WORKERS' COMPENSATION COVERAGE

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

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

CONTENTS

DEDUCTIBLE SELECTED AND COVERAGE AMOUNTS

WORKERS' COMPENSATION

DEDUCTIBLE SELECTED PER OCCURRENCE

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

SELF INSURANCE FUND

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

EXCESS INSURANCE

Excess Workers' Compensation –

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

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

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

YOLO COUNTY PUBLIC AGENCY
RISK MANAGEMENT INSURANCE AUTHORITY

CENTRAL POOL WORKERS' COMPENSATION COVERAGE

A. COVERAGE AGREEMENT

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

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

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

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

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

B. EXCLUSIONS

Coverage shall not apply:

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

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

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

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

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

C. ENTITIES COVERED

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

D. LIMITS

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

E. POLICY

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

F. FINES, PENALTIES, AND FEES

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

INSTRUCTIONS FOR REPORTING WORKERS' COMPENSATION CLAIMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

OSHA CASE NO.

FATALITY ☐

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

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME
1a. Policy Number
2. MAILING ADDRESS: (Number, Street, City, Zip)
2a. Phone Number
3. LOCATION if different from Mailing Address (Number, Street, City and Zip)
3a. Location Code
4. NATURE OF BUSINESS; e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.
5. State unemployment insurance acct.no
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

INJURY OR ILLNESS

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

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

EMPLOYEE

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

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

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

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

FORM 5020 (Rev7) June 2002

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

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

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

OSHA CASE NO.

FATALITY ☐

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

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

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

INJURY OR ILLNESS

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

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

EMPLOYEE

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

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

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

FORM 5020 (Rev7) June 2002

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

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

INSTRUCTIONS

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

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

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

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

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

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

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

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

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

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

8. Distribute the completed canary copy to LWP.

9. Distribute a photocopy of the form to YCPARMIA.

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

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

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

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

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

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

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

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

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabjador.*

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

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

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

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

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____a.m. _____p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.* _____

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

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

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

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

7/1/04 Rev.

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

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

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

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

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

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

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabjador.*

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

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

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

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

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

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

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

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

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

7/1/04 Rev.

CLAIMS HANDLING OVERVIEW

A. HISTORY OF WORKERS' COMPENSATION

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

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

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

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

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

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

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

B. WORKERS' COMPENSATION BENEFITS

BACKGROUND

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

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

COST EMPLOYERS PAY

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

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

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

CASH BENEFITS PAID TO EMPLOYEES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   - Loss of both eyes or sight in both eyes;

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

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

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

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

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

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

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

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

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

C. TEMPORARY DISABILITY

QUALIFYING CRITERIA

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

TERMINATION OF TD PAYMENTS

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

D. WHAT IS AN INJURY?

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

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

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

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

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

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

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

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

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

E. UNDER WHAT CIRCUMSTANCES IS AN INJURY COVERED?

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

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

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

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

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

F. SUPERVISOR PROCEDURES FOR PROCESSING WORKERS' COMPENSATION CLAIMS

FIRST AID

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

PROCEDURES

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

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

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

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

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

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

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

G. RETURN TO WORK

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

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

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

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

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

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

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

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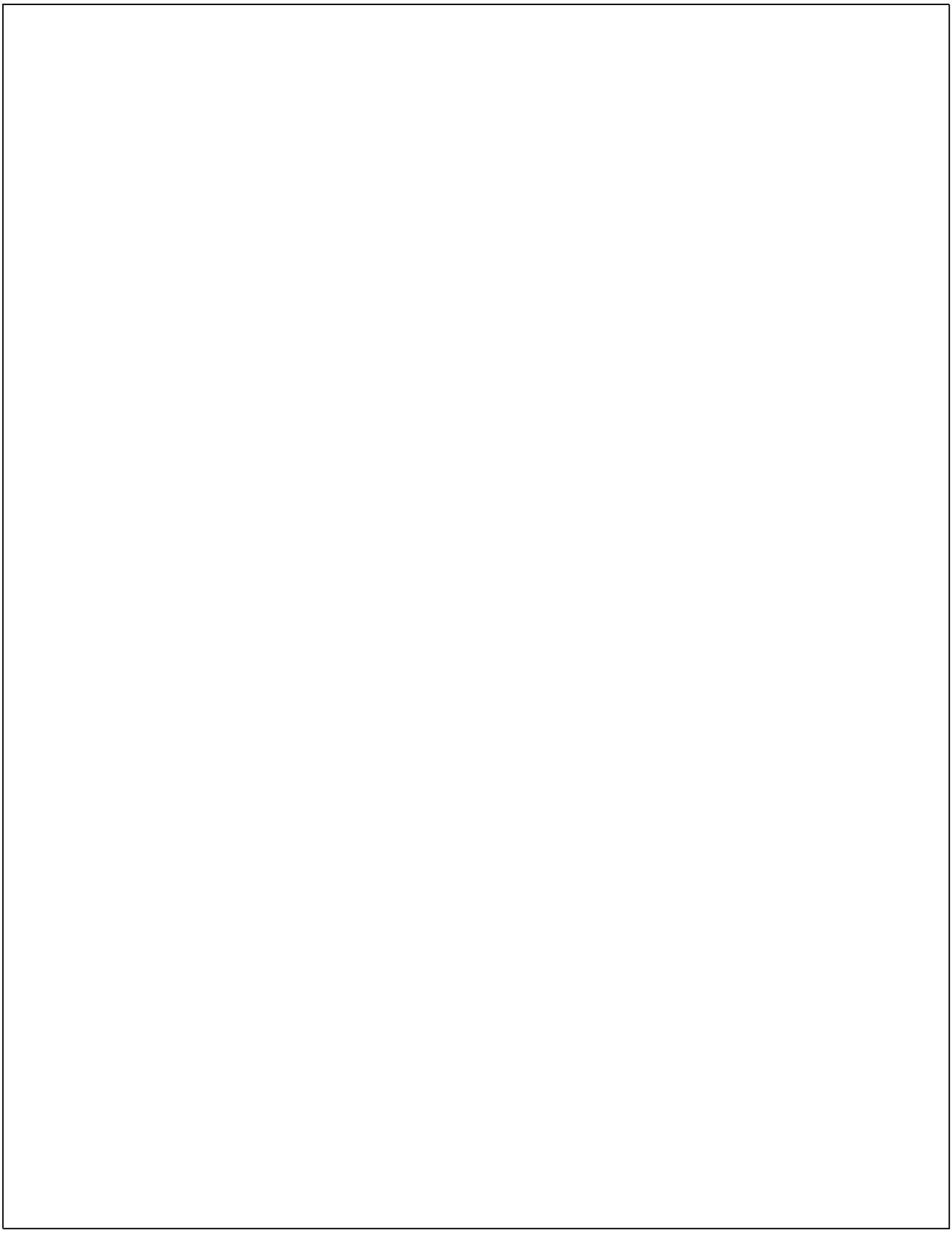

H. PERMANENT DISABILITY AND AMERICANS WITH DISABILITIES ACT

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

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

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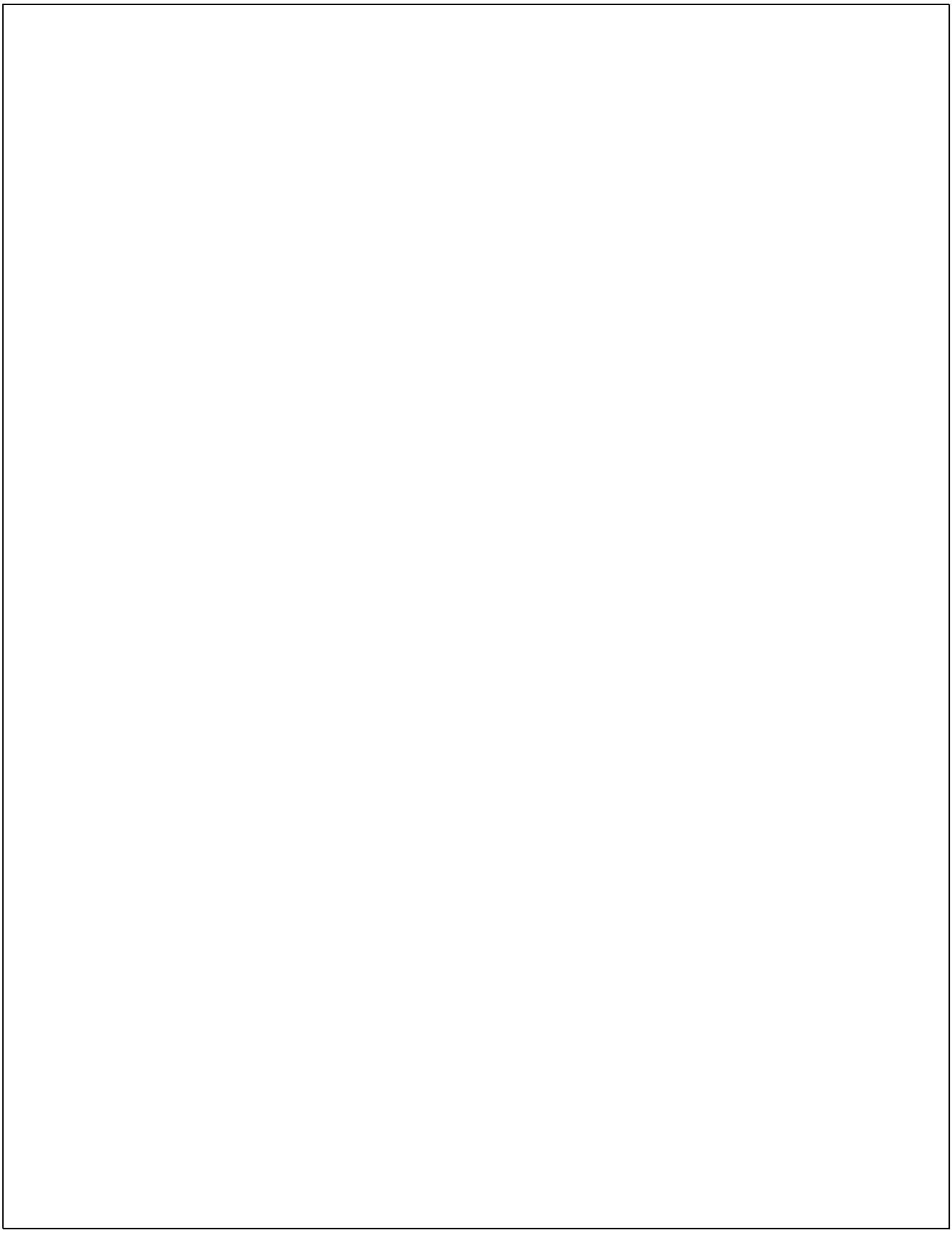

