§9810. General Provisions.

(a) This Article applies to benefit notices prepared on or after its effective date. Amendments to this Article filed with the Secretary of State in January, 1994 shall become effective for notices required to be sent on or after April 1, 1994.
(b) The Administrative Director may, at his or her discretion, issue and revise from time to time a Benefit Notice Instruction Manual as a guide for completing and serving the notices required by this Article.
(c) Benefit notice letters may be produced on the claims administrator's letterhead. The notice letters shall identify the employee's name, employer's name, the claim number, the date the notice was sent to the employee, and the date of injury. All notices shall clearly identify the name and telephone number and address of the person responsible for the payment and adjusting of the claim, and shall clearly state that additional information may be obtained from an Information and Assistance officer with the Division of Workers' Compensation. If the employer offers additional disability benefits in addition to those provided by law under workers' compensation, the claims administrator may incorporate the information within the notices required by these regulations. A single benefit notice may encompass multiple events.
~~(d) The claims administrator shall include a general benefits information pamphlet with the first notice sent to each employee pursuant to this article. The pamphlet shall meet the requirements of Section 9882 and shall be in the form prescribed by the Administrative Director.~~
~~(e)~~ (d) The claims administrator shall make available to the employee, upon request, copies of medical reports other than psychiatric reports which the physician has recommended not be provided to the employee.
~~(f)~~ (e) The claims administrator shall send a copy of each benefit notice, and any enclosures not previously served on the attorney (except benefit notice pamphlets), concurrently to the attorney of any represented employee.
~~(g)~~ (f) Any deadline for reply which is measured from the date a notice is sent, and all rights protected within the deadline, are extended if the notice is sent by mail, as follows: by 5 days if the place of mailing and the place of address are in the same state of the United States; by 10 days if the place of mailing and the place of address are in different states of the United States; by 20 days if the place of mailing is in and the place of address is outside the United States. All notices shall be mailed from the United States.
~~(h)~~ (g) Copies of all benefit notices sent to injured workers shall be maintained by the claims administrator in paper or electronic form.

NOTE: Authority cited: Sections 59, 133, 138.3, 138.4, 139.5(a)(2), 4061(a), (b), (d) and 5307.3, Labor Code. Reference: Sections 138.4, 139.5(a)(3), 4061 and 4650(a) through (d), Labor Code.

§9880. Written Notice to New Employees.

(a) Every employer shall provide to every new employee, either at the time of hire or ~~no later than~~ by the end of the first pay period, information concerning the rights, benefits and obligations under worker's compensation law. The content of the notice must be approved by the Administrative Director.
(b)The notice shall be easily understandable. It shall be available in both English and Spanish where there are Spanish-speaking employees.
~~(b)~~ (c) The notice provided shall be in writing, in non-technical terms and shall include the following information:
~~(1) An explanation of the extent and scope of coverage provided by the worker's compensation law.~~
~~(2) An explanation of an injured employee's rights to medical care and to select and change the treating physician.~~
~~(3) An explanation of an injured employee's rights to indemnify payments for disability or death and the availability of vocational rehabilitation services.~~
~~(4) The procedures for reporting accidents and injuries to the employer.~~
~~(5) Where further information may be obtained, including an explanation of services available from an Information and Assistance Officer.~~
(1) The name of the current compensation insurance carrier of the employer at the time of distribution, or when such is the fact, that the employer is self-insured, and who is responsible for claims adjustment;
(2) How to get emergency medical treatment, if needed;
(3) The kinds of events, injuries and illnesses covered by workers' compensation;
(4) The injured employee's right to receive medical care;
(5) How to obtain appropriate medical care for a job injury;
(6) The role and function of the primary treating physician;
(7) The rights of the employee to select and change the treating physician pursuant to the provisions of Labor Code Sections 4600 and 4601;
(8) A form that the employee may use as an optional method for notifying the employer of the name of the employee's "personal physician," as defined by Labor Code Section 4600, or "personal chiropractor," as defined by Labor Code Section 4601;
(9) The rights of the employee to receive temporary disability indemnity, permanent disability indemnity, vocational rehabilitation services, and death benefits, as appropriate;
(10) To whom the injuries should be reported;
(11) The existence of time limits for the employer to be notified of an occupational injury;
(12) The protections against discrimination provided pursuant to Section 132a; and
(13) The location and telephone number of the nearest information and assistance officer, including an explanation of services available.

