Division of Workers' Compensation

BENEFIT NOTICE
INSTRUCTION MANUAL

Title 8, California Code of Regulations,
Sections 9810 through 9815
(Revisions effective April 9, 2008)

December 2009

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INTRODUCTION

The purpose of this manual is to present advice for accurate and timely completion of benefit notices and mandatory forms that meet the requirements of the Administrative Director's regulations. The regulations which govern the requirements for these notices are in Title 8, California Code of Regulations, Chapter 4.5~Division of Workers' Compensation, Subchapter 1~Administrative Director Administrative Rules, Article 8, "Benefit Notices; Claims Administrator's Duties and Responsibilities; Claim Form and Notice of Potential Eligibility of Benefits; Regulatory Authority of the Administrative Director" Sections 9810-9815 (abbreviated 8, CCR §§9810-9815). These regulations are effective as of **April 9, 2008** The regulations apply to all workers' compensation dates of injury. When references to the regulations are made, they are by section and subdivision [for example, **§**9812**(a)(1)**].

The model notices presented in this manual are in English and Spanish and are the result of a combined effort of workers' compensation professionals from insurers, self-insured employers, third-party administrators, and employer and employee representative groups working together with the Division of Workers' Compensation. The intent of this effort is to provide forms which, if used in conjunction with the instructions provided, will improve communication with the injured worker and make it easier for the claims administrator to comply with the regulations governing the issuance of benefit notices.

Sections 9810(c) and (d) provide that each benefit notice letter, excepting those mandatory notices set forth in statute or where a specific notice form has been adopted as a regulation, may be produced on the claims administrator's letterhead. The notice letters must include the claims administrator's name, mailing address and telephone number, name of the employee, employer, the claim number, the date the notice was sent to the employee (or other claimant), and the date of injury. The term "claims administrator" includes the administrator for an alternative dispute resolution (ADR) program as established under Labor Code §3201.5 or 3201.7. The name, mailing address, and phone number of the claims representative must be clearly shown. Section 9811(f) contains mandatory language for notices, including mandatory ADR notice language.

Various events in the life of a workers' compensation claim trigger the requirement to issue a notice to the employee or claimant. There are required contents for each notice. 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. Information required to be given to the employee at each event is in the model notices presented in this manual. Information (other options) not relevant to the particular notice should be deleted as long as required contents of these regulations are included. Forms that may <u>not</u> be revised are those mandatory forms created to address retraining and/or return to work for dates of injury on and after January 1, 2004.

Benefit notice forms included in this manual are <u>model</u> forms. The format and language is not required to be issued as presented with the exception of the mandatory forms addressing retraining and return to work. The model notices in this manual may be revised to fit an individual claims administrator's preferences with the exception of the mandatory forms

mentioned above. Each model notice has (1) required information and (2) optional information specific to the event being addressed in the notice. Regulations require that specific enclosures shall be sent with some notices.

Claims administrators may continue to use forms that were used before this manual was produced as long as those forms meet the current requirements set forth in Title 8, California Code of Regulations, Sections 9810 through 9815. Ultimately, the claims administrator is responsible for compliance with the regulations governing the issuance of benefit notices, regardless of whether these model notices are used.

The Benefit Notice Manual can be accessed via internet, as well as the model benefit notices, the mandatory notices, and the DWC fact sheets. The DIR Informational Internet address is:

http://www.dir.ca.gov/DWC/dwc_home_page.htm

All benefit notices that are not mandatory by statute or these regulations require the "employee's (or claimant's) remedies" defined in §9811(f). There is separate mandatory language for notices subject to an alternative dispute resolution (ADR) program under Labor Code §§3201.5 or 3201.7. This language complies with the requirements of §9810(c) that "all notices clearly state that additional information may be obtained from Information and Assistance Officer and clearly indicate the name and telephone number of the person responsible for the payment and adjusting of the claim". For notices not subject to ADR criteria the last two sentences of this section should be completed as is appropriate to the notice.

Whenever there is a requirement to provide the request for QME panel under Labor Code §4062.1, regulations require that the notice shall have the following warning in not less than 12 point font at the top of the first page: **"You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully."**

Other Requirements and Definitions

- Section 9810(e): The claims administrator shall provide copies to the employee, upon request, of all medical reports relevant to any benefit notice issued, or which are not required to be provided along with a notice and have not yet been provided to the employee other than psychiatric reports which the physician has recommended not be provided to the employee.

- Section 9810(f): The claims administrator shall send a copy of each benefit notice, and any enclosures not previously served on the attorney, concurrently to the attorney of any represented employee.

- Section 9810(h): Copies of all benefit notices sent to injured workers shall be maintained by the claims administrator in the claims file. In lieu of retaining a copy of any attachments to the notice, the claims administrator may identify the attachments by name and revision date on the notice. These copies may be maintained in paper or electronic form.

- Section 9810(i): All benefit notices shall be made available in English and Spanish, as appropriate.

- Section 9811(c): "Date of knowledge of Injury and disability" means the date the employer had knowledge of (1) a worker's injury or claim of injury, and (2) the worker's inability or claimed inability to work because of the injury.

NOTICES REGARDING TEMPORARY DISABILITY

& SALARY CONTINUATION BENEFITS

8 CCR §9812(a) and §9814

NOTE TO CLAIMS ADMINISTRATOR: If using the model notice(s) it is recommended that inapplicable options and/or language be deleted to avoid a confusing message to the employee and any parties copied with the notice.

Title 8, California Code of Regulations (CCR) §9812(a) and §9814 address the requirements for notices addressing the start, delay, and denial of temporary disability (TD) payment and/or the provision of salary continuation in lieu of TD. Title 8, CCR, §§9812(b) through (d) address indemnity benefit resumption, change, and termination.

Instructions for completing the form: On all forms, complete the first and last sections as required by §9810(c). This regulation requires documentation of provision of any attachments sent with the notices. Attachments required with the TD notices may include the most recent version of the DWC fact sheet C addressing TD, DWC fact sheet E addressing the QME/AME process, and/or the Request for QME Panel Request (QME Form 105). The Workers' Compensation claim form (DWC-1) should be included if it has not been provided.

PAYMENT START / RESUME– TD/SALARY CONTINUATION

Requirements for the notice are in §9812(a)(1) for the first payment and in §9812(b) for resumed payment. Section 9814 provides the salary continuation notice requirements.

The model notice addresses the start / resumed payment of temporary disability indemnity or salary continuation: Complete all non-optional sections of the form. Complete the first section as appropriate for temporary disability indemnity payments. If salary continuation is provided in lieu of TD, omit the sentence that states "payments will sent to you every two weeks on …" and insert a sentence advising payments will continue "on your regular payday" and will continue until you are able …" If payments are being resumed following a period of time in which temporary disability benefits or salary continuation in lieu of temporary disability has not been provided, indicate that payments are being resumed rather than beginning. The first payment of TD must include "all indemnity then due" through the date of the payment.

Also, model paragraphs have been included to address situations where temporary partial disability (TPD/wage loss) is paid. Be aware that TPD payments are due on a biweekly basis, just as TTD payments are due.

When to send:

- **First:** No later than the 14th day after the employer's date of knowledge of injury and disability as defined by §9811(c).
- **Resume:** Within 14 days after the employer's date of knowledge of the entitlement to additional benefits.

Who to copy with notice:

- Applicant Attorney (if any)

Enclosures:

- **Required** with first notice: DWC Fact Sheet C- Temporary Disability (w/revision date);
- An explanation of the salary continuation plan specific to the employer is included (if appropriate)
- **Optional**: Workers' Compensation claim form (DWC-1) if not previously provided

PAYMENT STOP – TD/SALARY CONTINUATION

If the notice is for a final payment the requirements are in §9812(d): Complete all non-optional sections of the form. Provide a clear explanation of the reason for ending the benefit. Complete the total dollar amount paid at time of ending benefit, which benefit is ending, the period (or periods) paid, and the rate paid. An attachment detailing the payment record may be enclosed with the notice. Note the regulations require an accounting be made of all benefits paid in that species of benefit, including the dates and amounts paid and any related penalties.

When regulations require provision of the request for QME panel under Labor Code §4062.1, the notice shall have the following warning in not less than 12 point font at the top of the first page: **"You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully."**

The model notice has two sets of options for the employee, one set if unrepresented and one set if represented. It is important to choose and to complete the appropriate option and delete the other options to avoid a confusing message to the employee and any parties who are copied with the notice.

Option: Regulations do not require that credit be asserted for any overpayments. It is recommended this section be completed if applicable.

When to send: Together with the last payment. When the decision to end payments is made after the last scheduled payment, the notice is due no later than 14 days after that payment.

Note that Labor Code §4061 requires that a permanent disability notice must be sent together with the last payment of temporary disability indemnity.

Note that Labor Code §4658.5 requires a Notice of Potential Right to Supplemental Job Displacement Benefit be sent certified within 10 days of the last payment of temporary disability indemnity.

Who to copy with notice:

- Applicant Attorney (if any)

Enclosures:

- **Required:** Unless a copy has already been provided or there is a revision since the last provision, DWC Fact Sheet C- Temporary Disability (w/revision date);
- An explanation of the salary continuation plan specific to the employer is included (if appropriate);
- DWC Fact Sheet E QME/AME (w/revision date)**;**

- QME Panel Request form, QME Form 105 and attachment (if the employee is unrepresented and has had no prior comprehensive medical evaluation)
- **Optional:** Workers' Compensation claim form (DWC-1) if not previously provided
- Payment record

PAYMENT DELAY– TD/SALARY CONTINUATION

Section 9812(a)(2) provides the requirements for a notice of delay or subsequent delay in determining if any temporary disability (or salary continuation) is payable on an otherwise accepted claim. Complete all non-optional sections of the form. Provide a clear explanation of the reason for delaying the benefit including what information is needed to make a determination and a date the determination is likely to be made. If information needed is not received by the expected date of determination, a subsequent delay of benefits must issue. A new determination date is required at this time.

When regulations require provision of the request for QME panel under Labor Code §4062.1, the notice shall have the following warning in not less than 12 point font at the top of the first page: **"You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully."**

The model notice has two sets of options for the employee, one set if unrepresented and one set if represented. It is important to choose and to complete the appropriate option and delete the other options to avoid a confusing message to the employee and any parties who are copied with the notice.

When to send:

- **First:** Within 14 days of the date of knowledge of injury and disability.
- **Subsequent:** Not later than the determination date specified in the previous delay notice.

Who to copy with notice:

- Applicant Attorney (if any)

Enclosures:

- **Required with first delay:** DWC Fact Sheet E QME/AME (w/revision date)**;**
- QME Panel Request form, QME Form 105 and attachment (if the employee is unrepresented and has had no prior comprehensive medical evaluation)
- **Required with subsequent delay** Unless a copy has already been provided DWC Fact Sheet E QME/AME (w/revision date) **and** QME Panel Request form, QME Form 105 and attachment (if the employee is unrepresented and has had no prior comprehensive medical evaluation)
- **Optional:** Workers' Compensation claim form (DWC-1) if not previously provided

PAYMENT DENIAL– TD/SALARY CONTINUATION

Section 9812(a)(3) provides the requirements for a notice denial of any claimed temporary disability (or salary continuation) payment in a claim in which liability has been accepted. Complete all non-optional sections of the form. Complete the first paragraph. Provide a clear explanation of the reason for denying the benefit including the date(s) being denied. Avoid the

use of acronyms or Labor Code/Regulation citation without explanation of their meaning and how they apply to the decision to deny the benefits.

When regulations require provision of the request for QME panel under Labor Code §4062.1, the notice shall have the following warning in not less than 12 point font at the top of the first page: **"You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully."**

The model notice has two sets of options for the employee, one set if unrepresented and one set if represented. It is important to choose and to complete the appropriate option and delete the other options to avoid a confusing message to the employee and any parties who are copied with the notice.

When to send:

- Within 14 days after the determination to deny is made.

Who to copy with notice:

- Applicant Attorney (if any)

Enclosures:

- **Required:** DWC Fact Sheet C- Temporary Disability(w/revision date);
- DWC Fact Sheet E QME/AME (w/revision date)**;**
- QME Panel Request form, QME Form 105 and attachment (if the employee is unrepresented and has had no prior comprehensive medical evaluation).
- **Optional:** Workers' Compensation claim form (DWC-1) if not previously provided

MODEL BENEFIT NOTICES

REGARDING

TEMPORARY DISABILITY

&

SALARY CONTINUATION

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING TEMPORARY DISABILITY BENEFITS

PAYMENT START / RESUME

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

Payment for temporary disability is ***(option)*** starting / resuming and ***(option)*** enclosed / sent separately / included in your paycheck for the period starting DATE through DATE and will continue until you are able to return to work or your medical condition becomes permanent and stationary. Your weekly compensation rate is $INSERT RATE based on your earnings of $ AVERAGE WEEKLY WAGE per week. Payments will be sent to you every two weeks on DAY OF THE WEEK. You may receive less if you are earning partial wages. ***Include following sentence with salary continuation claims***: An explanation of the salary continuation plan specific to your employer is included with this notice.

Optional paragraphs for payment of temporary partial disability (wage loss):

Payment of temporary partial disability (also known as wage loss) is ***(option)*** starting / resuming and ***(option)*** enclosed / sent separately / included in your paycheck for the period starting DATE through DATE and will continue until you are able to return to work or your medical condition becomes permanent and stationary. Your compensation rate may vary from week to week depending upon the hours you work each week. Wage loss is calculated by taking your pre-injury average weekly earnings, subject to a statutory maximum rate, and subtracting your post-injury weekly earnings. The weekly wage loss paid is two-thirds of this difference.

We will contact your employer every two weeks to determine if wage loss is due and the amount owed, if any. At this time the information we have indicates you are working a total of INSERT NUMBER OF HOURS hours per week earning a total of $INSERT AMOUNT EARNED. Payments will be sent to you every two weeks on DAY OF THE WEEK. ***Include following***

sentence with salary continuation claims: An explanation of the salary continuation plan specific to your employer is included with this notice.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling ***(insert local I&A number).***

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at: http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to *[**choose appropriate option(s)**]* the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

cc: Applicant Attorney (if any)

Enc.:

- DWC Fact Sheet C – Temporary Disability (w/Rev. date)
- Brief explanation of the employer's specific salary continuation plan *(as applicable pursuant to Title 8 CCR §9814)*
- Workers' Compensation Claim form (DWC-1) *(if not previously provided)*

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee
Address
CityStateZip

Empleador:
Fecha de la lesión (accidente):
Número de reclamo:

AVISO SOBRE BENEFICIOS DE INCAPACIDAD TEMPORAL

COMENZAR / REASUMIR PAGO

CLAIMS ADMINISTRATOR NAME está administrando su reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los beneficios de incapacidad para su lesión de compensación de trabajadores de fecha indicada arriba.

El pago por incapacidad temporal está ***(option)*** comenzando / reasumiendo y ***(option)*** adjunto / enviado por separado / incluido en su nómina por el período empezando DATE a DATE y continuará hasta que usted pueda regresar a trabajar o hasta que su condición médica se vuelve permanente y estacionaria. Su tasa de compensación semanal es de $INSERT RATE basada en sus ingresos de $ AVERAGE WEEKLY WAGE por semana. Pagos le serán enviados cada dos semanas en DAY OF THE WEEK. Usted puede recibir menos si está ganando sueldos parciales. ***Include following sentence with salary continuation claims***: Una explicación del plan de continuación de salario específico a su empleador está incluida con este aviso.

Optional paragraphs for payment of temporary partial disability (wage loss):

El pago de incapacidad temporal parcial (también conocido como pérdida de sueldo) está ***(option)*** comenzando / reasumiendo y ***(option)*** adjunto / enviado por separado / incluido en su nómina por el período empezando DATE a DATE y continuará hasta que usted pueda regresar a trabajar o hasta que su condición médica se vuelve permanente y estacionaria. Su tasa de compensación puede variar de semana a semana según las horas que usted trabaja cada semana. La pérdida de sueldo es calculada tomando el promedio de sus ingresos semanales antes de la lesión, sujeto a la tasa máxima establecida por ley, y restándose el promedio de sus ingresos semanales después de la lesión. La pérdida de sueldo semanal pagada es dos tercios de esta diferencia.

Nos pondremos en contacto con su empleador cada dos semanas para determinar si la pérdida de sueldo es debida y la cantidad debida, si alguna. En este tiempo, la información que tenemos

indica que usted esta trabajando un total de INSERT NUMBER OF HOURS horas por semana y ganando un total de $INSERT AMOUNT EARNED. Los pagos le serán enviados cada dos semanas los DAY OF THE WEEK. ***Include following sentence with salary continuation claims***: Una explicación del plan de continuación de salario específico a su empleador está incluida con este aviso.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al ***(insert local I&A number).***

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en: http: //www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.

Para resolver una disputa, usted puede hacer una solicitud a *[**choose appropriate option(s)**]* la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____

Examinador(a) de Reclamos

cc: Applicant Attorney (if any)

Adjunto:

- DWC Hoja de Información C – Incapacidad Temporal (w/Rev. date)
- Breve explicación del plan de continuación de sueldo especifico al empleador *(as applicable pursuant to Title 8 CCR §9814)*
- Formulario de Reclamo de Compensación de Trabajadores (DWC-1) *(if not previously provided)*

Claims Administrator Name
Address
City_State_Zip
Telephone Number

You may lose important rights if you do not take certain actions within 10 days.

Read this letter and any enclosed fact sheets very carefully.

Date

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING TEMPORARY DISABILITY BENEFITS

DELAY

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

Although liability for your workers' compensation injury has been accepted, I cannot pay you temporary disability benefits for the period DATE through DATE at this time because REASON FOR DELAY. I expect to advise you of the status of these benefits by DATE.

Option: If benefit is delayed for medical issue and employee unrepresented, insert the following:

We ***(option)*** accept / disagree with the treating physician's evaluation of your temporary disability status. If you have received a comprehensive medical evaluation, you may return to that physician for a new evaluation.

If you are unrepresented, and have not received a comprehensive medical evaluation, you may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit. Attached is a form with which you may request assignment of a panel of Qualified Medical Evaluators. You have 10 days to request the panel. Once you have received the panel, you have 10 days to make the appointment.

Option: If benefit delayed for medical issue and employee is represented, insert the following:

For all dates of injury: We ***(option)*** accept / disagree with the treating physician's evaluation of your temporary disability status. If you have received a comprehensive medical evaluation, you may be asked to return to that physician for a new evaluation.

And insert one of the two paragraphs below as appropriate to date of injury:

For dates of injury 01/01/1994–12/31/2004: If you are represented, and no comprehensive medical evaluation has taken place you may obtain an evaluation by an Agreed Medical Evaluator. If no agreement can be reached, you may be evaluated by a Qualified Medical Evaluator. Arrangements for obtaining this evaluation should be discussed with your attorney.

or..

For dates of injury on/after 01/01/2005: If you are represented, and no comprehensive medical evaluation has taken place you may obtain an evaluation by an Agreed Medical Evaluator. If no agreement can be reached, you may be evaluated by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit. Arrangements for obtaining this evaluation should be discussed with your attorney.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (insert local I&A number).

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at:

http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to [**choose appropriate option(s)**] the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

cc: Applicant Attorney (if any)

Enc.:

- DWC Fact Sheet E – QME/AME (w/Rev. date)
- QME Panel Request (QME Form 105) and attachment
- Workers' Compensation Claim form (DWC-1) *(if not previously provided)*

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Usted puede perder derechos importantes si no toma ciertas acciones dentro de 10 días.
Lea muy cuidadosamente esta carta y cualquiera de las hojas de información que están adjuntas.

Date

Employee **Empleador:**
Address **Fecha de la lesión (accidente):**
CityStateZip **Número de reclamo:**

AVISO SOBRE BENEFICIOS DE INCAPACIDAD TEMPORAL

DEMORA

CLAIMS ADMINISTRATOR NAME está administrando su reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los beneficios de incapacidad para su lesión de compensación de trabajadores de fecha indicada arriba.

Aunque se ha aceptado la responsabilidad de su lesión de compensación de trabajadores, no puedo pagarle beneficios de incapacidad temporal por el período de DATE a DATE en este momento porque REASON FOR DELAY**.** Espero informarle el estado de estos beneficios el DATE.

Option: If benefit is delayed for medical issue and employee unrepresented, insert the following:

Nosotros *(option)* aceptamos / no estamos de acuerdo con la evaluación del médico que le está atendiendo sobre el estado de su incapacidad temporal. Si se le ha realizado una evaluación médica completa, usted puede regresar a aquel médico para una nueva evaluación.

Si no está representado, y no se le ha realizado una evaluación médica completa, usted puede obtener una evaluación de un Evaluador Médico Calificado obtenido de un panel asignado por la Unidad Médica de la DWC. Adjunto está el formulario con el cual usted puede solicitar la asignación de un panel de Evaluadores Médicos Calificados. Usted tiene 10 días para solicitar el panel. Una vez que usted ha recibido el panel, usted tiene 10 días para hacer la cita.

Option: If benefit delayed for medical issue and employee is represented, insert the following:

For all dates of injury: Nosotros ***(option)*** aceptamos / no estamos de acuerdo con la evaluación del médico que le está atendiendo sobre el estado de su incapacidad temporal. Si se le ha realizado una evaluación médica completa, pueden pedirle regresar a aquel médico para una nueva evaluación.

And insert one of the two paragraphs below as appropriate to date of injury:

For dates of injury 01/01/1994–12/31/2004: Si usted está representado, y ninguna evaluación médica completa se ha llevado acabo usted puede obtener una evaluación por un Evaluador Médico Acordado. Si no se llega a ningún acuerdo, usted puede ser evaluado por un Evaluador Médico Calificado. Debería hablar con su abogado sobre los arreglos para obtener esta evaluación.

or..

For dates of injury on/after 01/01/2005: Si usted está representado, y ninguna evaluación médica completa se ha llevado acabo usted puede obtener una evaluación por un Evaluador Médico Acordado. Si no se llega a ningún acuerdo, usted puede ser evaluado por un Evaluador Médico Calificado obtenido de un panel asignado por la Unidad Médica. Debería hablar con su abogado sobre los arreglos para obtener esta evaluación.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al **(insert local I&A number)**.

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en: http://www.dir.ca.gov/DWC/dwc_home_page.htm. Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.

Para resolver una disputa, usted puede hacer una solicitud a ***[choose appropriate option(s)]*** la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____

Examinador(a) de Reclamos

cc: Applicant Attorney (if any)

Adjunto:

- DWC Hoja de Información E – QME/AME (w/Rev. date)
- Solicitud para un panel de QME Bajo el Código laboral § 4062.1 Sin representación (QME Form 105)
- Formulario de Reclamo de Compensación de Trabajadores (DWC-1) *(if not previously provided)*

Claims Administrator Name
Address
City_State_Zip
Telephone Number

You may lose important rights if you do not take certain actions within 10 days.

Read this letter and any enclosed fact sheets very carefully.

Date

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING TEMPORARY DISABILITY BENEFITS

DENIAL

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

Although liability for your workers' compensation injury has been accepted, I cannot pay you temporary disability benefits for the period DATE through DATE because REASON FOR DENIAL.

Option: If denied for medical issue and employee unrepresented, insert one of the following:

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

Or

We ***(option)*** accept / disagree with the comprehensive medical evaluation of PHYSICIAN NAME and REPORT DATE of your temporary disability status. Should there be a disagreement, you may return to that physician for a new evaluation.

or

We ***(option)*** accept / disagree with the treating physician's evaluation of DATE of your temporary disability status. If you are unrepresented, and have not received a comprehensive medical evaluation, you may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit. Attached is a form with which you may request assignment of a panel of Qualified Medical Evaluators. You have 10 days to request the panel. Once you have received the panel, you have 10 days to make the appointment.

Option: If denied for medical issue and employee is represented, insert the following:

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

For dates of injury 01/01/1994 – 12/31/2004: If you are represented, and no comprehensive medical evaluation has taken place you may obtain an evaluation by an Agreed Medical Evaluator. If no agreement can be reached, you may be evaluated by a Qualified Medical Evaluator. Arrangements for obtaining this evaluation should be discussed with your attorney.

or..

For dates of injury on/after 01/01/2005: If you are represented, and no comprehensive medical evaluation has taken place you may obtain an evaluation by an Agreed Medical Evaluator. If no agreement can be reached, you may be evaluated by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit. Arrangements for obtaining this evaluation should be discussed with your attorney.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling ***(insert local I&A number).***

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at: http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to [**choose appropriate option(s)**] the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

cc: Applicant Attorney (if any)

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

- DWC Fact Sheet C – Temporary Disability (w/Rev. date)
- DWC Fact Sheet E – QME/AME (w/Rev. date)
- QME Panel Request form, QME Form 105 and attachment
- Workers' Compensation Claim form (DWC-1) *(if not previously provided)*

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Usted puede perder derechos importantes si no toma ciertas acciones dentro de 10 días.
Lea muy cuidadosamente esta carta y cualquiera de las hojas de información que están adjuntas.

Date

Employee	**Empleador:**
Address	**Fecha de la lesión (accidente):**
CityStateZip	**Número de reclamo:**

AVISO SOBRE BENEFICIOS DE INCAPACIDAD TEMPORAL

NEGACIÓN

CLAIMS ADMINISTRATOR NAME está administrando su reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los beneficios de incapacidad para su lesión de compensación de trabajadores de fecha indicada arriba.

Aunque se ha aceptado la responsabilidad de su lesión de compensación de trabajadores, no puedo pagarle beneficios de incapacidad temporal por el período de DATE a DATE porque REASON FOR DENIAL.

Option: If denied for medical issue and employee unrepresented, insert one of the following:

Nosotros ***(option)*** aceptamos / no estamos de acuerdo con la evaluación médica completa de PHYSICIAN NAME and REPORT DATE sobre el estado de su incapacidad temporal. Si decide disputar esta decisión usted puede archivar una Aplicación de Ajudicación con la Junta de Apelaciones de Compensación de Trabajadores (WCAB).

Or

Nosotros ***(option)*** aceptamos / no estamos de acuerdo con la evaluación médica completa de PHYSICIAN NAME and REPORT DATE sobre el estado de su incapacidad temporal. Si hay algún desacuerdo, usted puede regresar a aquel médico para una nueva evaluación.

or

Nosotros ***(option)*** aceptamos / no estamos de acuerdo con la evaluación del médico que le está atendiendo fechada DATE sobre el estado de su incapacidad temporal. Si no está representado, y no se le ha realizado una evaluación médica completa, usted puede obtener una evaluación de un Evaluador Médico Calificado obtenido de un panel asignado por la Unidad Médica de la DWC. Adjunto está el formulario con el cual usted puede solicitar la asignación de un panel de Evaluadores Médicos Calificados. Usted tiene 10 días para solicitar el panel. Una vez que usted ha recibido el panel, usted tiene 10 días para hacer la cita.

Option: If denied for medical issue and employee is represented, insert the following:

Nosotros ***(option)*** aceptamos / no estamos de acuerdo con la evaluación médica completa de PHYSICIAN NAME and REPORT DATE sobre el estado de su incapacidad temporal. Si decide disputar esta decisión usted puede archivar una Aplicación de Ajudicación con la Junta de Apelaciones de Compensación de Trabajadores (WCAB).

For dates of injury 01/01/1994 – 12/31/2004: Si usted está representado, y ninguna evaluación médica completa se ha llevado acabo usted puede obtener una evaluación por un Evaluador Médico Acordado. Si no se llega a ningún acuerdo, usted puede ser evaluado por un Evaluador Médico Calificado. Debería hablar con su abogado sobre los arreglos para obtener esta evaluación.

or..

For dates of injury on/after 01/01/2005: Si usted está representado, y ninguna evaluación médica completa se ha llevado acabo usted puede obtener una evaluación por un Evaluador Médico Acordado. Si no se llega a ningún acuerdo, usted puede ser evaluado por un Evaluador Médico Calificado obtenido de un panel asignado por la Unidad Médica. Debería hablar con su abogado sobre los arreglos para obtener esta evaluación.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al **(insert local I&A number)**.

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en: http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.

Para resolver una disputa, usted puede hacer una solicitud a ***[choose appropriate option(s)]*** la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____

Examinador(a) de Reclamos

cc: Applicant Attorney (if any)

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

- DWC Hoja de Información C – Incapacidad Temporal (w/Rev. date)
- DWC Hoja de Información E – QME/AME (w/Rev. date)
- Solicitud para un panel de QME Bajo el Código laboral § 4062.1 Sin representación (QME Form 105)
- Formulario de Reclamo de Compensación de Trabajadores (DWC-1) *(if not previously provided)*

Claims Administrator Name
Address
City_State_Zip
Telephone Number

You may lose important rights if you do not take certain actions within 10 days.

Read this letter and any enclosed fact sheets very carefully.

Date

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING TEMPORARY DISABILITY BENEFITS

PAYMENT TERMINATION

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

Payments are ending because REASON FOR ENDING PAYMENTS.

Benefits paid to you total $ AMOUNT. Benefits were paid to you as ***(options)*** temporary total disability / salary continuation / temporary partial disability: Period(s) paid were from DATE through DATE at $ RATE per week.

Complete / delete the following as appropriate:

- Please see the attached detailed payment record for specific periods and amount paid.
- Additionally, you have received 10% self-imposed increases totaling $ SII PAID.
- Included in the total benefit paid is an overpayment totaling $ AMOUNT. The overpayment was paid for the period(s) from DATE through DATE at $ RATE per week.

Option: IF employee unrepresented, insert one of the following:

We ***(option)*** accept / disagree with the comprehensive medical evaluation of PHYSICIAN NAME and REPORT DATE of your temporary disability status. Should there be a disagreement, you may return to that physician for a new evaluation.

or

We *(option)* accept / disagree with the treating physician's evaluation of REPORT DATE of your temporary disability status. If you are unrepresented, and have not received a comprehensive medical evaluation, you may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit. Attached is a form with which you may request assignment of a panel of Qualified Medical Evaluators. You have 10 days to request the panel. Once you have received the panel, you have 10 days to make the appointment.

Option: IF employee is represented, insert one of the following:

We *(option)* accept / disagree with the comprehensive medical evaluation of PHYSICIAN NAME and REPORT DATE of your temporary disability status. You may be asked to return to that physician for a new evaluation.

or

We *(option)* accept / disagree with the medical evaluation of PHYSICIAN NAME and REPORT DATE of your temporary disability status. If you are represented, and no comprehensive medical evaluation has taken place you may obtain an evaluation by an Agreed Medical Evaluator. If no agreement can be reached, you may be evaluated by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit. Arrangements for obtaining this evaluation should be discussed with your attorney.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling ***(insert local I&A number).***

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at: http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to [**choose appropriate option(s)**] the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

cc: Applicant Attorney (if any)

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

- DWC Fact Sheet C – Temporary Disability (w/Rev. date)
- DWC Fact Sheet E – QME/AME (w/Rev. date)
- QME Panel Request form, QME Form 105 and attachment
- Workers' Compensation Claim form (DWC-1) *(if not previously provided)*
- Payment record

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Usted puede perder derechos importantes si no toma ciertas acciones dentro de 10 días.
Lea muy cuidadosamente esta carta y cualquiera de las hojas de información que están adjuntas

Date

Employee **Empleador:**
Address **Fecha de la lesión (accidente):**
CityStateZip **Número de reclamo:**

AVISO SOBRE BENEFICIOS DE INCAPACIDAD TEMPORAL

TERMINACIÓN DE PAGO

CLAIMS ADMINISTRATOR NAME está administrando su reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los beneficios de incapacidad para su lesión de compensación de trabajadores de fecha indicada arriba.

Los pagos están terminando porque REASON FOR ENDING PAYMENTS.

Los beneficios pagados a usted totalizan $ AMOUNT. Beneficios fueron pagados a usted como ***(options)*** beneficios de incapacidad temporal / continuación de salario / incapacidad temporal parcial: El/Los período(s) pagados fueron de DATE hasta DATE a $ RATE por semana.

Complete / delete the following as appropriate:

- Por favor vea el registro de pago detallado adjunto para períodos específicos y cantidades pagadas.
- Además, usted ha recibido aumentos autoimpuestos de 10% totalizando $ SII PAID.
- Incluido en el total de beneficios pagado está un pago excesivo totalizando $ AMOUNT. El pago excesivo fue pagado por el/los período(s) de DATE hasta DATE a $ RATE por semana.

Option: IF employee unrepresented, insert one of the following:

Nosotros ***(option)*** aceptamos / no estamos de acuerdo con la evaluación médica completa de PHYSICIAN NAME and REPORT DATE sobre el estado de su incapacidad temporal. Si hay algún desacuerdo, usted puede regresar a aquel médico para una nueva evaluación.

or

Nosotros ***(option)*** aceptamos / no estamos de acuerdo con la evaluación del médico que le está atendiendo fechada REPORT DATE sobre el estado de su incapacidad temporal. Si no está representado, y no se le ha realizado una evaluación médica completa, usted puede obtener una evaluación de un Evaluador Médico Calificado obtenido de un panel asignado por la Unidad Médica de la DWC. Adjunto está el formulario con el cual usted puede solicitar la asignación de un panel de Evaluadores Médicos Calificados. Usted tiene 10 días para solicitar el panel. Una vez que usted ha recibido el panel, usted tiene 10 días para hacer la cita.

Option: IF employee is represented, insert one of the following:

Nosotros ***(option)*** aceptamos / no estamos de acuerdo con la evaluación médica completa de PHYSICIAN NAME and REPORT DATE sobre el estado de su incapacidad temporal. Pueden pedirle regresar a aquel médico para una nueva evaluación.

or

Nosotros***(option)*** aceptamos / no estamos de acuerdo con la evaluación médica de PHYSICIAN NAME and REPORT DATE sobre el estado de su incapacidad temporal. Si usted está representado, y ninguna evaluación médica completa se ha llevado acabo usted puede obtener una evaluación por un Evaluador Médico Acordado. Si no se llega a ningún acuerdo, usted puede ser evaluado por un Evaluador Médico Calificado obtenido de un panel asignado por la Unidad Médica. Debería hablar con su abogado sobre los arreglos para obtener esta evaluación.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al **(insert local I&A number)**.

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en: http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.

Para resolver una disputa, usted puede hacer una solicitud a ***[choose appropriate option(s)]*** la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____

Examinador(a) de Reclamos

cc: Applicant Attorney (if any)

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

- DWC Hoja de Información C – Incapacidad Temporal (w/Rev. date)
- DWC Hoja de Información E – QME/AME (w/Rev. date)
- Solicitud para un panel de QME Bajo el Código laboral § 4062.1 Sin representación (QME Form 105)
- Formulario de Reclamo de Compensación de Trabajadores (DWC-1) *(if not previously provided)*
- Registro de pago

INDEMNITY NOTICES
RESUMPTION, CHANGE, TERMINATION

8 CCR §9812(b), (c), (d)

NOTE TO CLAIMS ADMINISTRATOR: If using the model notice(s) it is recommended that inapplicable options and/or language be deleted to avoid a confusing message to the employee and any parties copied with the notice.

NOTICE REGARDING INDEMNITY BENEFIT RESUMED PAYMENT

8 CCR §9812(b)

Section 9812(b) provides the requirement for resumed indemnity benefit payment. Section 9814 provides the salary continuation notice requirements.

The model notice addresses the resumed payment indemnity. Complete all non-optional sections of the form. Specify which bendift type resuming indemnity payments. If the benefit being resumed is salary continuation in lieu of TD, omit the sentence that states "payments will sent to you every two weeks on …" and insert a sentence advising payments will continue "on your regular payday".

When to send:

- Within 14 days after the employer's date of knowledge of the entitlement to additional benefits.

Who to copy with notice:

- Applicant Attorney (if any)

Enclosures as appropriate to benefit:

- DWC Fact Sheet C- Temporary Disability (w/revision date);
- An explanation of the salary continuation plan specific to the employer is included (if appropriate)
- DWC Fact Sheet D- Permanent Disability (w/revision date);
- Workers' Compensation claim form (DWC-1) if not previously provided

NOTICE OF CHANGE IN BENEFIT RATE, PAYMENT AMOUNT, OR PAYMENT SCHEDULE

8 CCR §9812(c)

Requirements for the notice of change in benefit rate, payment amount, or payment schedule are in §9812(c). This regulation applies to all dates of injury and addresses changes in temporary disability, salary continuation, permenant disability, and vocational rehabilitation

indemnity benefit rate, payment amount, or schedules. **Section 9812(h)(2) provides requirements for changes in dependency (death) benefits for all dates of injury.**

Instructions for completing the form: As noted, this notice is used when modifying one type of benefit payment. Do not use this form when changing from one class of benefits to another, such as changing from temporary disability to permanent disability.

Complete all non-optional sections of the form. Identify the class of benefits being changed. All notices should include the date the change is going into effect, the period affected, and the reason for the change. Provide the new rate and/or amount to be paid, the date the change will begin, and a clear explanation for the change. If the schedule is changing, provide the new day of the week the payment will issue. When using the model notice, delete the options that do not address the specific change.

TD/TPD: If the change in amount is because the employee has returned to work part-time and is receiving temporary partial disability indemnity (wage loss), provide the formula for which the new rate is based.

> For example: "This rate is being changed to $AMOUNT per week beginning DATE because you have returned to work at reduced earnings. Your new rate is based on two-thirds of the difference between your reduced earnings of $AMOUNT per week and your average weekly earnings within the maximum allowable earnings at the time of your injury of $ AWW OR MAXIMUM per week."

The employee should be advised of the formula for determining the temporary partial disability indemnity (wage loss) rate.

PD: For injuries occurring on or after January 1, 2005 the administrator shall concurrently notify the injured worker of any increased or decreased payment of permanent disability indemnity pursuant to Labor Code §4658, subdivision (d).

Other: Example: Attorney fees for vocational rehabilitation maintenance allowance; Child support payments are being deducted; VRMA will no longer include a PD supplement; change from VRTD to VRMA; Dependency payments are changing because a new dependent has been identified;

When to send:

- The notice should issue prior to or on the date of the new payment and no later than the date the last payment was due in the previous schedule.

Who to copy with notice:

- Applicant Attorney (if any)

NOTICE REGARDING INDEMNITY BENEFIT

STOP PAYMENT

8 CCR §9812(d)

Requirements for the notice of termination of benefits are in §9812(d). This regulation applies to all dates of injury. Section 9812(h)(2) provides requirements for termination of dependency (death) benefits for all dates of injury. Complete all non-optional sections of the form. Provide a clear explanation of the reason for ending the benefit. Complete the total dollar amount paid at time of ending benefit, which benefit is ending, the period (or periods) paid, and the rate paid. An attachment detailing the payment record may be enclosed with the notice. Note the regulations require an accounting be made of all benefits paid in that species of benefit, including the dates and amounts paid and any related penalties/self-imposed increases.

When regulations require provision of the request for QME panel under Labor Code §4062.1, the notice shall have the following warning in not less than 12 point font at the top of the first page: **"You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully."** With the exception of any notice addressing VRMA , the model notice has two sets of options for the employee, one set if unrepresented and one set if represented. It is important to choose and to complete the appropriate option and delete the other options to avoid a confusing message to the employee and any parties who are copied with the notice.

Overpayments: Regulations do not require that credit be asserted for any overpayments. It is recommended this section be completed for accurate documentation of benefit provision.

PD: Note that Labor Code §4061 requires that a permanent disability notice must be sent <u>together with</u> the last payment of temporary disability indemnity.

SJDB: Note that Labor Code §4658.5 requires a Notice of Potential Right to Supplemental Job Displacement Benefit be sent <u>certified</u> within 10 days of the last payment of temporary disability indemnity.

When to send:

- Together with the last payment. When the decision to end payments is made after the last scheduled payment, the notice is due no later than 14 days after that payment.

Who to copy with notice:

- Applicant Attorney (if any)

Required enclosures /see specific regulations:

- DWC Fact Sheet C- Temporary Disability (w/revision date);
- An explanation of the salary continuation plan specific to the employer is included (if appropriate);
- DWC Fact Sheet D- Permanent Disability (w/revision date);
- DWC Fact Sheet E QME/AME (w/revision date)**;**
- QME Panel Request form, QME Form 105 and attachment (if the employee is unrepresented and has had no prior comprehensive medical evaluation)
- Workers' Compensation claim form (DWC-1) if not previously provided
- Payment record

MODEL BENEFIT NOTICES

REGARDING

RESUMPTION

CHANGE

TERMINATION

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING INDEMNITY BENEFITS

PAYMENT RESUME

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

Payment is being resumed for BENEFIT TYPE is ***(option)*** enclosed / sent separately / included in your paycheck for the period starting DATE through INSERT DATE. Your weekly compensation rate is $ RATE based on your earnings of $ AVERAGE WEEKLY WAGE per week. Payments will be sent to you every two weeks on DAY OF THE WEEK.

TPD: Optional paragraphs for resumed payment of temporary partial disability:

Payment of temporary partial disability (also known as wage loss) is resuming and ***(option)*** enclosed / sent separately / included in your paycheck for the period starting DATE through DATE and will continue until you are able to return to work or your medical condition becomes permanent and stationary. Your compensation rate may vary from week to week depending upon the hours you work each week. Wage loss is calculated by taking your pre-injury average weekly earnings, subject to a statutory maximum rate, and subtracting your post-injury weekly earnings. The weekly wage loss paid is two-thirds of this difference.

We will contact your employer every two weeks to determine if wage loss is due and the amount owed, if any. At this time the information we have indicates you are working a total of INSERT NUMBER OF HOURS hours per week earning a total of $INSERT AMOUNT EARNED. Payments will be sent to you every two weeks on DAY OF THE WEEK. ***Include following sentence with salary continuation claims***: An explanation of the salary continuation plan specific to your employer is included with this notice.

PD: Required information for resumed permanent disability payment (if applicable). For injuries occurring on or after January 1, 2005:

The report of PHYSICIAN'S NAME dated DATE The report advises your injury is permanent and stationary effective DATE. ***Option 1***: Your employer made a timely offer for you to ***(choose one)*** return to regular /modified/alternative work on DATE. The weekly PD rate of $RATE will be reduced by 15% to $REDUCED RATE effective the date of the offer of return to work. ***Option 2:*** Your employer did not make a timely offer to you of return to regular /modified/alternative work. The weekly PD rate of $RATE will be increased by 15% effective 60 days after INSERT P&S DATE to $INCREASED RATE effective DATE.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling ***(insert local I&A number).***

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at: http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to *[**choose appropriate option(s)**]* the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

cc: Applicant Attorney (if any)

Enc.: **As required by specific regulations**.

- DWC fact sheet C – Temporary Disability (w/Rev. date)
- Brief explanation of the employer's specific salary continuation plan *(as applicable pursuant to Title 8 CCR §9814)*
- DWC fact sheet D – Permanent Disability (w/Rev. date)
- Workers' Compensation Claim form (DWC-1) *(if not previously provided)*
- Other

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee
Address
CityStateZip

Empleador:
Fecha de la lesión (accidente):
Número de reclamo:

AVISO SOBRE LOS BENEFICIOS DE INDEMNIZACIÓN

REASUMIR PAGO

CLAIMS ADMINISTRATOR NAME está administrando su reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los beneficios de incapacidad para su lesión de compensación de trabajadores de fecha indicada arriba.

El pago está siendo reasumido para BENEFIT TYPE está ***(option)*** adjunto / enviado por separado / incluido en su nómina por el período empezando DATE hasta INSERT DATE. Su tasa de compensación semanal es de $INSERT RATE basada en sus ingresos de $ AVERAGE WEEKLY WAGE por semana. Pagos le serán enviados cada dos semanas en DAY OF THE WEEK.

TPD: Optional paragraphs for resumed payment of temporary partial disability:

El pago de incapacidad temporal parcial (también conocido como pérdida de sueldo) está reasumiendo y ***(option)*** adjunto / enviado por separado / incluido en su nómina por el período empezando DATE a DATE y continuará hasta que usted pueda regresar a trabajar o hasta que su condición médica se vuelve permanente y estacionaria. Su tasa de compensación puede variar de semana a semana según las horas que usted trabaja cada semana. La pérdida de sueldo es calculada tomando el promedio de sus ingresos semanales antes de la lesión, sujeto a la tasa máxima establecida por ley, y restándose el promedio de sus ingresos semanales después de la lesión. La pérdida de sueldo semanal pagada es dos tercios de esta diferencia.

Nos pondremos en contacto con su empleador cada dos semanas para determinar si la pérdida de sueldo es debida y la cantidad debida, si alguna. En este tiempo, la información que tenemos indica que usted esta trabajando un total de INSERT NUMBER OF HOURS horas por semana y ganando un total de $INSERT AMOUNT EARNED. Los pagos le serán enviados cada dos semanas los DAY OF THE WEEK. ***Include following sentence with salary continuation claims***:

Una explicación del plan de continuación de salario específico a su empleador está incluida con este aviso.

PD: Required information for resumed permanent disability payment (if applicable). For injuries occurring on or after January 1, 2005:

El informe de PHYSICIAN'S NAME fechado DATE indica que su lesión está permanente y estacionaria a partir de DATE. ***Option 1***: Su empleador le hizo una oferta a tiempo de ***(choose one)*** regresar a trabajo regular/modificado/alternativo en DATE. La tasa semanal de incapacidad permanente $RATE será reducida por 15% a $REDUCED RATE a partir de la fecha de la oferta de regresar a trabajar. ***Option 2:*** Su empleador no le hizo una oferta a tiempo de regresar a trabajo regular /modificado/alternativo. La tasa semanal de incapacidad permanente $RATE será aumentada por 15% a partir de 60 días después del INSERT P&S DATE a $INCREASED RATE a partir de DATE.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al **(insert local I&A number)**.

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en: http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.

Para resolver una disputa, usted puede hacer una solicitud a ***[choose appropriate option(s)]*** la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____

Examinador(a) de Reclamos

cc: Applicant Attorney (if any)

Adjunto: **As required by specific regulations**.

- DWC Hoja de Información C – Incapacidad Temporal (w/Rev. date)

- Breve explicación del plan de continuación de sueldo especifico al empleador *(as applicable pursuant to Title 8 CCR §9814)*
- DWC Hoja de Información D – Incapacidad Permanente (w/Rev. date)
- Formulario de Reclamo de Compensación de Trabajadores (DWC-1) *(if not previously provided)*
- Otro

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING INDEMNITY BENEFITS

PAYMENT CHANGE

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

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

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

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

PD: Required information for permanent disability payment (if applicable). For injuries occurring on or after January 1, 2005:

- The report of PHYSICIAN'S NAME dated DATE advises your injury is permanent and stationary effective DATE. ***Option 1***: Your employer made a timely offer for you to ***(choose one)*** return to regular /modified/alternative work on DATE. The weekly PD rate of $RATE will be reduced by 15% to $REDUCED RATE effective the date of the offer of return to work. ***Option 2:*** Your employer did not make a timely offer to you of return to regular /modified/alternative work. The weekly PD rate of $RATE will be increased by 15% effective 60 days after INSERT P&S DATE to $INCREASED RATE effective DATE.

- Other: INSERT EXPLANATION FOR OTHER CHANGE IN BENEFIT.

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

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (insert local I&A number).

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at:

http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to [**choose appropriate option(s)**] the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____
Claims Examiner

cc: Applicant Attorney (if any)

Enc.:

- TD Fact Sheet (w/Rev. date)
- PD Fact Sheet (w/Rev. date)
- Brief explanation of the employer's specific salary continuation plan *(as applicable pursuant to Title 8 CCR §9814)*

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee **Empleador:**
Address **Fecha de la lesión (accidente):**
CityStateZip **Número de reclamo:**

AVISO SOBRE LOS BENEFICIOS DE INDEMNIZACIÓN

CAMBIO DE PAGO

CLAIMS ADMINISTRATOR NAME está administrando su reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los beneficios de incapacidad para su lesión de compensación de trabajadores de fecha indicada arriba.

- Estamos cambiando la tasa de beneficio de INSERT BENEFIT TYPE. La tasa está siendo cambiada a $ INSERT WEEKLY RATE empezando con el pago de DATE porque INSERT REASON FOR CHANGE IN RATE.

- Estamos cambiando la cantidad del pago de INSERT BENEFIT TYPE. La cantidad está siendo cambiada a $ INSERT WEEKLY AMOUNT empezando con el pago de DATE porque INSERT REASON FOR CHANGE IN AMOUNT.

- Estamos cambiando el día previsto de la semana que le enviamos su INSERT BENEFIT TYPE. Empezando con el pago de DATE cheques serán enviados cada dos semanas en DAY OF WEEK.

PD: Required information for permanent disability payment (if applicable). For injuries occurring on or after January 1, 2005:

- El informe de PHYSICIAN'S NAME fechado DATE indica que su lesión está permanente y estacionaria a partir de DATE. ***Option 1***: Su empleador le hizo una oferta a tiempo de ***(choose one)*** regresar a trabajo regular /modificado/alternativo en DATE. La tasa semanal de incapacidad permanente $RATE será reducida por 15% a $REDUCED RATE a partir de la fecha de la oferta de regresar a trabajar. ***Option 2:*** Su empleador no le hizo una oferta a tiempo de regresar a trabajo regular /modificado/alternativo. La tasa semanal de incapacidad permanente $RATE será aumentada por 15% a partir de 60 días después del INSERT P&S DATE a $INCREASED RATE a partir de DATE.

- Otro: INSERT EXPLANATION FOR OTHER CHANGE IN BENEFIT.

Seguiremos proporcionando cualquier otro beneficio debido como descrito en la información enviada previamente.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al **(insert local I&A number)**.

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en: http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.

Para resolver una disputa, usted puede hacer una solicitud a *[**choose appropriate option(s)**]* la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____
Examinador(a) de Reclamos

cc: Applicant Attorney (if any)

Adjunto:

- DWC Hoja de Información C – Incapacidad Temporal (w/Rev. date)
- DWC Hoja de Información D – Incapacidad Permanente (w/Rev. date)
- Breve explicación del plan de continuación del sueldo especifico al empleador *(as applicable pursuant to Title 8 CCR §9814)*

Claims Administrator Name
Address
City_State_Zip
Telephone Number

You may lose important rights if you do not take certain actions within 10 days.

Read this letter and any enclosed fact sheets very carefully.

Date

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING INDEMNITY BENEFITS

PAYMENT TERMINATION

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

Payments are ending because REASON FOR ENDING PAYMENTS HERE.

Benefits paid to you total $ TOTAL BENEFIT AMOUNT PAID. Benefits were paid to you as ***(option)*** temporary total disability / salary continuation / temporary partial disability; or permanent disability; or vocational rehabilitation maintenance allowance; or vocational rehabilitation temporary disability. Period(s) paid were from DATE through DATE at $RATE per week.

Complete / delete the following as appropriate:

- Please see the attached detailed payment record for specific periods and amount paid.
- Additionally, you have received 10% self-imposed increases totaling $TOTAL SII PAID.
- Included in the total benefit paid is an overpayment totaling $AMOUNT. The overpayment was paid for the period(s) from DATE through DATE at $RATE per week.

Option: With the exception of any Notice of VRMA - IF employee unrepresented, insert one of the following:

We ***(option)*** accept / disagree with the comprehensive medical evaluation of PHYSICIAN NAME and REPORT DATE of your temporary disability status. Should there be a disagreement, you may return to that physician for a new evaluation.

or

We ***(option)*** accept / disagree with the treating physician's evaluation of REPORT DATE of your BENEFIT TYPE status. If you are unrepresented, and have not received a comprehensive medical evaluation, you may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit. Attached is a form with which you may request assignment of a panel of Qualified Medical Evaluators. You have 10 days to request the panel. Once you have received the panel, you have 10 days to make the appointment.

Option: With the exception of any Notice of VRMA - IF employee is represented, insert one of the following:

We ***(option)*** accept / disagree with the comprehensive medical evaluation of PHYSICIAN NAME and REPORT DATE of your BENEFIT TYPE status. You may be asked to return to that physician for a new evaluation.

or

We ***(option)*** accept / disagree with the medical evaluation of PHYSICIAN NAME and REPORT DATE of your BENEFIT TYPE status. If you are represented, and no comprehensive medical evaluation has taken place you may obtain an evaluation by an Agreed Medical Evaluator. If no agreement can be reached, you may be evaluated by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit. Arrangements for obtaining this evaluation should be discussed with your attorney.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling ***(insert local I&A number).***

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at: http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to *[**choose appropriate option(s)**]* the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

cc: Applicant Attorney (if any)

Enc.: **As required by specific regulations**.

- DWC fact sheet C – Temporary Disability (w/Rev. date)
- Brief explanation of the employer's specific salary continuation plan *(as applicable pursuant to Title 8 CCR §9814)*
- DWC fact sheet D – Permanent Disability (w/Rev. date)
- DWC fact sheet E – QME/AME (w/Rev. date)
- QME Panel Request (QME Form 105 and attachment)
- Workers' Compensation Claim form (DWC-1) *(if not previously provided)*
- Payment Record
- Other

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Usted puede perder derechos importantes si no toma ciertas acciones dentro de 10 días.
Lea muy cuidadosamente esta carta y cualquiera de las hojas de información que están adjuntas

Date

Employee **Empleador:**
Address **Fecha de la lesión (accidente):**
CityStateZip **Número de reclamo:**

AVISO SOBRE BENEFICIOS DE INDEMNIZACIÓN

TERMINACIÓN DE PAGO

CLAIMS ADMINISTRATOR NAME está administrando su reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los beneficios de incapacidad para su lesión de compensación de trabajadores de fecha indicada arriba.

Los pagos están terminando porque REASON FOR ENDING PAYMENTS HERE.

Los beneficios pagados a usted totalizan $ AMOUNT. Beneficios fueron pagados a usted como ***(options)*** beneficios de incapacidad temporal / continuación de salario / incapacidad temporal parcial; o incapacidad permanente; o pagos de pensión de rehabilitación vocacional; o incapacidad temporal de rehabilitación vocacional: El/Los período(s) pagados fueron de DATE hasta DATE a $ RATE por semana.

Complete / delete the following as appropriate:

- Por favor vea el registro de pago detallado adjunto para períodos específicos y cantidades pagadas.
- Además, usted ha recibido aumentos autoimpuestos de 10% totalizando $ SII PAID.
- Incluido en el total de beneficios pagado está un pago excesivo totalizando $ AMOUNT. El pago excesivo fue pagado por el/los período(s) de DATE hasta DATE a $ RATE por semana.

Option: With the exception of any Notice of VRMA - IF employee unrepresented, insert one of the following:

Nosotros ***(option)*** aceptamos / no estamos de acuerdo con la evaluación médica completa de PHYSICIAN NAME and REPORT DATE sobre el estado de su incapacidad temporal. Si hay algún desacuerdo, usted puede regresar a aquel médico para una nueva evaluación.

or

Nosotros ***(option)*** aceptamos / no estamos de acuerdo con la evaluación del médico que le está atendiendo fechada REPORT DATE sobre el estado de su **BENEFIT TYPE**. Si no está representado, y no se le ha realizado una evaluación médica completa, usted puede obtener una evaluación de un Evaluador Médico Calificado obtenido de un panel asignado por la Unidad Médica de la DWC. Adjunto está el formulario con el cual usted puede solicitar la asignación de un panel de Evaluadores Médicos Calificados. Usted tiene 10 días para solicitar el panel. Una vez que usted ha recibido el panel, usted tiene 10 días para hacer la cita.

Option: With the exception of any Notice of VRMA - IF employee is represented, insert one of the following:

Nosotros ***(option)*** aceptamos / no estamos de acuerdo con la evaluación médica completa de PHYSICIAN NAME and REPORT DATE sobre el estado de su **BENEFIT TYPE.** Pueden pedirle regresar a aquel médico para una nueva evaluación.

or

Nosotros***(option)*** aceptamos / no estamos de acuerdo con la evaluación médica de PHYSICIAN NAME and REPORT DATE sobre el estado de su **BENEFIT TYPE**. Si usted está representado, y ninguna evaluación médica completa se ha llevado acabo usted puede obtener una evaluación por un Evaluador Médico Acordado. Si no se llega a ningún acuerdo, usted puede ser evaluado por un Evaluador Médico Calificado obtenido de un panel asignado por la Unidad Médica. Debería hablar con su abogado sobre los arreglos para obtener esta evaluación.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al (**insert local I&A number**).

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en: http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para

beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.

Para resolver una disputa, usted puede hacer una solicitud a ***[choose appropriate option(s)]*** la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____

Examinador(a) de Reclamos

cc: Applicant Attorney (if any)

Adjunto: **As required by specific regulations**.

- DWC Hoja de Información C – Incapacidad Temporal (w/Rev. date)
- Breve explicación del plan de continuatión de sueldo especifico al empleador *(as applicable pursuant to Title 8 CCR §9814)*
- DWC Hoja de Información D – Incapacidad Permanente (w/Rev. date)
- DWC Hoja de Información E – QME/AME (w/Rev. date)
- Solicitud para un panel de QME Bajo el Código laboral § 4062.1 Sin representación (QME Form 105)
- Formulario de Reclamo de Compensación de Trabajadores (DWC-1) *(if not previously provided)*
- Registro de pago
- Otro

NOTICES REGARDING PERMANENT DISABILITY BENEFITS

8 CCR §§9812(e) through (g)

NOTE TO CLAIMS ADMINISTRATOR: If using the model notice(s) it is recommended that inapplicable options and/or language be deleted to avoid a confusing message to the employee and any parties copied with the notice.

Labor Code §4650(b) states, "If the injury causes permanent disability, the first payment shall be made within 14 days after the date of the last payment of temporary disability indemnity. When the last payment of temporary disability indemnity has been made pursuant to subdivision (c) of §4656, and regardless of whether the extent of permanent disability can be determined at that date, the employer nevertheless shall commence the timely payment required by this subdivision and shall continue to make these payments until the employer's reasonable estimate of permanent disability indemnity due has been paid, and if the amount of permanent disability indemnity due has been determined, until that amount has been paid."

Title 8, California Code of Regulations (CCR) §§9812(e) through (g) provide the requirements for notices addressing permanent disability (PD) payment.

- DOI Pre 1991: 8 CCR §§9812(e)(1) PD start; (e)(2) PD start and monitor, (e)(3) PD monitor, (e)(4) PD denial
- DOI 1991-1993: 8 CCR §§9812(f)(1) PD monitor, (f)(2) P&S with PD, (f)(3) PD start, (f)(4) PD denial
- DOI 1994 & continuing: 8 CCR §§9812(g)(1) PD monitor, (g)(2) P&S with PD, (g)(3) PD denial, (g)(4) PD start

The model notices presented are in compliance with the benefit notice regulations for dates of injury on and after January 1, 1994 [§9812(g)].

Instructions for completing the form: Complete all non-optional sections of the form. The final section of this form includes the mandatory language of Labor Code §4061(b) as part of the mandatory employee's (or claimant's) remedies statement required by §9811(e). The current regulation requires provision of the TD Fact Sheet (DWC Fact Sheet C), PD Fact Sheet (DWC Fact Sheet D) and the QME/AME Fact Sheet (DWC Fact Sheet E) with specified notices.

Other information required to be provided in the notice to the injured worker varies depending on two factors (1) the date of injury and (2) the event that triggers the requirement. The model PD notices consist of separate optional sections which can be used in different combinations to provide necessary information to the injured worker.

When regulations require provision of the request for QME panel under Labor Code §4062.1, the notice shall have the following warning in not less than 12 point font at the top of the first page: **"You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully."**

The model notice has two sets of options for the employee, one set if unrepresented and one set if represented. It is important to choose and to complete the appropriate option and delete the other options to avoid a confusing message to the employee and any parties who are copied with the notice.

PD MONITOR - Title 8, CCR §9812(g)(1)

Notice is due when TD terminates and there is an expectation of PD. Complete all non-optional sections of the form. Choose and complete the appropriate optional section including the expected date of determination. Delete other options If information needed is not received by the expected date of determination, a subsequent delay of benefits must issue. The subsequent delay has the same information requirements as the initial delay. Subsequent notices are required to provide a new date of expected determination. Provide a clear explanation of the reason(s) for continued monitoring.

- **Option 1: First notice** with the termination of temporary disability (TD) when the injury is not permanent and stationary (P&S) and may cause permanent disability.
- **Option 2: Subsequent notice** when there is knowledge that the injury is P&S, however there are no rateable factors of PD and no advice regarding future medical care**.**
- **Option 3: Subsequent notice** when there is knowledge that the injury is P&S, and factors for PD, but no advice regarding future medical care**.**
- **Option 4: Subsequent notice** when there is knowledge that the injury is P&S and advice regarding future medical care, but no factors for PD.

When to send:

- **First:** Together with the last payment of temporary disability indemnity (TD). If there is no TD, there is no regulation requiring a PD monitoring notice.
- **Subsequent:** Not later than the determination date specified in the previous notice.

Who to copy with notice:

- Applicant Attorney (if any)

Enclosures / see regulation:

- Workers' Compensation claim form (DWC-1) if not previously provided

P&S WITH PD - Title 8, CCR §9812(g)(2)

Notice is due when the injury is permanent and stationary with objective permanent disability factors and the physician has provided advice regarding continued medical care. Complete all non-optional sections of the form. Complete the date of the most current monitoring notice (if any). Delete this sentence if no PD monitoring notice issued prior to this notice. Complete date of receipt of the report and necessary disability information, including the report date and

physician's name. Complete the section(s) addressing the PD and future medical. Select the appropriate options advising employee of the right to disagree. Sections 9812(g)(2)(A) through (D) provide specific advice for unrepresented and represented employees including, but not limited to, intention to have the report rated by the Disability Evaluation Unit (DEU).

Note that regulations require "A copy of the medical report on which the estimate of the amount of permanent disability was based…" "… shall be provided with the notice".

When regulations require provision of the request for QME panel under Labor Code §4062.1, the notice shall have the following warning in not less than 12 point font at the top of the first page: **"You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully."**

The model notice has two sets of options for the employee, one set if unrepresented and one set if represented. It is important to choose and to complete the appropriate option and delete the other options to avoid a confusing message to the employee and any parties who are copied with the notice.

Note: Section 9812(f)(2) for dates of injury 1991 through 1993 requires this advice to be provided "within 5 working days after receiving information" indicating P&S and potential PD.

When to send:

- Within 14 days after the last payment of TD, or within 14 days after knowledge that the employee's injury has resulted in PD.

Who to copy with notice:

- Applicant Attorney (if any)

Enclosures / see regulation:

- DWC fact sheet C - Temporary Disability (w/revision date)
- DWC fact sheet D – Permanent Disability (w/revision date)
- DWC fact sheet E – QME/AME (w/revision date)
- QME Panel Request form, QME Form 105 and attachment (if the employee is unrepresented and has had no prior comprehensive medical evaluation)
- Workers' Compensation claim form (DWC-1) if not previously provided
- Medical Report(s) (w/date)

PD DENIAL - Title 8, CCR §9812(g)(3)

Notice is due when the claims administrator determines the injury has caused no permanent disability and there is decision to deny permanent disability indemnity payment. Complete all non-optional sections of the form. Complete the date and choose the option best suited to your notice. Delete inappropriate options. Sections 9812(g)(3)(A) through (D) provide specific advice for unrepresented and represented employees including, but not limited to, intention to have the report rated by the Disability Evaluation Unit (DEU).

Note that regulations require "A copy of the medical report on which the determination of no permanent disability was based…" "… shall be provided with the notice".

When regulations require provision of the request for QME panel under Labor Code §4062.1, the notice shall have the following warning in not less than 12 point font at the top of the first page: **"You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully."**

The model notice has two sets of options for the employee, one set if unrepresented and one set if represented. It is important to choose and to complete the appropriate option and delete the other options to avoid a confusing message to the employee and any parties who are copied with the notice.

Option: While not required by regulation, if the employee has been provided with the advice regarding potential supplemental job displacement benefit (SJDB), it may be reasonable to include advice to the employee that since there is no PD, the employee is not entitled to the benefit.

When to send:

- Together with the last payment of temporary disability indemnity or
- Within 14 days of knowledge that the injury is permanent and stationary or has caused no permanent disability.

Who to copy with notice:

- Applicant Attorney (if any)

Enclosures / see regulation:

- DWC fact sheet D – Permanent Disability (w/revision date)
- DWC fact sheet E – QME/AME (w/revision date)
- QME Panel Request form (QME Form-105 and attachment)
- Workers' Compensation claim form (DWC-1) if not previously provided
- Medical Report(s) (w/date)

PD START - Title 8, CCR §9812(g)(4)

Notice is due when the claims administrator determines the injury has caused permanent disability whether or not the injury is permanent and stationary, whether or not the extent of the disability is known. The model notice may be used for the first payment or for resumed payment.

Complete all non-optional sections of the form. Choose and complete the options best suited to your notice. Provide a clear and complete explanation of the factors for payment of permanent disability indemnity. Delete inappropriate options.

Required: For injuries occurring on or after January 1, 2005 the administrator shall concurrently notify the injured worker of any increased or decreased payment pursuant to Labor Code §4658, subdivision (d).

When to send:

- **First payment:** Within 14 days after the last payment of temporary disability indemnity or within 14 days after knowledge that the injury has resulted in permanent disability, whichever is later.

- **Resumed payment:** Within 14 days after the employer's date of knowledge of the entitlement to additional benefits.

Who to copy with notice:

- Applicant Attorney (if any)

Enclosures / see regulation:

- DWC fact sheet D – Permanent Disability (w/revision date)
- Workers' Compensation claim form (DWC-1) if not previously provided
- Medical Report(s) (w/date)

PD CHANGE §9812(c);

If the notice is to advise the employee that permanent disability payments are changing the rate, amount, or scheduled day the requirements are in §9812(c).

PD STOP §9812(d);

If the notice is to advise the employee that permanent disability payments are ending the requirements are in §9812(d).

MODEL BENEFIT NOTICES

REGARDING

PERMANENT DISABILITY

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING PERMANENT DISABILITY BENEFITS

MONITOR FOR DISABILITY STATUS

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

Complete/delete as appropriate:

Option 1: Monitor injury for permanent and stationary status:
It is too soon to tell if you will have any permanent disability from your injury. I will be checking with your doctor until your condition is permanent and stationary. At that time your doctor will determine whether you have any permanent disability and if there will be need for further medical care. I expect to have this information by DATE. I will notify you of the status of permanent disability at that time.

Option 2: Subsequent notice - knowledge of P&S, unknown factors for PD & future medical care:
On DATE a notice issued advising that we would continue to check with your doctor to determine when your condition is permanent and stationary. While your doctor has determined your condition is permanent and stationary on DATE, we also need to know whether you have any permanent disability and if there is a need for further medical care. We have not received the necessary information and are extending the determination date to DATE. I will notify you of the status of permanent disability at that time.

Option 3: Subsequent notice - knowledge of P&S and factors for PD, but not future medical care:
On DATE a notice issued advising that we would continue to check with your doctor to determine the status of permanent disability for your injury. While your doctor has determined your condition is permanent and stationary on DATE and has provided us with factors of permanent disability, we do not have knowledge if there is need for further medical care. We

have not received the necessary information and are extending the determination date to DATE. I will notify you of the status of permanent disability at that time.

Option 4: Subsequent notice – knowledge of P&S and future medical care but not factors for PD

On DATE a notice issued advising that we would continue to check with your doctor to determine the status of permanent disability for your injury. While your doctor has determined your condition is permanent and stationary on DATE and has advised if there is need for further medical care, we do not have factors of permanent disability. We have not received the necessary information and are extending the determination date to DATE. I will notify you of the status of permanent disability at that time.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling ***(insert local I&A number).***

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at: http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to [***choose appropriate option(s)***] the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

cc: Applicant Attorney (if any)

Enc.:

- Workers' Compensation Claim form (DWC-1) *(if not previously provided)*
- Other

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee
Address
CityStateZip

Empleador:
Fecha de la lesión (accidente):
Número de reclamo:

AVISO SOBRE BENEFICIOS DE INCAPACIDAD PERMANENTE

MONITORIZACIÓN DE ESTADO DE INCAPACIDAD

CLAIMS ADMINISTRATOR NAME está administrando su reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los beneficios de incapacidad para su lesión de compensación de trabajadores de fecha indicada arriba.

Complete/delete as appropriate:

Option 1: Monitor injury for permanent and stationary status:
Es demasiado pronto para decir si usted tendrá alguna incapacidad permanente a causa de su lesion. Estaré verificando con su médico hasta que su condición esté permanente y estacionaria. Entonces su médico determinará si usted tiene alguna incapacidad permanente y si habrá la necesidad para cuidado médico adicional. Espero tener esta información para el DATE. Le notificaré del estado de la incapacidad permanente entonces.

Option 2: Subsequent notice - knowledge of P&S, unknown factors for PD & future medical care:
En DATE un aviso fue enviado indicando que seguiríamos verificando con su médico para determinar cuando su condición está permanente y estacionaria. Mientras su médico ha determinado que su condición está permanente y estacionaria el DATE, también tenemos que saber si usted tiene incapacidad permanente y si hay la necesidad para cuidado médico adicional. No hemos recibido la información necesaria y estamos extendiendo la fecha de la determinación a DATE. Le notificaré del estado de la incapacidad permanente entonces.

Option 3: Subsequent notice - knowledge of P&S and factors for PD, but not future medical care:
En DATE un aviso fue enviado indicando que seguiríamos verificando con su médico para determinar el estado de incapacidad permanente para su lesión. Mientras su médico ha determinado que su condición está permanente y estacionaria el DATE y nos ha proporcionado con factores de incapacidad permanente, no sabemos si hay la necesidad para cuidado médico

adicional. No hemos recibido la información necesaria y estamos extendiendo la fecha de la determinación a DATE. Le notificaré del estado de la incapacidad permanente entonces.

Option 4: Subsequent notice – knowledge of P&S and future medical care but not factors for PD

En DATE un aviso fue enviado indicando que seguiríamos verificando con su médico para determinar el estado de incapacidad permanente para su lesión. Mientras su médico ha determinado que su condición está permanente y estacionaria el DATE y ha indicado si hay la necesidad para cuidado médico adicional, no tenemos factores de incapacidad permanente. No hemos recibido la información necesaria y estamos extendiendo la fecha de la determinación a DATE. Le notificaré del estado de la incapacidad permanente entonces.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al **(insert local I&A number)**.

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en: http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.

Para resolver una disputa, usted puede hacer una solicitud a ***[choose appropriate option(s)]*** la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____

Examinador(a) de Reclamos

cc: Applicant Attorney (if any)

Adjunto:

- Formulario de Reclamo de Compensación de Trabajadores (DWC-1) *(if not previously provided)*
- Otro

Claims Administrator Name
Address
City_State_Zip
Telephone Number

You may lose important rights if you do not take certain actions within 10 days.

Read this letter and any enclosed fact sheets very carefully.

Date

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING PERMANENT DISABILITY BENEFITS

PERMANENT DISABILITY ADVICE

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

Your doctor provided advice that your condition is permanent and stationary, whether you have any permanent disability, and if there is a need for further medical care in the ***(1 option)*** report dated DATE from PHYSICIAN NAME which is enclosed ***(2 option)*** reports dated DATES from PHYSICIAN NAME which are enclosed.

The report provides objective information regarding permanent disability. Based on the information provided in the report, your permanent disability rating is INSERT%. This rating is equivalent to $ TOTAL AMOUNT, which is paid at the weekly permanent disability rate of $ RATE for NUMBER weeks. The report indicates that you ***(option)*** are / are not in need of continuing medical care.

For injuries occurring on or after January 1, 2005:

The report advises your injury is permanent and stationary effective DATE. ***Option 1***: Your employer made a timely offer for you to ***(choose one)*** return to regular /modified/alternative work on DATE. The weekly PD rate of $RATE will be reduced by 15% to $REDUCED RATE effective the date of the offer of return to work. ***Option 2:*** Your employer did not make a timely offer to you of return to regular /modified/alternative work. The weekly PD rate of $RATE will be increased by 15% effective 60 days after INSERT P&S DATE to $INCREASED RATE effective DATE.

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

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

or

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

Option: If employee unrepresented, insert one of the following:

We ***(option)*** accept / disagree with the comprehensive medical evaluation of PHYSICIAN NAME and REPORT DATE of your permanent disability status. Should there be a disagreement, you may return to that physician for a new evaluation.

or

We ***(option)*** accept / disagree with the treating physician's evaluation of DATE of your permanent disability status. If you are unrepresented, and have not received a comprehensive medical evaluation, you may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit. Attached is a form with which you may request assignment of a panel of Qualified Medical Evaluators. You have 10 days to request the panel. Once you have received the panel, you have 10 days to make the appointment.

Option: If employee is represented, insert the following:

We *(option)* accept / disagree with the comprehensive medical evaluation of PHYSICIAN NAME and REPORT DATE of your permanent disability status.

***Option: For dates of injury 01/01/1994 – 12/31/2004*:** If you are represented, and no comprehensive medical evaluation has taken place you may obtain an evaluation by an Agreed Medical Evaluator. If no agreement can be reached, you may be evaluated by a Qualified Medical Evaluator. Arrangements for obtaining this evaluation should be discussed with your attorney.

or..

Option: For dates of injury on/after 01/01/2005: If you are represented, and no comprehensive medical evaluation has taken place you may obtain an evaluation by an Agreed Medical Evaluator. If no agreement can be reached, you may be evaluated by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit. Arrangements for obtaining this evaluation should be discussed with your attorney.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling ***(insert local I&A number).***

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at: http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to *[**choose appropriate option(s)**]* the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

cc: Applicant Attorney (if any)

Enc.: **As required by specific regulations**.

- Medical report(s)
- DWC fact sheet C – Temporary Disability (w/Rev. date)
- DWC fact sheet D – Permanent Disability (w/Rev. date)
- DWC fact sheet E – QME/AME (w/Rev. date)
- QME Panel Request (QME Form 105 and attachment)
- Workers' Compensation Claim form (DWC-1) *(if not previously provided)*
- Other

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Usted puede perder derechos importantes si no toma ciertas acciones dentro de 10 días.
Lea muy cuidadosamente esta carta y cualquiera de las hojas de información que están adjuntas

Date

Employee **Empleador:**
Address **Fecha de la lesión (accidente):**
CityStateZip **Número de reclamo:**

AVISO SOBRE BENEFICIOS DE INCAPACIDAD PERMANENTE

CONSEJOS SOBRE LA INCAPACIDAD PERMANENTE

CLAIMS ADMINISTRATOR NAME está administrando su reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los beneficios de incapacidad para su lesión de compensación de trabajadores de fecha indicada arriba.

Su médico ha aconsejado que su condición está permanente y estacionaria, si usted tiene alguna incapacidad permanente y si hay la necesidad para cuidado médico adicional en ***(1 option)*** el informe fechado DATE de PHYSICIAN NAME que está adjunto ***(2 option)*** los informes fechados DATES de PHYSICIAN NAME que están adjuntos.

El informe proporciona información objectiva sobre la incapacidad permanente. Basado en la información proporcionada en el informe, su clasificación de incapacidad permanente es de INSERT%. Esta clasificación equivale a $ TOTAL AMOUNT, que es pagada a la tasa semanal de incapacidad permanente de $ RATE por NUMBER semanas. El informe indica que usted ***(option)*** está /no está necesitado de cuidado médico continuo.

For injuries occurring on or after January 1, 2005:

El informe indica que su lesión está permanente y estacionaria a partir del DATE. ***Option 1***: Su empleador le hizo una oferta a tiempo de ***(choose one)*** regresar a trabajo regular /modificado/alternativo en DATE. La tasa semanal de incapacidad permanente $RATE será reducida por 15% a $REDUCED RATE a partir de la fecha de la oferta de regresar a trabajar. ***Option 2:*** Su empleador no le hizo una oferta a tiempo de regresar a trabajo regular/modificado/alternativo. La tasa semanal de incapacidad permanente $RATE será

aumentada por 15% a partir de 60 días después del INSERT P&S DATE a $INCREASED RATE a partir de DATE.

Tanto usted y yo tenemos el derecho de no estar de acuerdo con las conclusiones del médico y solicitar una evaluación médica completa.

Option: (option) Hemos pedido/Estamos pidiendo que el informe de su médico que lo está atendiendo se clasifique para incapacidad permenente por la Unidad de Evaluación de Incapacidades (DEU). Usted recibirá una copia de esta clasificación de la DEU.

or

Option: No estamos pidiendo que el informe de su médico que lo está atendiendo se clasifique para incapacidad permenente por la Unidad de Evaluación de Incapacidades (DEU). Si no está representado, usted puede ponerse en contacto con el oficial de Información y Asistencia para que el informe sea revisado y clasificado por la DEU.

Option: If employee unrepresented, insert one of the following:

Nosotros ***(option)*** aceptamos / no estamos de acuerdo con la evaluación médica completa de PHYSICIAN NAME and REPORT DATE sobre el estado de su incapacidad permanente. Si hay algún desacuerdo, usted puede regresar a aquel médico para una nueva evaluación.

or

Nosotros ***(option)*** aceptamos / no estamos de acuerdo con la evaluación del médico que le está atendiendo fechada DATE sobre el estado de su incapacidad permanente. Si no está representado, y no se le ha realizado una evaluación médica completa, usted puede obtener una evaluación de un Evaluador Médico Calificado obtenido de un panel asignado por la Unidad Médica de la DWC. Adjunto está el formulario con el cual usted puede solicitar la asignación de un panel de Evaluadores Médicos Calificados. Usted tiene 10 días para solicitar el panel. Una vez que usted ha recibido el panel, usted tiene 10 días para hacer la cita.

Option: If employee is represented, insert the following:

Nosotros ***(option)*** aceptamos / no estamos de acuerdo con la evaluación médica completa de PHYSICIAN NAME and REPORT DATE sobre el estado de su incapacidad permanente.

Option: For dates of injury 01/01/1994 – 12/31/2004: Si usted está representado, y ninguna evaluación médica completa se ha llevado acabo usted puede obtener una evaluación por un Evaluador Médico Acordado. Si no se llega a ningún acuerdo, usted puede ser evaluado por un Evaluador Médico Calificado. Debería hablar con su abogado sobre los arreglos para obtener esta evaluación.

or..

Option: For dates of injury on/after 01/01/2005: Si usted está representado, y ninguna evaluación médica completa se ha llevado acabo usted puede obtener una evaluación por un

Evaluador Médico Acordado. Si no se llega a ningún acuerdo, usted puede ser evaluado por un Evaluador Médico Calificado obtenido de un panel asignado por la Unidad Médica. Debería hablar con su abogado sobre los arreglos para obtener esta evaluación.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al (**insert local I&A number**).

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en: http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.

Para resolver una disputa, usted puede hacer una solicitud a *[**choose appropriate option(s)**]* la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____

Examinador(a) de Reclamos

cc: Applicant Attorney (if any)

Adjunto: **As required by specific regulations**.

- Informe(s) médico(s)
- DWC Hoja de Información D – Incapacidad Permanente (w/Rev. date)
- DWC Hoja de Información E – QME/AME (w/Rev. date)
- Solicitud para un panel de QME Bajo el Código laboral § 4062.1 Sin representación (QME Form 105)
- Formulario de Reclamo de Compensación de Trabajadores (DWC-1) *(if not previously provided)*
- Otro

Claims Administrator Name
Address
City_State_Zip
Telephone Number

You may lose important rights if you do not take certain actions within 10 days.

Read this letter and any enclosed fact sheets very carefully.

Date

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING PERMANENT DISABILITY BENEFITS

DENIAL

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

On DATE you ***(option)*** returned to work / were released to return to work / were discharged from care / and based upon the report of DATE from PHYSICIAN'S NAME, ***(option)*** your treating physician / a Qualified Medical Evaluator / an Agreed Medical Evaluator, you have recovered from your injury with no permanent disability. I accept the findings described in this report. For this reason, no permanent disability payments are payable. A copy of the report is attached to this notice. The report indicates that you ***(option)*** are / are not in need of continuing medical care.

Option:

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

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

or

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

Option: If employee unrepresented, insert one of the following:

We ***(option)*** accept / disagree with the comprehensive medical evaluation of PHYSICIAN NAME and REPORT DATE of your permanent disability status. Should there be a disagreement, you may return to that physician for a new evaluation.

or

We ***(option)*** accept / disagree with the treating physician's evaluation of DATE of your permanent disability status. If you are unrepresented, and have not received a comprehensive medical evaluation, you may obtain an evaluation by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit. Attached is a form with which you may request assignment of a panel of Qualified Medical Evaluators. You have 10 days to request the panel. Once you have received the panel, you have 10 days to make the appointment.

Option: If employee is represented, insert the following:

We ***(option)*** accept / disagree with the comprehensive medical evaluation of PHYSICIAN NAME and REPORT DATE of your permanent disability status.

Option: For dates of injury 01/01/1994 – 12/31/2004: If you are represented, and no comprehensive medical evaluation has taken place you may obtain an evaluation by an Agreed Medical Evaluator. If no agreement can be reached, you may be evaluated by a Qualified Medical Evaluator. Arrangements for obtaining this evaluation should be discussed with your attorney.

or..

Option: For dates of injury on/after 01/01/2005: If you are represented, and no comprehensive medical evaluation has taken place you may obtain an evaluation by an Agreed Medical Evaluator. If no agreement can be reached, you may be evaluated by a Qualified Medical Evaluator obtained from a panel issued by the DWC Medical Unit. Arrangements for obtaining this evaluation should be discussed with your attorney.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your

attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling ***(insert local I&A number).***

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at: http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to *[**choose appropriate option(s)**]* the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

cc: Applicant Attorney (if any)

Enc.: **As required by specific regulations**.

- Medical Report(s)
- DWC fact sheet D – Permanent Disability (w/Rev. date)
- DWC fact sheet E – QME/AME (w/Rev. date)
- QME Panel Request (QME Form 105 and attachment)
- Workers' Compensation Claim form (DWC-1) *(if not previously provided)*
- Other

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Usted puede perder derechos importantes si no toma ciertas acciones dentro de 10 días.
Lea muy cuidadosamente esta carta y cualquiera de las hojas de información que están adjuntas.

Date

Employee
Address
CityStateZip

Empleador:
Fecha de la lesión (accidente):
Número de reclamo:

AVISO SOBRE BENEFICIOS DE INCAPACIDAD PERMANENTE

NEGACIÓN

CLAIMS ADMINISTRATOR NAME está administrando su reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los beneficios de incapacidad para su lesión de compensación de trabajadores de fecha indicada arriba.

En DATE usted ***(option)*** regresó a trabajar / fue permitido a regresar a trabajar / fue dado de alta / y basado en el informe fechado DATE de PHYSICIAN'S NAME, ***(option)*** su médico que lo está atendiendo / el Evaluador Médico Calificado / el Evaluador Médico Acordado, usted se ha recuperado de su lesión sin ninguna incapacidad permanente. Acepto las conclusiones descritas en este informe. Por esta razón los beneficio de incapacidad permanente no se pueden pagar. Una copia del informe está adjuntada a este aviso. El informe indica que usted ***(option)*** está /no está necesitado de cuidado médico continuo.

Option:

Algunos empleados lesionados en o después del 1 de enero de 2004 pueden tener derecho a un beneficio suplementario por el desplazamiento de trabajo (SJDB) . Para ser eligible, usted debe tener una Indemnización por incapacidad permanente parcial, no debe haber recibido ninguna oferta de trabajo Modificado o Alternativo de su empleador y no debe haber vuelto a trabajar para el empleador sesenta (60) días después de la terminación de los beneficios por incapacidad temporal. Como la lesion no ha causado ninguna incapacidad permanente, usted no tiene derecho al beneficio suplementario por desplazamiento de trabajo.

Option: *(option)* Hemos pedido/Estamos pidiendo que el informe de su médico que lo está atendiendo se clasifique para incapacidad permenente por la Unidad de Evaluación de Incapacidades (DEU). Usted recibirá una copia de esta clasificación de la DEU.

or

Option: No estamos pidiendo que el informe de su médico que lo está atendiendo se clasifique para incapacidad permenente por la Unidad de Evaluación de Incapacidades (DEU). Si no está representado, usted puede ponerse en contacto con el oficial de Información y Asistencia para que el informe sea revisado y clasificado por la DEU.

Option: If employee unrepresented, insert one of the following:

Nosotros ***(option)*** aceptamos / no estamos de acuerdo con la evaluación médica completa de PHYSICIAN NAME and REPORT DATE sobre el estado de su incapacidad permanente. Si hay algún desacuerdo, usted puede regresar a aquel médico para una nueva evaluación.

or

Nosotros ***(option)*** aceptamos / no estamos de acuerdo con la evaluación del médico que le está atendiendo fechada DATE sobre el estado de su incapacidad permanente. Si no está representado, y no se le ha realizado una evaluación médica completa, usted puede obtener una evaluación de un Evaluador Médico Calificado obtenido de un panel asignado por la Unidad Médica de la DWC. Adjunto está el formulario con el cual usted puede solicitar la asignación de un panel de Evaluadores Médicos Calificados. Usted tiene 10 días para solicitar el panel. Una vez que usted ha recibido el panel, usted tiene 10 días para hacer la cita.

Option: If employee is represented, insert the following:

Nosotros ***(option)*** aceptamos / no estamos de acuerdo con la evaluación médica completa de PHYSICIAN NAME and REPORT DATE sobre el estado de su incapacidad permanente.

Option: For dates of injury 01/01/1994 – 12/31/2004: Si usted está representado, y ninguna evaluación médica completa se ha llevado acabo usted puede obtener una evaluación por un Evaluador Médico Acordado. Si no se llega a ningún acuerdo, usted puede ser evaluado por un Evaluador Médico Calificado. Debería hablar con su abogado sobre los arreglos para obtener esta evaluación.

or..

Option: For dates of injury on/after 01/01/2005: Si usted está representado, y ninguna evaluación médica completa se ha llevado acabo usted puede obtener una evaluación por un Evaluador Médico Acordado. Si no se llega a ningún acuerdo, usted puede ser evaluado por un Evaluador Médico Calificado obtenido de un panel asignado por la Unidad Médica. Debería hablar con su abogado sobre los arreglos para obtener esta evaluación.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al **(insert local I&A number)**.

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en: http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.

Para resolver una disputa, usted puede hacer una solicitud a ***[choose appropriate option(s)]*** la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administra.

Atentamente,

_____

Examinador(a) de Reclamos

cc: Applicant Attorney (if any)

Adjunto: **As required by specific regulations**.

- Informe(s) médico(s)
- DWC Hoja de Información D – Incapacidad Permanente (w/Rev. date)
- DWC Hoja de Información E – QME/AME (w/Rev. date)
- Solicitud para un panel de QME Bajo el Código laboral § 4062.1 Sin representación (QME Form 105)
- Formulario de Reclamo de Compensación de Trabajadores (DWC-1) *(if not previously provided)*
- Otro

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING PERMANENT DISABILITY BENEFITS

PAYMENT START / RESUME

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

Payment is ***(choose one)*** starting /resuming for permanent disability and is ***(choose one)*** enclosed / sent separately for the period starting DATE through DATE Your weekly compensation rate is $ RATE based on your earnings of $ AVERAGE WEEKLY WAGE per week. Payments will be sent to you every two weeks on DAY OF THE WEEK and will continue until permanent disability benefits are paid ***(option 1)*** as estimated to be due upon termination of temporary disability indemnity payments based upon EXPLANATION ***(option 2)*** has been determined by EXPLANATION OF PERMANENT DISABILITY DUE. These payments will be deducted from any award you may receive.

For injuries occurring on or after January 1, 2005:

The report of PHYSICIAN'S NAME dated DATE advises your injury is permanent and stationary effective DATE. ***Option 1***: Your employer made a timely offer for you to ***(choose one)*** return to regular /modified/alternative work on DATE. The weekly PD rate of $RATE will be reduced by 15% to $REDUCED RATE effective the date of the offer of return to work. ***Option 2:*** Your employer did not make a timely offer to you of return to regular /modified/alternative work. The weekly PD rate of $RATE will be increased by 15% effective 60 days after INSERT P&S DATE to $INCREASED RATE effective DATE.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or

disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling ***(insert local I&A number).***

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at: http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to *[**choose appropriate option(s)**]* the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

cc: Applicant Attorney (if any)

Enc.: **As required by specific regulations**.

- Medical Report(s)
- DWC fact sheet D – Permanent Disability (w/Rev. date)
- Workers' Compensation Claim form (DWC-1) *(if not previously provided)*
- Other

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee **Empleador:**
Address **Fecha de la lesión (accidente):**
CityStateZip **Número de reclamo:**

AVISO SOBRE BENEFICIOS DE INCAPACIDAD PERMANENTE

COMENZAR / REASUMIR PAGO

CLAIMS ADMINISTRATOR NAME está administrando su reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los beneficios de incapacidad para su lesión de compensación de trabajadores de fecha indicada arriba.

El pago está ***(choose one)*** comenzando/reasumiendo por incapacidad permanente y está ***(choose one)*** adjunto / enviado por separado por el período empezando DATE hasta DATE. Su tasa de compensación semanal es de $ RATE basada en sus ingresos de $ AVERAGE WEEKLY WAGE por semana. Pagos le serán enviados cada dos semanas en DAY OF THE WEEK y continuarán hasta que los beneficios de incapacidad permanente son pagados ***(option 1)*** como estimado de lo debido a la terminación de los pagos de indemnidad por incapacidad temporal basado sobre EXPLANATION ***(option 2)*** ha sido determinado por EXPLANATION OF PERMANENT DISABILITY DUE. Estos pagos serán descontados de cualquier indemnización que usted puede recibir.

For injuries occurring on or after January 1, 2005:

El informe de PHYSICIAN'S NAME fechado DATE indica que su lesión está permanente y estacionaria a partir del DATE. ***Option 1***: Su empleador le hizo una oferta a tiempo de ***(choose one)*** regresar a trabajo regular /modificado/alternativo en DATE. La tasa semanal de incapacidad permanente $RATE será reducida por 15% a $REDUCED RATE a partir de la fecha de la oferta de regresar a trabajar. ***Option 2:*** Su empleador no le hizo una oferta a tiempo de regresar a trabajo regular/modificado/alternativo. La tasa semanal de incapacidad permanente $RATE será aumentada por 15% a partir de 60 días después del INSERT P&S DATE a $INCREASED RATE a partir de DATE.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a:

(***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al **(insert local I&A number)**.

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en: http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.

Para resolver una disputa, usted puede hacer una solicitud a ***[choose appropriate option(s)]*** la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____

Examinador(a) de Reclamos

cc: Applicant Attorney (if any)

Adjunto: **As required by specific regulations**.

- Informe(s) médico(s)
- DWC Hoja de Información D – Incapacidad Permanente (w/Rev. date)
- Formulario de Reclamo de Compensación de Trabajadores (DWC-1) *(if not previously provided)*
- Otro

NOTICE OF DENIAL OF CLAIM FOR WORKERS' COMPENSATION BENEFITS

8 CCR §9812(i)

NOTE TO CLAIMS ADMINISTRATOR: If using the model notice(s) it is recommended that inapplicable options and/or language be deleted to avoid a confusing message to the employee and any parties copied with the notice.

Requirements for the notice are in Title 8, CCR §9812(i). This regulation applies to all dates of injury. Section 9812(h)(4) provides requirements for denial of dependency (death) benefits for all dates of injury.

If denying <u>all liability</u> for the claim: Complete all non-optional sections of the form. Complete the date and choose the option best suited to your notice. Clearly explain the reasons for the denial. Delete inappropriate options.

If denying <u>partial liability</u> for the claim: Complete all non-optional sections of the form. Complete the date and choose the option best suited to your notice. Clearly explain the reasons for the denial and what is being denied. Delete inappropriate options.

Avoid the use of acronyms or Labor Code/Regulation citation without explanation of their meaning and how they apply to the decision to deny the benefits. Avoid jargon, such as "... your injury was not AOE/COE." Be specific to the reason for denial.

- Do not use vague, all-inclusive statements, such as "Your claim is denied because your injury was not industrial" or "Your claim is denied because our investigation indicates your injury is not industrial."
- Do use specific statements, such as "Your claim is denied because your medical records and the report of PHYSICIAN NAME dated DATE indicate that your disability and need for treatment are a result of a longstanding medical problem and were not caused or aggravated by your work" or "Your claim is denied because our investigation reveals that your injury is the result of a skiing accident and did not occur as claimed."

Note: For unrepresented workers, Labor Code §4060(e)(1) requires that each notice shall describe the administrative procedures available to the injured employee with respect to a comprehensive medical-legal evaluation. Unrepresented workers need to be advised when the compensability of the claim is based upon a medical decision. Should they choose to dispute the medical decision, the procedure is through Labor Code §4062.1. If there has been no prior comprehensive medical evaluation, place the following warning in not less than 12 point font at the top of the first page of the notice: "You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully." Attach a copy of the Request for QME Panel (QME form 105 and attachment) to the notice.

Note: For claims reported on or after April 19, 2004, if an injured worker is entitled to medical care under Labor code §5402(c) the claims administrator shall advise the injured worker to send

all bills for such treatment to the claims administrator for consideration of payment unless he or she has done so already.

Note: For claims reported on or after April 19, 2004, regardless of the date of injury, when the claims administrator sends a notice of denial of all liability to the employee, the notice shall advise the employee to send for consideration of payment all bills for medical services provided between the date the completed claim form was given to the employer and the date the claim is rejected. The notice shall advise the injured worker that the employer's liability for medical treatment under this Labor Code section is limited to ten thousand dollars ($10,000).

Required copy: All lien claimants or all persons or entities who can reasonably be identified by the claims administrator from information in the claims file to be potential lien claimants on account of their having furnished benefits, goods, or services for which a lien may be filed under Labor Code §§4903 through 4906 inclusive.

When to send:

- No later than 14 days after the determination to deny was made.

Who to copy with notice:

- Applicant Attorney (if any)
- All lien claimants

Enclosures / see regulation:

- DWC fact sheet E – QME/AME (w/revision date)
- QME Panel Request form, QME Form 105 and attachment (if the employee is unrepresented and has had no prior comprehensive medical evaluation)
- Workers' Compensation claim form (DWC-1) if not previously provided

NOTICE OF DELAY IN DETERMINING LIABILITY

FOR WORKERS' COMPENSATION BENEFITS

8 CCR §9812(j)

NOTE TO CLAIMS ADMINISTRATOR: If using the model notice(s) it is recommended that inapplicable options and/or language be deleted to avoid a confusing message to the employee and any parties copied with the notice.

Requirements for the notice are in Title 8, CCR §9812(j). This regulation applies to all dates of injury. Section 9812(h)(3) provides requirements for delay of dependency (death) benefits for all dates of injury.

If delaying <u>all liability</u> for the claim: Complete all non-optional sections of the form. Complete the date and choose the option best suited to your notice. Clearly explain the reasons for the delay, the need, if any, for additional information and an expected date of determination. Delete inappropriate options. If information needed is not received by the expected date of

determination, a subsequent delay of benefits must issue. A new determination date is required at this time.

If delaying partial liability for the claim: Complete all non-optional sections of the form. Complete the date and choose the option best suited to your notice. Clearly explain the reasons for the delay, the need, if any, for additional information and a new expected date of determination. Delete inappropriate options. If information needed is not received by the expected date of determination, a subsequent delay of benefits must issue. A new determination date is required at this time.

Note: For unrepresented workers, Labor Code §4060(e)(1) requires that each notice shall describe the administrative procedures available to the injured employee with respect to a comprehensive medical-legal evaluation. Unrepresented workers need to be advised when the compensability of the claim is based upon a medical decision. Should they choose to dispute the medical decision, the procedure is through Labor Code §4062.1. Place the following warning in not less than 12 point font at the top of the first page of the notice: "You may lose important rights if you do not take certain actions within 10 days. Read this letter and any enclosed fact sheets very carefully." Attach a copy of the Request for QME Panel (QME) to the notice.

Note: For injuries which occur on or after January 1, 1990, the notice shall include an explanation that the claim is presumed to be compensable if not denied within 90 days from the filing of the claim form, and that this presumption can be rebutted only with evidence discovered after the 90-day period.

Note: For claims reported on or after April 19, 2004, regardless of the date of injury, if the claims administrator send s a notice of delay in its decision whether to accept or deny liability for the claim, the notice shall include an explanation that Labor Code §5402(c) provides that within one working day after an employee files a claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treatment guidelines, for the alleged injury and shall continue to provide treatment until the date that liability is rejected. The notice shall advise the injured worker that the employer's liability for medical treatment under this Labor Code section is limited to ten thousand dollars ($10,000).

When to send:

- **First:** Within 14 days of the date of knowledge of injury.
- **Subsequent:** Not later than the determination date specified in the previous notice.

Who to copy with notice:

- Applicant Attorney (if any)
- Lien claimants (if any)

Enclosures / see regulation:

- DWC fact sheet E – QME/AME (w/revision date)
- QME Panel Request form, QME Form 105 and attachment (if the employee is unrepresented and has had no prior comprehensive medical evaluation)
- Workers' Compensation claim form (DWC-1) if not previously provided

MODEL BENEFIT NOTICES

REGARDING

DENIAL OF BENEFIT

&

DELAY OF BENEFIT

Claims Administrator Name
Address
City_State_Zip
Telephone Number

You may lose important rights if you do not take certain actions within 10 days.

Read this letter and any enclosed fact sheets very carefully.

Date

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING

DENIAL OF WORKERS' COMPENSATION BENEFIT

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

Complete / delete as applicable:

Option 1 FULL DENIAL: After careful consideration of all available information, we are denying liability for your claim of injury. Workers' compensation benefits are being denied because EXPLANATION FOR DENIAL. Enclosed for your review with this notice is an informative fact sheet addressing questions about qualified medical evaluators and agreed medical evaluators (QME/AME).

Or

Option 2 PARTIAL DENIAL: After careful consideration of all available information, we are denying liability only for your claim of injury to EXPLANATION because EXPLANATION FOR PARTIAL DENIAL OF BENEFIT. Enclosed for your review with this notice is an informative fact sheet addressing questions about qualified medical evaluators and agreed medical evaluators (QME/AME).

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

shall continue to provide such medical treatment until the claims administrator accepts or denies liability for the claim. Until the date the claim is accepted or rejected, liability for medical treatment under this Labor Code section shall be limited to a maximum of ten thousand dollars ($10,000).

Unless you have done so already, you should send me all medical treatment bills for consideration of payment.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling ***(insert local I&A number).***

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at: http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to *[**choose appropriate option(s)**]* the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

cc: Applicant Attorney (if any)
cc: Lien claimant(s)

Enc.: **As required by specific regulations**.

- DWC fact sheet E – QME/AME (w/Rev. date)
- QME Panel form (QME Form 105 and attachment)
- Workers' Compensation Claim form (DWC-1) *(if not previously provided)*
- Other

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Usted puede perder derechos importantes si no toma ciertas acciones dentro de 10 días.
Lea muy cuidadosamente esta carta y cualquiera de las hojas de información que están adjuntas

Date

Employee
Address
CityStateZip

Empleador:
Fecha de la lesión (accidente):
Número de reclamo:

AVISO SOBRE

NEGACIÓN DEL BENEFICIO DE COMPENSACIÓN DE TRABAJADORES

CLAIMS ADMINISTRATOR NAME está administrando su reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los beneficios de incapacidad para su lesión de compensación de trabajadores de fecha indicada arriba.

Complete / delete as applicable:

Option 1 FULL DENIAL: Después de la deliberación de toda la información disponible, negamos la responsabilidad de su reclamo de lesión. Los beneficios de compensación de trabajadores están siendo negados porque EXPLANATION FOR DENIAL. Adjunto para su revisión con este aviso está una hoja de información dirigiéndose a preguntas sobre evaluadores médicos calificados y evaluadores médicos acordados (QME/AME).

Or

Option 2 PARTIAL DENIAL: Después de la deliberación de toda la información disponible, negamos la responsabilidad de sólo su reclamo de lesión a EXPLANATION porque EXPLANATION FOR PARTIAL DENIAL OF BENEFIT. Adjunto para su revisión con este aviso está una hoja de información dirigiéndose a preguntas sobre evaluadores médicos calificados y evaluadores médicos acordados (QME/AME).

Para reclamos reportados en o después del 19 de abril de 2004, sin importar la fecha de la lesión, si usted le presentó un formulario de reclamo a su empleador o administrador de reclamos, la sección del Código Laboral 5402 (c) dispone que dentro de un día hábil después de que usted archiva el formulario de reclamo, el empleador autorizará la provisión de todo tratamiento, conforme a las pautas de tratamiento aplicables, para la lesión presunta y seguirá proporcionando tal tratamiento médico hasta que el administrador de reclamos acepte o niegue

la responsabilidad del reclamo. Hasta la fecha en que el reclamo sea aceptado o rechazado, la responsabilidad para el tratamiento médico bajo esta sección del Código Laboral será limitada a un máximo de diez mil dólares ($10,000).

A menos que usted ya lo haya hecho, debería enviarme todas las facturas del tratamiento médico para consideración de pago.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al **(insert local I&A number)**.

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en: http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.

Para resolver una disputa, usted puede hacer una solicitud a ***[choose appropriate option(s)]*** la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____

Examinador(a) de Reclamos

cc: Applicant Attorney (if any)
cc: Lien claimant(s)

Adjunto: **As required by specific regulations**.

- DWC Hoja de Información E – QME/AME (w/Rev. date)
- Solicitud para un panel de QME Bajo el Código laboral § 4062.1 Sin representación (QME Form 105)
- Formulario de Reclamo de Compensación de Trabajadores (DWC-1) *(if not previously provided)*
- Otro

Claims Administrator Name
Address
City_State_Zip
Telephone Number

You may lose important rights if you do not take certain actions within 10 days.

Read this letter and any enclosed fact sheets very carefully.

Date

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING

DELAY OF WORKERS' COMPENSATION BENEFIT

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

Complete / delete as applicable:

Option 1: Workers' compensation benefits are being delayed because EXPLANATION FOR DELAY. In order to make a decision, we need ITEM(S) NECESSARY FOR RESOLUTION OF ISSUE(S). We will notify you of our decision on or before DATE. ***(Option if medical issue)*** Because this delay of benefits is related to a medical issue enclosed with this notice is an informative fact sheet for your review.

Or

Option 2: Workers' compensation benefits are being delayed for the period DATE through DATE because EXPLANATION FOR DELAY. In order to make a decision, we need ITEM(S) NECESSARY FOR RESOLUTION OF ISSUE(S). We will notify you of our decision on or before DATE. ***(Option)*** Because this delay of benefits is related to a medical issue enclosed with this notice is an informative fact sheet for your review.

Option 3: Subsequent notice(s)
On DATE a notice issued advising of delay of your workers' compensation benefits pending receipt of EXPLANATION FOR DELAY. In order to make a decision, we need ITEM(S) NECESSARY FOR RESOLUTION OF ISSUE(S). We have not received the necessary

information and are extending the determination date to DATE. I will contact you when this information has been received.

Option if delay relates to compensability of claim.

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

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

Unless you have done so already, you should send me all medical treatment bills for consideration of payment.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling ***(insert local I&A number).***

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at: http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to *[**choose appropriate option(s)**]* the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

cc: Applicant Attorney (if any)

Enc.: **As required by specific regulations**.

- DWC fact sheet E – QME/AME (w/Rev. date)
- QME Panel form (QME Form 105 and attachment)
- Workers' Compensation Claim form (DWC-1) *(if not previously provided)*
- Other

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Usted puede perder derechos importantes si no toma ciertas acciones dentro de 10 días.
Lea muy cuidadosamente esta carta y cualquiera de las hojas de información que están adjuntas

Date

Employee
Address
CityStateZip

Empleador:
Fecha de la lesión (accidente):
Número de reclamo:

AVISO SOBRE

DEMORA DEL BENEFICIO DE COMPENSACIÓN DE TRABAJADORES

CLAIMS ADMINISTRATOR NAME está administrando su reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los beneficios de incapacidad para su lesión de compensación de trabajadores de fecha indicada arriba.

Complete / delete as applicable:

Option 1: Los beneficios de compensación de trabajadores están siendo postergados porque EXPLANATION FOR DELAY. Para tomar una decisión, necesitamos ITEM(S) NECESSARY FOR RESOLUTION OF ISSUE(S). Le notificaremos de nuestra decisión en o antes de DATE. ***(Option if medical issue)*** Porque esta demora de beneficios está relacionada con una cuestión médica adjunto con este aviso está una hoja de información para su revisión.

Or

Option 2: Los beneficios de compensación de trabajadores están siendo postergados por el período de DATE hasta DATE porque EXPLANATION FOR DELAY. Para tomar una decisión, necesitamos ITEM(S) NECESSARY FOR RESOLUTION OF ISSUE(S). Le notificaremos de nuestra decisión en o antes de DATE. ***(Option)*** Porque esta demora de beneficios está relacionada con una cuestión médica adjunto con este aviso está una hoja de información para su revisión.

Option 3: Subsequent notice(s)
En DATE un aviso fue enviado indicando la demora de sus beneficios de compensación de trabajadores pendiente al recibo de EXPLANATION FOR DELAY. Para tomar una decisión, necesitamos ITEM(S) NECESSARY FOR RESOLUTION OF ISSUE(S). No hemos recibido la

información necesaria y estamos extendiendo la fecha de determinación a DATE. Me pondré en contacto con usted cuando esta información ha sido recibida.

Option if delay relates to compensability of claim.

Para lesiones que ocurren en o después del 1 de enero de 1990, hay una presunción legal antes de la Junta de Apelaciones de Compensación de Trabajadores que su reclamo es compensable si no es negado 90 días después de que le devuelve un Formulario de Reclamo del Empleado a su empleador. Esa presunción puede ser refutada sólo con información que no podía ser descubierta dentro del período de 90 días.

Para reclamos reportados en o después del 19 de abril de 2004, sin importar la fecha de la lesión, si usted le presentó un formulario de reclamo a su empleador o administrador de reclamos, la sección del Código Laboral 5402 (c) dispone que dentro de un día hábil después de que usted archiva el formulario de reclamo, el empleador autorizará la provisión de todo tratamiento, conforme a las pautas de tratamiento aplicables, para la lesión presunta y seguirá proporcionando tal tratamiento médico hasta que el administrador de reclamos acepte o niegue la responsabilidad del reclamo. Hasta la fecha en que el reclamo sea aceptado o rechazado, la responsabilidad para el tratamiento médico bajo esta sección del Código Laboral será limitada a un máximo de diez mil dólares ($10,000).

A menos que usted ya lo haya hecho, debería enviarme todas las facturas del tratamiento médico para consideración de pago.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al **(insert local I&A number)**.

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en: http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.

Para resolver una disputa, usted puede hacer una solicitud a *[**choose appropriate option(s)**]* la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____

Examinador(a) de Reclamos

cc: Applicant Attorney (if any)

Adjunto: **As required by specific regulations**.

- DWC Hoja de Información E – QME/AME (w/Rev. date)
- Solicitud para un panel de QME Bajo el Código laboral § 4062.1 Sin representación (QME Form 105)
- Formulario de Reclamo de Compensación de Trabajadores (DWC-1) *(if not previously provided)*
- Otro

NOTICES REGARDING WORKERS' COMPENSATION DEPENDENCY BENEFITS

Title 8, CCR §§9812(h)(1) through (h)(4)

NOTE TO CLAIMS ADMINISTRATOR: If using the model notice(s) it is recommended that inapplicable options and/or language be deleted to avoid a confusing message to the employee and any parties copied with the notice.

Title 8 CCR §9812(h) provides for notices to dependents in death cases. These regulations are for use with all dates of injury. Requirements for content of these notices are in Title 8 CCR §§9812(h)(1) through (h)(4). These notices are sent to each dependent. A "dependent" includes any person who may be or has claimed to be entitled to workers' compensation benefits as the result of an employee's death and includes the parent or legal guardian of minor dependent children. Compensation includes that which was accrued and unpaid to an injured worker before his or her death. If a new dependent is identified, copies of all prior notices must be sent to that dependent if they address benefits to which that dependent may be entitled.

DEPENDENCY - FIRST PAYMENT - §9812(h)(1).

Requirements for the notice of first payment of workers' compensation benefits are in Section 9812(h)(1). Complete all non-optional sections of the form. Notice is provided to the estate of the employee/each dependent.

Option 1: For the first payment of death benefits, complete the first and last sections as required by §9810(c). Complete the first optional section as appropriate.

Option 2: For payments of compensation which were due the deceased employee before his or her death and are payable to the estate of the deceased employee: Complete the first and last sections as required by §9810(c). Complete the second optional section, as appropriate. Note that this type of payment may be the first and the final payment of unpaid compensation.

Note that both options may be relevant to the claim and notice. Complete /delete the language as appropriate to the claim.

When to send:

- Within 14 days after the claims administrator's date of knowledge of the death and of the identity and address of the dependent(s).

Who to copy with notice:

- Applicant Attorney (if any)
- All dependents

DEPENDENCY CHANGE OF RATE, AMOUNT, OR SCHEDULE - §9812(h)(2)

Requirements for the notice are in §9812(h)(2). This subdivision addresses changes to benefit payments and the termination of benefit payments.

To advise the dependent(s) of a change in benefit rate, amount, a change in the day that payments are made, or other change: Complete all non-optional sections of the form. Complete the option(s) that address the change being made. Delete any option not specific to this notice.

When to send:

- Before or with the changed payment, but not later than 14 days after the last payment made before the change.

Who to copy with notice:

- Applicant Attorney (if any)
- All dependents

DEPENDENCY STOP PAYMENT- §9812(h)(2)

Requirements for the notice are in §9812(h)(2). This subdivision addresses changes to benefit payments and the termination of benefit payments.

To advise the dependent(s) of a final payment of dependency benefits (death benefits): Complete all non-optional sections of the form. Provide a clear explanation of the reason for ending the benefit. Complete the total dollar amount paid at time of ending benefit, which benefit is ending, the period (or periods) paid, and the rate paid. Include advice whn penalties were paid. An attachment detailing the payment record may be enclosed with the notice. Note the regulations require an accounting be made of all benefits paid in that species of benefit, including the dates and amounts paid and any related penalties.

When to send:

- With the last payment or, if the decision to end benefits was made after the date of the last payment, within 14 days of the payment.

Who to copy with notice:

- Applicant Attorney (if any)
- All dependents

Enclosure:

- Record detailing payments made.

DEPENDENCY DELAY - §9812(h)(3)

Requirements for the notice are in Section 9812(h)(3). Complete all non-optional sections of the form. Provide a clear explanation of the reason for delaying the benefit, what information is needed to make the decision, and an anticipated date when the decision will be made. The reasons for delay of the benefit may not fit the language provided in the model notice, at which time the claims administrator is encouraged to provide the more complete language. The model notice provides four options. The first two options address total delay of the benefit, the third addresses a partial delay of benefit, and the fourth includes language that may be used for any subsequent delay in the benefit provision decision.

When to send:

- **First:** Within 14 days after the claims administrator's date of knowledge of the death, the identity and address of the affected dependent, and the nature of the benefit claimed or which might be due.
- **Subsequent:** On or before the determination date on the previous delay notice.

Who to copy with notice:

- Applicant Attorney (if any)
- All dependents

DEPENDENCY DENIAL - §9812(h)(4)

Requirements for the notice of denial of dependency benefits are in §9812 (h)(4) Complete all non-optional sections of the form. Provide a clear explanation of the reason for delaying the benefit, what information is needed to make the decision, and an anticipated date when the decision will be made. The reasons for delay of the benefit may not fit the language provided in the model notice, at which time the claims administrator is encouraged to provide the more complete language. The model notice provides two options. The first option addresses total denial of the benefit, the second addresses a partial denial of benefit.

Avoid the use of acronyms or Labor Code/Regulation citation without explanation of their meaning and how they apply to the decision to deny the benefits. Avoid jargon, such as "... your injury was not AOE/COE." Be specific to the reason for denial.

- Do not use vague, all-inclusive statements, such as "Your claim is denied because the employee's death was not industrial" or "Your claim is denied because our investigation indicates the employee's death is not industrial."
- Do use specific statements, such as "Your claim is denied because your medical records and the report of PHYSICIAN NAME dated DATE indicate that the employee's death was not caused by work stress" or "Your claim is denied because our investigation reveals that you are not a dependent of the deceased employee."

When to send:

- No later than 14 days after the determination to deny was made.

Who to copy with notice:

- Applicant Attorney (if any)
- All dependents

MODEL BENEFIT NOTICES

REGARDING

DEPENDENCY

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Dependent /
Estate of Employee Name
Address
City_State_ Zip Code

Employee:
Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING DEPENDENCY BENEFITS

FIRST PAYMENT

CLAIMS ADMINISTRATOR NAME is handling the workers' compensation claim of EMPLOYEE NAME on behalf of EMPLOYER NAME. This notice is to advise of the status of dependency benefit payments for the workers' compensation injury on the date shown above. A copy of this notice will be sent to all dependents.

Option 1: Payment for death benefits is due to each dependent. The total due is $AMOUNT. The total due to you is $AMOUNT based upon EXPLANATION OF AMOUNT AND CALCULATION. The payment is ***(option)*** enclosed / sent separately. The weekly compensation rate is $INSERT RATE. Payments will be sent to every two weeks on DAY OF THE WEEK until the benefit is paid in full.

You may also be entitled to reimbursement of up to $AMOUNT for burial expenses.

Option 2: Payment for TYPE OF INDEMNITY BENEFIT had accrued prior to the employee's death and $AMOUNT is due to each dependent. The total due to you is based upon EXPLANATION OF AMOUNT AND CALCULATION. The payment is ***(option)*** enclosed / sent separately. The weekly compensation rate is $INSERT RATE based on EXPLANATION.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling ***(insert local I&A number).***

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at: http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to *[**choose appropriate option(s)**]* the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

cc: Applicant Attorney (if any)
cc: Dependent(s)

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Dependent /	**Empleado:**
Estate of Employee Name	**Empleador:**
Address	**Fecha de la lesión (accidente):**
CityStateZip	**Número de reclamo:**

AVISO SOBRE BENEFICIOS DE DEPENDENCIA

PRIMER PAGO

CLAIMS ADMINISTRATOR NAME está administrando el reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los pagos de beneficios de dependencia para la lesión de compensación de trabajadores de fecha indicada arriba. Una copia de este aviso se le enviará a todos los dependientes.

Option 1: El pago para beneficios por muerte es debido a cada dependiente. El total debido es $AMOUNT. El total debido a usted es $AMOUNT basado en EXPLANATION OF AMOUNT AND CALCULATION. El pago está ***(option)*** adjunto / enviado por separado. La tasa de compensación semanal es de $INSERT RATE. Pagos le serán enviados cada dos semanas en DAY OF THE WEEK hasta que el beneficio sea pagado en su totalidad.

Usted también puede tener derecho al reembolso de hasta $AMOUNT para gastos de entierro.

Option 2: Los pagos por TYPE OF INDEMNITY BENEFIT se habían acumulado antes de la muerte del empleado y $AMOUNT es debido a cada dependiente. El total debido a usted es EXPLANATION OF AMOUNT AND CALCULATION. El pago está ***(option)*** adjunto / enviado por separado. La tasa de compensación semanal es de $INSERT RATE basado en EXPLANATION.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al **(insert local I&A number)**.

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en: http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.

Para resolver una disputa, usted puede hacer una solicitud a *[**choose appropriate option(s)**]* la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____

Examinador(a) de Reclamos

cc: Applicant Attorney (if any)
cc: Dependent(s)

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Dependent /
Estate of Employee Name
Address
City_State_ Zip Code

Employee:
Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING DEPENDENCY BENEFITS

CHANGE IN PAYMENT

CLAIMS ADMINISTRATOR NAME is handling the workers' compensation claim of EMPLOYEE NAME on behalf of EMPLOYER NAME. This notice is to advise of the status of dependency benefit payments for the workers' compensation injury on the date shown above. A copy of this notice will be sent to all dependents.

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

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

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

Option 4: Other: INSERT EXPLANATION FOR OTHER CHANGE IN BENEFIT.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling ***(insert local I&A number).***

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at: http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to *[**choose appropriate option(s)**]* the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

cc: Applicant Attorney (if any)
cc: Dependent(s)

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Dependent /
Estate of Employee Name
Address
CityStateZip

Empleado:
Empleador:
Fecha de la lesión (accidente):
Número de reclamo:

AVISO SOBRE BENEFICIOS DE DEPENDENCIA

CAMBIO DE PAGO

CLAIMS ADMINISTRATOR NAME está administrando el reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los pagos de beneficios de dependencia para la lesión de compensación de trabajadores de fecha indicada arriba. Una copia de este aviso se le enviará a todos los dependientes.

Option 1: Estamos cambiando la tasa de beneficio de INSERT BENEFIT TYPE. La tasa está siendo cambiada a $ INSERT WEEKLY RATE empezando con el pago de DATE porque INSERT REASON FOR CHANGE IN RATE.

Option 2: Estamos cambiando la cantidad del pago de INSERT BENEFIT TYPE. La cantidad está siendo cambiada a $ INSERT WEEKLY AMOUNT empezando con el pago de DATE porque INSERT REASON FOR CHANGE IN AMOUNT.

Option 3: Estamos cambiando el día previsto de la semana que le enviamos su INSERT BENEFIT TYPE. Empezando con el pago de DATE cheques serán enviados cada dos semanas en DAY OF WEEK.

Option 4: Otro: INSERT EXPLANATION FOR OTHER CHANGE IN BENEFIT.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión,

usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al **(insert local I&A number)**.

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en: http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.

Para resolver una disputa, usted puede hacer una solicitud a ***[choose appropriate option(s)]*** la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____

Examinador(a) de Reclamos

cc: Applicant Attorney (if any)
cc: Dependent(s)

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Dependent /
Estate of Employee Name
Address
City_State_ Zip Code

Employee:
Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING DEPENDENCY BENEFITS

PAYMENT TERMINATION

CLAIMS ADMINISTRATOR NAME is handling the workers' compensation claim of EMPLOYEE NAME on behalf of EMPLOYER NAME. This notice is to advise of the status of dependency benefit payments for the workers' compensation injury on the date shown above. A copy of this notice will be sent to all dependents.

Payments are ending because REASON FOR ENDING PAYMENTS HERE.

Benefits paid to you total $ AMOUNT. Benefits were paid to you as TYPE OF BENEFIT. Period(s) paid were from DATE through DATE at $ RATE per week.

Complete / delete the following as appropriate:

- Please see the attached detailed payment record for specific periods and amount paid.
- Additionally, you have received 10% self-imposed increases totaling $TOTAL SII.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling ***(insert local I&A number).***

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at: http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you

might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to *[**choose appropriate option(s)**]* the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

Enc. ***(Option)***

- Payment record

cc: Applicant Attorney (if any)
cc: Dependent(s)

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Dependent /
Estate of Employee Name
Address
CityStateZip

Empleado:
Empleador:
Fecha de la lesión (accidente):
Número de reclamo:

AVISO SOBRE BENEFICIOS DE DEPENDENCIA
TERMINACIÓN DE PAGO

CLAIMS ADMINISTRATOR NAME está administrando el reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los pagos de beneficios de dependencia para la lesión de compensación de trabajadores de fecha indicada arriba. Una copia de este aviso se le enviará a todos los dependientes.

Pagos están terminando porque REASON FOR ENDING PAYMENTS HERE.

Los beneficios pagados a usten totalizan $ AMOUNT. Beneficios fueron pagados a usted como TYPE OF BENEFIT. El/Los período(s) pagados fueron de DATE hasta DATE a $ RATE por semana.

Complete / delete the following as appropriate:

- Por favor vea el registro de pago detallado adjunto para períodos específicos y cantidades pagadas.
- Además, usted ha recibido aumentos autoimpuestos de 10% totalizando $ TOTAL SII.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al (**insert local I&A number**).

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en: http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.
Para resolver una disputa, usted puede hacer una solicitud a ***[choose appropriate option(s)]*** la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____
Examinador(a) de Reclamos

Adjunto: ***(Option)***

- Registro de pago

cc: Applicant Attorney (if any)
cc: Dependent(s)

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Dependent /
Estate of Employee Name
Address
City_State_ Zip Code

Employee:
Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING DEPENDENCY BENEFITS

DELAY

CLAIMS ADMINISTRATOR NAME is handling the workers' compensation claim of EMPLOYEE NAME on behalf of EMPLOYER NAME. This notice is to advise of the status of dependency benefit payments for the workers' compensation injury on the date shown above. A copy of this notice will be sent to all dependents.

Option 1: I am not able to determine whether benefits are due at this time because EXPLANATION OF REASON FOR DELAY. In order to make a decision, I need EXPLANATION OF INFORMATION NEEDED PRIOR TO DECISION. I will contact you once the information has been received or by DATE.

Option 2: Prior to the death of EMPLOYEE NAME, TYPE OF BENEFIT benefits had accrued, but were not paid. Based on available information, I am unable to determine if you are eligible for these benefits. To reach a decision, I need EXPLANATION OF INFORMATION NEEDED PRIOR TO DECISION. I will contact you once the information has been received or by DATE.

Option 3 Partial delay: Prior to the death of EMPLOYEE NAME, TYPE OF BENEFIT benefits had accrued, but were not paid for the period DATE through DATE. Based on available information, I am unable to determine if you are eligible for these benefits. To reach a decision, I need EXPLANATION OF INFORMATION NEEDED PRIOR TO DECISION. I will contact you once the information has been received or by DATE.

Option 4 Subsequent delay: On DATE a notice of delay of benefits issued indicating need for EXPLANATION OF INFORMATION NEEDED PRIOR TO DECISION. This information has not been received therefore we are extending the delay. I will contact you once the information has been received or by DATE.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and***

telephone number). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling ***(insert local I&A number).***

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at: http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to *[**choose appropriate option(s)**]* the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

Enc. ***(Option)***

cc: Applicant Attorney (if any)
cc: Dependent(s)

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Dependent /
Estate of Employee Name
Address
CityStateZip

Empleado:
Empleador:
Fecha de la lesión (accidente):
Número de reclamo:

AVISO SOBRE BENEFICIOS DE DEPENDENCIA

DEMORA

CLAIMS ADMINISTRATOR NAME está administrando el reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los pagos de beneficios de dependencia para la lesión de compensación de trabajadores de fecha indicada arriba. Una copia de este aviso se le enviará a todos los dependientes.

Option 1: No puedo determinar si los beneficios son debidos en este momento porque EXPLANATION OF REASON FOR DELAY. Para tomar una decisión, necesitamos EXPLANATION OF INFORMATION NEEDED PRIOR TO DECISION. Me pondré en contacto con usted cuando la información ha sido recibida o para el DATE.

Option 2: Antes de la muerte de EMPLOYEE NAME, beneficios de TYPE OF BENEFIT se habían acumulado, pero no fueron pagados. Basado en información disponible, no puedo determinar si usted es elegible para estos beneficios. Para llegar a una decisión, necesito EXPLANATION OF INFORMATION NEEDED PRIOR TO DECISION. Me pondré en contacto con usted una vez que la información ha sido recibida o para el DATE.

Option 3 Partial delay: Antes de la muerte de EMPLOYEE NAME, beneficios de TYPE OF BENEFIT habían acumulado, pero no fueron pagados por el período de DATE hasta DATE. Basado en información disponible, no puedo determinar si usted es elegible para estos beneficios, necesito EXPLANATION OF INFORMATION NEEDED PRIOR TO DECISION. Me pondré en contacto con usted una vez que la información ha sido recibida o para el DATE.

Option 4 Subsequent delay: En DATE se le envió un aviso de demora de beneficios indicando necesidad de EXPLANATION OF INFORMATION NEEDED PRIOR TO DECISION. No hemos recibido la información necesaria por lo tanto estamos extendiendo la fecha de determinación. Me pondré en contacto con usted cuando la información ha sido recibida o para DATE.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al **(insert local I&A number)**.

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en: http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.
Para resolver una disputa, usted puede hacer una solicitud a *[**choose appropriate option(s)**]* la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____

Examinador(a) de Reclamos

Adjunto: ***(Option)***

cc: Applicant Attorney (if any)
cc: Dependent(s)

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Dependent /
Estate of Employee Name
Address
City_State_ Zip Code

Employee:
Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING DEPENDENCY BENEFITS

DENIAL

CLAIMS ADMINISTRATOR NAME is handling the workers' compensation claim of EMPLOYEE NAME on behalf of EMPLOYER NAME. This notice is to advise of the status of dependency benefit payments for the workers' compensation injury on the date shown above. A copy of this notice will be sent to all dependents.

Option 1 FULL Denial: After careful consideration of all available information, we are denying liability for the claim for workers' compensation dependency benefits because EXPLANATION OF REASON FOR DENIAL.

Option 1 PARTIAL Denial: After careful consideration of all available information, we are denying liability for the claim for workers' compensation dependency benefits only for SPECIFY PARTIAL BENEFIT because EXPLANATION OF REASON FOR DENIAL.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling ***(insert local I&A number).***

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at: http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to *[**choose appropriate option(s)**]* the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

Enc.

cc: Applicant Attorney (if any)
cc: Dependent(s)

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Dependent /
Estate of Employee Name
Address
CityStateZip

Empleado:
Empleador:
Fecha de la lesión (accidente):
Número de reclamo:

AVISO SOBRE BENEFICIOS DE DEPENDENCIA

NEGACIÓN

CLAIMS ADMINISTRATOR NAME está administrando el reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los pagos de beneficios de dependencia para la lesión de compensación de trabajadores de fecha indicada arriba. Una copia de este aviso se le enviará a todos los dependientes.

Option 1 FULL Denial: Después de la deliberación de toda la información disponible, negamos la responsabilidad de su reclamo para beneficios de dependencia de compensación de trabajadores porque EXPLANATION OF REASON FOR DENIAL.

Option 1 PARTIAL Denial: Después de la deliberación de toda la información disponible, negamos la responsabilidad de su reclamo para beneficios de dependencia de compensación de trabajadores sólo para SPECIFY PARTIAL BENEFIT porque EXPLANATION OF REASON FOR DENIAL.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al **(insert local I&A number)**.

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en: http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para

beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.
Para resolver una disputa, usted puede hacer una solicitud a ***[choose appropriate option(s)]*** la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____
Examinador(a) de Reclamos

Adjunto:

cc: Applicant Attorney (if any)
cc: Dependent(s)

VOCATIONAL REHABILITATION NOTICES

Title 8, CCR, Sections 9813(a) through (d)

For injuries occurring through December 31, 2003

(Requirements of Labor Code Section 139.5 are repealed effective January 1, 2009.)

Vocational rehabilitation issues are addressed by the DWC, Retraining and Return to Work Unit (formerly known as the Rehabilitation Unit)

Information related to vocational rehabilitation & regulations may be accessed on the DWC website at: http://www.dir.ca.gov/dwc/rehab.html

- Title 8, California Code of Regulations, article 7, vocational rehabilitation sections 10122 - 10133.4
- Title 8, California Code of Regulations, section 10132.1 (sets forth a fee schedule for specific services provided within the $16,000 cap established for rehabilitation services by the 1993 reforms)
- Help in Returning to Work Pamphlet

Access to vocational rehabilitation forms other than those required by Title 8, CCR, Section 9813 may be accessed on the DWC website at: http://www.dir.ca.gov/dwc/forms.html

NOTE TO CLAIMS ADMINISTRATOR: If using the model notice(s) it is recommended that inapplicable options and/or language be deleted to avoid a confusing message to the employee and any parties copied with the notice.

Title 8, California Code of Regulations (CCR) §§9813(a) through (d) provide the requirements for notices addressing vocational rehabilitation benefits (VR).

- DOI through December 31, 2003: 8 CCR §§9813(a)(1) VR start; (a)(2) VR delay, (a)(3) VR denial, (a)(4) Interruption or deferral of VR
- DOI Pre 1990: 8 CCR §§9813(b)(1) Potential Eligibility
- DOI 1990-1993: 8 CCR §§9813(c)(1) 90 day advice, (c)(2) Potential eligibility, (c)(3) Reminder of potential elibibility (c)(4) Intention to withhold maintenance allowance
- DOI 1994 -2003: 8 CCR §§9813(d)(1) 90 day advice, (d)(2) Potential eligibility, (d)(3) Reminder of potential elibibility (d)(4) Intention to withhold maintenance allowance

The model notices presented are in compliance with the benefit notice regulations for dates of injury January 1, 1994 through December 31, 2003. [§9813(d)].

VR PAYMENT START / RESUME - 8 CCR §9813(a)(1)

All dates of injury through December 31, 2003

This notice requirement is found in §9813(a)(1) and applies to all dates of injury through December 31, 2003. Complete all non-optional sections of the form. Payment resumption requirements are found in §9812(b). If the employee requested permanent disability supplements, include the amount of the supplement as required by §9813(a)(1).

NOTE: This notice may be used if the claims administrator is making payments of VRMA at the temporary disability rate (VRTD) as required by §10125.1(c) with any delay while the employer is attempting to identify the availability of alternate or modified work, up until the offer is made on DWC Form RU-94.

For the first payment of vocational rehabilitation maintenance allowance (VRMA): Complete the first section as appropriate for VRMA payments**.** Delete the following paragraph.

If VRMA at the TD rate (VRTD) is provided, complete the first paragraph and include the paragraph explaining the reasons for payment of VRTD and when the benefit may change.

Resumed payments: Indicate that payments are being resumed rather than beginning.

When to send:

- **First:** Within 14 days after the employee requested vocational rehabilitation services.
- **Resume:** Within 14 days after the employer's date of knowledge of the entitlement to additional VRMA.

Who to copy with notice:

- Applicant Attorney (if any)

Enclosures / see regulation:

- Medical Report(s) (w/date)

VR POTENTIAL ELIGIBILITY & DELAY - 8 CCR §9813(a)(2)

The delay in provision of vocational rehabilitation services notice requirement is found in §9813(a)(2) and applies to all dates of injury through December 31, 2003. Complete all non-optional sections of the form. The model notice provides a selection of options for delay of services. Explain the reason for issing the notice by choosing Option 1 or Option 2 and delete the one not selected. Complete the sentence explaining the reason for delay and delete the alternate choices. Provide an expected date of determination. If information needed is not received by the expected date of determination, a subsequent delay of benefits must issue. The subsequent delay has the same information requirements as the initial delay.

Situtations that require a Notice of Potential Eligibility:

- Physician determination of medical eligibility for vocational rehabilitation.
- 365 days of aggregate temporary total disability (TTD) has occurred, <u>and</u> a prior Notice of Potential Eligibility has not been sent.

Labor Code §4637 requires that the notice include instructions as to how the employee may apply for vocational rehabilitation services. Accordingly, the Vocational Rehabilitation Reply

Form must be enclosed with the Notice of Potential Eligibility, even when there is a delay in determining whether there will be an offer of vocational rehabilitation services. (Instructions for VR Reply form and a model form are provided in this section.)

Labor Code §4636(d) requires that for injuries occurring in 1990 or after, the employee must be provided with the treating physician's final medical report together with notice of the procedures for contesting the treating physician's determination.

Title 8, CCR §10125.1(c) requires that "...the maintenance allowance payable during any delay caused by the employer or claims administrator shall be paid to the injured worker at the temporary disability rate...."

Title 8 CCR §10133.2 provides the language for the "Help in Returning to Work" pamphlet. Other enclosures as required.

When to send:

First: Within 10 days after the employee requested vocational rehabilitation services.

Subsequent: Not later than the date specified in the previous notice.

Who to copy with notice:

- Applicant Attorney (if any)

Enclosures / see regulation:

- Vocational Rehabilitation Reply form
- Help in Returning to Work pamphlet (w/Rev.date)
- Medical Report(s) (w/date)

VOCATIONAL REHABILITATION REPLY FORM

Instructions for completing the form.

Complete the Section 9810(c) language (employee, mailing address, etc.). Insert name of claims examiner / individual to whom the Reply should be directed.

When to send: Together with each Notice of Potential Eligibility.

- Notice of Potential Eligibility and Delay of Vocational Rehabilitation
- Subsequent Notice of Potential Eligibility and Delay of Vocational Rehabilitation
- Notice of Potential Eligibility for Vocational Rehabilitation
- Reminder Notice of Potential Eligibility for Vocational Rehabilitation

VR DENIAL - 8 CCR §9813(a)(3)

The denial of vocational rehabilitation services notice requirement are found in §9813(a)(3) and applies to all dates of injury through December 31, 2003. Complete all non-optional sections of the form. The model notice provides a selection of options for denial of services. Explain the reason for issing the notice by choosing the best option(s) and delete the ones not selected. Provide a clear explanation for the denial of benefits. Avoid the use of acronyms or Labor Code/Regulation citation without explanation of their meaning and how they apply to the decision to deny the benefits.

When to send:

- Within 10 days after the employee requested vocational rehabilitation services.
- Within 10 days of receipt of the treating physician's final report (after 90 days of aggregate TTD) determining that the employee is medically ineligible for VR services.
- Within 10 days of receipt of a document on which the claims administrator relies when determining the employee is not eligible for vocational rehabilitation services.

Who to copy with notice:

- Applicant Attorney (if any)

Enclosures / see regulation:

- DWC Fact Sheet E – QME/AME (w/Rev.date)
- Medical Report(s) (w/date)
- Request for Dispute Resolution (RU-103)
- Help in Returning to Work pamphlet (w/Rev. date)
- Other (describe)

VR INTERRUPTION / DEFERRAL - 8 CCR §9813(a)(4)

The interruption or deferral of vocational rehabilitation services notice requirement are found in §9813(a)(4) and applies to all dates of injury through December 31, 2003. The model notice provides required and optional language.

Instructions for completing the form: Complete all non-optional sections of the form. Complete the dates and the explanation for the interruption or deferral of services. Insert the latest date for resumption of benefits. Complete/delete the next three options as appropriate to this notice. