treatment requested, correspondence regarding disputed treatment, employee information and "all other relevant documents."

Contemporaneous service must be made on the employee and the requesting physician. The foregoing must be supplied to the IMR within 10 days for regular treatment requests, and 24 hours for Expedited Treatment requests. The IMR will make a determination on the request within 30 days for regular requests, or 3 days for Expedited Requests, based upon the standards of medical necessity as defined in Labor Code §4610.5(c).

The IMR determination is deemed a determination of the AD and is binding upon all parties. The grounds for appeal are limited to fraud, conflict of interest, bias, or mistake of fact. If the decision of the AD is reversed, the matter is remanded to the AD to submit dispute to IMR by a different review organization. Any decision of medical necessity must be "promptly" implemented by the employer.

2. Temporary Disability Benefits

During periods when injured workers are temporarily incapacitated from the effects of their injuries and unable to work, they are entitled to receive compensation payments. The rate of TD payments is dependent upon employment status as well as earnings. For injuries prior to 4/19/04, the duration of temporary disability payments is not limited by statute. For injuries on or after 4/19/04, aggregate temporary disability payments for a single injury shall not extend for more than 104 compensable weeks within a period of two years from the date of commencement of temporary disability payment. For injuries on or after 1/1/08, aggregate temporary disability payments for a single injury shall not extend for more than 104 compensable weeks within five years of the date of injury. This change allows for the temporary disability to be paid any time with in the five years of the date of injury. Exceptions to these limitations are provided in the case of nine statutorily specific injuries and illnesses for which TD may extend to 240 weeks (Labor Code §4656(c)). Temporary disability benefits are not taxable.

a. Public Safety Officers

Labor Code §4850 defines several categories of public safety officers (this includes any police officers, deputies or firefighters of a district, city or county fire department whose principle duties include active police or fire fighting) who are to receive, in lieu of temporary disability, payment of "full salary" and benefits for up to one year. Effective 1-1-10, Labor Code §4850 requires the injured worker to be "employed, on a regular full-time basis". This recent amendment deleted the requirement for membership in a retirement program. The period of one year does not have to be continuous. After the termination of one year of benefits, the public safety officers are entitled to regular compensation benefits and may also be entitled to retirement benefits. If the

injured worker is still temporarily totally disabled after payment of one year of full salary continuation benefits, then he/she will receive TD in accordance with Labor Code §4656 for an additional year or a total of 104 weeks of disability benefits. Pursuant to the recent Court of Appeal case of County of *Alameda v. WCAB* (*Knittel*) (2013), 78 CCC 81, the payments made under §4850 do count toward the 104 week limitation for "aggregate disability benefits". As a result, the maximum for a qualifying safety officer is 52 weeks of §4850 salary continuation, followed by 52 weeks of temporary disability payments payable at 2/3 Average Weekly Wages up to the maximum, $1,128.43. These full salary benefits are not taxable, but the employer can continue the usual payroll deductions as the taxation of this income is an issue between the taxpayer and the IRS. 26 USC 104 provides that "amounts received under Workmen's Compensation" are not taxable income. Consider and be guided by any employment agreements or MOU regarding withholding of taxes when providing "full salary" benefits under Labor Code §4850.

Volunteer Firefighters and Reserve Police Officers are presumed to have maximum wage earning regardless of their compensation from the safety work or elsewhere. (Labor Code §4458 and §4458.2). The presumption of maximum wages does not apply to full-time paid Firefighters or Police.

For statutory language applicable to UC employees (Police & Fire), refer to Labor Code §4804.1 & §4804.4. For statutory language applicable to CSU employees (police), refer to Labor Code §4816.

b. Non-Public Safety Employees

Employees who are not entitled to the full salary in lieu of temporary disability pursuant to Labor Code §4850 are entitled to temporary disability indemnity benefits (TD). Temporary disability indemnity benefits continue during the period while employees are incapacitated from their usual and customary occupation until they have either returned to work, returned to partial duty, been declared permanent and stationary (and therefore have fully recovered or have permanent disability restrictions), or the statutory period for payment of TD has expired. Temporary disability benefits are payable every two weeks at the rate of two thirds of injured workers' average weekly wages subject to statutory maximums as set out in Table II.

Employers can limit their obligation to pay temporary disability indemnity by offering modified duty to employees. Upon release by a physician of the employee to modified duty, an employer may stop paying temporary disability indemnity benefits if they are able to offer the employee work within his stated restrictions. This occurs even if an employee refuses to return to the modified duty upon release. Because this issue is often subject to litigation, it is recommended that any and all offers of modified or alternative work to an

employee by the employer be made in writing. If the employer is unable to accommodate the restrictions given by the physician the employee's right to receive temporary disability indemnity benefits continues.

Early return to work, through offers of modified work, saves money and keeps the injured worker involved with the employment environment creating a positive relationship through the recovery process. An employer should maintain clearly defined job descriptions of all employees' usual work and light duty opportunities. These descriptions of work options should be quickly communicated to the treating doctor by providing them to the claims administrator or directly by the employer. The goal is to have the treating doctor know that the employer wants the injured worker back as soon as possible and is willing to provide temporary light duty if needed.

In summary, the employer's obligation to pay temporary disability benefits for the effects of an injury continues until one of the following: 1) permanent and stationary status; 2) an offer of modified or regular work; 3) but in no event more than 104 weeks for most injuries (unless limited exceptions found in Labor Code §4856).

3. Permanent Disability Benefits

Should an industrial injury leave an employee with permanent impairment, the employee is entitled to an award of money based upon the employee's injury or disfigurement, his occupation, and age. Volunteer Firefighters and Reserve Police Officers are presumed to have maximum wage earning regardless of their compensation from the safety work or elsewhere. (Labor Code §4458 and §4458.2). The presumption of maximum wages does not apply to full-time paid Firefighters or Police. **For injuries on or after 1/1/13**, Permanent Disability (PD) is governed by new Labor Code §4660.1(c)(1), which eliminates some psychiatric injuries such as sexual dysfunction and sleep impairment as compensable consequences (with notable exceptions for violent crimes or catastrophic injuries). Injured employees can still receive treatment however, for injuries affecting those body parts or giving rise to those conditions.

Labor Code §4650(b) is amended to provide (**Effective 1-1-13 for all dates of injury**) that if the employer offers an injured employee a job that pays at least 85% of his pre-injury wages and compensation or if the employee is employed in a position that pays at least 100 percent of the pre-injury wages and compensation, no PD advances are required to be paid **prior to a PD award by the WCAB**.

When a PD award is made, the PD amount due is calculated from the last date of TD or the date the employee's disability became P&S, whichever is earlier. This incentivizes both the employee to return to work as soon as possible, and the employer to make a job offer paying at least 85% of pre-injury wages and compensation as soon as possible.

In summary, the employer is not required to begin PD indemnity if the employee returns to work with his employer at 85% of pre-injury wages and compensation, or is working at a job that pays 100% of pre-injury wages and compensation – **even if the employee is working for a different employer**.

For pre-1/1/13 dates of injury, Labor Code §4658(d)(2), still requires a 15% PD increase for employers with 50 or more employees. However regardless of the number of employees, permanent partial disability benefits may be reduced by 15% per week if the employer offers regular, modified or alternative work within 60 days of the employee's condition becoming permanent and stationary. Labor Code §4658(d)(3)(A). Failure to offer regular, modified or alternative work within 60 days of the employee's condition becoming permanent and stationary will result in a 15% increase in the weekly PD benefit thereafter. **For injuries occurring on or after 1/1/13, the 15% increase or decrease has been eliminated.**

An employee left permanently and totally disabled as a result of an industrial injury will still receive the temporary disability indemnity benefits in effect on the date of injury for the remainder of his life. Life Pension provisions also remain unchanged. The Supreme Court has decided that the COLAs operative in Labor Code §4659(c) for injuries after 1/1/03 are to begin on the January 1st of the year following the date the worker became entitled to receive and actually begins receiving either permanent total disability payments or a life pension payment.

4. Apportionment of Permanent Disability

In general, an employer is responsible to pay only for the permanent disability directly caused by the industrial injury. The law of apportionment is set forth in Labor Code §4663 and §4664; however, its interpretation is highly complex and often litigated. The California Appellate Court in *Benson v. WCAB* 170 CA 4th 1535, 37 CWCR 27, 74 CCC 113, held that "the new statutory scheme requires apportionment to each cause of a permanent disability, including each distinct industrial injury." Labor Code §4663(e) states that apportionment as to causation shall not apply to the presumptive injuries under Labor Code §3212 et seq. (see also Section II, C presumptions). Thus a Public Safety worker whose injury is covered by presumption in Labor Code §§3212 - 3213 is excluded from apportionment to pre-existing conditions, but not actual disability previously awarded by the WCAB.

5. Vocational Rehabilitation Benefits

Workers injured before 1/1/04 that are unable to return to their usual and customary occupations as a result of their injuries, are eligible pursuant to Labor Code §139.5 to vocational rehabilitation benefits to assist them in the return to employment, but must request services before 1/1/09. As of 1/1/09 Labor Code §139.5 ceased to be in effect. The WCAB issued a unanimous decision in *Weiner v. Ralph's Co.* (2009) 37 CWCR 147, 74 CCC 736 (en banc) which held that the repeal of 139.5 terminated all rights to

vocational rehabilitation benefits or services where the right to VR benefits had not vested prior to 1/1/09.

6. Supplemental Job Displacement Vouchers And the Interactive Process

For Dates of Injury 1/1/04 – 12/31/12 qualified employees are entitled to supplemental job displacement vouchers (Labor Code §4658.5). Workers injured on or after 1/1/05 are not entitled to Vocational Rehabilitation Benefits discussed previously in Section IV. Up to 10% of the value of the vouchers may be designated for vocational or return to work counseling. This benefit does not provide a weekly maintenance allowance and is a reduced benefit when compared to its predecessor. The amount of this benefit is determined by the amount of permanent disability. (See Form L3 & M2). A voucher must be used within five years of the date of injury or within two years of the date it was furnished if it was issued **on or after 1/1/13**.

Effective 1/1/13, there are new limitations on the monetary value of vouchers for **dates of injury on or after 1/1/13**. Vouchers now have an expiration date; new vouchers for injuries **on or after 1/1/13** are capped at $6,000. Also, vouchers for injuries **on or after 1/1/13** cannot be settled, and injuries sustained during the use of the voucher are not compensable. **For the dates of injury on or after 1/1/13**, the voucher expires two years after the date it is furnished or five years after the date of injury (Labor Code §4658.7). Covered voucher expenses have been expanded under the new legislation.

For dates of injury on or after 1/1/2013, a voucher must be used within five years of the date of injury or within two years of the date it was furnished if it was issued **on or after 1/1/13**, whichever is later (§4658.5(d)). For dates of injury **on or after 1/1/13**, the voucher expires two years after the date it is furnished or five years after the date of injury (§4658.7).

Covered voucher expenses have been expanded.

For injuries on or after 1/1/13, the applicant is entitled to a voucher if he has residual disability and the employer does not make an appropriate timely job offer lasting 12 months. A timely offer is within 60 days of the carrier receiving the first P&S report from the treating physician or medical-legal evaluator. An appropriate job offer must be within the applicant's work restrictions.

To ensure that the offer is within the work restrictions, Labor Code §4658.7 essentially puts the burden on the carrier to start the interactive process. The new code section provides that if the employer or carrier provides the employee's job description to the physician, that physician shall evaluate and identify work restrictions. The carrier must then send the work restrictions to the employer in order to evaluate the availability of appropriate work (§4658.7(b)). The obligation of the employer to initiate the interactive process may have civil implications pursuant to AB 2222. Employers should familiarize themselves with the requirements of the FEHA/ADA and AB 2222 in handling

employment decisions. It is recommended that employers have prepared Job Descriptions and engage in the interactive process to explore reasonable accommodations of the employee's disability, by meeting with the employee to discuss those accommodations, even if the injury is impossible to accommodate or there is no alternative work is available. Failure to undertake the interactive process may result in a civil lawsuit in state or federal court.

Offers of modified or alternative work must be made by the employer through the use of Form 10133.35 (Form L1) for **injuries occurring on or after 1/1/13**, or Form DWC-AD 10133.53 (Form L3).

For positions which involve public safety (such as police, firefighters and emergency personnel), the requirement to provide reasonable accommodation is tempered by a recognition that the public's safety must be maintained. Accommodation in these cases may not be required if the employer maintains reasonable physical fitness standards that the injured worker cannot meet or if increased risk to the public can be shown. Remember the process by which an accommodation must be reasonable and involve communication with the injured worker.

The AD has established a Return to Work Supplement Program, if an injured has first received a supplemental job displacement benefit for injuries occurring on or after 1/1/13, as contained in 8 California Code of Regulations §17302 through §17309.

7. Dependency (Death) Benefits

Should an employee be killed or sustain injuries which result in death as a result of an injury during the course and scope of employment, his dependents (or the estate in certain instances), are entitled to statutory benefits. The amount of benefits is determined by the date of injury, the level of dependency and the number of dependents. In addition, the families of deceased employees, regardless of dependency, are entitled to a burial benefit up to a statutory maximum according to the chart in Table IV subject to proof of actual expenses.

In order for death benefits to be payable, the injured employee's death must occur within 240 weeks of the date of injury.

Families of safety members who are killed in the line of duty may be entitled to special death benefits from CalPERS or other retirement systems.