NOTE: Authority cited: Sections 133, 138.3, 138.4, 3550, 3551, and 5307.3, Labor Code. Reference: Sections 139.6, 3550, 3551, 3600, 4600, 4601, 4603, 4650, 4651, 4700, 4702 and 4703, Labor Code.

§9881. Posting of Notice to Employees.

(a) Every employer shall post and keep posted in a conspicuous location frequented by employees during the hours of the workday a ~~n~~Notice to Employees. ~~approved by the administrative director.~~

(b) The Notice to Employees poster shall be easily understandable. It shall be posted in both English and Spanish where there are Spanish-speaking employees.

~~(b)~~ (c) The ~~posting~~ ~~n~~Notice to Employees poster shall include the following information:

~~(1) Advice to employees that all injuries should be reported and identifying the individual to whom job accidents and injuries should be reported.~~

~~(2) Advice concerning the employee's rights to medical care and to select or change the treating physician.~~

~~(3) Advice concerning the employee's entitlement to indemnify payments and vocational rehabilitation services.~~

~~(4) Advice that the employer may not be responsible for compensation because of an injury due to the employee's voluntary participation in any off-duty recreational, social, or athletic activity that is not a part of the employee's work-related duties.~~

~~(5) Whether the employer is self-insured for worker's compensation or, if not, the name of the current insurer, and the location of the person or office responsible for claims adjustment.~~

~~(6) The street address and telephone number of the nearest Information and Assistance Officer.~~

~~(7) Emergency telephone numbers for physician, hospital, ambulance, police and firefighting services.~~

(1) The name of the current compensation insurance carrier of the employer, or when such is the fact, that the employer is self-insured, and who is responsible for claims adjustment.
(2) How to get emergency medical treatment, if needed.
(3) Emergency telephone numbers for physician, hospital, ambulance, police and firefighting services.
(4) The kinds of events, injuries and illnesses covered by workers' compensation.
(5) Advice that the employer may not be responsible for compensation because of an injury due to the employee's voluntary participation in any off-duty recreational, social, or athletic activity that is not a part of the employee's work-related duties.
(6) The injured employee's right to receive medical care.
(7) The rights of the employee to select and change the treating physician pursuant to the provisions of Labor Code Section 4600.
(8) The rights of the employee to receive temporary disability indemnity, permanent disability indemnity, vocational rehabilitation services, and death benefits, as appropriate.
(9) To whom the injuries should be reported.
(10) The existence of time limits for the employer to be notified of an occupational injury.
(11) The protections against discrimination provided pursuant to Section 132a.

(12) The location and telephone number of the nearest information and assistance officer.

(c) The employer may post the Administrative Director's approved Notice to Employee Poster provided in Section 9881.1. If the employer chooses not to use the Notice to Employee Poster provided in Section 9881.1, the employer may use a poster which meets the posting requirements of Labor Code Section 3550, includes the information required by this regulation, and has been approved by the Administrative Director.

NOTE: Authority cited: Sections 133, 138.3, 139.6, 3550 and 5307.3, Labor Code. Reference: Sections 3550, 3600, 4600, 4601 and 4603, Labor Code.

§ 9881.1 Notice to Employees Poster

[Notice to Employees Poster Attached]

Note:	Authority Cited:	Sections 133, 138.3, 139.6, 3550 and 5307.3, Labor Code
	Reference:	Sections 3550, 4600, 4601 and 4603, Labor Code

STATE OF CALIFORNIA - DEPARTMENT OF INDUSTRIAL RELATIONS
Division of Workers' Compensation

Notice to Employees--Injuries Caused By Work

You may be entitled to workers' compensation benefits if you are injured or become ill because of your job. Workers' compensation covers most work-related physical or mental injuries and illnesses. An injury or illness can be caused by one event (such as hurting your back in a fall) or by repeated exposures (such as hurting your wrist from doing the same motion over and over).

Benefits. Workers' compensation benefits include:

1. **Medical Care:** Doctor visits, hospital services, physical therapy, lab tests, x-rays, and medicines that are reasonably necessary to treat your injury. You should never see a bill.

2. **Temporary Disability Benefits:** Payments if you lose wages while recovering.

3. **Permanent Disability Benefits:** Payments if your injury causes a permanent disability.

4. **Vocational Rehabilitation:** Services and payments if your injury prevents you from returning to your usual job or occupation.

5. **Death Benefits:** Paid to dependents of a worker who dies from a work-related injury or illness.

