



Workers' Compensation For Employers

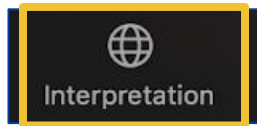
February 22, 2023 | 10am



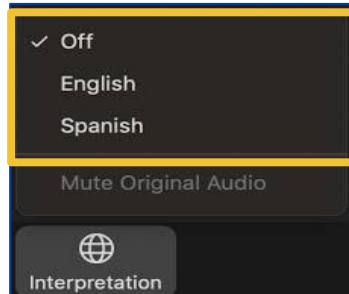
INTERPRETATION / INTERPRETACIÓN

Computer (Computadora)

Step/Paso 1:

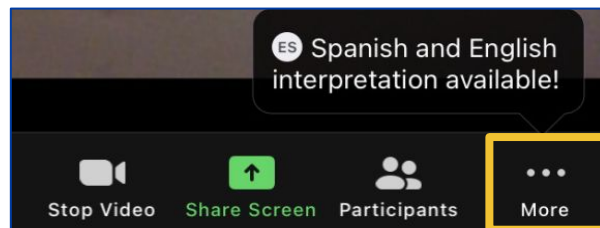


Step/Paso 2:

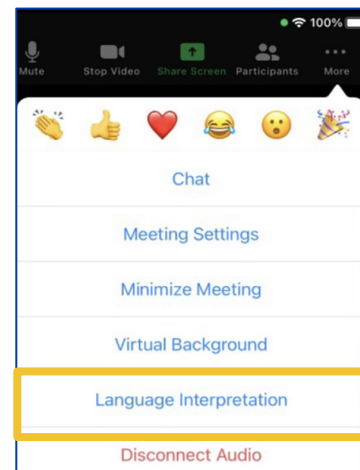


Tablet & Smartphone (Tableta y Celular)

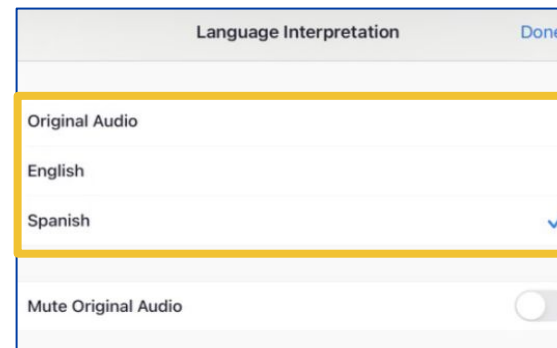
Step/Paso 1:



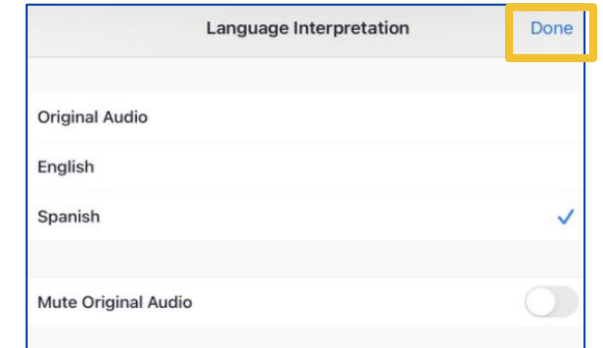
Step/Paso 2:



Step/Paso 3:



Step/Paso 4:



UNDERSTANDING THE WORKERS' COMPENSATION PROCESS – THE EMPLOYER'S VIEW



State of California
Department of
Industrial Relations



State of California
Gavin Newsom
Governor

Presenters

Information Assistance Unit

- Tristan Juan (Central Region Supervisor)
- Marife Solano (Northern Region Supervisor)
- Linda Guillen (Southern Region Supervisor)

Disclaimer

- “The opinions expressed herein are not the opinions of the State of California, the Department of Industrial Relations, the Workers’ Compensation Appeals Board, the Division of Workers’ Compensation, or other judges. They are the opinions of the presenter only. Each case is different and must be evaluated on its own merits.”
- “The materials presented are for reference only and not to be construed as legal advice.”

Agenda

- This presentation will explain what workers' compensation is, the employer's responsibilities, the benefits and resources.
- The presentation will be for 30 minutes with time for questions and answers after the presentation.

What is workers' compensation?

- Began in 1914
- Bargain between workers and employers.
- No fault insurance
- Not subject to a lawsuit
- Required to carry Workers' Compensation
- Insurance at no expense to the employee.



Who is the Division of Workers' Compensation (DWC)?

DWC oversees the administration of claims and oversees the workers' compensation court system that helps resolve disputes over benefits.

DWC's 24 statewide offices provide resources for employers and workers:

- DWC's Information and Assistance (I & A) Unit helps all parties understand their rights and responsibilities.
- I & A services are free of charge.