The Legislature has enacted §5406.7 effective 1/1/2015. This provides a potential lengthening of the time to file for a presumptive cancer related death claim available to dependents of certain safety personnel under §3212.1. This new statute will apply to all pending cases but its application is complex. If applicable, it will extend the time to claim a death benefit from the statutory 240 weeks up to 420 weeks. It is recommended that you seek legal advice to determine if this extension applies. The Legislature has provided

that this provision will only be effective through 1/1/2019 and thereafter it is automatically repealed.

B. Retirement Benefits

The majority of public employees of the State of California are members of one of three retirement systems; the Public Employees' Retirement System (CalPERS), the County Employees' Retirement Law of 1937, or the State Teachers' Retirement System. For our purposes we will focus on the first two in this discussion. Coordination of the benefits under CalPERS and the County Employees' Retirement Law of 1937 (CERL) is relevant and critical to the provision of workers' compensation benefits.

1. Public Employees' Retirement System (CalPERS)

For public safety members, the provision of benefits under the public Employees' Retirement Systems has significant impact on workers' compensation benefits. These include the following:

a. CalPERS safety members who are permanently disabled from their work because of an industrial injury can receive a service connected disability retirement (this is also called an industrial disability retirement or "IDR"). Upon receipt of a service connected disability retirement benefit, or advances from the employer of those benefits under Labor Code §4850.3 or 4850.4, salary continuation under Labor Code §4850 ends. When an employer makes advances under Labor Code §4850.3 or §4850.4 the employer is paid back by CalPERS when the disability retirement is affirmed by CalPERS.

b. In addition to termination of benefits pursuant to Labor Code §4850, a service connected disability retirement terminates the obligation of the employer to pay temporary disability indemnity benefits and vocational rehabilitation maintenance allowance benefits if applicable. It does not affect the obligation to pay permanent disability benefits, or supplemental job displacement vouchers.

c. For a non-service connected disability retirement or a retirement for service, the obligation to pay temporary disability indemnity and vocational rehabilitation maintenance allowance benefits is not affected. Service connected disability payments are usually 50% of the member's "final compensation" which is determined by one of several formulas depending upon the option the employer selected. Non-service connected disability benefits and service retirement are determined based upon years of service and earnings.

Effective January 1, 2003, Labor Code §4850.4 requires an employer to make advances in cases where the Industrial Disability Retirement is disputed, and there is no current authority for reimbursement by PERS should the injury be found to be non-industrial.

However, the agency may pursue recovery (Labor Code §4850.4(8)). For general information about PERS call or write:

CalPERS
Benefit Application Services Division
P. O. Box 2796
Sacramento, CA 95812
T: 888-225-7377
www.calpers.ca.gov/

2. County Employees' Retirement Law of 1937 (CERL)

For public safety members, the provisions of benefits under the County Employees Retirement Law of 1937 are distinct from the provisions of CalPERS.

a. CERL safety members who are permanently disabled from their work because of an industrial injury can receive a service-connected disability retirement. Upon receipt of a service-connected disability retirement benefit, or advances from the employer of those benefits under Labor Code §4850.3, salary continuation under Labor Code §4850 ends. However, as distinguished from CalPERS, when an employer makes advances under Labor Code §4850.3, the Labor Code does not provide that the employer be reimbursed by the retirement association under CERL.

b. Unlike CalPERS, a service-connected disability retirement under CERL does not terminate temporary disability indemnity benefits or vocational rehabilitation maintenance allowance benefits. This issue was distinguished in *Pennington v. WCAB*, County of Los Angeles, 20 Cal. App. 3d 55 (1971) and *Burns v. WCAB and County of Los Angeles*, 190 Cal. App. 3d 759 (1987).

c. A safety member who is a member of both CalPERS and CERL, as a result of employment under both systems during the course of his career, and is granted a service-connected disability retirement may continue to receive temporary disability indemnity benefits or vocational rehabilitation benefits, despite the fact that if only having been a member of CalPERS, such benefits would have ended.

For retirements under both CalPERS and **the County Employees' Retirement Law of 1937, service connected disability retirement benefits are generally non-taxable** whereas retirement benefits based on length of service are taxable. Therefore even if the benefits are relatively comparable, the tax free benefit of a disability retirement substantially weigh in favor of the employee to retire for service connected disability reasons.

For general information about the County Employee's Retirement Law of 1937 call or write your local County retirement association office.

SECTION IV

PENALTIES

IV.

PENALTIES

Workers' Compensation law provides for several different types of "penalties" payable by employers and/or their insurance companies and adjusting agencies for various violations of either the law or public policy. The important ones are outlined as follows:

A. Serious and Willful Misconduct – Labor Code §4551 and §4553

Should the employee be able to demonstrate that his injury was sustained as a result of Serious and Willful Misconduct on the part of the employer, the employer is obligated to pay to the employee a supplemental benefit totaling 50% of all compensation and medical benefits payable to the employee. This benefit is payable by the employer, not the insurance company and/or a third party administrator (TPA), and may not be insured against although the employer may buy insurance to cover the costs of defending such a claim.

In order for an employee to demonstrate that the injury occurred as a result of Serious and Willful Misconduct, he must demonstrate either one of the following two:

1. That the injury occurred as a result of the violation of a safety order which was designed to prevent the type of injury which occurred and that the employer through a managing representative had knowledge of the existence of the safety order and the violation of same, or

2. The employer had knowledge that a substantial risk of harm existed and took no steps to prevent the harm or correct the defect which was proximate cause of the resulting injury.

    a. There is also a provision for the employer to claim that an injury was a result of the employee's own Serious and Willful Misconduct. If the WCAB determines that the employee's injury was caused by such conduct, the employee's benefits are to be reduced by 50%. This remedy is rarely granted and is limited in application (Labor Code §4551).

B. Employer Discrimination Under Labor Code §132(a)

Labor Code §132(a) prohibits an employer from retaliating against an employee for filing or making known the intent to file a claim for workers' compensation benefits. The Supreme Court has held that an injured worker must show two elements to establish discrimination under §132(a). The injured worker must show the right to a benefit, condition of employment or status to which he or she is in some way "singled out" detrimentally, and that the detriment is not simply the result of a uniformly applied policy that is not itself discriminatory. When those two elements are shown then the employer must show its action, though detrimental to the injured

worker, was the result of a reasonable "business necessity". *Department of Rehabilitation v. WCAB* (*Lauher*) 30 Cal. 4th 1281, 68 CCC 831 (Supreme Court, 2003). Any action that affects the employee's benefits, employment status, seniority, etc., must be considered as potentially conflicting with this protection and evaluated as to the possibility of being considered discriminatory.

In the event of a finding of employer violation of Labor Code §132(a), the employee is entitled to reinstatement with lost wages and benefits from the date of the discriminatory act, plus penalty of 50% of all benefits provided, up to a maximum of $10,000, and costs of up to $250. Similar to Serious and Willful misconduct, an employer cannot insure against a claim for benefits under Labor Code §132(a).

Further, a separate civil remedy for industrial injury discrimination is allowed, and creates an even greater liability which is generally not covered by insurance. *City of Moorpark, et al v. Superior Court of Ventura County (Dillon),* (1999), 18 Cal. 4th 1143, 63 CCC 944 (Supreme Court).

C. Miscellaneous Penalty Provisions

1. Unreasonable Delay in Payment of Benefits

Labor Code §5814 provides that in the event of a delay in the provision of benefits without reasonable doubt from a medical or legal standpoint, the benefit delayed (e.g.: a temporary disability payment) shall be increased up to 25% but not more than $10,000. If the delay is merely the failure to pay a medical bill (where the services were timely provided), a different penalty applies payable to the medical provider (LC §4603.2).

2. Delayed Disability Payments

An automatic, self-imposed penalty for any delayed payment of temporary or permanent disability requires a 10% increase on the amount delayed (Labor Code §4650). This penalty highlights the need for the claims examiner, employer and medical professional to effectively communicate with one another.

3. Unreasonable Delay in Paying an Award by a Public Entity

Labor Code §5814.5 provides for a special penalty for employers who are found to have unreasonably delayed payment on an award. Such a finding also entitles the injured worker to have attorney's fees for enforcing the Award ordered in addition to the Labor Code §5814 penalty for delay.

4. Costs for Frivolous or Dilatory Tactics (Labor Code §5813)

For injured workers whose claims are filed after 1/1/94, there is also a provision for an award against a party whose actions are determined by the WCAB to be frivolous or solely for causing delay, of attorney's fees, costs and a special penalty of up to $2,500. This penalty may be assessed against either party and is not limited to payment by the defendant.

SECTION V

CLAIMS HANDLING

V.

CLAIMS HANDLING

A. Teamwork

When a claim is presented, it is of utmost importance that the employer and claims administrator work together to gather facts necessary to process the claim. Under Labor Code §5402, the administrator has only 90 days from the time the Claim Form was filed with the employer to accept or deny the claim. Further, during the 90 day delay time period or until a denial issues, the employer must pay up to $10,000 in reasonable medical costs consistent with utilization review limitations (Labor Code §§5402, 4610, 4616). Failure to act timely results in the claim being "presumed" accepted. This places considerable time pressure on the claims administrator and employer to accomplish the factual investigation and as may be required, obtain medical evidence to address causation issues.

An employer should have one person act as the "contact person" for the claims administrator to gather necessary facts and forms. This individual should become familiar with general claims handling to facilitate the process. Such a person is convenient as a central source of information for the employer and administrator. The position requires strict confidentiality as to all information, written or verbal as claims may become adversarial or result in litigation beyond workers' compensation. An employer must insure that documents concerning claims are properly secured with limited access. Labor Code §3762 further protects the injured worker's right to privacy by limiting the medical information the employer can receive to (1) the diagnosis and the treatment provided for this condition and (2) information necessary to modify work duties. This limitation makes it difficult for claims examiners to fully communicate the medical status of an injured worker to the employer, and eliminates the prior practice of providing full medical reports to the employer. Nevertheless, the employer does have a "bill of rights" in Labor Code §3761 which provides for an information exchange regarding (1) the filing of claims directly upon the carrier, (2) an employer's right to give information to dispute any aspect of the case or its settlement and (3) how reserves are calculated.

We hope to see further legislation that will help the employer and claims examiner exchange necessary medical information, yet protecting the employee's privacy.

B. Early Employer Investigation

The employer can help the claims administrator by sharing background information that either proves or disproves a claim. Questionable claims should be clearly identified in order that the claims administrator can proceed with appropriate investigation. The filing of false claims by an employee is punishable as a felony; however, a corollary is the false denial of a claim is likewise punishable (Labor Code §5401.7). Thus it is important to establish facts and evidence to handle claims appropriately.

The employer should in a normal course of business investigate an industrial accident to document facts, retain physical evidence, identify witnesses, and obtain photographs as appropriate. Identifying the cause of an accident is critical to future prevention, by eliminating the problem, i.e. defective equipment, or becoming a topic for safety and training meetings.

This information gathered by the employer gives the claims administrator a chance to take appropriate action within the short time limits of the law and provides an opportunity for the employer to knowledgeably participate in either claim acceptance or rejection.

Employers must exercise care to avoid improper disclosure of medical and personnel information in their possession to third parties other than the claims administrator. Further disclosure of such material by the claims administrator to third parties may require medical, psychiatric, or employment/personnel record releases from the injured worker before disclosure can be made. Employers should be especially careful to abide by the "Peace Officers Bill of Rights Act" and the "Firefighter's Bill of Rights Act" with respect to personnel records of these safety employees. [Govt. Code §3300 et.seq (POBRA), and §§3250 et seq. (FBRA)]. Particularly, in psychiatric injury claims where a "good faith personnel action" defense is asserted against the safety officer, the personnel record must be secured by proper release before disclosure to third parties such as reviewing physicians. If the safety officer refuses, a special court proceeding called a "*Pitchess* Motion" exists in which the judge will make a confidential, "in camera", review of the protected records allowing disclosure only to the extent necessary for the litigation. *Pitchess v. Superior Court* (1974) 11 Cal. 3d 531. If there is any doubt by the employer regarding the confidentiality of records, it should be fully discussed with the claims administrator before any disclosure is made to third parties.

C. Continuing Employer Involvement

Even after a claim is accepted, an employer gaining knowledge that disproves the claim or any portion of it should communicate it to the claims administrator immediately. Most often this kind of information concerns the activities of the injured worker when they are inconsistent with the nature of the injury or, the activities demonstrate an ability to perform at least light duty work. In some cases, fraud may be involved requiring undercover investigation and appropriate legal steps. The employer plays a vital role by continuing to communicate facts about the claim and the injured worker's activities which in turn maintains the integrity of the system as well as keeping it financially viable.

D. Key Personnel/Special Circumstances

Sometimes key or confidential personnel like the chief, a board member, or the contact person is the subject of a workers' compensation claim. When this occurs it is necessary to avoid any conflict of interest or inappropriate disclosure of confidential information. Should this occur, consideration of an alternate claims contact person, or removal of the file entirely to the administrator may be needed. Discuss how to best handle claims with special circumstances or personnel with the claims administrator and, if need be, with legal counsel.

E. Mistakes to Avoid

Twelve mistakes employers make that increase worker compensation costs are listed below with a brief description of the consequence. It provides a good checklist for effective claims handling at the employer level.

COMMON EMPLOYER MISTAKES AND CONSEQUENCES

1. The Employer Ignores Employee's Report of Injury

Employer/claims administrator is charged with knowledge of injury from the earliest date of knowledge.

2. The Employer Fails to Forward Claim Form or Medical Bills to Claims Administrator

Claims administrator is charged with knowledge from date of the employer's receipt of the DWC-1. Failure to timely forward medical bills may preclude adjustment of charges and result in expensive penalties.

3. The Employer Fails to Investigate or Report Relevant Information Regarding Injury to Claims Administrator

Claims administrator barred from presenting employer's investigation or information in employer's possession to rebut presumption of injury if it could have been discovered within the first 90 days. Employers should be aware that legislative changes in 2013 now permit the administrator to file an Application for Adjudication to commence formal discovery without incurring applicant attorney's fee for litigation.

4. The Employer Fails to Direct Employee to Designated Medical Provider

Failure to make immediate offer of medical care and direct employee to obtaining care results in waiver of right to control medical care.

5. The Employer Fails to Provide Accurate Wage Statement When Requested

Claims administrator is required to pay benefits at maximum rates unless it can prove otherwise by a wage statement. This can also result in penalties if payments are made at an inaccurate lower rate.

6. The Employer Refuses to Provide Early Return to Work (ERTW) Program (Temporary Modified Work)

Across the board increase in all benefits particularly TD and employee loyalty/interest for the work diminishes.

7. The Employer Refuses to Consider Alternative/Modified Work Options and Does Not Engage the Employee in the Interactive Process

Across the board increase in costs for all benefits, particularly rehabilitation for injuries prior to 1/1/04 and for injuries on or after 1/1/05, permanent disability, and possible FEHA and ADA exposure. AB 2222 requires employers to use an "interactive process" to involve the employee in the accommodation process. Additionally, under legislation effective 2013, an offer of return to work either full or modified duty serves to delay permanent disability advances under §4650 (b)(2) until an award issues which can be advantageous for settlement.

8. The Employer Fails to Correct Known/Acknowledged Safety Hazards

Potential exposure for "Serious and Willful Misconduct," an uninsurable 50% penalty, on all workers' compensation benefits provided and increased risk for more claims.

9. The Employer Fails to Control Receipt and Distribution of Medical Information

Exposure to possible civil liability for invasion of privacy (especially AIDS information).

10. The Employer Fails to Train Employees on Workers' Compensation & Safety Issues, and/or to Become Involved in Claims Handling

All of the above consequences.

11. Failure to Maintain a Roster of Volunteer Firefighters, Non-Firefighter Personnel and Fire Cadets

Non-qualified employee may be able to assert a claim for special firefighter presumptive injuries or presumed maximum temporary disability benefits.

12. Failure to Maintain Confidentiality of Medical and Personnel Information Concerning Safety Officers

This can result in civil lawsuit, sanctions, and fines. Special protection for safety officers POBRA and FBRA. Records concerning HIV status and psychiatric are specially protected.

SECTION VI

COMMONLY USED FORMS

VI.

COMMONLY USED FORMS

Disclosure: The forms and notices included within this guidebook are not exhaustive. A complete compilation of forms can be found at the following two links:

http://www.dir.ca.gov/dwc/forms.html
http://www.dir.ca.gov/dwc/BenefitNoticeManual/BenefitNoticeManual.pdf

A. DWC-1 Workers' Compensation Claim Form

The DWC-1 Claim Form must be provided to an employee, either personally or by First Class Mail, within one day of an industrial injury if that injury results in lost time or medical treatment beyond first aid (Labor Code §5401). "First aid" is defined as "one time treatment of minor scratches, cuts, burns, splinters or other minor industrial injury." Minor industrial injury specifically excludes "serious" exposure to hazardous substances as defined by Labor Code §6302(i).

B. Form 5020 - Employer's Report of Occupational Injury or Illness

Form 5020 must be filed within five days of an industrial injury or occupational disease claim when injury or disease results in lost time beyond the day of the injury, or medical treatment beyond first aid as defined by Labor Code §5401.

C. Form 5021 - Doctor's First Report of Occupational Injury or Illness

Form 5021 must be completed by the doctor, as well as one section by the employee if they are able to do so and filed within five days of the initial exam by any physician providing treatment for an occupational injury or disease. Subsequently doctor's reports may be narrative or use "physicians progress Report," "Treating physician's Permanent and Stationary Report" entitled PR-2 and PR-3 respectively. New forms are being created as a result of passage of SB899 to address the new permanent disability schedule and apportionment issues.

D. Application for Adjudication of Claim

An Application for Adjudication must be filed in post-1/1/94 injuries in order to invoke the jurisdiction of the WCAB to allow discovery beyond obtaining records informally.

E. Notice Regarding Temporary Disability Benefits

The Notice Regarding Temporary Disability Benefits must be used whenever temporary disability payments are first made. The purpose of this notice is to inform the injured worker that his claim has been accepted, and to briefly explain the benefits that will be received. The form

also reports initial payments to the Division of Workers' Compensation. In cases of employees entitled to Labor Code §4850 benefits or other employees entitled to wage continuation or benefits in excess of statutory disability benefits, the form 500-F should be used.

F. Notice Regarding Permanent Disability Benefits Denial

The Notice Regarding Permanent Disability Benefits Denial should be used when the first and final payments of temporary disability benefits are being made at the same time, primarily in instances with very short amounts of lost time.

G. Notice Regarding Delay of Workers' Compensation Benefit

The Notice Regarding Delay of Workers' Compensation Benefit is used when a claim is placed on delay, where insufficient information is available to either accept or deny a claim for temporary disability benefits. The form must identify the reason for the delay and the decision, and inform the injured worker of the date by which the decision is likely to be made. This decision date cannot be more than 90 days after the date of the injury.

H. Notice Regarding Denial of Workers' Compensation Benefit

The Notice Regarding Denial of Workers' Compensation Benefit is to be used when a decision has been made to deny the claim. This notice relates both to eligibility for temporary as well as permanent disability benefits. The Division of Workers' Compensation requires that the denial notice must be sent within 14 days after the decision has been made, and must be sent to the employee within 90 days after the injury occurs to avoid the presumption of compensability provided for in Labor Code §5402.

I. Notice Regarding Indemnity Benefits Payment Change

As noted above, the Notice Regarding Indemnity Benefits Payment Change must be used whenever the injured worker first receives benefits in excess of the statutory temporary disability benefits, most commonly in relation to employees entitled to receive §4850 benefits. Even though the employee is entitled to further benefits, the form must identify the statutory maximum and minimum benefits, particularly as eligibility for Labor Code §4850 benefits is limited to one year.

J. DWC Form IMR - Application for Independent Medical Review

This form is completed by, or on behalf of, the injured worker within 30 days following a Utilization Review decision letter delaying, denying or modifying a treating physician's request for medical services or treatment.

K. DWC Form RFA - Request for Authorization for Medical Treatment

This form is to be attached to the treating physician's report to request authorization for treatment. This form is **required** to initiate the Utilization Review process required by Labor Code 4610.

L. DWC Notices of Offer of Regular Work and Modified or Alternative Work

L1 DWC - AD 10133.35 - Notice of Offer of Regular, Modified, or Alternative Work for **dates of injury on or after 1/1/13**.

L2 DWC - AD 10118 - Notice of Offer of Regular Work for **dates of injury between 1/1/05 to 12/31/12, inclusive.**

L3 DWC - AD 10133.53 - Notice of Offer of Modified or Alternative Work for **dates of injury between 1/1/04 to 12/31/12, inclusive**.

The proper form depending on date of injury must be used when making an offer or modified, alternative or regular work. Remember to employ an interactive process with the injured worker before making a return to work decision (AB2222).

M. DWC Supplemental Job Displacement Vouchers

M1 DWC - AD 10133.32 - Supplemental Job Displacement Non Transferrable Voucher Form for **dates of injury on or after 1/1/13**.

M2 DWC - AD 10133.57 - Supplemental Job Displacement Non Transferable Training Voucher Form for **dates of injury between 1/1/04 to 12/31/12**.

The proper form depends on the date of injury. For **dates of injury on or after 1/1/13** the voucher expires in two years, whereas prior to 1/1/13 there is no expiration of the voucher. The voucher expiration date is triggered by date of **receipt** of the voucher by the injured worker. The voucher for **dates of injury on or after 1/1/13** should be sent certified mail.

N. Rosters

This is a sample format which can be modified. A similar format should be used to list non-firefighting volunteers. Each department should therefore keep at least two lists, volunteer firefighters and non-firefighting volunteers. Three forms are included:

- Firefighters
- General Volunteers (Non-Firefighters)
- Fire Cadets (Limited Duties)

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 AL 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 in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

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.

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. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

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. ☐ Check if you agree to receive notices about your claim by email only. ☐ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónic.* Employee's e-mail. _____ *Correo electrónic del empleado.* _____.

You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*

9. Signature of employee. *Firma del empleado.* _____

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

10. Name of employer. *Nombre del empleador.* _____

11. Address. *Dirección.* _____

12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____

13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____

14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____

15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* _____

_____,

16. Insurance Policy Number. *El número de la póliza de Seguro.* _____

17. Signature of employer representative. *Firma del representante del empleador.* _____

18. Title. *Título.* _____ 19. 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.

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*

State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

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

OSHA CASE

FATALITY

B

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 DAY'S 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 (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/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 814300.29 (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 WERE 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.

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

FILING OFTHIS FORM IS NOT AN ADMISSION OF LIABILITY

STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Department of Industrial Relations, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. Insurer Name and Address

2. Employer Name

3. Address No. and Street | City | Zip Code

4. Nature of business (e.g. food manufacturing, building construction, retailer of women's clothes.)

5. Patient Name (first Name, middle initial , last name) | 6. Sex | 7. Date of Birth

8. Address No. and Street | City | Zip Code | 9.Phone Number

10. Occupation (Specific job title) | 11. Social Security Number | 12. Address No. and Street Where Injury Occurred

City Where Injury Occ. | County | 13. Date and hour of injury or onset of illness

14. Date last worked | 15. Date and hour of 1st exam or treatment | 16. Have you or your office previously rendered treatment

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately, inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. **Describe how the accident or exposure happened.** (Give specific object, machinery or chemical. Use reverse side if more space is required.)

18. **SUBJECTIVE COMPLAINTS**

19. O**bjective Findings**

A. Physical Examination

B. X-ray and laboratory results (State if none or pending.)

STATEOF CALIFORNIA **DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS**

C

20. **DIAGNOSES**(if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved?

1. _____ ICD-10 _____
2. _____ ICD-10 _____
3. _____ ICD-10 _____
4. _____ ICD-10 _____
5. _____ ICD-10 _____
6. _____ ICD-10 _____
7. _____ ICD-10 _____
8. _____ ICD-10 _____
9. _____ ICD-10 _____
10. _____ ICD-10 _____
11. _____ ICD-10 _____
12. _____ ICD-10 _____

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? If "no," please explain below:

22. Is there any other current condition that will impede or delay patient's recovery? If "yes," please explain below:

23. **TREATMENT RENDERED** (Use reverse side if more space is required.)

24. If further treatment required, specify treatment plan/estimated duration.

25. If hospitalized as inpatient, give hospital name and location

Date admitted Estimated length of stay

26. WORK STATUS - Is patient able to perform usual work? ☐ Yes ☐ No

If "no", date when patient can return to Regular work Modified work

Specify restrictions

STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

C

Physician Signature: ***(****original signature, do not stamp)*

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code section 139.3.

Physician signature _____ Cal. License Number: _____

Executed at: _____ Date *(mm/dd/yyyy)*: _____

Physician Name _____ Specialty: _____

Physician address: _____ Phone Number _____

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

PRIVACY NOTICE: The Administrative Director is authorized to maintain the records of the Division of Workers' Compensation (DWC). (Cal. Lab. Code § 126.) The Information Practices Act of 1977 and the Federal Privacy Act require the Administrative Director to provide this notice to individuals who submit information to the DWC pertaining to a workers' compensation claim. (Cal. Civ. Code § 1798.17; Public Law 93-579.)

The principal purpose for requesting information from injured workers, dependents, lien claimants, physician, employers or their representatives is to administer the California workers' compensation system. Each form shows which fields are required to be completed for DWC to process the form. If a required field in a form is incomplete or unreadable, the DWC may return the form to the individual for correction or may reject the form. Providing a social security number is required on this form pursuant to Labor Code § 6409. If you do not provide your security number, the DWC may return the form to you for correction or reject the form. If you do not have a social security number, indicate this in the space provided for the injured worker's social security number. As permitted by law, social security numbers are used to help properly identify injured workers and to conduct statistical research as allowed under the Labor Code.

As authorized by law, information furnished on this form may be given to: you, upon request; the public, pursuant to the Public Records Act; a governmental entity, when required by state or federal law; to any person, pursuant to a subpoena or court order pursuant to any other exception in Civil Code § 1798.24.

An individual has a right of access to records containing his/her personal information that are maintained by the Administrative Director. An individual may also amend, correct, or dispute information in such personal records. (Cal. Civ. Code §§ 1798.34-1798.3.) You may request a copy of the DWC's policies and procedures for inspection of records at the address below. Copies of the procedures and all records are ten cents ($0.10) per page, payable in advance. (Cal. Civ. Code § 1798.33.) Requests should be sent to: Division of Workers' Compensation- Medical Unit, P.O. Box 71010, Oakland, CA 94612. Tel: (510) 286-3700 or (800) 794.6900. Fax: (510) 622-3467.

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
APPLICATION FOR ADJUDICATION OF CLAIM

D

☐ Amended Application

Case No.

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).)