Naming Your Own Physician Before Injury. If you want to choose the doctor who will treat you for a job injury or illness during the first 30 days after the injury, you must tell your employer the name and address of your personal physician *before* you are injured. You must do this in *writing*. For instructions, see the written information about workers' compensation that your employer is now required to give to new employees.

If You Get Hurt:

1. **Get Medical Care.** If you need first aid, contact your employer. If you need emergency care, call for help immediately. Emergency phone numbers:

   Ambulance _____ Fire Dept. _____ Police _____

   Doctor _____ Hospital _____

2. **Report Your Injury.** Report the injury immediately to your supervisor or to:
   Employer representative _____ phone number _____.
   Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you a claim form within one working day after learning about your injury.

3. **See Your Primary Treating Physician (PTP).** This is the doctor with overall responsibility for treating your injury or illness. If you named your personal physician before injury (see above), you may see him or her for treatment. Otherwise, your employer has the right to select the physician who will treat you for the first 30 days. If you wish to change in the first 30 days, the claims administrator must select a new physician within five days of your request. (But if you gave your employer the name of your personal chiropractor or acupuncturist in writing before you were injured, you may switch to the chiropractor or acupuncturist upon request.) If a doctor says you still need medical care after 30 days, you can switch to a doctor of your own choice. Special rules apply if your employer offers a Health Care Organization (HCO). Contact your employer for more information.

Discrimination: It is illegal for your employer to punish or fire you for having a work injury or illness, for filing a claim, or testifying in another person's workers' compensation case. If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

Questions? Learn more about workers' compensation by reading the information that your employer is required to give you at time of hire. If you have questions, see your employer or the claims administrator (who handles workers' compensation claims for your employer):

Claims Administrator _____

Address _____ City _____ State ____ Zip _____

Phone _____Policy Expiration Date _____

The employer is insured for workers' compensation by _____
(Enter "self-insured" if appropriate)

If the workers' compensation policy has expired, contact a Labor Commissioner at the Division of Labor Standards Enforcement - their number can be found in your local White Pages under California State Government, Department of Industrial Relations.

You can get free information from a State Division of Workers' Compensation Information & Assistance Officer.
The nearest Information & Assistance Officer is at:

Address _____ City _____ Phone _____

Hear recorded information and a list of local offices by calling toll-free **(800) 736-7401**. Learn more online: **www.dir.ca.gov.**

False claims and false denials. 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 and may be fined and imprisoned.

Your employer may not be liable for the payment of workers' compensation benefits for any injury that arises from your voluntary participation in any **off-duty, recreational, social, or athletic activity** that is not part of your work-related duties.

ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES
Division De Compensación Al Trabajador

Aviso a los Empleados—Lesiones Causadas por el Trabajo

Es posible que usted tenga derecho a beneficios de compensación para trabajadores, si usted se lesiona o se enferma a causa de su trabajo. La compensación para trabajadores cubre la mayoría de las lesiones y enfermedades físicas o mentales relacionadas con el trabajo. Una lesión o enfermedad puede ser causada por un evento (como por ejemplo el lastimarse la espalda en una caída) o por acciones repetidas (como por ejemplo lastimarse la muñeca por hacer el mismo movimiento una y otra vez).

Beneficios. Los beneficios de compensación para trabajadores incluyen:

1. **Atención Médica:** Consultas con el médico, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro.

2. **Beneficios por Incapacidad Temporal:** Pagos, si usted pierde sueldos, mientras se recupera.

3. **Beneficios por Incapacidad Permanente:** Pagos, si su lesión le ocasiona una incapacidad permanente.

4. **Rehabilitación Vocacional:** Servicios y pagos, si su lesión le evita regresar a su empleo u ocupación normal.

5. **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muera a causa de una lesión o enfermedad relacionada con el trabajo.

Designación de su Propio Médico Antes de una Lesión. Si usted desea elegir al médico que le atenderá a causa de una lesión o enfermedad relacionada con el trabajo durante los primeros 30 días después de la lesión, usted tiene que decirle, al empleador, el nombre y la dirección de su médico personal, *antes* de que usted se lesione. Usted tiene que hacer esto *por escrito*. Para instrucciones, vea la información escrita sobre la compensación para trabajadores, que ahora se le exige a su empleador darle a los empleados nuevos.