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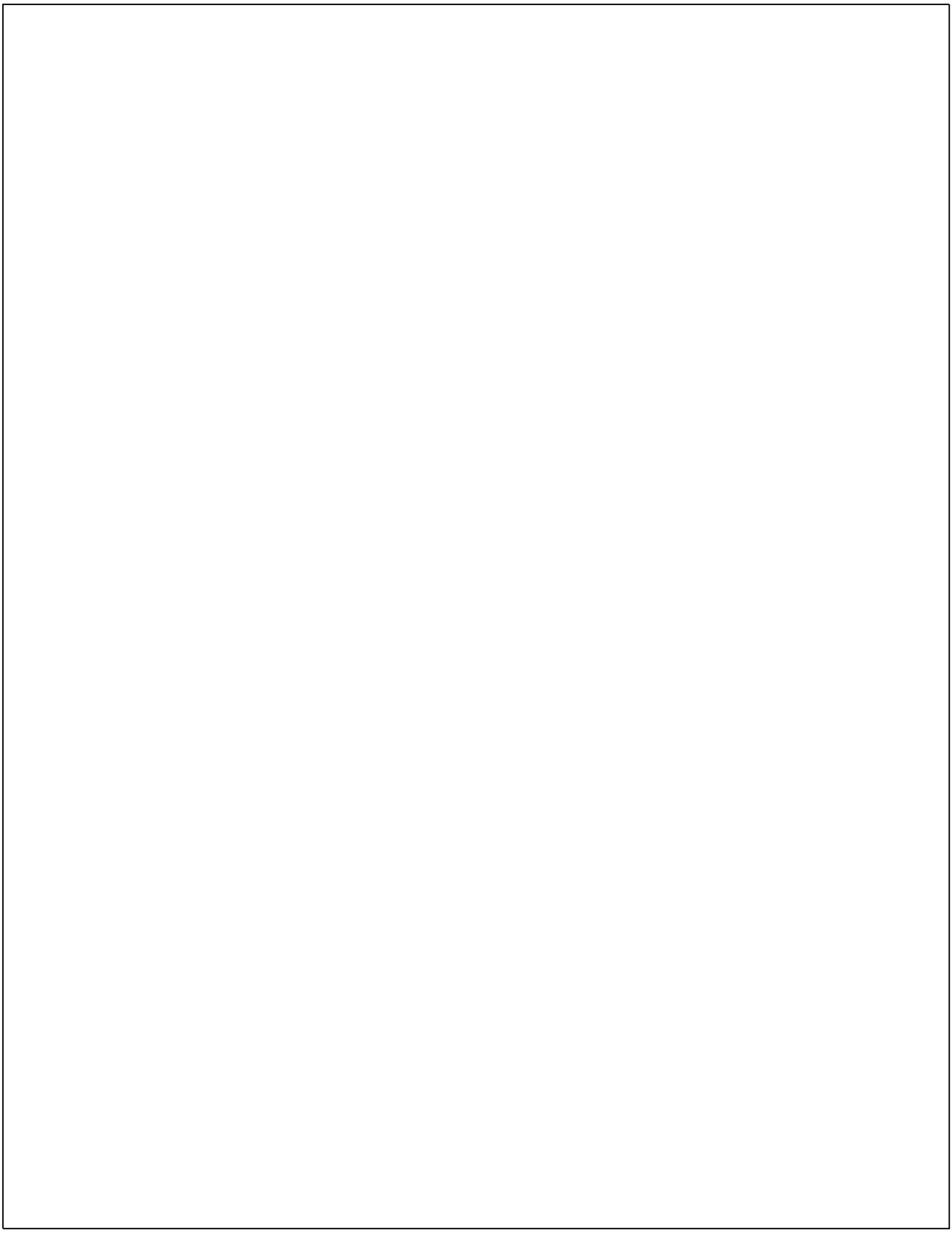

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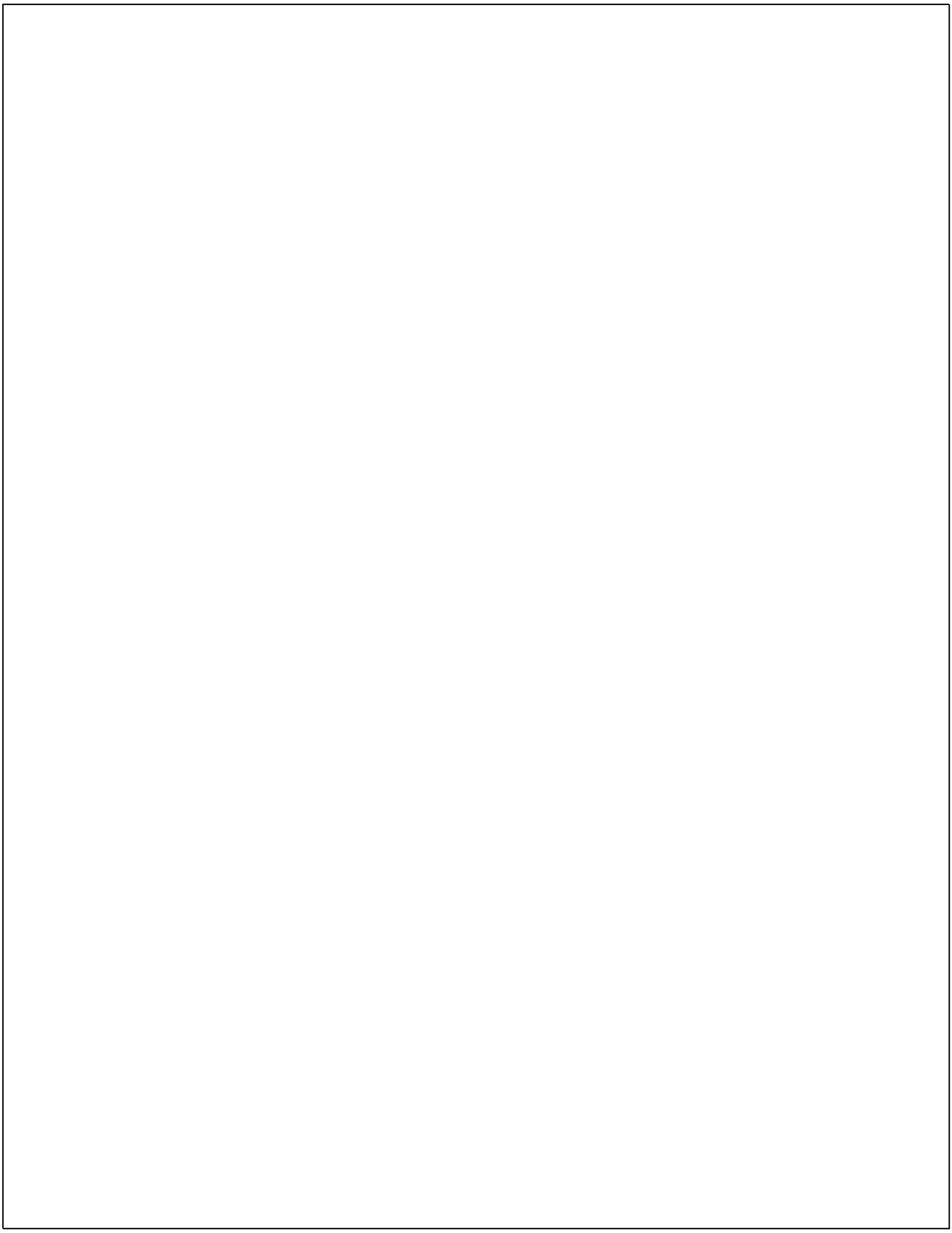