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

Injured Worker (Completion of this section is required)

First Name MI

Last Name

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

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

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

City State Zip Code

Applicant (If other than Injured Worker)

☐ Insurance Carrier ☐ Employer ☐ Lien Claimant

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

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

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Employer Information (Completion of this section is required)

D

☐ 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

IT IS CLAIMED THAT (Complete all relevant information):

1. The injured worker, born _____ (DATE OF BIRTH: MM/DD/YYYY), while employed as a(n) _____ (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)

suffered a :

☐ specific injury _____ (Date of injury: MM/DD/YYYY)

☐ cumulative injury which began on _____ (Start Date: MM/DD/YYYY) and ended on _____ (End Date: MM/DD/YYYY)

The injury occurred at _____

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

City State Zip Code

(State which parts of the body were injured)

D

Body Part 1: _____

Body Part 2: _____

Body Part 3: _____

Body Part 4: _____

Other Body Parts: _____

2. The injury occurred as follows:

(EXPLAIN WHAT THE WORKER WAS DOING AT THE TIME OF INJURY AND HOW THE INJURY OCCURED)

3. Actual earnings at the time of injury:

Rate of Pay $ _____ ☐ Monthly ☐ Weekly ☐ Hourly

State value of tips, meals, lodging, or other advantages, regularly received $ _____ ☐ Monthly ☐ Weekly ☐ Hourly

Number of hours worked per week _____

4. The injury caused disability as follows:

Last day off work due to injury: _____ MM/DD/YYYY

First Period of Disability: Start Date _____ MM/DD/YYYY End Date _____ MM/DD/YYYY

Second Period of Disability: Start Date _____ MM/DD/YYYY End Date _____ MM/DD/YYYY

5. Compensation:

Compensation was paid: ☐ Yes ☐ No

Total paid: _____

Weekly rate(s): _____

Date of last payment: _____ MM/DD/YYYY

6. Has the worker received any unemployment insurance benefits and/or any unemployment compensation disability benefits (state disability) since the date of injury? ☐ Yes ☐ No

7. Medical treatment:

Medical treatment was received: ☐ Yes ☐ No

All treatment was furnished by the Employer or Insurance Carrier: ☐ Yes ☐ No

Date of last treatment: _____
MM/DD/YYYY

Other treatment was provided/paid by: _____
(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)

Did Medi-Cal pay for any health care related to this claim? ☐ Yes ☐ No

Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or examined for this injury, but that were not provided or paid for by the employer or insurance carrier:

_____
Name of Doctor/Hospital/Clinic 1 (Please leave blank spaces between numbers, names or words)

_____
Name of Doctor/Hospital/Clinic 2 (Please leave blank spaces between numbers, names or words)

8. Other cases have been filed for industrial injuries by this worker as follows:

_____ Case Number 1

_____ Case Number 2

_____ Case Number 3

_____ Case Number 4

9. This application is filed because of a disagreement regarding liability for:

☐ Temporary disability indemnity
☐ Permanent disability indemnity
☐ Reimbursement for medical expense
☐ Rehabilitation
☐ Medical treatment
☐ Supplemental Job Displacement/Return to Work
☐ Compensation at proper rate
☐ Other (Specify) _____

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.

D

☐ Law Firm/Attorney ☐ Non-Attorney Representative

Law Firm or Company Name (If Applicable)

Law Firm Number (If Applicable)

Attorney/Representative First Name MI

Attorney/Representative Last Name

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

City State Zip Code

Applicant Attorney/Representative Signature Applicant Signature

Dated at _____, California
City

Date _____
MM/DD/YYYY

INSTRUCTIONS

FILING AND SERVICE OF A DECLARATION OF READINESS IS A PREREQUISITE TO THE SETTING OF A CASE FOR HEARING.

D

Effect of Filing Application

Filing of this application begins formal proceedings against the defendant(s) named in your application.

Assistance in Filling Out Application

You may request the assistance of an information and assistance officer of the Division of Workers' Compensation.

Right to Attorney

You may be represented by an attorney or agent, or you may represent yourself. The attorney's fee will be set by the Workers' Compensation Appeals Board at the time the case is decided and is ordinarily payable out of your award.

Filling Out Application

For "amended" applications, the venue choice must be the same as that specified on the original application, unless an order changing venue has issued. A street or P.O. Box address within the United States must be entered for the place where the injury occurred. Therefore, if the injury did not occur at a fixed or identifiable location (such as a field, a highway, or on water), or if the injury occurred outside of the United States, the employer's business address or another appropriate address must be specified; however, a short explanation regarding the place of injury may be appended to the application. If medical treatment has been paid for by Medi-Cal, Medicare, group health insurance, or a private carrier, please specify.

Service of Documents

Your attorney or agent will serve all documents in accordance with Labor Code section 5501 and the Workers' Compensation Appeals Board's Rules of Practice and Procedure.

If you have no attorney or agent, copies of this application will be served by the Workers' Compensation Appeals Board on all parties. If you file any other document, you must mail or deliver a copy of the document to all parties in the case.

IMPORTANT!

If any applicant is under 18 years of age, it will be necessary to file a Petition for Appointment of Guardian ad Litem. Forms for this purpose may be obtained at the district office of the Workers' Compensation Appeals Board, or by calling the district office and requesting this form.

Claims Administrator Name
Address
City_State_Zip
Telephone Number
[include if available] *Website address*

Date ***[if requested]*** SENT VIA E-MAIL TO
employee's e-mail address

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING TEMPORARY DISABILITY BENEFITS

PAYMENT START

CLAIMS ADMINISTRATOR NAME is handling your workers' compensation claim on behalf of EMPLOYER NAME. This notice is to advise you of the status of disability benefits for your workers' compensation injury on the date shown above.

[Include the following paragraph for payment of temporary total disability.]
Payment for ***(select one:)*** *temporary disability / salary continuation in lieu of temporary disability* is starting and ***(select one:)*** *enclosed / sent separately / included in your paycheck* for the period starting DATE through DATE, in the amount of $AMOUNT, and will continue until you are able to return to work or your medical condition becomes permanent and stationary. Your weekly compensation rate is $INSERT RATE based on your earnings of $ AVERAGE WEEKLY WAGE per week. You may receive less if you are earning partial wages. *[**Include if applicable**:] The waiting period is from DATE through DATE and is not paid unless you are off work for more than 14 days.*

[Include the following paragraph for payment of temporary partial disability (wage loss).]
Payment of temporary partial disability (also known as wage loss) is starting and ***(select one:)*** *enclosed / sent separately / included in your paycheck* for the period starting DATE through DATE in the amount of $AMOUNT, and will continue until you are able to return to work or your medical condition becomes permanent and stationary. Your compensation rate may vary from week to week depending upon your modified wage and the hours you work each week. Wage loss

is calculated by taking your pre-injury average weekly earnings, subject to a statutory maximum rate, and subtracting your post-injury weekly earnings. The weekly wage loss paid is two-thirds of this difference. We will contact your employer every two weeks to determine if wage loss is due and the amount owed, if any. At this time the information we have indicates you are earning a total of $AMOUNT EARNED per week. {***Include if applicable:]*** *The waiting period is from DATE through DATE and is not paid unless you are off work for more than 14 days.*

[Select one]

[Include for both TTD and TPD (wage loss)]
Payments will be sent to you every two weeks on DAY OF THE WEEK.

[Include for Salary Continuation]
Payments will be included in your paycheck on your regular payday**.** An explanation of the salary continuation plan specific to your employer is included with this notice.

[MANDATORY: include for all notices:]

Additional information may be found in the publication ***Workers' Compensation in California: A Guidebook for Injured Workers***. A complete copy of the Guidebook may be obtained on the Division of Workers' Compensation website (see *URL* below) or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation. Temporary Disability is discussed in chapter 5 of the Guidebook.

Guidebook for Injured Workers:
http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html
Chapter 5:Temporary Disability:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter5.pdf

The State of California requires that you be given the following information:

[MANDATORY LANGUAGE: Select one of the following:]

[Include the following two paragraphs for all claims not subject to an alternative dispute resolution (ADR) program:]
You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call, [***insert either "***me, the ADJUSTER'S NAME***"or a specific claims department name and telephone number***]. You also have the right to be represented by an attorney of your choice. However, if you are represented by an attorney, you should call your attorney, not [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***].

For information about the workers' compensation claims process and your rights and obligations, go to www.dir.ca.gov or contact an information and assistance (I&A) officer of the

State Division of Workers' Compensation. For recorded information and a list of offices, call (800)736-7401.

[For claims subject to an ADR program, include to the extent appropriate according to the ADR agreement:]

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call [*insert either "*me, the ADJUSTER'S NAME*" or a specific claims department name and telephone number*] or *(insert name, title and telephone of ombudsperson or mediator)*. However, if you are represented by an attorney, you should call your attorney, not [*insert either "*me, the ADJUSTER'S NAME*" or a specific claims department name and telephone number*], the ombudsperson or mediator.

[Optional language for claims subject to an ADR program under LC §3201.5 – Include if appropriate under the provisions of the ADR program:]

In accordance with the INSERT UNION NAME *agreement, active participation by an attorney is not allowed in the Ombudsman and Mediation stages of the ADR workers' compensation process. However, you have the right to consult with an attorney and your right to obtain legal advice is not limited and you may obtain such at your own expense at any time. If the Ombudsman and Mediation stages of dispute resolution are unsuccessful and a written request for Arbitration has been timely filed, attorney participation is allowed.*

For information about the workers' compensation claims process and your rights and obligations, contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. Be sure to inform the I&A officer that your claim is subject to an alternative dispute resolution program. For a list of offices, go to www.dwc.ca.gov or call (800) 736-7401.]

[Select one:]

This notice is being sent to you electronically per your request. Please confirm that you want to continue receiving notices electronically and update your e-mail address as necessary.

Applicant's Attorney (if any): This notice is being sent to you electronically per your request. Please confirm that you want to continue receiving notices electronically and update your e-mail address as necessary.

[MANDATORY LANGUAGE – required on all notices in bold type.]

Keep this notice. It contains important information about your workers' compensation benefits.

Sincerely,

Claims Examiner

cc: APPLICANT ATTORNEY *(if any)*

Enc.: Brief explanation of the employer's specific salary continuation plan *(as applicable pursuant to Title 8 CCR §9814)*

Claims Administrator Name
Address
City_State_Zip
Telephone Number
[include if available] *Website address*

Date
Employee
Address
City_State_Zip

[Option] SENT VIA E-MAIL TO employee's e-mail address

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING PERMANENT DISABILITY BENEFITS DENIAL

CLAIMS ADMINISTRATOR NAME is handling your workers' compensation claim on behalf of EMPLOYER NAME. This notice is to advise you of the status of disability benefits for your workers' compensation injury on the date shown above.

On **DATE** you ***(choose one)*** *returned to work / were released to return to work / were discharged from care.*

[A. Select 1 or 2]

(1) Based upon the report of DATE from PHYSICIAN'S NAME, ***(select one)*** *your treating physician / a Qualified Medical Evaluator / an Agreed Medical Evaluator*,

(2) Based on (***insert non-medical or other basis for determination)***, you have recovered from your injury with no permanent disability. For this reason, no permanent disability payments are payable. ***(Include if based on a medical report:)*** *A copy of the report is attached to this notice.*

[Mandatory: include for all claims:]

You and I both have the right to disagree with the physician's findings and request a comprehensive medical evaluation.

[Important: Choose appropriate option below for unrepresented or represented employee:]

[B. If employee unrepresented, include the following:]

[(1) Choose A or B if the determination is based on the findings of a treating physician:]

(A) We ***(select one)*** *have requested/are requesting* the report of your treating physician be rated for permanent disability by the Disability Evaluation Unit (DEU). You will be receiving a copy of this rating from the DEU.

(B) We are not requesting the report of your treating physician be rated for permanent disability by the Disability Evaluation Unit (DEU). If you are unrepresented, you may contact the Information and Assistance officer to have the report reviewed and rated by the DEU.

[(2) Choose (A) if determination is based on a comprehensive medical evaluation of QME or B if determination is based upon evaluation of the treating physician.]

(A) The determination of permanent disability is based on the comprehensive medical evaluation of QME (***insert name***) dated ***(insert date of report)***. If you dispute the results of the evaluation, you may file an Application for Adjudication of Claim with the WCAB.
(B) The determination of permanent disability is based on the evaluation of treating physician (***insert name***) dated (***insert date of report***)**.** I ***(select one)*** *agree/disagree* with the results of the evaluation. If you disagree with the results of the evaluation of the treating physician, you may obtain an evaluation by a Qualified Medical Evaluator (QME). You must notify me in writing of your objection to the determination of the treating physician within thirty (30) days of the date you received the treating physician's report. ***(Select 1 if the employee has not previously been evaluated by a QME, or 2 if the employee has previously been evaluated by a QME:)***

(1) To request a QME you must either contact (***insert "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***) to request the form to submit to the state Division of Workers' Compensation (DWC) to request a panel of three Qualified Medical Evaluators (QMEs), or you may download the form from the DWC website: http://www.dir.ca.gov/dwc/FORMS/QMEForms/QMEForm105.pdf. Instructions for completion of the form are found here: http://www.dir.ca.gov/dwc/FORMS/QMEForms/QMEForm105-Instructions.pdf.

(2) Please contact (***insert*** "me, the ADJUSTER'S NAME" ***or a specific claims department name and telephone number***) to arrange for a new evaluation with QME (***insert name***) if you disagree with the results of the evaluation of the treating physician.

[C. <u>If employee is represented, include the following:</u>]
If you are represented, you may contact your attorney with any questions.

Option:

Some employees injured on or after January 1, 2004 may be entitled to a supplemental job displacement benefit (SJDB). To be eligible, you must have an Award for permanent partial disability, must not have received an offer of Modified or Alternate work from your employer and have not returned to work for the employer within sixty (60) days of the termination of temporary disability benefits. Because the injury has not caused any permanent disability, you are not entitled to a supplemental job displacement benefit.

<u>Mandatory: include for all notices:</u>
Additional information may be found in the publication ***Workers' Compensation in California: A Guidebook for Injured Workers***. A complete copy of the Guidebook may be obtained on the Division of Workers' Compensation website (see *URL* below) or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation. Permanent Disability is discussed in chapter 7 of the Guidebook.
Guidebook for Injured Workers:
http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html
Chapter 7: Permanent Disability:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter7.pdf

Chapter 4: Resolving Problems with Medical Care & Medical Reports
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter4.pdf

The State of California requires that you be given the following information:
[Mandatory Language: Select one of the following:]
[Include the following two paragraphs for all claims not subject to an alternative dispute resolution (ADR) program:]
You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call, [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***]. You also have the right to be represented by an attorney of your choice. However, if you are represented by an attorney, you should call your attorney, not [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***].
For information about the workers' compensation claims process and your rights and obligations, go to www.dir.ca.gov or contact an Information and Assistance (I&A) Officer of the State Division of Workers' Compensation. For recorded information and a list of offices, call (800)736-7401.

[For claims subject to an ADR program, include to the extent appropriate according to the ADR agreement:]
You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***] or ***(insert name, title and telephone of ombudsperson or mediator)***. However, if you are represented by an attorney, you should call your attorney, not [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***],** the ombudsperson or mediator.
[Optional language for claims subject to an ADR program under LC §3201.5 – Include if appropriate under the provisions of the ADR program:]
In accordance with the INSERT UNION NAME *agreement, active participation by an attorney is not allowed in the Ombudsman and Mediation stages of the ADR workers' compensation process. However, you have the right to consult with an attorney and your right to obtain legal advice is not limited and you may obtain such at your own expense at any time. If the Ombudsman and Mediation stages of dispute resolution are unsuccessful and a written request for Arbitration has been timely filed, attorney participation is allowed.*
For information about the workers' compensation claims process and your rights and obligations, contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. Be sure to inform the I&A officer that your claim is subject to an alternative dispute resolution program. For a list of offices, go to www.dwc.ca.gov or call (800) 736-7401.

[Select one:]
This notice is being sent to you electronically per your request. Please confirm that you want to continue receiving notices electronically and update your e-mail address as necessary.

Applicant's Attorney (if any): This notice is being sent to you electronically per your request. Please confirm that you want to continue receiving notices electronically and update your e-mail address as necessary.

[Mandatory Language – required on all notices in bold type.]
Keep this notice. It contains important information about your workers' compensation benefits.

Sincerely,

_____
Claims Examiner

cc: APPLICANT ATTORNEY ***(if any)***
Enc.: Medical Report(s) (***As required by specific regulations***)
Claims Administrator Name
Address
City_State_Zip
Telephone Number
[include if available] *Website address*

Claims Administrator Name
Address
City_State_Zip
Telephone Number
[include if available] *Website address*

Date ***[Option]*** SENT VIA E-MAIL TO employee's e-mail address

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING

DELAY OF WORKERS' COMPENSATION BENEFIT

CLAIMS ADMINISTRATOR NAME is handling your workers' compensation claim on behalf of EMPLOYER NAME. This notice is to advise you of the status of disability benefits for your workers' compensation injury on the date shown above.

Select (1), (2)or (3):

(1) Workers' compensation benefits are being delayed because EXPLANATION FOR DELAY. In order to make a decision, we need ITEM(S) NECESSARY FOR RESOLUTION OF ISSUE(S). We will notify you of our decision on or before DATE.

(2) Workers' compensation benefits are being delayed for the period DATE through DATE because EXPLANATION FOR DELAY. In order to make a decision, we need ITEM(S) NECESSARY FOR RESOLUTION OF ISSUE(S). We will notify you of our decision on or before DATE.

(3) Subsequent notice(s): On DATE a notice was issued advising of delay of your workers' compensation benefits pending receipt of EXPLANATION FOR DELAY. In order to make a decision, we need ITEM(S) NECESSARY FOR RESOLUTION OF ISSUE(S). We have not received the necessary information and are extending the determination date to DATE. I will contact you when this information has been received.

[*(Include if the delay is related to a medical issue and the claims administrator is requesting a comprehensive medical evaluation for an unrepresented employee:)]*

To resolve this issue and allow me to make a determination on your entitlement to benefits, a comprehensive medical evaluation is needed. Enclosed is a form that you must submit to the state Division of Workers' Compensation (DWC) within **10 days** to request a panel of three Qualified Medical Evaluators (QMEs). If you do not submit the form within **10 days** we will have the right to submit the form. In addition, within **10 days** after the DWC sends you a panel, you must choose a QME from the panel, make an appointment to be examined by the QME, and inform me of your choice and appointment time. If you inform us of your choice but you do not arrange the appointment, we will arrange the appointment. If you do not inform us of your choice, we may choose the QME who will examine you and arrange the appointment.

If employee is represented, include the following:

If you are represented, you may contact your attorney with any questions.

For injuries which occur on or after January 1, 1990, there is a legal presumption before the Workers' Compensation Appeals Board that your claim is compensable if it is not denied within 90 days of your returning an Employee Claim Form to your employer. That presumption can be rebutted only with information that could not be discovered within the 90-day period.

For claims reported on or after April 19, 2004, regardless of the date of injury, if you submitted a claim form to your employer or claims administrator, Labor Code section 5402(c) provides that within one working day after you file the claim form, the employer shall authorize the provision of medical treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide such treatment until the claims administrator accepts or denies liability for the claim. Until the date the claim is accepted or rejected, liability for medical treatment under this Labor Code section shall be limited to a maximum of ten thousand dollars ($10,000).

MANDATORY: include for all notices:

Additional information may be found in the publication ***Workers' Compensation in California: A Guidebook for Injured Workers.*** A complete copy of the Guidebook may be obtained at the website of the Division of Workers' Compensation (see *URL* below) or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation. Chapters 2, 4 and 9 of the Guidebook contain information addressing the determination of liability for a workers' compensation claim and the QME process.

Guidebook for Injured Workers:
http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html

Chapter 2: After You Get Hurt on the Job
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter2.pdf

Chapter 4: Resolving Problems with Medical Care and Medical Reports:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter4.pdf

Chapter 9: For More Information and Help
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter9.pdf

The State of California requires that you be given the following information:

[MANDATORY LANGUAGE: Select one of the following:]

[Include the following two paragraphs for all claims not subject to an alternative dispute resolution (ADR) program:]

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call, [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***]. You also have the right to be represented by an attorney of your choice. However, if you are represented by an attorney, you should call your attorney, not [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***].

For information about the workers' compensation claims process and your rights and obligations, go to www.dir.ca.gov or contact an Information and Assistance (I&A) Officer of the State Division of Workers' Compensation. For recorded information and a list of offices, call (800)736-7401.

[For claims subject to an ADR program, include to the extent appropriate according to the ADR agreement:]

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***] or ***(insert name, title and telephone of ombudsperson or mediator)***. However, if you are represented by an attorney, you should call your attorney, not [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***],** the ombudsperson or mediator.

[Optional language for claims subject to an ADR program under LC §3201.5 – Include if appropriate under the provisions of the ADR program:]

In accordance with the INSERT UNION NAME *agreement, active participation by an attorney is not allowed in the Ombudsman and Mediation stages of the ADR workers' compensation process. However, you have the right to consult with an attorney and your right to obtain legal advice is not limited and you may obtain such at your own expense at any time. If the Ombudsman and Mediation stages of dispute resolution are unsuccessful and a written request for Arbitration has been timely filed, attorney participation is allowed.*

For information about the workers' compensation claims process and your rights and obligations, contact an Information and Assistance (I&A) Officer of the state Division of Workers' Compensation. Be sure to inform the I&A officer that your claim is subject to an alternative dispute resolution program. For a list of offices, go to www.dwc.ca.gov or call (800) 736-7401.]

[Select one:]

This notice is being sent to you electronically per your request. Please confirm that you want to continue receiving notices electronically and update your e-mail address as necessary.

Applicant's Attorney (if any): This notice is being sent to you electronically per your request. Please confirm that you want to continue receiving notices electronically and update your e-mail address as necessary.

[MANDATORY LANGUAGE – required on all notices in bold type.]
Keep this notice. It contains important information about your workers' compensation benefits.

Sincerely,

_____
Claims Examiner

cc: APPLICANT ATTORNEY ***(if any)***

Enc.: QME Panel form (QME Form 105 and attachment) ***(if applicable)***

Claims Administrator Name
Address
City_State_Zip
Telephone Number
[include if available] *Website address*

Date ***[Option]*** SENT VIA E-MAIL TO employee's e-mail address

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING

DENIAL OF WORKERS' COMPENSATION BENEFIT

CLAIMS ADMINISTRATOR NAME is handling your workers' compensation claim on behalf of EMPLOYER NAME. This notice is to advise you of the status of disability benefits for your workers' compensation injury on the date shown above.

Select 1 or 2:

(1) FULL DENIAL: After careful consideration of all available information, we are denying liability for your claim of injury. Workers' compensation benefits are being denied because EXPLANATION FOR DENIAL. ***(If denial is based on a medical report, insert the following):*** A copy of the report is attached to this notice.

(2) PARTIAL DENIAL: After careful consideration of all available information, we are accepting liability only for your claim of injury to LIST ACCEPTED BODY PART(S). Liability is being denied for LIST DENIED BODY PART(S) because EXPLANATION FOR PARTIAL DENIAL OF BENEFIT. ***(If denial is based on a medical report, insert the following):*** A copy of the report is attached to this notice.

For claims reported on or after April 19, 2004, regardless of the date of injury, if you submitted a claim form to your employer or claims administrator, Labor Code section 5402(c) provides that within one working day after you file the claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide such medical treatment until the claims administrator accepts or denies liability for the claim. Until the date the claim is accepted or rejected, liability for medical

treatment under this Labor Code section shall be limited to a maximum of ten thousand dollars ($10,000).

Unless you have done so already, you should immediately send for consideration of payment, all bills for medical services provided between the date the completed claim form was given to the employer and the date that liability for the claim is rejected.

If employee unrepresented and determination based on a medical report, select (1), (2) or (3) below:

(1)(Choose if the employee has not previously received a comprehensive medical evaluation:)

If you disagree with the decision to deny your claim and wish to obtain a comprehensive medical evaluation, enclosed is a form that you must submit to the state Division of Workers' Compensation (DWC) within **10 days** to request a panel of three Qualified Medical Evaluators (QMEs). If you do not submit the form within **10 days** we will have the right to submit the form. In addition, within **10 days** after the DWC sends you a panel, you must choose a QME from the panel, make an appointment to be examined by the QME, and inform me of your choice and appointment time. If you inform us of your choice but you do not arrange the appointment, we will arrange the appointment. If you do not inform us of your choice, we may choose the QME who will examine you and arrange the appointment.

Choose (2) or (3) if the employee has already received a comprehensive medical evaluation:

(2) We ***(select one:)*** *accept / disagree* with the comprehensive medical evaluation of **PHYSICIAN NAME** and **REPORT DATE**. If you choose to dispute this decision you may file an Application for Adjudication of Claim with the Workers' Compensation Appeals Board (WCAB).

(3) Since you have already received a comprehensive medical evaluation, if you disagree with the decision to deny your claim, please contact (*insert* ***"me, the ADJUSTER'S NAME"*** *or a specific claims department name and telephone number*) to arrange to return to the same medical evaluator for a new evaluation.

If employee is represented, include the following:

If you are represented, you may contact your attorney with any questions.

MANDATORY: include for all notices:

Additional information may be found in the publication **Workers' Compensation in California: A Guidebook for Injured Workers**. A complete copy of the Guidebook may be obtained at the website of the Division of Workers' Compensation (see *URL* below) or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation. Chapters 2, 4 and 9 of the Guidebook contain information addressing the determination of liability for a workers' compensation claim and the QME process.

Guidebook for Injured Workers:
http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html

Chapter 2: After You Get Hurt on the Job
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter2.pdf

Chapter 4: Resolving Problems with Medical Care and Medical Reports:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter4.pdf

Chapter 9: For More Information and Help
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter9.pdf

The State of California requires that you be given the following information:

[MANDATORY LANGUAGE: Select one of the following:]

[Include the following two paragraphs for all claims not subject to an alternative dispute resolution (ADR) program:]
You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call, [***insert "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***]. You also have the right to be represented by an attorney of your choice. However, if you are represented by an attorney, you should call your attorney, not [***insert either me, the adjuster's name or a specific claims department name and telephone number***].

For information about the workers' compensation claims process and your rights and obligations, go to www.dir.ca.gov or contact an Information and Assistance (I&A) Officer of the State Division of Workers' Compensation. For recorded information and a list of offices, call (800)736-7401.

[For claims subject to an ADR program, include to the extent appropriate according to the ADR agreement:]
You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***] or ***(insert name, title and telephone of ombudsperson or mediator)***. However, if you are represented by an attorney, you should call your attorney, not [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***],** the ombudsperson or mediator.

[Optional language for claims subject to an ADR program under LC §3201.5 – Include if appropriate under the provisions of the ADR program:]
In accordance with the INSERT UNION NAME *agreement, active participation by an attorney is not allowed in the Ombudsman and Mediation stages of the ADR workers' compensation process. However, you have the right to consult with an attorney and your right to obtain legal advice is not limited and you may obtain such at your own expense at any time. If the Ombudsman and Mediation stages of dispute resolution are unsuccessful and a written request for Arbitration has been timely filed, attorney participation is allowed.*

For information about the workers' compensation claims process and your rights and obligations, contact an Information and Assistance (I&A) Officer of the state Division of Workers' Compensation. Be sure to inform the I&A officer that your claim is subject to an alternative dispute resolution program. For a list of offices, go to www.dwc.ca.gov or call (800) 736-7401.]

[Select one:]

This notice is being sent to you electronically per your request. Please confirm that you want to continue receiving notices electronically and update your e-mail address as necessary.

Applicant's Attorney (if any): This notice is being sent to you electronically per your request. Please confirm that you want to continue receiving notices electronically and update your e-mail address as necessary.

[MANDATORY LANGUAGE – required on all notices in bold type.]

Keep this notice. It contains important information about your workers' compensation benefits.

Sincerely,

_____

Claims Examiner

cc: APPLICANT ATTORNEY *(if any)*
SERVICE PROVIDERS ON FILE
LIEN CLAIMANT(S)

Enc.: *(Choose enclosures as appropriate.)*

- Medical Report(s) *(if applicable)*
- QME Panel form (QME Form 105 and attachment) *(to unrepresented employees)*

Date

[Option] SENT VIA E-MAIL TO employee's e-mail address

Employee
Address
City_State_Zip
(*Option)* Employee's e-mail address

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING INDEMNITY BENEFITS

PAYMENT CHANGE

INSERT CLAIMS ADMINISTRATOR NAME is handling your workers' compensation claim on behalf of INSERT EMPLOYER NAME. This notice is to advise you of the status of disability benefits for your workers' compensation injury on the date shown above.

Select one or more of the following as applicable:

(1) We are changing the benefit rate for INSERT BENEFIT TYPE. The rate is being changed to $INSERT WEEKLY RATE beginning with the payment on DATE because INSERT REASON FOR CHANGE IN RATE.

(2) We are changing the payment amount for INSERT BENEFIT TYPE. The amount is being changed to $ INSERT WEEKLY AMOUNT beginning with the payment on DATE because INSERT REASON FOR CHANGE IN AMOUNT.

(3) We are changing the scheduled day of the week that we send your INSERT BENEFIT TYPE. Beginning with the payment on DATE checks will be sent every two weeks on DAY OF WEEK.

(4) INSERT EXPLANATION FOR OTHER CHANGE IN BENEFIT (Example: child support or payments to be deducted, etc).]

For injuries occurring from January 1, 2005 through December 31, 2012, include the following for PD benefits if permanent and stationary:

The report advises your injury is permanent and stationary effective DATE.
Select (1) or (2):
(1) Your employer made a timely offer for you to return to ***(choose one)*** regular /modified/alternative work on DATE. The weekly PD rate of $RATE will be reduced by 15% to $REDUCED RATE effective INSERT OFFER DATE, the date of the offer of return to work.

(2) Your employer did not make a timely offer for you to return to regular /modified/alternative work. The weekly PD rate of $RATE will be increased by 15% effective 60 days after INSERT P&S DATE to $INCREASED RATE effective DATE.

We will continue to provide any other benefits due you as described in the benefit information previously sent to you.

MANDATORY: include for all notices:

Additional information may be found in the publication **Workers' Compensation in California: A Guidebook for Injured Workers**. A complete copy of the Guidebook may be obtained at the website of the Division of Workers' Compensation (see *URL* below) or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation.

Guidebook for Injured Workers:
http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html
[*(Select the 1 or 2 below as appropriate for the notice:)*
(1) Temporary Disability is discussed in chapter 5 of the Guidebook.
Chapter 5: Temporary Disability:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter5.pdf
(2) Permanent Disability is discussed in chapter 7 of the Guidebook.
Chapter 7: Permanent Disability:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter7.pdf]

The State of California requires that you be given the following information:

MANDATORY LANGUAGE: Select one of the following:]

[Include the following two paragraphs for all claims not subject to an alternative dispute resolution (ADR) program:]
You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call, [***insert either "***me, the ADJUSTER'S NAME***"or a specific claims department name and telephone number***]. You also have the right to be represented by an attorney of your choice. However, if you are represented by an attorney, you should call your attorney, not [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***].

For information about the workers' compensation claims process and your rights and obligations, go to www.dir.ca.gov or contact an Information and Assistance (I&A) Officer of the State Division of Workers' Compensation. For recorded information and a list of offices, call (800)736-7401.

[For claims subject to an ADR program, include to the extent appropriate according to the ADR agreement:]

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***] or ***(insert name, title and telephone of ombudsperson or mediator)***. However, if you are represented by an attorney, you should call your attorney, not [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***],** the ombudsperson or mediator.

[Optional language for claims subject to an ADR program under LC §3201.5 – Include if appropriate under the provisions of the ADR program:]

In accordance with the INSERT UNION NAME *agreement, active participation by an attorney is not allowed in the Ombudsman and Mediation stages of the ADR workers' compensation process. However, you have the right to consult with an attorney and your right to obtain legal advice is not limited and you may obtain such at your own expense at any time. If the Ombudsman and Mediation stages of dispute resolution are unsuccessful and a written request for Arbitration has been timely filed, attorney participation is allowed.*

For information about the workers' compensation claims process and your rights and obligations, contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. Be sure to inform the I&A officer that your claim is subject to an alternative dispute resolution program. For a list of offices, go to www.dwc.ca.gov or call (800) 736-7401.]

[Select one:]

This notice is being sent to you electronically per your request. Please confirm that you want to continue receiving notices electronically and update your e-mail address as necessary.

Applicant's Attorney (if any): This notice is being sent to you electronically per your request. Please confirm that you want to continue receiving notices electronically and update your e-mail address as necessary.

[MANDATORY LANGUAGE – required on all notices in bold type.]

Keep this notice. It contains important information about your workers' compensation benefits.

Sincerely,

_____

Claims Examiner

cc: APPLICANT ATTORNEY ***(if any)***

Enc.: Brief explanation of the employer's specific salary continuation plan ***(as applicable pursuant to Title 8 CCR §9814)***

State of California, Division of Workers' Compensation

APPLICATION FOR INDEPENDENT MEDICAL REVIEW

DWC Form IMR

J

TO REQUEST INDEPENDENT MEDICAL REVIEW:

1. **Sign and date this application and consent to obtain medical records.**
2. **Mail or fax the application and a copy of the written decision you received that denied or modified the medical treatment requested by your physician to:**
   DWC-IMR, c/o Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
   FAX Number: (916) 605-4270
3. **Mail or fax a copy of the signed application to your Claims Administrator.**

Type of Utilization Review: ☐ Regular ☐ Expedited	Modification after Appeal ☐

Employee Name (First, MI, Last):	
Address:	
Phone Number:	Employer Name:
Claim Number:	Date of Injury (MM/DD/YYYY):
WCIS Jurisdictional Claim Number (if assigned):	EAMS Case Number (if applicable):
Employee Attorney (if known):	
Address:	
Phone Number:	Fax Number:

Requesting Physician Name (First, MI, Last):	
Practice Name:	Specialty:
Address:	
Phone Number:	Fax Number:

Claims Administrator Name:	
Adjuster/Contact Name:	
Address:	
Phone Number:	Fax Number:

Disputed Medical Treatment (complete below section)
Primary Diagnosis (Use ICD Code where practical):
Date of Utilization Review Determination Letter:
Is the Claims Administrator disputing liability for the requested medical treatment besides the question of medical necessity? ☐ Yes ☐ No Reason:
List each specific requested medical services, goods, or items that were denied or modified in the space below. Use additional pages if the space below is insufficient.
1.
2.
3.
4.

Request for Review and Consent to Obtain Medical Records

I request an independent medical review of the above-described requested medical treatment. I certify that I have sent a copy of this application to the claims administrator named above. I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature:	Date:

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM J

If your workers' compensation claims administrator sent you a written determination letter that denied or mo a request for medical treatment made by your treating physician, you can request, at no cost to you, an Independent Medical Review (IMR) of the medical treatment request by a physician who is not connected to your claims administrator. If the IMR is decided in your favor, your claims administrator must give you the service or treatment your physician requested.

IF YOU DECIDE NOT TO PARTICIPATE IN THE IMR PROCESS YOU MAY LOSE YOUR RIGHT TO CHALLENGE THE DENIAL, DELAY, OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO ON PAGE ONE OF THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this form with a copy of the written determination letter that denied or modified the medical treatment requested by your physician. You must also send a copy of the signed application to your claims administrator.

- The information on the form was filled in by your claims administrator. If you believe that any of the information is incorrect, submit a separate sheet that provides the correct information.
- If you wish to have your attorney, treating physician, parent, guardian, relative, or other person act on your behalf in filing this application, complete the attached authorized representative designation form and return it with your application. This person may sign the application for you and submit documents on your behalf.
- If the recommended medical treatment that was denied or modified must be provided to you immediately because you are facing an imminent and serious threat to your health, and your claims administrator did **not** perform an expedited or rushed review on your physician's request, this application **must** be submitted with a statement from your physician, supported by medical records, that confirms your condition.
- Mail or fax the application and a copy of the utilization review decision to:

  DWC-IMR, c/o Maximus Federal Services, Inc.
  P.O. Box 138009, Sacramento, CA 95813-8009
  FAX Number: (916) 605-4270

- **Your IMR application, along with a copy of the written determination letter, must be received by Maximus Federal Services, Inc. within thirty-five (35) days from the mailing date of the written determination letter informing you that the medical treatment requested by your treating physician was denied or modified.**
- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written determination letter.

Your Right to Provide Information

You have the right to submit, either directly or through your treating physician, information to support the requested medical treatment. Such information may include:

- Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.
- Reasonable information and documents showing that the recommended medical treatment is or was medically necessary, including all documents or records provided by your treating physician or any additional material you believe is relevant.
- Evidence that the medical guidelines relied upon to deny or modify your physician's requested medical treatment does not apply to your condition or is scientifically incorrect.
- If the medical treatment was provided on an urgent care or emergency basis, information or justification that the requested medical treatment was medically necessary for your medical condition

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local offices by calling toll-free 1-800-736-7401. You may also go to the DWC website at www.dwc.ca.gov.

Authorized Representative Designation for Independent Medical Review
(To accompany the Application for Independent Medical Review, DWC Form IMR)

J

Section I. To be completed by the Employee:

Employee Name (Print):	

I wish to designate

Name of Individual (Print):	

to act on my behalf regarding my Application for Independent Medical Review. I authorize this individual to receive any notice or request in connection with my appeal, and to provide medical records or other information on my behalf. I further authorize the Division of Workers' Compensation, and the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application, to speak to this individual on my behalf regarding my Application for Independent Medical Review. I understand that I have the right to designate anyone that I wish to be my authorized representative and that I may revoke this designation at any time by notifying the Division of Workers' Compensation or the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application.

In addition to designating the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the independent review organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature:		Date:

Section II. To be completed by the Authorized Representative designated above. Law firms, organizations, and groups may represent the Employee, but an individual must be designated to act on the Employee's behalf.

I accept the above designation to act as the above-named Employee's authorized representative regarding their Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be their authorized representative.

Name:			
I am a/an:			
(Professional status or relationship to the Employee, e.g., attorney, relative, etc.)			
Address:			
City:	State:		Zip Code:
Phone Number:		Fax Number:	
State Bar Number (if applicable):			
Representative Signature:			Date:

State of California, Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

DWC Form RFA

K

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

☐ New Request ☐ Resubmission – Change in Material Facts
☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
☐ Check box if request is a written confirmation of a prior oral request.

Employee Information			
Name (Last, First, Middle):			
Date of Injury (MM/DD/YYYY):		Date of Birth (MM/DD/YYYY):	
Claim Number:		Employer:	
Requesting Physician Information			
Name:			
Practice Name:		Contact Name:	
Address:		City:	State:
Zip Code:	Phone:	Fax Number:	
Specialty:		NPI Number:	
E-mail Address:			
Claims Administrator Information			
Company Name:		Contact Name:	
Address:		City:	State:
Zip Code:	Phone:	Fax Number:	
E-mail Address:			

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)

Requesting Physician Signature:	Date:

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)

Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

Instructions for Request for Authorization Form

Warning: Private healthcare information is contained in the Request for Authorization for Medical Treatment, DWC Form RFA. The form can only go to other treating providers and to the claims administrator.

Overview: The Request for Authorization for Medical Treatment (DWC Form RFA) is required for the employee's treating physician to initiate the utilization review process required by Labor Code section 4610. A Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment must be attached. The DWC Form RFA is not a separately reimbursable report under the Official Medical Fee Schedule, found at California Code of Regulations, title 8, section 9789.10 et seq.

Checkboxes: Check the appropriate box at the top of the form. Indicate whether:

- This is a new treatment request for the employee or the resubmission of a previously denied request based on a change in material facts regarding the employee's condition. A resubmission is appropriate if the facts that provided the basis for the initial utilization review decision have subsequently changed such that the decision is no longer applicable to the employee's current condition. Include documentation supporting your claim.
- Review should be expedited based on an imminent and serious threat to the employee's health. A request for expedited review must be supported by documentation substantiating the employee's condition.
- The request is a written confirmation of an earlier oral request.

Routing Information: This form can be mailed, faxed, or e-mailed to the address, fax number, or e-mail address designated by the claims administrator for this purpose. The requesting physician must complete all identifying information regarding the employee, the claims administrator, and the physician.

Requested Treatment: The DWC Form RFA must contain all the information needed to substantiate the request for authorization. If the request is to continue a treatment plan or therapy, please attach documentation indicating progress, if applicable.

- List the diagnosis (required), the ICD Code (required), the specific service/good requested (required), and applicable CPT/HCPCS code (if known).
- Include, as necessary, the frequency, duration, quantity, etc. Reference to specific guidelines used to support treatment should also be included.
- For requested treatment that is: (a) inconsistent with the Medical Treatment Utilization Schedule (MTUS) found at California Code of Regulations, title 8, section 9792.20, et seq.; or (b) for a condition or injury not addressed by the MTUS, you may include scientifically based evidence published in peer-reviewed, nationally recognized journals that recommend the specific medical treatment or diagnostic services to justify your request.

Requesting Physician Signature: Signature/Date line is located under the requested treatment box. A signature by the treating physician is mandatory.

Claims Administrator/URO Response: Upon receipt of the DWC Form RFA, a claims administrator must respond within the timeframes and in the manner set forth in Labor Code section 4610 and California Code of Regulations, title 8, section 9792.9.1. To communicate its approval on requested treatment, the claims administrator may complete the lower portion of the DWC Form RFA and fax it back to the requesting provider. (Use of the DWC Form RFA is optional when communicating approvals of treatment; a claims administrator may utilize other means of written notification.) If multiple treatments are requested, indicate in comments section if any individual request is being denied or referred to utilization review.

State of California
Division of Workers' Compensation

L1

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.

POSITION REQUIREMENTS

L1

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):

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

L1

☐ PTP ☐ QME ☐ AME

Name of doctor who approved job restrictions (optional):

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: _____

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

L1

☐ 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.

State of California
Division of Workers' Compensation

L2

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 _____ and ended on _____.
(START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

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

Employer _____
(Name of Firm)

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

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

L2

☐ 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 $ _____ (Weekly Wages), that are equivalent to or more than 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.

THIS SECTION TO BE COMPLETED BY EMPLOYEE:

L2

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: _____

THIS SECTION TO BE COMPLETED BY EMPLOYEE:

L2

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

State of California
Division of Workers' Compensation

L3

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.

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

L3

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):

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

L3

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:

NOTICE TO THE PARTIES

L3

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.

SUPPLEMENTAL JOB DISPLACEMENT NON-TRANSFERABLE VOUCHER FORM
FOR INJURIES OCCURRING ON OR AFTER 1/1/13

M1

This is a supplemental job displacement non-transferrable $6,000 voucher for education-related retraining and/or skill enhancement. It can be used for education, counseling and/or training services. You can take this voucher to a California public school or to a state-certified provider on the Eligible Training Provider List, at http://etpl.edd.ca.gov and the school will be directly reimbursed upon receipt of a documented invoice by the claims examiner. You can also present this voucher to a counselor, which can be selected from the list on the Division of Workers' Compensation's ("DWC") website at: http://www.dir.ca.gov/dwc/SJDB/VRTWC_list.pdf.

This voucher may be applied to any of the following expenses at the choice of the injured employee:

(1) Education-related retraining or skill enhancement, or both, at a California public school or with a provider that is certified and on the Eligible Training Provider List, including payment of tuition, fees, books, and other expenses required by the school for retraining or skill enhancement.

(2) Occupational licensing or professional certification fees, related examination fees, and examination preparation course fees.

(3) The services of licensed placement agencies, vocational or return-to-work counseling, and résumé preparation, all up to a combined limit of $600.

(4) Tools required by a training or educational program in which the employee is enrolled.

(5) Computer equipment including, monitors, software, networking devices, keyboards, mouse, printers, and tablet computers of up to $1,000 submitted with appropriate documentation (page 4 of this packet). The employer may give the employee the option to obtain computer equipment directly from the employer. The employee shall not be entitled to reimbursement for games or any entertainment media.

(6) Up to $500 as a miscellaneous expense reimbursement or advance, payable upon request (by submitting page 3 of this packet via email or regular mail) without need for itemized documentation or accounting. The employee is not entitled to any other voucher payment for transportation, travel expenses, telephone or internet access, clothing or uniforms, or incidental expenses.

Because you have received this Voucher and are unable to return to your usual employment, you may be eligible for a Return-to-Work Supplement. You must apply within one year from the date this Voucher was served on you. You should make a copy of the Voucher which you will need to apply for the Return-to-Work Supplement. Details about the Return-to-Work supplement program are available from the Department of Industrial Relations on its website, www.dir.ca.gov, or by calling 510-286-0787.

If you pay for eligible expenses, you may be reimbursed for these expenses upon submission of documented receipts to the claims administrator for reimbursement. Reimbursement payments must be made by the claims administrator within 45 calendar days upon receipt of voucher, receipts, and documentation.

If you decide to voluntarily withdraw from a program, you may not be entitled to a full refund of the voucher.

If there is a dispute regarding this voucher, the employee or claims administrator may file Form DWC-AD 10133.55 "Request for Dispute Resolution before the Administrative Director" with the Administrative Director, Division of Workers' Compensation, P.O. Box 420603, San Francisco, CA 94142-0603.

If you have a question or need more information, you can contact your employer or the claims administrator. You can also contact a DWC Information and Assistance ("I&A") Officer. Contact information for I&A can be found at: http:www.dir.ca.gov/dwc/ianda.html.

This section is to be completed by the Claims Administrator

M1

Employee Last Name | Employee First Name | MI

Claims Administrator | Claims Representative

Claims Mailing Address

City | State | Zip Code | Claim No.

Claims Phone Number | Claims Email Address (optional) | Date of Injury

After this voucher expires, it will be unusable. All claims for expenses and reimbursement must be submitted to the claims adjuster before the expiration date.

Date Voucher Expires: _____
MM/DD/YYYY

Vocational Return-to-Work Counselor (if any) (To Be Completed By the Employee)
If you will be using the services of a vocational return-to-work counselor, and/or training provider/school, please complete the bottom of this page and mail it to the claims administrator.

Last Name | First name | MI

Address:

City: | State | Zip Code

Phone

Funds used for counseling (not to exceed $600): $ _____

Training Provider or School Details (if any) (To Be Completed By the Employee)

Provider Name

Address.

City | State | Zip Code

Phone

Training Cost: $ _____

The Injured Employee Must Sign and Date this Voucher Form

Signature: _____ Date _____
MM/DD/YYYY

M1

REQUEST FOR MISCELLANEOUS EXPENSES
SUPPLEMENTAL JOB DISPLACEMENT NON-TRANSFERABLE VOUCHER FORM

This section is to be completed by the Claims Administrator

Employee Last Name _____ Employee First Name _____ MI _____

Claims Administrator _____ Claims Representative _____

Claims Mailing Address _____

City _____ State _____ Zip Code _____ Claim No. _____

Claims Email Address _____ Date of Injury _____

☐ I request $500 as a miscellaneous expense reimbursement or advance.

Injured Employee Signature: _____ Date _____
MM/DD/YYYY

If you would like to request miscellaneous expenses, please complete this form and submit it to the claims adjuster. If an e-mail address was provided, you can submit this form via e-mail, otherwise, please mail this form to the claims adjuster. You will not be entitled to any other voucher payment for transportation, travel expenses, expenses, telephone or internet access, clothing or uniforms or incidental expenses.

If you are requesting reimbursement for the purchase of computer expenses, please mail a Request for Purchase of Computer Equipment (page 4) to the claims adjuster with appropriate documentation.

If you are requesting reimbursement for the purchase of tuition, fees, books, and/or tools, please mail a Request for Reimbursement of Expenses (page 5) to the claims adjustor with appropriate documentation. Payments must be made by the claims adjustor within 45 calendar days of receipt of the request.

REQUEST FOR PURCHASE OF COMPUTER EQUIPMENT
SUPPLEMENTAL JOB DISPLACEMENT NON-TRANSFERABLE VOUCHER FORM

M1

This section is to be completed by the Claims Administrator

Employee Last Name _____ Employee First Name _____ MI _____

Claims Administrator _____ Claims Representative _____

Claims Mailing Address _____

City _____ State _____ Zip Code _____ Claim No. _____

Claims Phone Number _____ Date of Injury _____

I request a total of $ _____

☐ A receipt of purchased equipment is attached for reimbursement.

☐ A written invoice is attached.

☐ I accept the claims administrator's/employer's offer to furnish computer equipment. (If an offer was provided.)

Injured Employee Signature: _____ Date _____
MM/DD/YYYY

Up to $1,000 for purchase(s) of computer equipment including, monitors, software, networking devices, keyboards, mouse, printers, and tablet computers is available. You are not entitled to reimbursement for purchase of games or any entertainment media.

If the computer equipment will be provided directly to you, your employer must provide the computer equipment along with documentation of the cost of the computer equipment within 45 days of receipt of this Request for Purchase of Computer Equipment.

Payment of tuition, fees, books, and tools may also be reimbursed using page 5.

If you have requested $500 in miscellaneous expenses, you are not entitled to reimbursement for transportation, travel expenses, telephone or internet access, clothing, uniforms, or incidental expenses.

M1

REQUEST FOR REIMBURSEMENT OF EXPENSES
SUPPLEMENTAL JOB DISPLACEMENT NON-TRANSFERABLE VOUCHER FORM

This section is to be completed by the Claims Administrator

Employee Last Name _____ Employee First Name _____ MI _____

Claims Administrator _____ Claims Representative _____

Claims Mailing Address _____

City _____ State _____ Zip Code _____ Claim No. _____

Claims Phone Number _____ Date of Injury _____

I request a total of $ _____ for reimbursement for expenses Complete receipts or other documentation must be attached.

Injured Employee Signature: _____ Date _____
MM/DD/YYYY

If you would like to request reimbursement of expenses for tuition, fees, books, and tools, please complete this page and mail it to the claims adjuster with documentation substantiating your expenses.

If you have requested $500 in miscellaneous expenses, you are not entitled to reimbursement for transportation, travel expenses, telephone or Internet access, clothing, uniforms, or incidental expenses.

For computer equipment purchases, please complete a Request for Purchase of Computer Equipment (page 4) and mail it to the claims adjuster with appropriate documentation.

PROOF OF SERVICE

M1

On _____, I served the foregoing document(s): Supplemental Job Displacement Non-Transferable Voucher for Injuries Occurring on or After 1/1/13 (Form DWC - AD 10133.32) for Claim Number

_____to the parties listed below:

Name of Injured Worker:

Address:

ADJ Number:

Attorney(s) Name:

Firm Name:

Address:

_____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.

Executed on _____at _____, CA.

Signature of Person who Served the Papers: _____

Print Name: _____

State of California
Division of Workers' Compensation

M2

SUPPLEMENTAL JOB DISPLACEMENT NONTRANSFERABLE TRAINING VOUCHER FORM FOR INJURIES OCCURRING BETWEEN 1/1/04-12/31/12, INCLUSIVE DWC - AD 10133.57

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

First Name _____ MI _____

Last Name _____

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

City _____ State _____ Zip Code _____

Claim Number _____ Date of Birth: MM/DD/YYYY _____

Phone _____ Date Voucher Expires _____ MM/DD/YYYY

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

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

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

City _____ State _____ Zip Code _____

Claims Representative _____ Phone _____

$ _____ is available to the injured employee based on _____% of Permanent Partial Disability Award

Vocational Return to Work Counselor (if any) (To Be Completed By Employee) (All information in this sect ust om ete

M2

First Name _____ MI _____

Last Name _____

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

City _____ State _____ Zip Code _____

Phone _____ Funds used for vocational and return to work counseling $ _____
(10% maximum of voucher value)

Training Provider Details (To Be Completed By Employee - Attach additional pages for each provider) (Complete information in this section if applicable) (Institutions must list their names in the first name box)

First Name _____

Last Name _____

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

City _____ State _____ Zip Code _____

Phone

Expiration Date _____
MM/DD/YYYY

Provider Approval Number _____

Provider Contact Name _____

Training Cost _____

The Injured Employee Must Sign and Date this Voucher Form

Injured Employee Signature _____

Date _____
MM/DD/YYYY

Note to Claims Administrator: Upon receipt of voucher, receipts and documentation from the employee, reimbursement payments to the employee or direct payments to VRTWC and training providers must be made within 45 calendar days.

You have been determined eligible for this nontransferable, Supplemental Job Displacement Vouch[illegible] This voucher may be used for the payment of tuition, fees, books, and other expenses required by a state approved or ac[illegible]ol that you enroll in for the purpose of education related retraining or skill enhancement, or both. The school will be [illegible]reimbursed upon receipt of a documented invoice by the claims administrator of the costs outlined above.

M2

If you pay for the eligible expenses, you may be reimbursed for these expenses upon submission of documented receipts to the claims administrator for immediate reimbursement. If you decide, however, to voluntarily withdraw from a program, you may not be entitled to a full refund of the voucher. If you choose to use the services of a vocational counselor, no more than 10 percent of the voucher may be used for vocational or return to work counseling.

In order to initiate your training or return to work counseling, present the voucher to the school or the vocational and return to work counselor of your choice, chosen from the list developed by the Division of Workers' Compensation's Administrative Director.

A list of vocational and return to work counselors is available on the Division of Workers' Compensation's website www.dir.ca.gov or upon request. The school and/or counselor should contact ~~me~~ the claims administrator regarding direct payment from your supplemental job displacement benefit.

This supplemental job displacement voucher must be used before the expiration date specified on the first page. After this voucher expires, it will be unusable. All claims for expenses and reimbursement must be submitted to the claims adjuster before the expiration date.

If there is a dispute regarding this voucher, the employee or claims administrator may file Form DWC-AD 10133.55 "Request for Dispute Resolution before the Administrative Director" with the Administrative Director, Division of Workers' Compensation, P.O. Box 420603, San Francisco, CA 94142-0603.

If you have a question or need more information, you can contact your employer or the claims administrator. You can also contact a DWC Information and Assistance ("I&A") Officer. Contact information for I&A can be found at: http://www.dir.ca.gov/dwc/ianda.html.

VOLUNTEER FIRE DEPARTMENT ROSTER REPORT
FOR

_____ FIRE DEPARTMENT DATE _____

NAMES OF VOLUNTEER FIREFIGHTERS	ACTIVE	DATE REMOVED *	DATE ADDED *
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
21.			
22.			
23.			

*** use this column only for additions or deletions**

VOLUNTEER FIRE DEPARTMENT ROSTER REPORT
FOR

_____ FIRE DEPARTMENT DATE _____

NAMES OF GENERAL VOLUNTEERS (NON-FIREFIGHTERS)	ACTIVE	DATE REMOVED *	DATE ADDED *
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
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21.			
22.			
23.			

*** use this column only for additions or deletions**

VOLUNTEER FIRE DEPARTMENT ROSTER REPORT
FOR

_____ FIRE DEPARTMENT DATE _____

NAMES OF FIRE CADETS (LIMITED TO PARTIAL DUTIES / TRAINING)	ACTIVE	DATE REMOVED *	DATE ADDED *
1.			
2.			
3.			
4.			
5.			
6.			
7.			
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23.			

*** use this column only for additions or deletions**

SECTION VII

TABLES

TABLE I

EVIDENTIARY PRESUMPTIONS UNDER LABOR CODE §§3212 - 3213 as of 2013

OFFICER CLASSIFICATION	HEART TROUBLE/ PNEUMONIA	HERNIA	TUBERCULOSIS	CANCER	LOWER BACK	BLOOD BORNE INFECTIOUS DISEASES MRSA	MENINGITIS	BIOCHEMICAL	LYME DISEASE
Sheriff's Office	3212.5 **	3212	3212.6	3212.1	3213.2 **	3212.8	3212.9	3212.85	3212.12
Police Officer	3212.5 **	3212	3212.6	3212.1	3213.2 **	3212.8	3212.9	3212.85	3212.12
DA investigators/ inspectors	3212.5 **	3212	3212.6	3212.1		3212.8	3212.9	3212.85	3212.12
Department of Justice officers	3212.7	3212.7	3212.7	3212.1		3212.8		3212.85	3212.12
Firefighters (local)	3212	3212	3212.6	3212.1		3212.8	3212.9	3212.85	
Dept. Forestry f/fighters	3212	3212	3217.7	3212.1		3212.8	3212.9	3212.85	
UC firefighters	3212.4	3212.4	3212.6	3212.1		3212.8	3212.9	3212.85	
UC police	3213 **	3212	3212.6 ****		3213.2 **	3212.8		3212.85	3212.12
CSU firefighters	3212	3212	3212.6	3212.1		3212.8	3212.9	3212.85	3212.12
CSU police		3212				3212.8	3212.9		
Fish & Game Wardens	3212	3212		3212.1		3212.8		3212.85	3212.12
CHP Officers	3212.3 / 3212.5 **	3212	3212.6	3212.1	3213.2 **	3212.8	3212.9	3212.85	3212.12
Other State police	3212.3 **	3212	3212.6	***		3212.8		3212.85	3212.12
Dept/Corrections parole, probation, Custodial Officers or Youthful Offender parole Board and Youth Auth. Group Counselors & Supervisors, Security, Custodial parole officers	3212.10	3212.7	3212.10	***		3212.8	3212.9 & 3212.10	3212.85	3212.12
Lifeguards				3212.11 (skin cancer)					
CA Conservation Corps									3212.12

* Anti-attribution clause precludes evidence of causation from pre-existing disease in §§ 3212, 3212.3, 3212.4, 3212.5, 3212.7, 3212.8, 3212.11 and 3213.
After 1-1-07 no apportionment of Permanent Disability resulting from any presumptive injury unless a prior award exists. See §4663(e) & §4664.
** Presumption arises only after 5 years; and for LC §3213.2, Lower Back presumption, additionally requires a duty belt is a condition of employment
*** All peace Officers sworn under §§830.1, 830.2, and 830.37 are expressly covered under the cancer presumption §3212.1(a).
However, specific penal Code limitations may not be controlling, cases are divided. **See** *San Francisco B.A.R.T. v. WCAB (Ennis)*, 72 CCC 1694. **Compare** *Joy v. City of Woodland*, 74 CCC 871 (upholding statutory limitations).
Seek advice of counsel if not expressly covered.
**** Limited to Officers engaging in custodial duties.
WARNING: Where specified in the presumption, only those stated peace Officers defined by specific penal code sections get the presumption.

TABLE II

TEMPORARY DISABILITY BENEFITS

Injury During Period	Max Earnings****	Rate Payable	Min Earnings	Payable
1/1/84 - 12/31/89*	$336.00	$224.00	$168.00	$112.00
1/1/90 - 12/31/90**	$399.00	$266.00	See Below *	$112.00
1/1/91 - 6/30/94**	$504.00	$336.00	See Below **	$112.00
7/1/94 - 6/30/95**	$609.00	$406.00	“ ”	$112.00
7/1/95 - 6/30/96**	$672.00	$448.00	“ ”	$112.00
7/1/96 - 12/31/02	$735.00	$490.00	“ ”	$112.00
1/1/03 - 12/31/03	$903.00	$602.00	$189.00	$126.00
1/1/04 - 12/31/04		$728.00	$189.00	$126.00
1/1/05 - 12/31/06	$1,260.00	$840.00	$189.00	$126.00
1/1/07 - 12/31/07	$1322.49	$881.66	$198.37	$132.25
1/1/08 - 12/31/08	$1,374.50	$916.33	$206.17	$137.45
1/1/09 - 12/31/09	$1,437.10	$958.01	$215.55	$143.70
1/1/10 - 12/31/11	$1,480.04	$986.69	$222.01	$148.00
1/1/12 - 12/31/12	$1,515.75	$1,010.50	$227.36	$151.57
1/1/13 - 12/31/13	$1,600.08	$1,066.72	$240.00	$160.00
1/1/14 - 12/31/14	$1,611.96	$1,074.64	$241.79	$161.19
1/1/15 - 12/31/15	$1,654.94	$1,103.29	$248.25	$165.49
1/1/16 - 12/31/16	$1,692.64	$1,128.43	$253.89	$169.26
1/1/17 – 12/31/17	$1,758.85	$1,172.57	$263.82	$175.88
Labor Code §4850 Benefits***	(Full Salary)	(Full Salary)	(Full Salary)	(Full Salary)

*

For injuries after 1/1/90, but before 12/31/90 minimum rates are as follows:

For AWE < $98, TD = $98
For AWE > $98, but < $112, TD = AWE
For AWE > $112, minimum TD = $112

**

For injuries on or after 1/1/91 but before 1/1/07 minimum TD rates are calculated as follows:

For AWE < $126, TD = AWE (i.e.: If AWE = $45, Then TD = $45)
For AWE > $126, Minimum TD = $126

***

Full salary means the guaranteed salary payment for the position (i.e.: job description, memorandum of understanding [“MOU”] if applicable). Routine overtime or past annual average salary does not decide the issue. However if there is required overtime which is part of the job requirement such as a firefighter who is required to work 56 hours per week, year-round, then such overtime is part of full salary.

****

Labor Code §4458 (volunteer firefighters) and §4458.2 (reserve police officers) provide presumption of maximum earnings.

*****

For injuries occurring after 1/1/07, the minimum and maximum earnings for computing rates payable will be increased in conjunction with the “State Average Weekly Wage” (SAWW), as determined by the U.S. Department of Labor. This resulted in no increase until 1/1/07.

TABLE III

PERMANENT PARTIAL DISABILITY: MINIMUM AND MAXIMUM RATES

Date of Injury	Minimum - Maximum PD Rate	Labor Code Section
1-1-84 to 12-31-90	$70 - $140	L.C. §4453 (b)(2)
1-1-91 to 6-30-94		
1:0 to 14:3	$70 - $140	L.C. §4453 (b)(2)
25:0 to 99:3	$70 - $148	L.C. §4453 (b)(4)
7-1-94 to 6-30-95		
1:0 to 14:3	$70 - $140	L.C. §4453 (b)(2)
15:0 to 24:3	$70 - $148	L.C. §4453 (b)(3)
25:0 to 69:3	$70 - $158	L.C. §4453 (b)(5)
70:0 to 99:3	$70 - $168	L.C. §4453 (b)(6)
7-1-95 to 6-30-96		
1:0 to 14:3	$70 - $140	L.C. §4453 (b)(2)
15:0 to 24:3	$70 - $154	L.C. §4453 (b)(3)
25:0 to 69:3	$70 - $164	L.C. §4453 (b)(5)
70:0 to 99:3	$70 - $198	L.C. §4453 (b)(6)
7-1-96 to 12-31-02		
1:0 to 14:3	$70 - $140	L.C. §4453 (b)(2)
15:0 to 24:3	$70 - $160	L.C. §4453 (b)(3)
25:0 to 69:3	$70 - $170	L.C. §4453 (b)(5)
70:0 to 99:3	$70 - $230	L.C. §4453 (b)(6)
1-1-03 to 12-31-03		
1:0 to 69:0	$100 - $185	L.C. §4453 (b)(6)
70:0 to 99:0	$100 - $230	L.C. §4453 (b)(7)
1-1-04 to 12-31-04		
1:0 to 69:0	$105 - $200	L.C. §4453 (b)(6)
70:0 to 99:0	$105 - $250	L.C. §4453 (b)(7)
1-1-05 to 12-31-05*		
1:0 to 69:0	$105 - $220	L.C. §4453 (b)(6)
70:0 to 99:0	$105 - $270	L.C. §4453 (b)(7)
1-1-06 to 12-31-12*		
1:0 to 69:0	$130 - $230	L.C. §4453 (b)(6)
70:0 to 99:0	$130 - $270	L.C. §4453 (b)(7)
1-1-13 to 12-31-13		
1:0 to 54:0	$160 - $230	L.C. §4453(b)(8)
55:0 to 69:0	$160 - $270	L.C. §4453(b)(8)
70:0 to 99:0	$160 - $290	L.C. §4453(b)(8)
1-1-14 and after		
1: to 99:00	$160 - $290	L.C. §4453(b)(9)

* Actual rates subject to a 15% increase or decrease depending on size of employer and availability of regular, modified or alternate employment (L.C. §4658(d)). This increase/decrease does not apply to injuries on or after 1-1-13.

Life pension, PD > 70:0

Formula : (PD - 60) x 0.015 x Earnings

Example - for 80% PD Award for 2015 injury at maximum $515.38:
(80 – 60) x 0.015 x $515.38 = $154.61/week

Subject to annual SAWWs COLA beginning January 1 of the calendar year following year in which LP benefits begin.

Max weekly earnings, Labor Code §4659

4-1-74 to 6-30-94	107.69
7-1-94 to 6-30-95	157.69
7-1-95 to 6-30-96	207.69
7-1-96 to 12-31-05	257.69*
1-1-06 to 12-31-16	515.38*

* For injuries on or after 1-1-03, a COLA adjustment will increase benefits. The Supreme Court decided that the increases begin on January 1st of the year following the date the worker became entitled to receive and actually begins receiving either permanent total disability payments or a life pension payment.

TABLE IV

DEATH BENEFITS PAYABLE FOR TOTAL AND PARTIAL DEPENDENCY

Applicable to Injuries Occurring on or After January 1, 1991 Labor Code §4702

Status of Dependence		Death or Injury On or After			
		01/01/91	**07/01/94**	**07/07/96**	**01/01/06**
A.	One total and no partial dependents	95,000	115,000	125,000	250,000
B.	Two or more total dependents, regardless of the number of partial dependents	115,000	135,000	145,000	290,000
C.	Three or more total dependents, regardless of the number of partial dependents	115,000	150,000	160,000	320,000
D.	One total and one or more partial dependents	95,000*	115,000*	125,000*	250,000*
	* plus four times the amount annually support of any partial dependents, with the total paid not to exceed:	115,000	125,000	145,000	290,000
E.	No total and one or more partial	Four times the amount annually devoted to the support of partial dependents, not to exceed:			8 times support:
	dependents	95,000	115,000	125,000	250,000
F.	For injuries on or after 1/1/04, where there are no total nor partial dependents, $250,000 is payable to the Director of Industrial Relations – Death Without Dependents Unit.*				

* The estate benefit has been held unconstitutional in *Six Flags, Inc. v. WCAB* (B184245, 2nd Dist. Court of Appeals). Consult counsel for status.

Death Benefits are payable in installments in the same manner and amounts as temporary disability indemnity per Labor Code §4702(b), and are subject to increases under §4661.5 where earning qualify for the new maximum.

For injuries on or after 1/1/06, death benefits payable to a beneficiary physically or mentally "incapacitated from earning" continue for life of the child.

Labor Code §5406.7 may, under special circumstances, extend the time for filing for the dependent's death benefit up to 420 weeks for presumptive cancer claims under Labor Code §3212.1. We recommend legal advice be obtained for its application. This provision automatically sunsets and is repealed on and after 1/1/2019.

Maximum Burial Expense Benefit: Labor Code §4701(a)

Date of Injury	Maximum Benefit
1/1/91 to 12/31/2012	5,000 All employees
1/1/13 to present	10,000 All employees