Si Usted se Lastima:

1. **Obtenga Atención Médica.** Si usted necesita primeros auxilios, comuníquese con su empleador. Si usted necesita atención de emergencia, pida ayuda inmediatamente. Los números de teléfono de emergencia son:

   Ambulancia _____ Dept. de Bomberos _____ Policía _____

   Doctor _____ Hospital _____

2. **Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a:
   El/la representante del empleador _____ Número de teléfono _____.
   No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. A su empleador se le exige proporcionarle un formulario de reclamo, en un plazo de un día laboral, a partir de que sepa lo referente a su lesión.

3. **Consulte al Médico Primario que le Atienda (PTP).** Este es el médico con toda la responsabilidad para dar el tratamiento para su lesión o enfermedad. Si usted designó a su médico personal antes de la lesión (vea uno de los párrafos anteriores), usted puede consultarlo para el tratamiento. De otra forma, su empleador tiene derecho a seleccionar al médico que le atenderá durante los primeros 30 días. Si usted desea cambiar en los primeros 30 días, el/la administrador(a) de reclamos tiene que seleccionar un nuevo médico, en un plazo de cinco días, a partir de su petición. (Sin embargo, si usted le dió a su empleador, por escrito, el nombre de su quiropráctico o acupunturista personal, antes de que se lesionara, usted puede cambiarse a dicho quiropráctico o acupunturista, cuando lo solicite.) Si el doctor dice que usted aún necesita atención médica, después de 30 días, usted puede cambiar al médico de su preferencia. Hay reglas especial que son aplicables cuando su empleador ofrece un Organización del Cuidado Médico (HCO). Hable con su empleador para más información.

Discriminación: Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por atestiguar en el caso de compensación para trabajadores de otra persona. Si es probado, puede ser que usted reciba pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios, y gastos hasta un límite establecido por el estado.

¿Preguntas? Obtenga más información sobre la compensación para trabajadores, leyendo la información que ahora se le exige a su empleador darle a los empleados nuevos. Si usted tiene preguntas, vea a su empleador o al/a la administrador(a) de reclamos (que maneja los reclamos de compensación para trabajadores por su empleador):

Administrador(a) de Reclamos _____

Dirección _____ Ciudad _____ Estado ____ Código postal _____

Teléfono _____ Fecha de Vencimiento de la Póliza _____

El empleador está asegurado para compensación para trabajadores con _____
(Anote "autoasegurado" si es pertinente)

Si la póliza de compensación para trabajadores se ha vencido, comuníquese con el Comisionado del Trabajo, en la Division of Labor Standards Enforcement. Su número puede encontrarse en las Páginas Blancas de su guía telefónica local, bajo el encabezado en inglés de *California State Government, Department of Industrial Relations*.

Usted puede obtener información gratuita de un Oficial de Asistencia e Información, de la División de Compensación al Trabajador. El Oficial de Asistencia e Información más cercano se localiza en:

Dirección _____ Ciudad _____ Teléfono _____

Usted puede escuchar información grabada, y una lista de las oficinas locales, llamando al número gratuito **(800) 736-7401**.
Usted puede obtener más información en el Internet en: **www.dir.ca.gov.** Enlácese a la sección de Compensación para Trabajadores.

Los reclamos falsos y rechazos falsos del reclamo. Cualquier persona que haga o que ocasione que se haga una declaración o una representación relevante intencionalmente falsa o fraudulenta, con el fin de obtener, o negar beneficios o pagos de compensación para trabajadores, es culpable de un delito grave y puede resultar en una multa y encarcelación.

Es posible que su empleador o asegurador no sea responsible por el pago de beneficios de compensactión laboral debido a una lesión causada por la participación voluntaria del empleado en cualquier **actividad recreativa, social, o atlética** fuera del trabajo que no sea parte de los deberes laborales del empleado.

~~§9882. Written Notice to Injured Employees; Pamphlet Contents.~~

~~(a) Within five working days of notice or knowledge of any injury, the employer shall advise the employee of the compensation to which he or she may be entitled and the rights, benefits, and obligations under the workers' compensation law.~~
~~(b) The advice shall be in writing, in non-technical terms available in both English and Spanish, and shall include the following information:~~
~~(1) An explanation of an injured employee's rights to medical care and to select or change the treating physician.~~
~~(2) An explanation of an injured employee's rights to indemnity payments for disability or death, including information on the amount and frequency of such payments.~~
~~(3) An explanation of the nature and availability of vocation rehabilitation services.~~
~~(4) An explanation of the employee's protections against discrimination because of a work injury.~~
~~(5) An explanation of the procedures for claiming compensation, time limits for filing a claim, and methods to resolve disputes, including the employee's right to consult and Information and Assistance Officer or an attorney.~~
~~(6) Where further information may be obtained, including an explanation of services available from an Information and Assistance Officer.~~

~~NOTE: Authority cited: Sections 133, 138.3, 138.4, 139.6, and 5402, Labor Code. Reference: Sections 132(a), 139.5, 3600, 4600, 4601, 4650, 4658, 4700, 4701, 4702, 4703, 4401-4411 and 5400-5412, Labor Code.~~

§9883. Publication of Information, Approval, Spanish Translation.