What are the employer responsibilities in California?

- California law requires employers to have compensation insurance.
- Employees cannot pay or offset the cost of the policy.
- Benefits cover all workers, including part-time employees.

Employer responsibilities (continued)

- Purchase policy through an agent or broker or become self-insured.
- Provide new employees time of hire pamphlets.
- Post required notices in conspicuous locations.

Forms available online:

Time of Hire Pamphlets:

<https://www.dir.ca.gov/dwc/DWCPamphlets/TimeofHirePamphlet.pdf>.

Notice to Employees—Injuries Caused By Work

<https://www.dir.ca.gov/dwc/NoticePoster.pdf>

What to do if an injury occurs at the workplace?



Photographer
Bob Gumpert

What to do if an injury occurs?

- Provide the workers' compensation claim form (DWC-1) to employee.
- Authorize or refer the injured employee to get medical treatment.
- Within one working day from receipt of the claim form from employee, fill out the employer section and send the completed form to insurance carrier or claims administrator and send a copy to employee.
- Complete Employer's Report of Occupational Injury form (DWC form 5020).

All forms are available online at <https://www.dir.ca.gov/dwc/forms.html>

Workers' Compensation Claim Form

<https://www.dir.ca.gov/dwc/DWCForm1.pdf>



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

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 División de Compensación al Trabajador al (800) 736-7401 para oír información grabada. Una explicación de los beneficios de compensación de trabajadores esta 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.

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.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios 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.

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 donde ocurrió el accidente.* _____

6. Describe injury and part of body affected. *Describe 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 electrónico.* Employee's e-mail. _____ *Correo electrónico 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 electrónica.*

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 administradora 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.

Empleador: Se requiere que Ud. feche esta forma y que provea 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

Employer's Report of Occupational Injury or Illness (Form 5020)

<https://www.dir.ca.gov/dosh/doshreg/form5020.pdf>

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.
<p>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.</p> <p>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.</p>				FATALITY <input type="checkbox"/>
1. FIRM NAME		1a. Policy Number		Please do not use this column CASE 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		OWNERSHIP
4. NATURE OF BUSINESS, e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.		5. State unemployment insurance acct.no		INDUSTRY
6. TYPE OF EMPLOYER: Private State County City School District <input type="checkbox"/> Other Gov't, Specify: _____				
7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yyyy)	8. TIME INJURY/ILLNESS OCCURRED AM PM	9. TIME EMPLOYEE BEGAN WORK AM PM	10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yyyy)	OCCUPATION
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? Yes No	12. DATE LAST WORKED (mm/dd/yyyy)	13. DATE RETURNED TO WORK (mm/dd/yyyy)	14. IF STILL OFF WORK, CHECK THIS BOX.	SEX
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/yyyy)	18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yyyy)	
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				AGE
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)		20a. COUNTY	21. ON EMPLOYER'S PREMISES? Yes No	DAILY HOURS
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.		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				WEEKLY HOURS
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.				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				COUNTY
27. Name and address of physician (number, street, city, zip)		27a. Phone Number		NATURE OF INJURY
28. Hospitalized as an inpatient overnight? <input type="checkbox"/> No <input type="checkbox"/> 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 14300.35(b)(2)(E)2.				SOURCE
30. EMPLOYEE NAME		31. SOCIAL SECURITY NUMBER	32. DATE OF BIRTH (mm/dd/yyyy)	EVENT
33. HOME ADDRESS (Number, Street, City, Zip)		33a. PHONE NUMBER		SECONDARY SOURCE
34. SEX Male Female	35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)		36. DATE OF HIRE (mm/dd/yyyy)	EXTENT OF INJURY
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 _____		38. 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/yyyy)

Simplified flow chart

Injury or illness occurs at work.
Immediately notify your supervisor.

Employer gives you a claim form. You complete the employee section and return it to your supervisor. Keep the bottom copy for your records.

If your employer does not give you the claim form, contact an I&A officer.

Your employer completes the claim form and sends a copy to you and the insurance company.

Within one day after you deliver the claim form, your employer must authorize medical treatment under industrial guidelines, to a maximum of \$10,000, while investigating your claim. If authorization not provided, contact an I&A officer.

Within 14 days, the insurance company should send you one of three notices letting you know the status of your claim. The notice will tell you if the insurance company accepts, denies, or will delay your claim for review.

Denies: Contact an I&A officer

Accepts: You will receive benefits and services.

Delays: An investigation can take up to 90 days. During investigation, no benefits other than medical treatment will usually be provided. You may be able to collect state disability payments during the investigation period and must apply separately at EDD. If you do not receive a final notice either accepting or denying your claim within 90 days, your claim will be presumed accepted. Contact an I&A officer.

What are the workers' compensation benefits?