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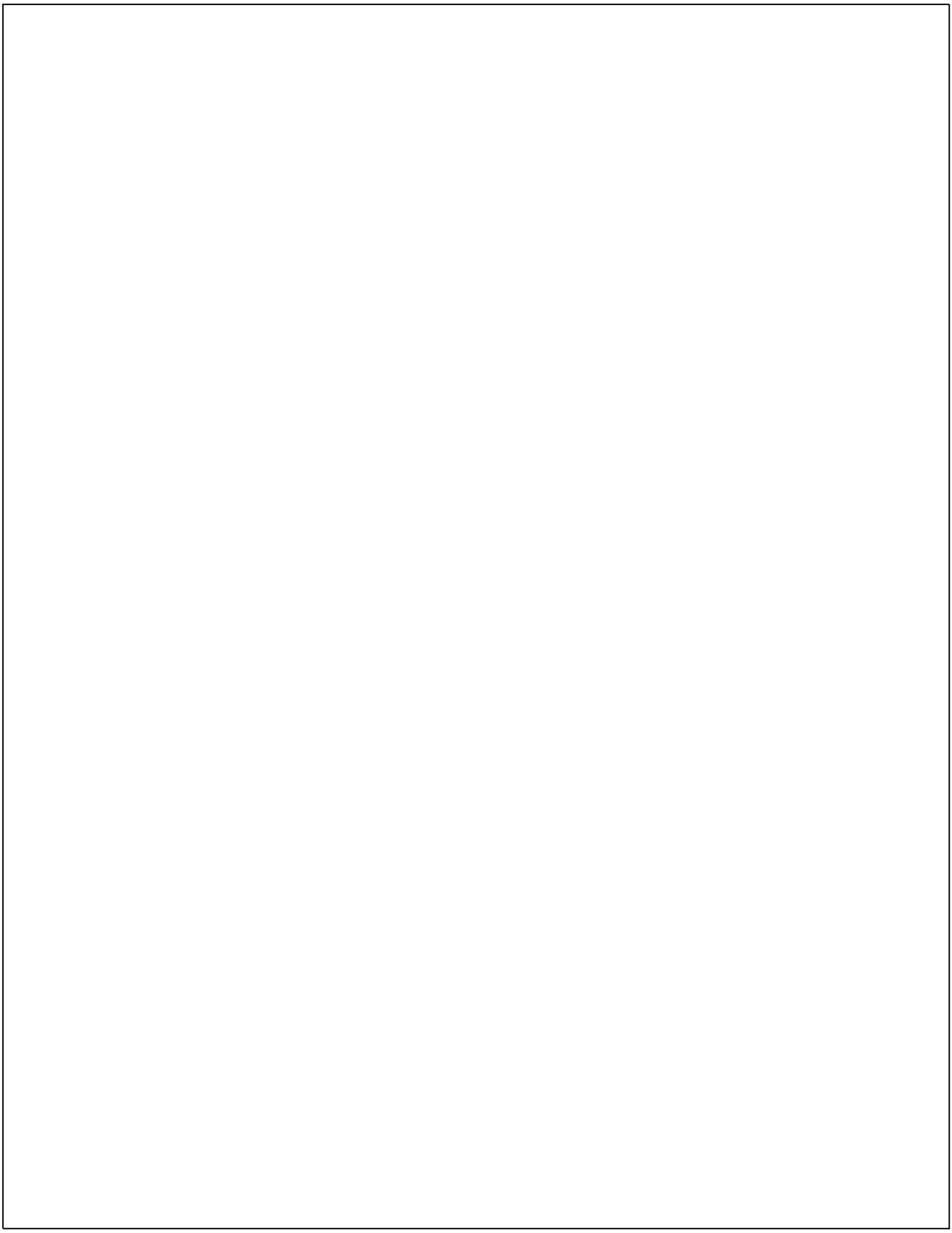

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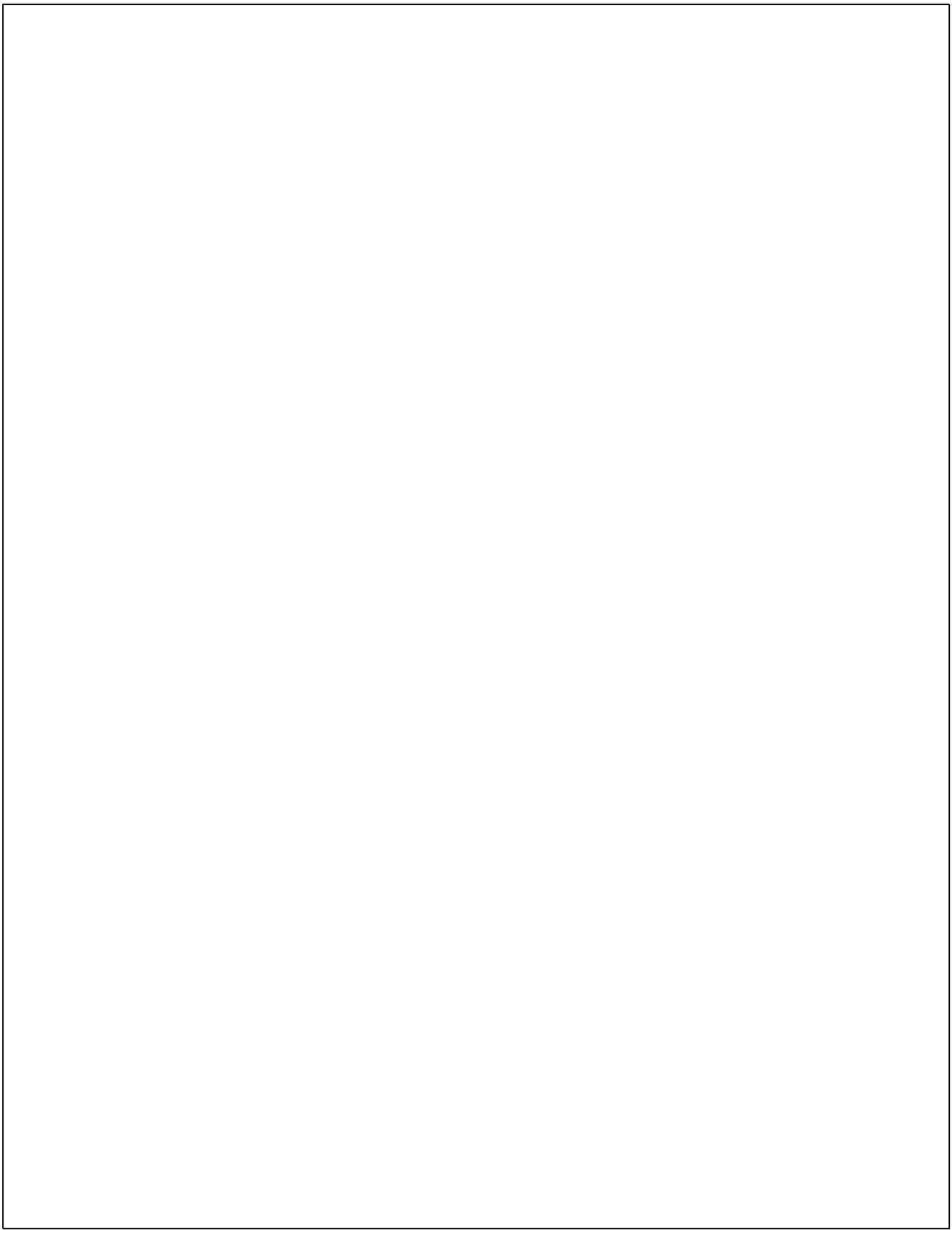

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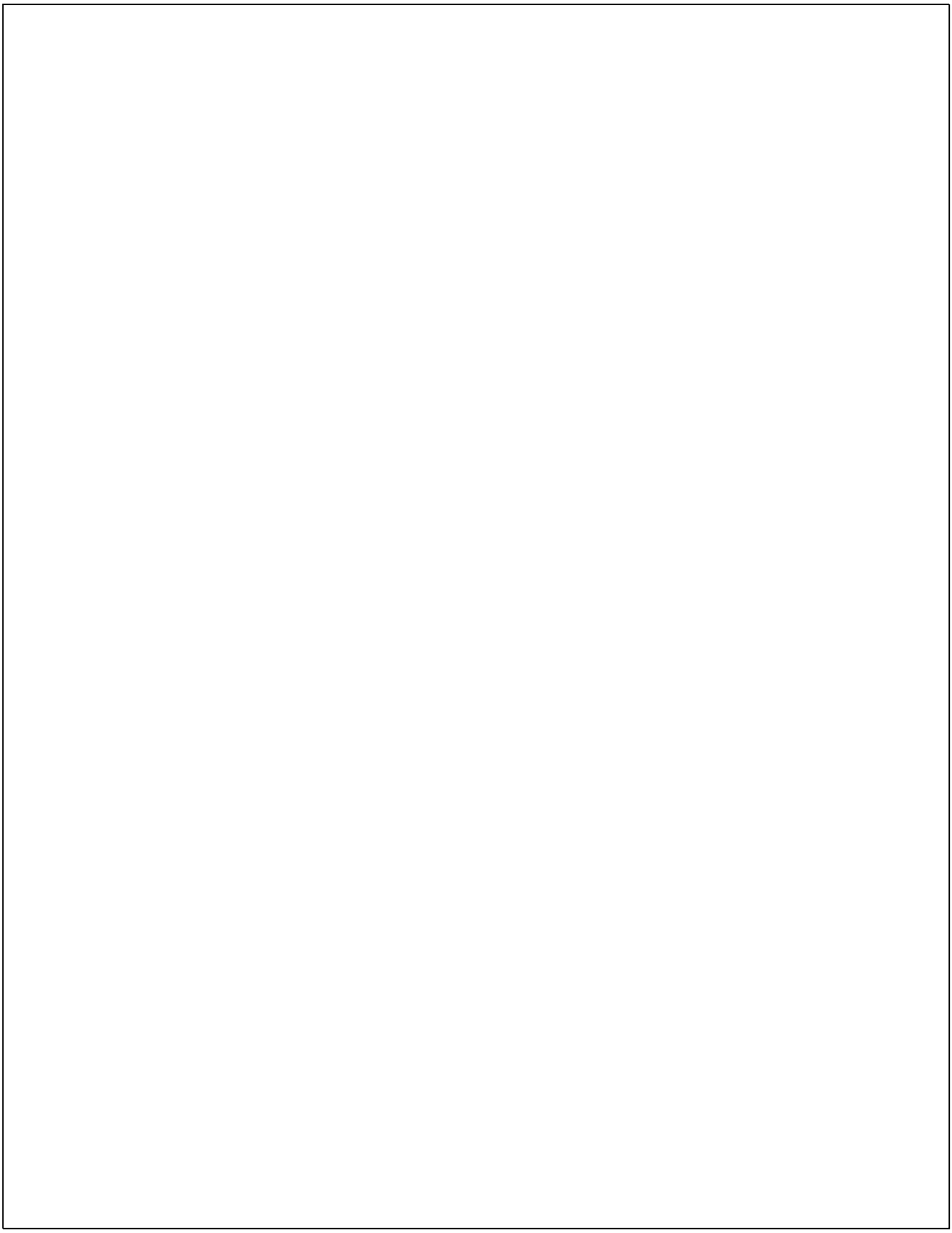