(a) Insurers, employers or private enterprises may prepare and publish for their use or sale the ~~posting notice~~ Notice to Employees poster and/or ~~pamphlet(s)~~ the Written Notice to New Employees required by this Article upon prior approval of the form and content by the Administrative Director. The ~~notice~~ Notice to Employees poster and/or ~~pamphlet~~ Written Notice to New Employees may include a logotype. The addition only of a logotype to a previously approved ~~notice~~ Notice to Employees poster or ~~pamphlet~~ Written Notice to New Employees does not require additional approval.

~~(b)~~ (1) Any ~~pamphlet so printed~~ published Written Notice to New Employees shall be available in English and Spanish and shall include the information specified in Section ~~9882(b)~~ 9880.

(2) Any published Notice to Employees poster shall be available in English and Spanish, where there are Spanish-speaking employees, and shall include the information specified in Section 9881.

~~(c)~~ (b) All matter published subsequent to the effective date of ~~these~~ this regulation~~s and approval of the Administrative Director~~ shall indicate that the ~~notice, pamphlet or~~ written informational material has been approved by the Administrative Director.

~~(d)~~ (c) Publications other than those of the Administrative Director or the Workers' Compensation Appeals Board may reflect the employer, private publisher or insurance carrier identifier or logotype.

~~(e) Where appropriate the employer or insurance carrier shall also provide a Spanish translation of the written notices required by this article.~~

NOTE: Authority cited: Sections 133,139.6, 3550, 3551, and 5307, Labor Code. Reference: Section 139.6, 3550, and 3551, Labor Code.

~~§10117. Claim Form.~~

~~The Employee's Claim for Workers' Compensation Benefits is the form set forth in Section 10118 of this Article. The employer portion of the form may also include other information pertinent to the claim, including a logo or other employer-identifying information, but such information shall in no way impose additional duties or prohibitions on the employee or delay the processing of the claim. The claim form consists of at least an original and three (3) copies; each copy designates to whom the dated copy should be given: (1) employee; (2) claims administrator; (3) employee's temporary receipt.~~

~~NOTE: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 5401, 5401.7 and 5402, Labor Code.~~

~~§10118. Form.~~

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

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

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

If you are injured or become ill because of your job, you may be entitled to workers' compensation benefits.

Complete the "**Employee**" section and give the form to your employer. Keep the copy marked "**Employee's Temporary Receipt**" until you receive the dated copy from your employer. You may call the Division of Workers' Compensation at 1-800-736-7401 if you need help in filling out this form or in obtaining your benefits. An explanation of workers' compensation benefits is included on the back of this form.

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

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.

PETICION DEL EMPLEADO PARA BENEFICIOS DE COMPENSACIÓN DEL TRABAJADOR

Si Ud. se ha lesionado o se ha enfermado a causa de su trabajo, Ud. tiene derecho a recibir beneficios de compensación al trabajador.
*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 fechada de su empleador. Si Ud. necesita ayuda para completar esta forma o para obtener sus beneficios, Ud. puede hablar con la Division de Compensación al Trabajador llamando al 1-800-736-7401. En la parte de atrás de esta forma se encuentra una explicación de los beneficios de compensación al trabajador.*

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

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 "felonía".

Employee: *Empleado:*

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 y 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 give the employee a copy immediately as a receipt.
Empleador—complete esta sección y déle inmediatamente una copia al empleado como recibo.

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 administradora de seguros.* _____
15. Insurance Policy Number. *El número de la póliza del 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 <u>one working day</u> 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 <u>un día hábil</u> desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

Original (Employer's Copy)
DWC Form 1 (REV. 1/94)

ORIGINAL (Copia del Empleador)
DWC Forma 1 (REV. 1/94)

WORKERS' COMPENSATION BENEFITS

Medical Care. All medical care for your work injury or illness will be paid for by your employer or employer's insurance company. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your employer or employer's insurance company will pay the cost directly so you should never see a bill.

Payment for Lost Wages. If you can't work because of a job injury or illness, you will receive "temporary disability" benefit payments. The payments will stop when your doctor says you are able to return to work. These benefits are tax free. Temporary disability payments are two-thirds of your average weekly pay, up to a maximum set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized or cannot work for more than 14 days.

Payment for Permanent Disability. If the injury or illness results in a permanent handicap, permanent disability benefit payments will be paid after recovery. The amount of benefits will depend on the type of injury, and your age and occupation.

Rehabilitation. If the injury or illness prevents you from returning to the same type of job, you may qualify for "vocational rehabilitation benefits". These benefits include services to help you get back to work. If you qualify for vocational rehabilitation, the costs will be paid by your employer or employer's insurance company, up to a maximum set by state law.

Death Benefits. If the injury or illness causes death, payments may be made to relatives or household members who were financially dependent on the worker.

Disclosure of Medical Records. After you make a claim for workers' compensation benefits, your medical records will not have the same privacy that people usually expect for medical records. Records of all medical treatment you have received, even for injuries or illnesses that are not caused by your work, may be read by a variety of people. If you do not agree to voluntarily release medical records, they can be "subpoenaed" and ordered to be released. A workers' compensation judge may "seal" (keep private) certain medical records if the worker requests privacy.

For More Information. If you need help filling out this form, or if you have questions about workers' compensation benefits, please call an Information and Assistance Officer in the local office of the Division of Workers' Compensation. You may hear recorded information and a list of local offices by calling this toll free number: **1-800-736-7401. This is a free service of the State of California. You may also consult an attorney.**

BENEFICIOS DE COMPENSACIÓN AL TRABAJADOR

Cuidado Médico. *Todo el cuidado médico por su lesión o enfermedad causada en el trabajo será pagado por su empleador/patrón o su compañía de seguros. Los beneficios médicos pueden incluír tratamiento por un doctor, servicios de hospital, fisioterapia, análisis de laboratorio, rayos-x, y medicamentos. Su empleador o la compañía de seguros de su empleador pagará directamente el costo, así Ud. nunca tendrá que ver una cuenta.*

Pago por Pérdida de Sueldos. *Si Ud. no puede trabajar debido a una enfermedad o lesión causada en el trabajo, Ud. recibirá pagos de beneficio de "incapacidad temporal". Los pagos se detendrán cuando su médico indique que Ud. puede volver a su trabajo. Estos beneficios son libres de impuestos. Los pagos por incapacidad temporal son dos-tercios del promedio de su pago semanal, hasta un máximo asignado por la ley del estado. No se efectúa pago por los tres primeros días que Ud. esta incapacitado a menos que Ud. este hospitalizado o no pueda trabajar por más de 14 días.*

Pagos por Incapacidad Permanente. *Si los resultados de la lesión o enfermedad producen un impedimento o incapacidad permanente, se efectuarán pagos de incapacidad permanente después de la recuperación.*

Rehabilitación. *Si la lesión o enfermedad le impide a Ud. volver al mismo trabajo, puede ser que Ud. califique para los "beneficios de rehabilitación vocacional". Estos beneficios incluyen servicios para ayudarlo a que Ud. vuelva a trabajar. Si Ud califica para rehabilitación vocational, los costos serán pagados por su empleador o su compañía de seguros, hasta un maximo asignado por la ley del estado.*

Beneficios de Muerte. *Si la lesión o emfermedad resulta en muerte, los pagos pueden ser efectuados a parientes o a miembros de la familia quienes dependen financieramente del trabajador.*

Revelación de Expedientes Médicos. *Después de que Ud. efectúa un reclamo para beneficios de compensación del trabajador sus expedientes médicos no tendrán la misma privacidad que la gente por lo general espera de los expedientes médicos. Un expediente de todos los tratamientos médicos que Ud. haya recibido, inclusive de lesiones o enfermedades que no hayan sido causadas por su trabajo, pueden ser leídos por distintas personas. Si Ud. no esta de acuerdo a entregar voluntariamente los archivos médicos, pueden ser ordenados en un "comparendo" (orden judicial) y que ordenan su entrega. Un juez de compensaciones al trabajador, puede "cerrar" (mantenido en privado) ciertos expedientes médicos si el trabajador solicita privacidad.*

Información y Asistencia. ***Si Ud. necesita ayuda para completar esta forma, o si Ud. tiene preguntas relacionadas con sus beneficios, por favor póngase en contacto con un Oficial de Información y Asistencia en la oficina local de la División de Compensación al Trabajador. Ud. puede escuchar información grabada y una lista de las oficinas locales llamando gratis al número: 1-800-736-7401. Este es un servicio gratis del Estado de California. Ud. también puede consultar a un abogado.***

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§10117.1 Claim Form and Notice of Potential Eligibility for Benefits.

The employee's form for filing a workers' compensation claim and the Notice of Potential Eligibility for Benefits is a mandatory form set forth in Section 10118.1 of this Article. The employer portion of the form may also include other information pertinent to the claim, including a logo or other employer-identifying information, but such information shall in no way impose additional duties or prohibitions on the employee or delay the processing of the claim. The claim form consists of an original and three (3) copies.

NOTE: Authority cited: Sections 133 and 5307.3, Labor Code. Reference: Sections 5401, 5401.7 and 5402, Labor Code.

§10118.1 Workers' Compensation Claim Form (DWC 1) and Notice of Potential Eligibility

[Workers' Compensation Claim Form (DWC 1) and Notice of Potential Eligibility Attached]

Note: Authority Cited: Sections 133 and 5307.3, Labor Code
Reference: Sections 5401, 5407.1 and 5402, Labor Code

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Formulario de Reclamo de Compensación para Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Attached is the form for filing a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If required you will be notified by the claims administrator, who is responsible for handling your claim, about your eligibility for benefits.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Your employer will then complete the "Employer" section, give you a dated copy, keep one copy and send one to the claims administrator. Benefits can't start until the claims administrator knows of the injury, so complete the form as soon as possible.

Medical Care: Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your claims administrator will pay the costs directly so you should never see a bill.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness. Generally your employer selects the PTP you will see for the first 30 days, unless you have predesignated your treating doctor. If you wish to change during the first 30 days, the claims administrator will select one for you. If a doctor says you still need treatment after 30 days, you can switch to the doctor of your choice. Special rules apply if your employer offers a Health Care Organization (HCO). Contact your employer for more information. If your employer has not put up a poster describing your rights to workers' compensation you may choose your own doctor immediately.

If medical care has not been authorized by your employer's claims administrator you have several options. Contact your claims administrator to find out the status of your claim. If the claim hasn't been accepted yet, you can go to your group health plan for care, find a doctor, clinic or hospital who will bill the claims administrator directly, or use public health services.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, you will receive temporary disability payments. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Si Ud. se lesiona o se enferma, ya sea física o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación para trabajadores. Se adjunta el formulario para presentar un reclamo de compensación para trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran, dependiendo de la índole de su reclamo. Si se requiere, el/la administrador(a) de reclamos, quien es responsable del manejo de su reclamo, le notificará a usted, lo referente a su elegibilidad para beneficios.

Para presentar un reclamo, complete la sección del formulario designada para el "Empleado", guarde una copia, y déle el resto a su empleador. Entonces, su empleador completará la sección designada para el "Empleador", le dará a Ud. una copia fechada, guardará una copia, y enviará una al/a la administrador(a) de reclamos. Los beneficios no pueden comenzar hasta, que el/la administrador(a) de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

Atención Médica: Su administrador(a) de reclamos pagará toda la atención médica razonable y necesaria, para su lesión o enfermedad relacionada con el trabajo. Es posible que los beneficios médicos incluyan el tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio y las medicinas. Su administrador(a) de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro.

El Médico Primario que le Atiende-*Primary Treating Physician PTP* es el médico con toda la responsabilidad para dar el tratamiento para su lesión o enfermedad. Generalmente, su empleador selecciona al *PTP* que Ud. verá durante los primeros 30 días, a menos que Ud. haya designado con anticipación al médico que le atienda. Si usted desea cambiar durante los primeros 30 días, el/la administrador(a) de reclamos seleccionará uno por Ud. Si el doctor dice usted aún necesita tratamiento después de 30 días, Ud. puede cambiar al médico de su preferencia. Hay reglas especiales que son aplicables cuando su empleador ofrece una Organización del Cuidado Médico (HCO). Hable con su empleador para más información. Si su empleador no ha colocado un poster describiendo sus derechos para la compensación para trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

Si el/la administrador(a) de reclamos de su empleador no le autoriza la atención médica, Ud. tiene varias opciones. Comuníquese con su administrador(a) de reclamos, para averiguar la situación de su reclamo. Si el reclamo todavía no se ha aceptado, usted puede ir a su plan médico colectivo para recibir atención, buscar un médico, clínica u hospital que cobrará directamente al/a la administrador(a) de reclamos, o utilizar servicios médicos públicos.

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación para los trabajadores, sus expedientes médicos no tendrán la misma privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un(a) juez de compensación para trabajadores posiblemente decida qué expedientes se revelarán. Si Ud. solicita privacidad, es posible que el/la juez "selle" (mantenga privados) ciertos expedientes médicos.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. recibirá pagos por incapacidad temporal.

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Formulario de Reclamo de Compensación para Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

Return to Work: To help you to return to work as soon as possible, you should actively communicate with your treating doctor, claims administrator, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may be temporary or may be extended depending on the nature of your injury or illness.

Payment for Permanent Disability: If a doctor says your injury or illness results in a permanent disability, you may receive additional payments. The amount will depend on the type of injury, your age, occupation, and date of injury.

Vocational Rehabilitation: If a doctor says your injury or illness prevents you from returning to the same type of job and your employer doesn't offer modified or alternative work, you may qualify for vocational rehabilitation. If you qualify, your claims administrator will pay the costs, up to a maximum set by state law.

Death Benefits: If the injury or illness causes death, payments may be made to relatives or household members who were financially dependent on the deceased worker.

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it. If you are not receiving benefits you may be able to get State Disability Insurance (SDI) benefits. Call State Employment Development Department at (800) 480-3287.

You can obtain free information from an information and assistance officer of the State Division of Workers' Compensation, or you can hear recorded information and a list of local offices by calling **(800) 736-7401**. You may also go to the DWC web site at **www.dir.ca.gov.** Link to Workers' Compensation.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at **www.californiaspecialist.org**.

Es posible que estos pagos cambien o paren, cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estatales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado(a) de noche, o no pueda trabajar durante más de 14 días.

Regreso al Trabajo: Para ayudarle a regresar a trabajar lo antes posible, Ud. debe comunicarse de manera activa con el médico que le atienda, el/la administrador(a) de reclamos y el empleador, con respecto a las clases de trabajo que Ud. puede hacer mientras se recupera. Es posible que ellos coordinen esfuerzos para regresarle a un trabajo modificado, o a otro trabajo, que sea apropiado desde el punto de vista médico. Este trabajo modificado, u otro trabajo, podría extenderse o no temporalmente, dependiendo de la índole de su lesión o enfermedad.

Pago por Incapacidad Permanente: Si el doctor dice que su lesión o enfermedad resulta en una incapacidad permanente, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, su edad, su ocupación y la fecha de la lesión.

Rehabilitación Vocacional: Si el doctor dice que su lesión o enfermedad le evita regresar a la misma clase de trabajo, y su empleador no le ofrece trabajo modificado o alterno, es posible que usted reúna los requisitos para rehabilitación vocacional. Si Ud. reúne los requisitos, su administrador(a) de reclamos pagará los costos, hasta un máximo establecido por las leyes estatales.

Beneficios de Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a los parientes o a las personas que vivan en el hogar, que dependían económicamente del/de la trabajador(a) difunto(a).

Es ilegal que su empleador le castigue o despida, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por atestiguar en el caso de compensación para trabajadores de otra persona. (El Codigo Laboral sección 132a). Si es probado, puede ser que usted reciba pagos por perdida de sueldos, reposición del trabajo, aumento de beneficios, y gastos hasta un límite establecido por el estado.

Ud. tiene derecho a estar en desacuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador(a) de reclamos, para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios de Seguro Estatal de Incapacidad (SDI). Llame al Departamento Estatal del Desarrollo del Empleo (EDD) al (800) 480-3287.

Ud. puede obtener información gratis, de un oficial de información y asistencia, de la División estatal de Compensación al Trabajador *(Division of Workers' Compensation – DWC)*, o puede escuchar información grabada, así como una lista de oficinas locales, llamando al **(800) 736-7401**. Ud. también puede ir al sitio electrónico en el Internet de la DWC en **www.dir.ca.gov.** Enlácese a la sección de Compensación para Trabajadores.

Ud. puede consultar con un(a) abogado(a). La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un(a) abogado(a), sus honorarios se tomarán de sus beneficios. Para obtener nombres de abogados de compensación para trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, ó vaya a su sitio electrónico en el Internet en **www.californiaspecialist.org**.

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 until you receive the 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 at time of hire describing workers' compensation benefits and the procedures to obtain them.

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

Ud. también debería haber recibido de su empleador al tiempo de ser empleado 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 "felonía".

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 ocurrió 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.* _____
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.

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*