- Medical care
- Temporary disability benefits
- Permanent disability benefits
- Supplemental job displacement benefits

Workers' compensation benefits (continue)

- Return-to-Work Supplement of \$5,000.00 (for Date of Injury on or after 1/1/2013)
- Death benefits

Visit the frequently asked questions section for injured workers for more information

<https://www.dir.ca.gov/dwc/WCFaqIW.html>

How do you resolve disputes?

- Application for Adjudication of Claim
- Conferences
- Trials
- Settlements – Stipulations (Stips) and Compromise & Release (C & R)
- Findings and Award
- Appeals

DWC – Information and Assistance (I &A) Unit

- Assist injured workers who do not have legal representation.
- Services are free.
- In 2020, I&A received more than 157,000 calls.

Toll-free **1-800-736-7401** or contact the Information Service Center at **(909) 383-4522**.

Resources

- Visit the DWC website for additional information <https://www.dir.ca.gov/dwc/>
- Educational materials available in multiple languages <https://www.dir.ca.gov/dwc/iwguides.html>
- Injured worker guidebook <https://www.dir.ca.gov/injuredworkerguidebook/injuredworkerguidebook.html>
- Fact Sheet for Employers <https://www.dir.ca.gov/dwc/faqs.html>

<u>ANAHEIM, 92806-2131</u> 1065 North Link, Suite 170 Information & Assistance Unit (714) 414-1801	<u>SACRAMENTO, 95834-2962</u> 160 Promenade Circle, Suite 300 Information & Assistance Unit (916) 928-3158
<u>BAKERSFIELD, 93301-1929</u> 1800 30 th Street, Suite 100 Information & Assistance Unit (661) 395-2514	<u>SALINAS, 93906-2204</u> 1880 N Main Street, Suites 100 & 200 Information & Assistance (831) 443-3058
<u>EUREKA, 95501-0529 * Virtual office *</u> Information & Assistance Unit (707) 441-5723	<u>SAN BERNARDINO, 92401-1411</u> 464 W Fourth Street, Suite 239 Information & Assistance Unit (909) 383-4522
<u>FRESNO, 93721-2219</u> 2550 Mariposa Street, Suite 4078 Information & Assistance Unit (559) 445-5355	<u>SAN DIEGO, 92108-4424</u> 7575 Metropolitan Drive, Suite 202 Information & Assistance Unit (619) 767-2082
<u>LONG BEACH, 90810-1870</u> 1500 Hughes Way, Suite C203 Information & Assistance Unit (424) 450-2565	<u>SAN FRANCISCO, 94102-7014</u> 455 Golden Gate Avenue, 2 nd Floor Information & Assistance Unit (415) 703-5020
<u>LOS ANGELES, 90013-1105</u> 320 W 4 th Street, 9 th Floor Information & Assistance Unit (213) 576-7389	<u>SAN JOSE, 95113-1402</u> 100 Paseo de San Antonio, Suite 241 Information & Assistance Unit (408) 277-1292
<u>MARINA DEL REY, 90292-6902</u> 4720 Lincoln Boulevard, 2 nd and 3 rd Floors Information & Assistance Unit (310) 482-3820	<u>SAN LUIS OBISPO, 93401-8736</u> 4740 Allene Way, Suite 100 Information & Assistance Unit (805) 596-4159
<u>OAKLAND, 94612-1499</u> 1515 Clay Street, 6 th Floor Information & Assistance Unit (510) 622-2861	<u>SANTA ANA, 92707-7704</u> 2 MacArthur Place, Suite 600 Information & Assistance Unit (714) 942-7576
<u>OXNARD, 93030-7912</u> 1901 N Rice Avenue, Suite 100 Information & Assistance Unit (805) 485-3528	<u>SANTA BARBARA, 93101-7538 * Satellite office *</u> 130 E Ortega Street Information & Assistance Unit (805) 568-1390
<u>POMONA, 91768-1653</u> 732 Corporate Center Drive Information & Assistance Unit (909) 623-8568	<u>SANTA ROSA, 95404-4771</u> 50 "D" Street, Suite 420 Information & Assistance Unit (707) 576-2452
<u>REDDING, 96002-0940</u> 250 Hemsted Drive, 2 nd Floor, Suite B Information & Assistance Unit (530) 225-2047	<u>STOCKTON, 95202-2314</u> 31 E Channel Street, Suite 344 Information & Assistance Unit (209) 948-7980
<u>RIVERSIDE, 92501-3337</u> 3737 Main Street, Suite 300 Information & Assistance Unit (951) 782-4347	<u>VAN NUYS, 91401-3370</u> 6150 Van Nuys Boulevard, Suite 105 Information & Assistance Unit (818) 901-5374

I&A Unit District Office Locations

<https://www.dir.ca.gov/dwc/dir2.htm>



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Department of
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