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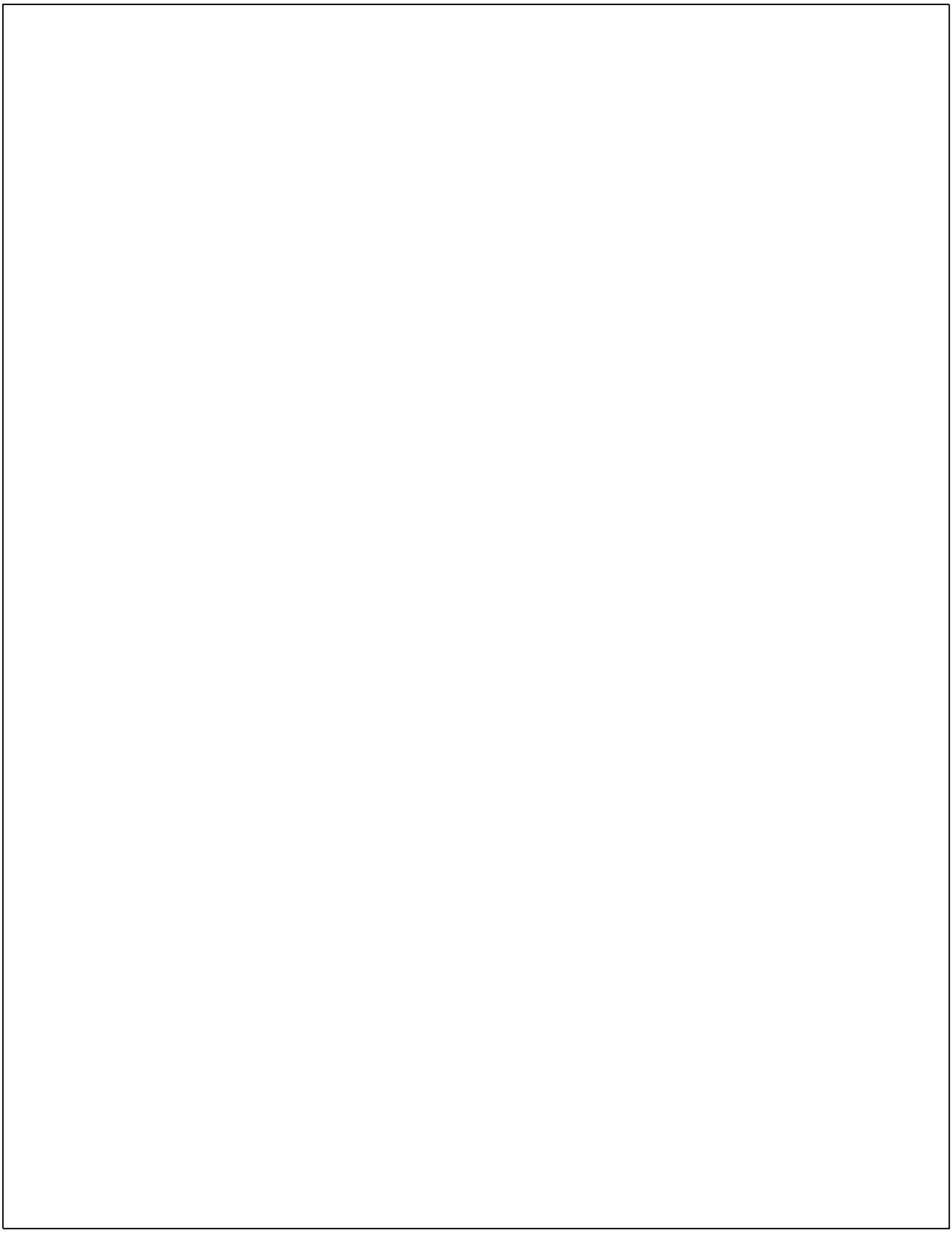

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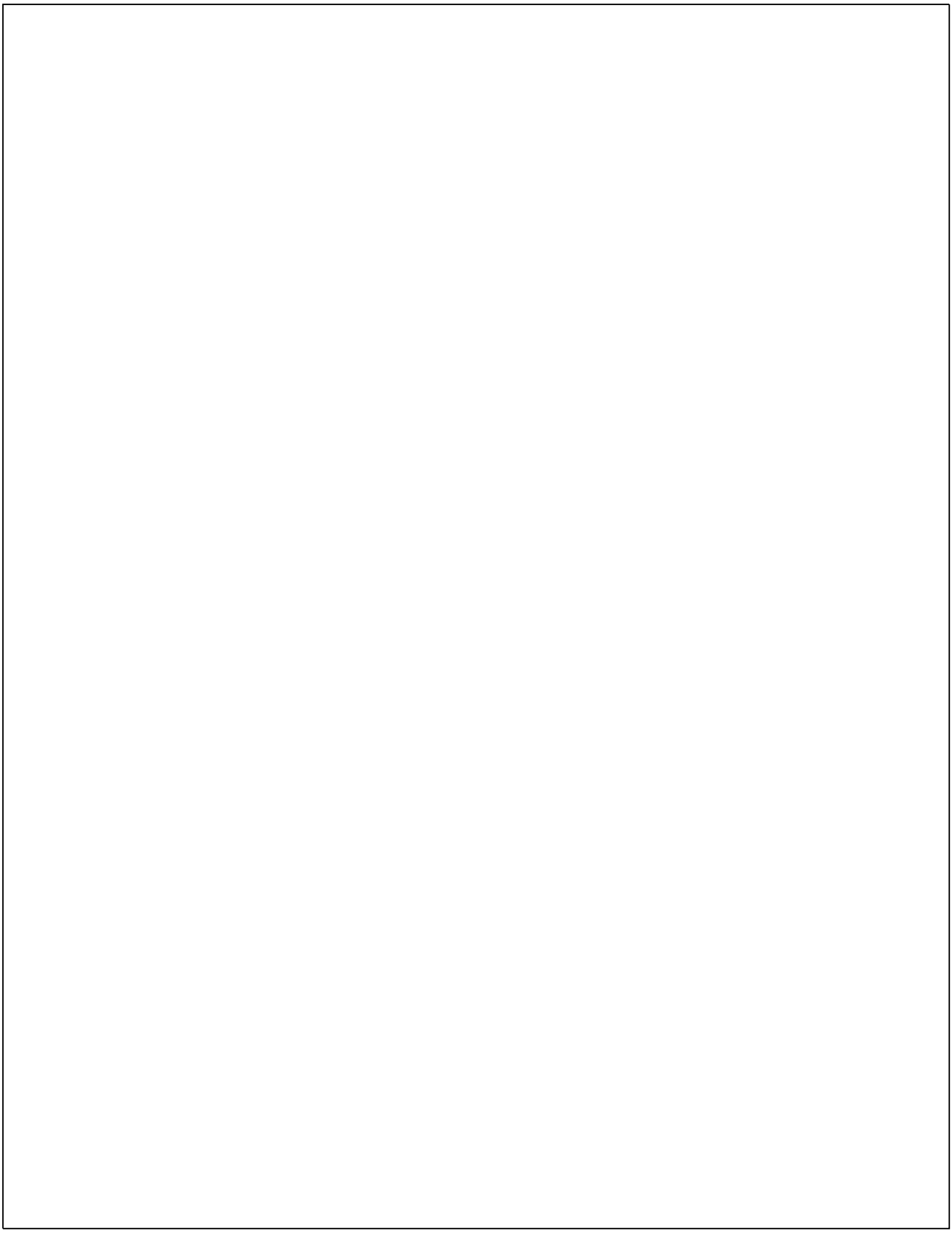

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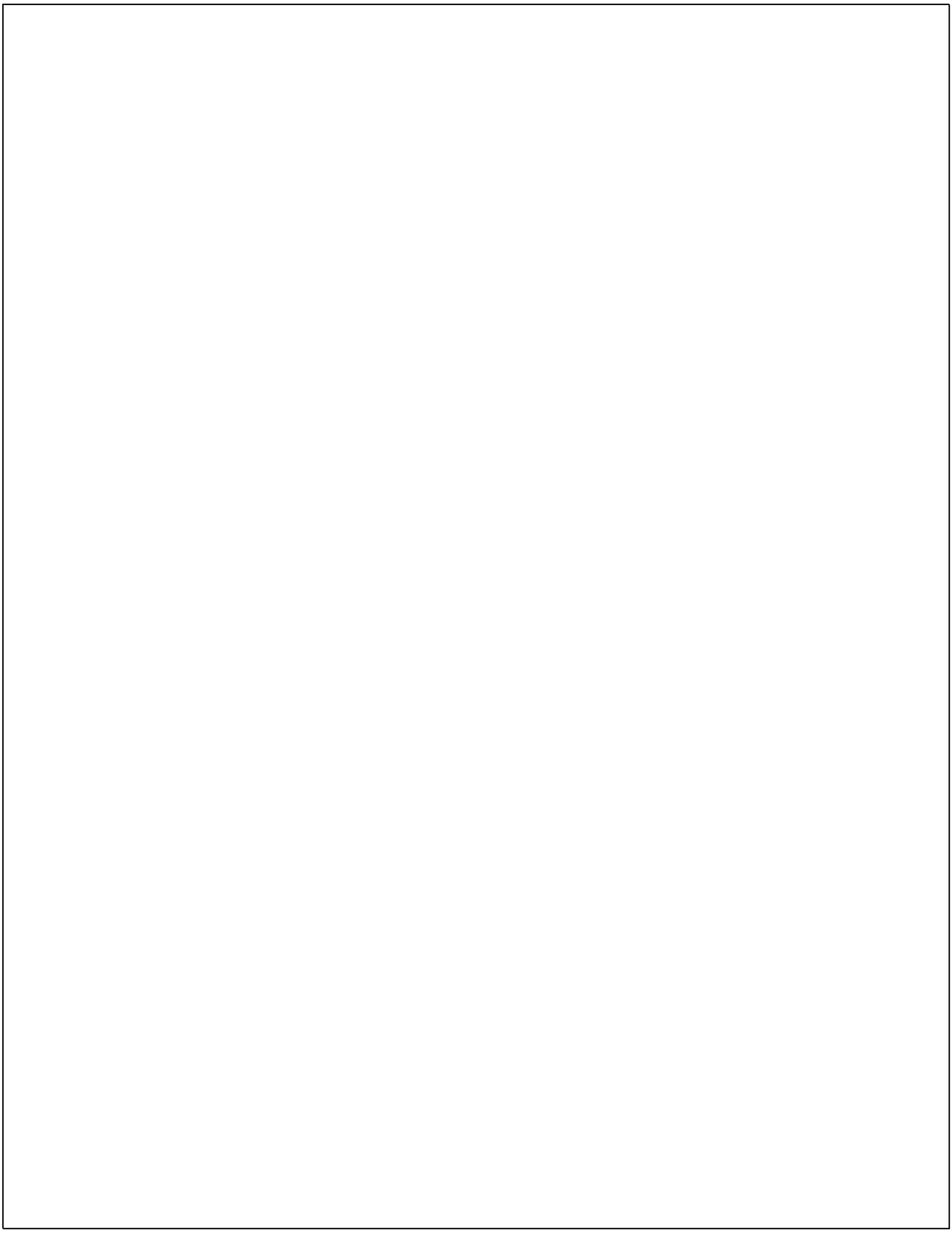

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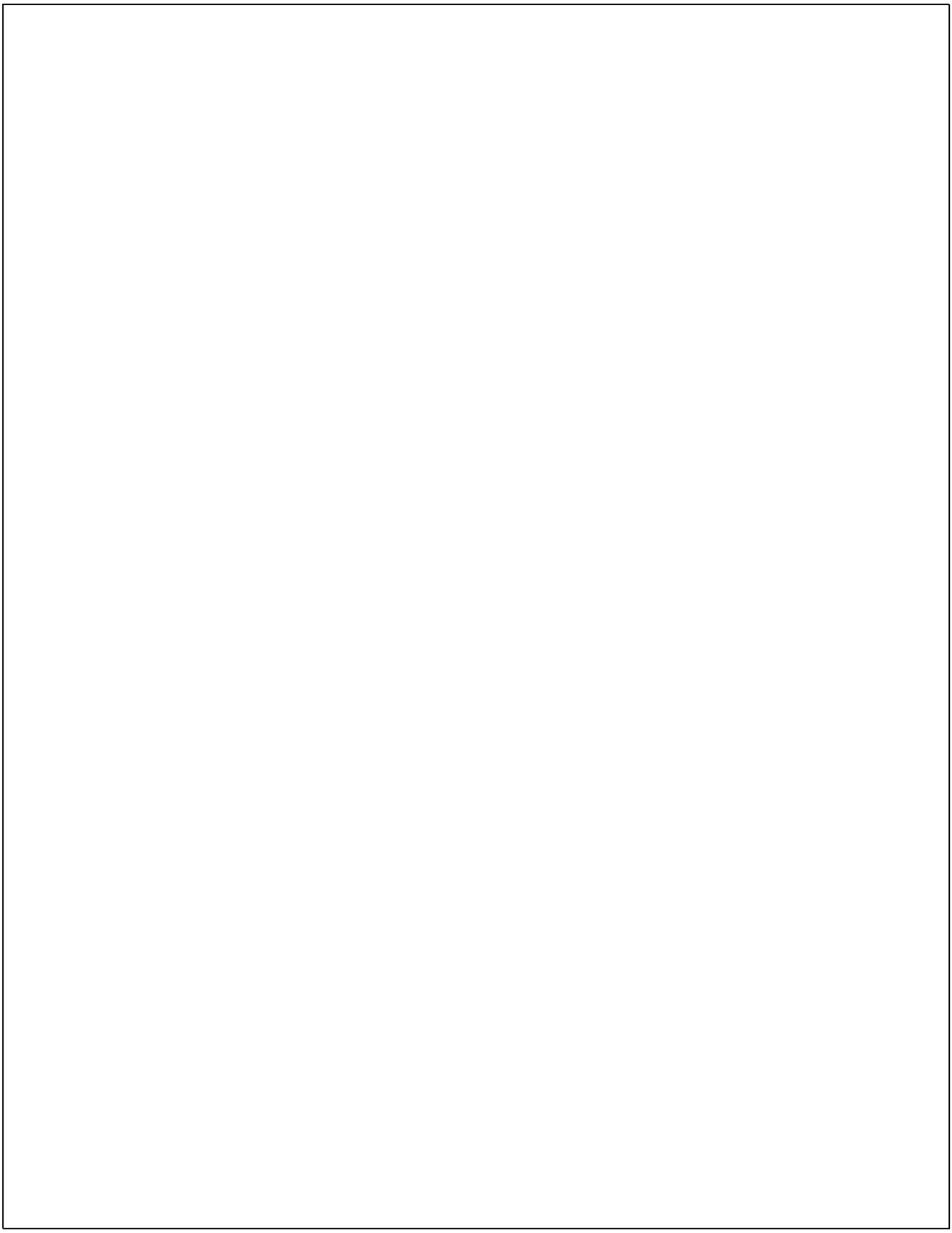

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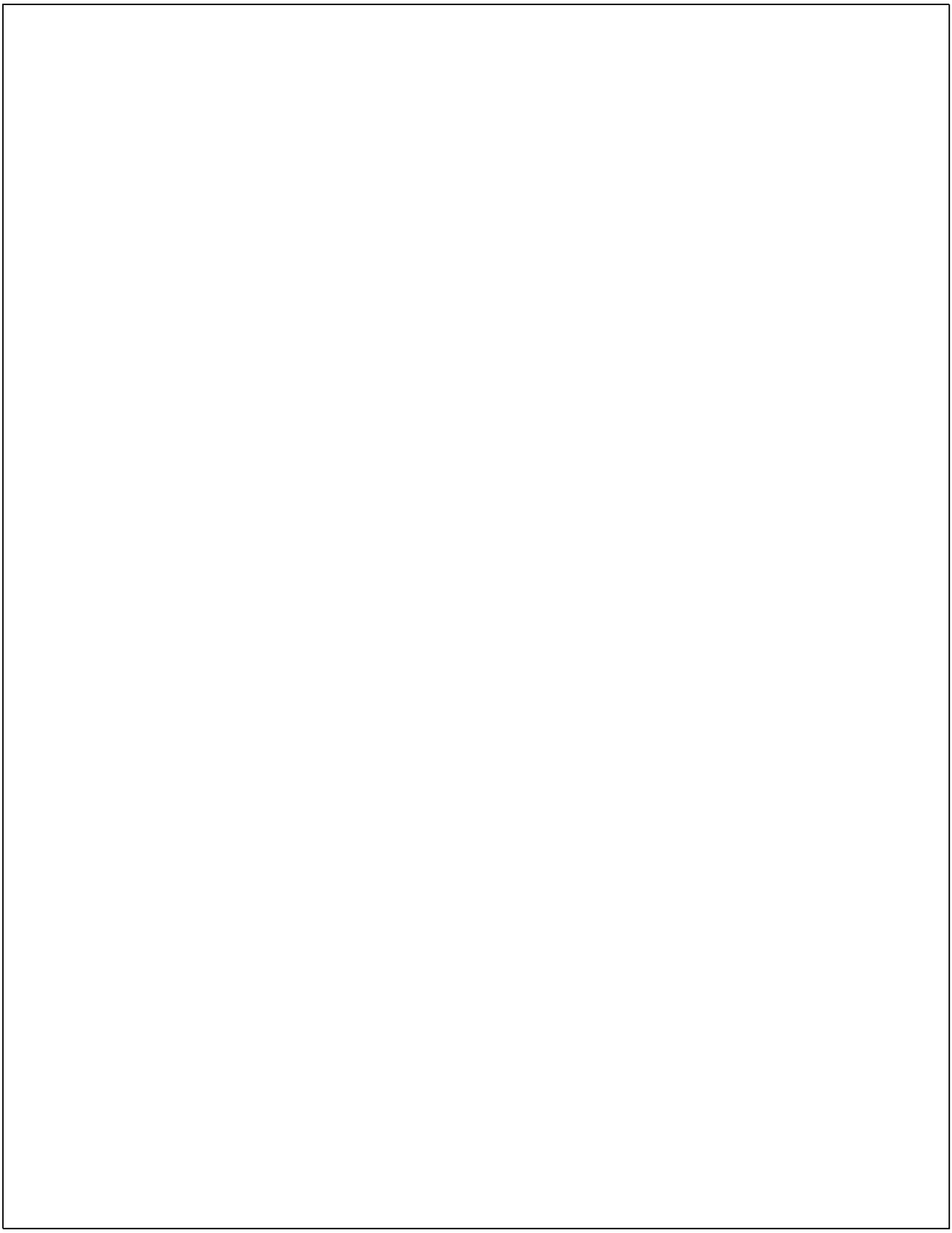

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H. MEDICAL MANAGEMENT

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

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

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

I. SETTLEMENTS

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

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

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

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

On the following pages are Samples of related forms.

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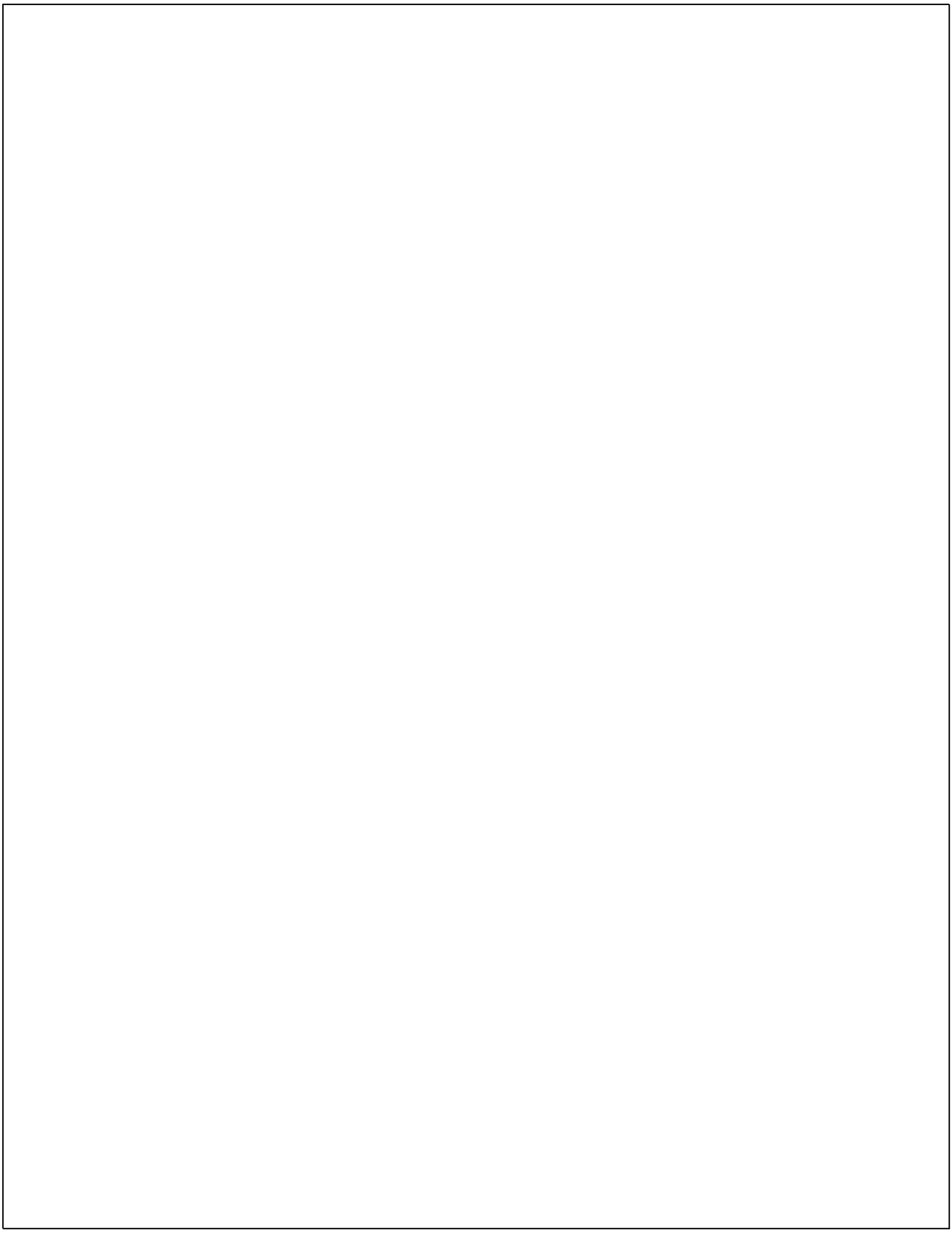

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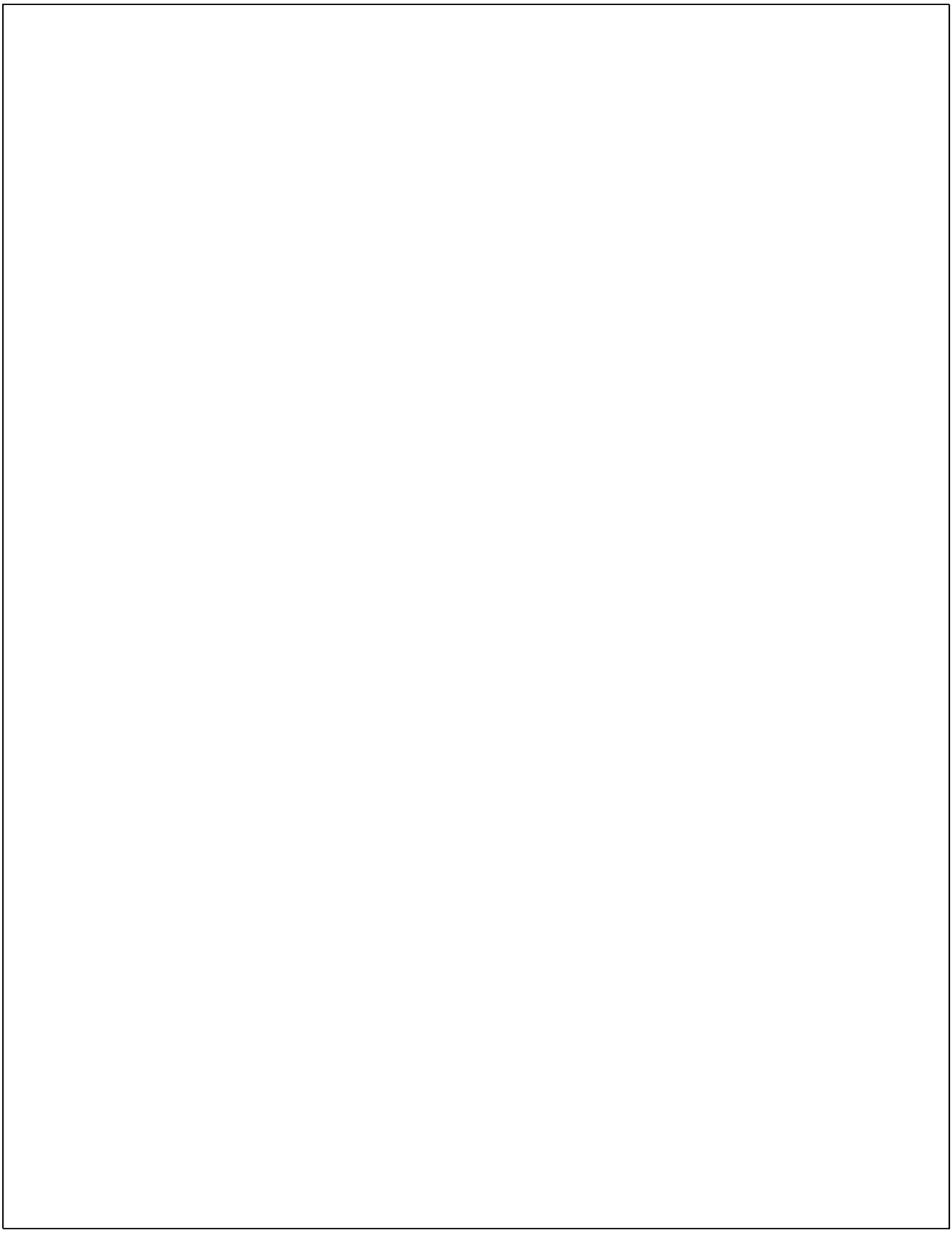

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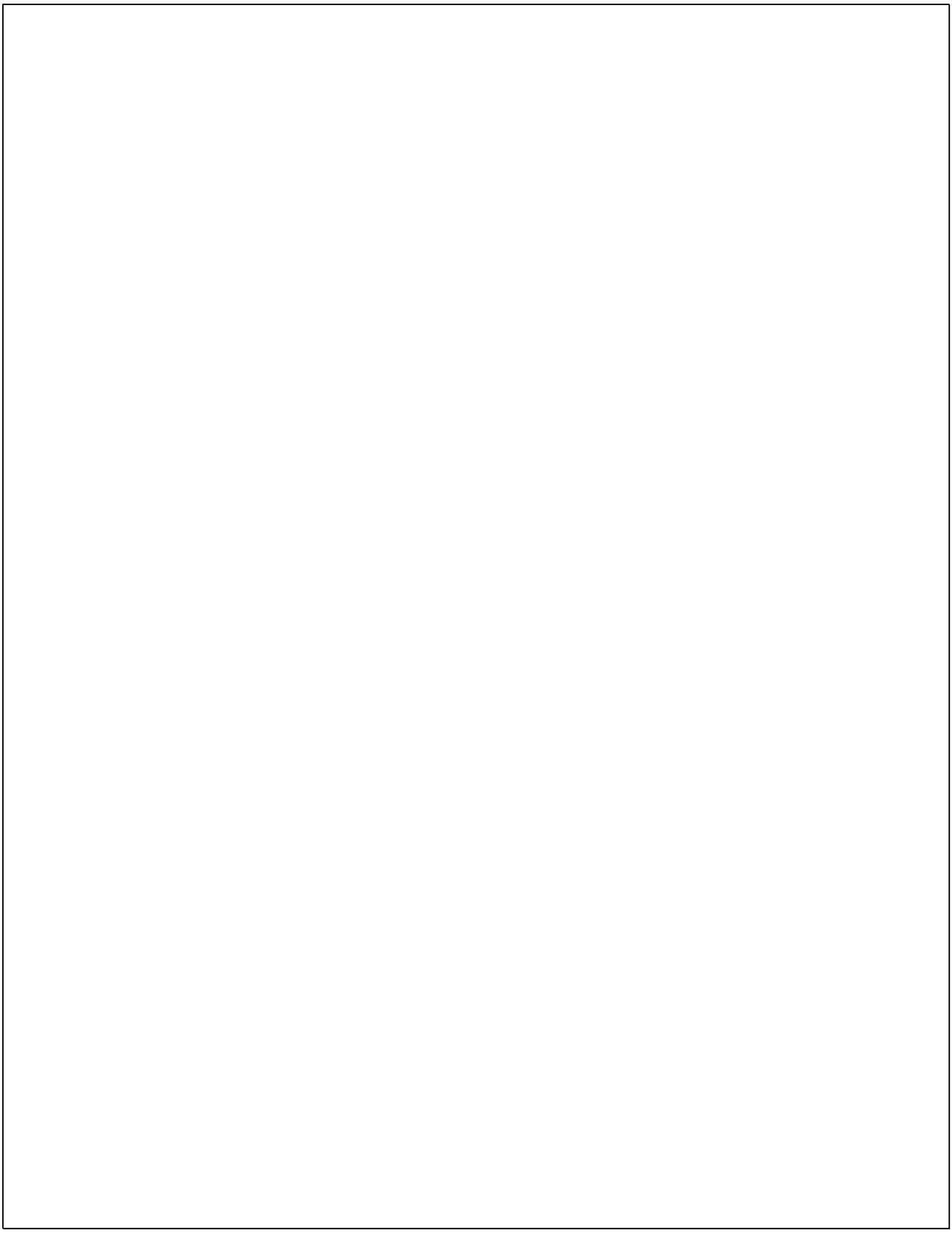

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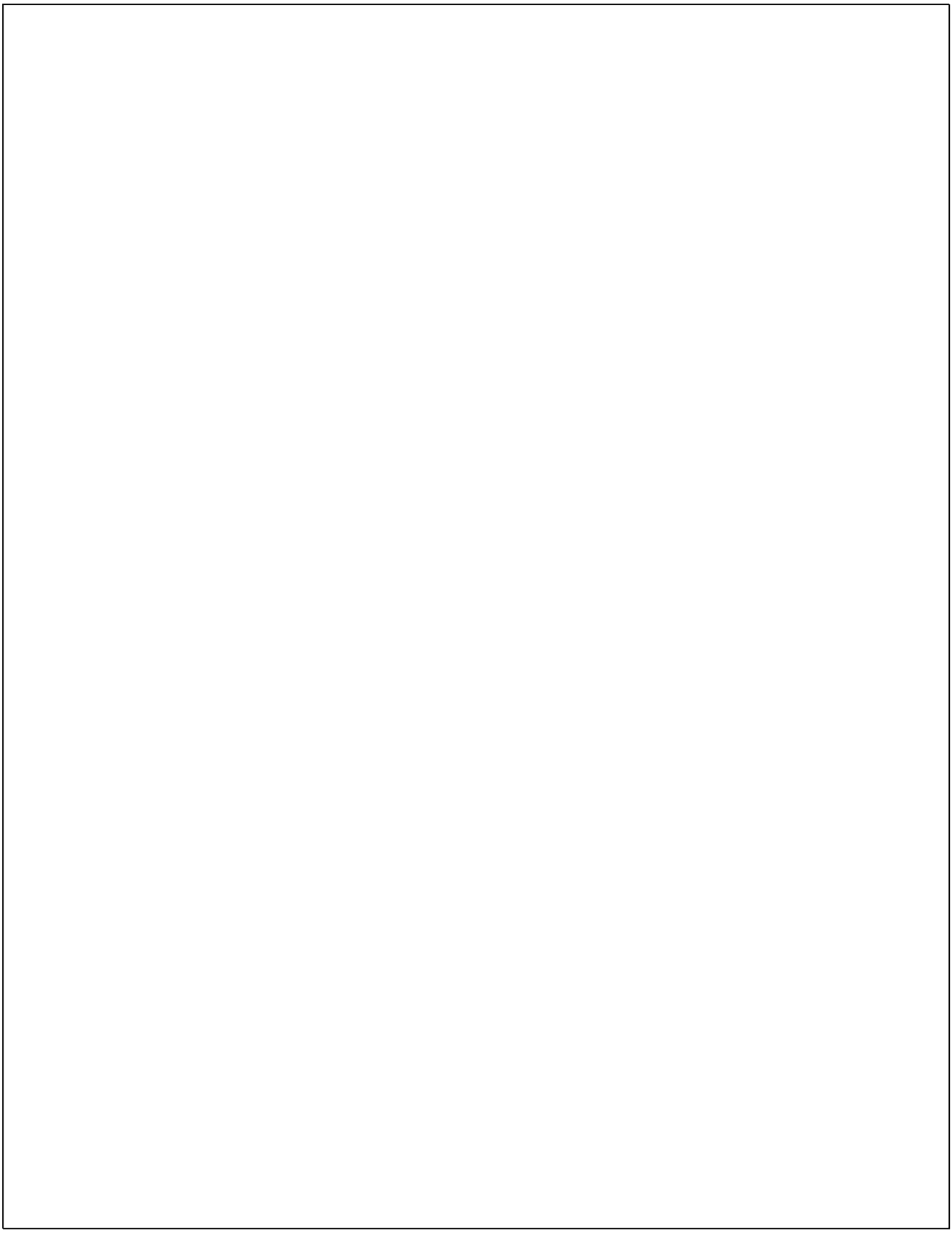

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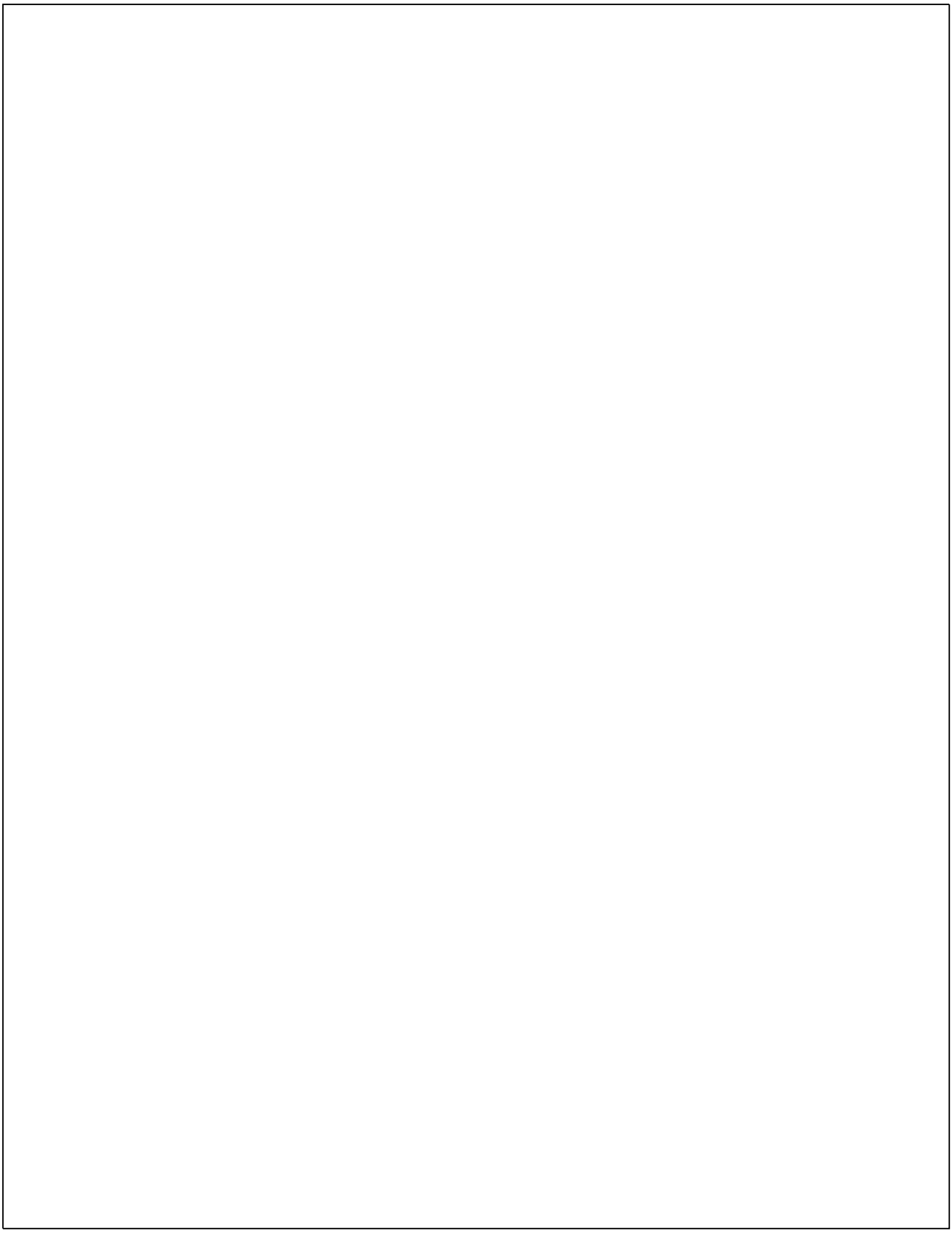

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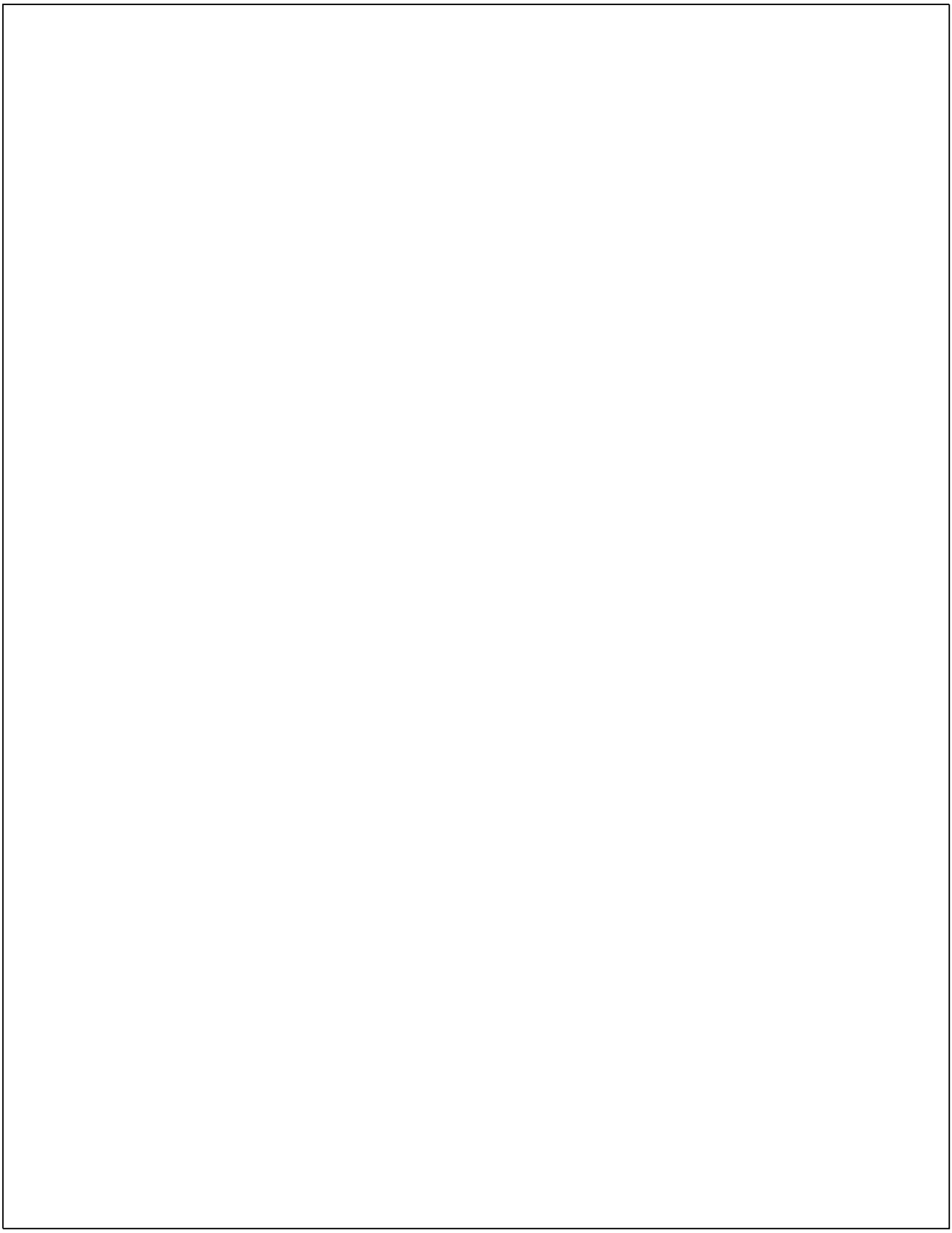

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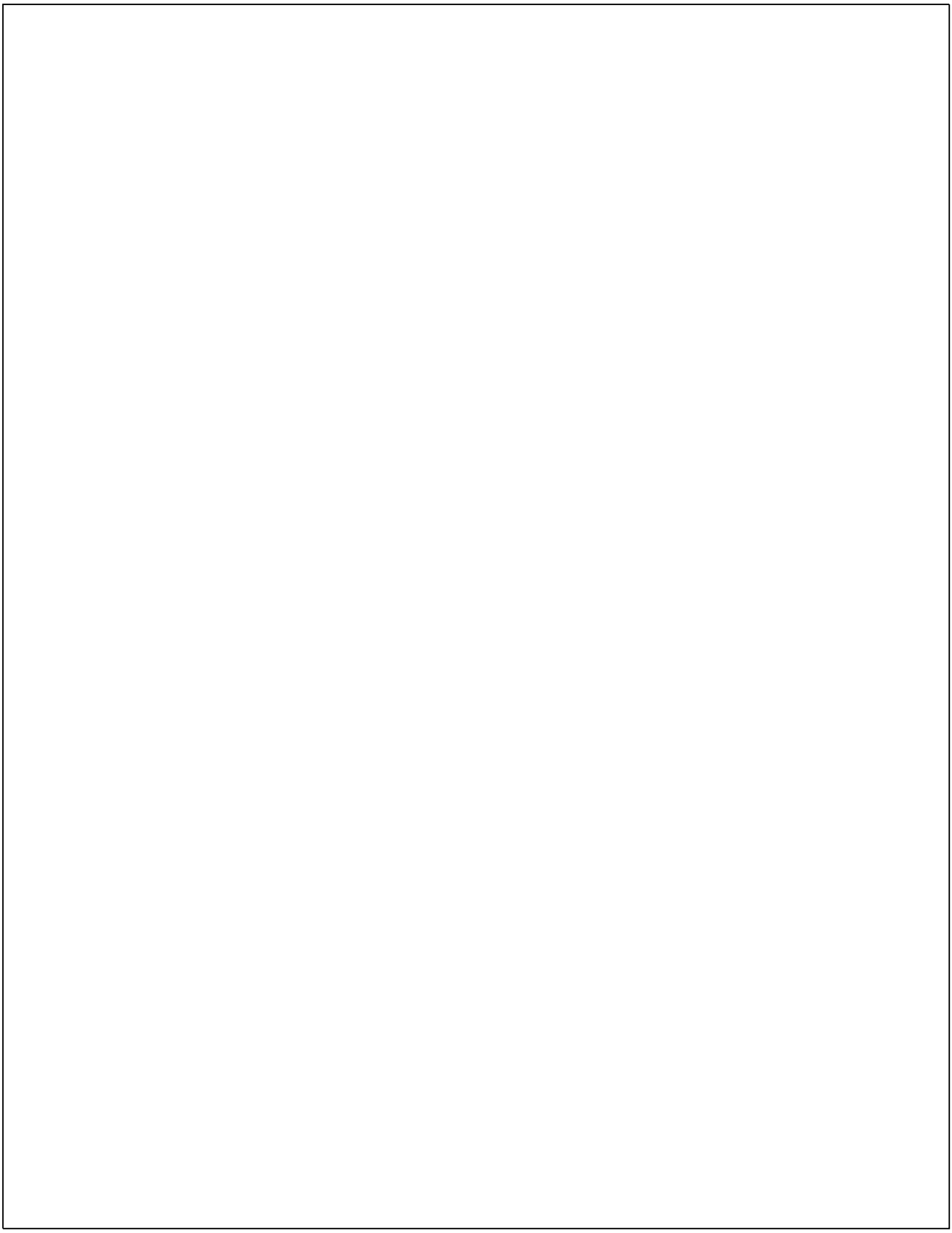

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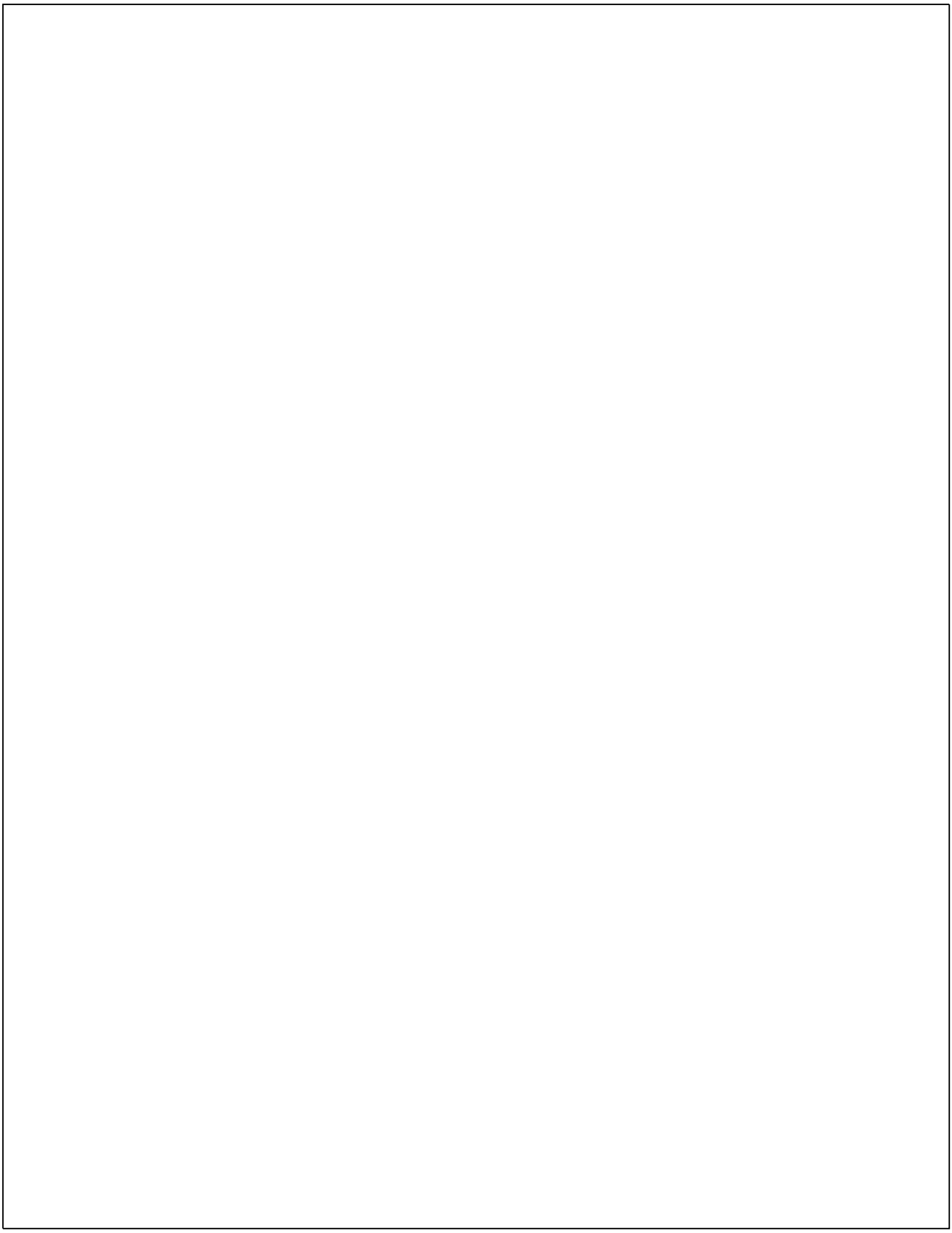

QUESTIONS AND ANSWERS

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

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

A. How does the workers' comp process begin?

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

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

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

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

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

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

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

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

D. Where does the employee receive medical treatment?

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

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

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

F. When can the employee return to work?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RESERVED FOR FUTURE ADDITIONS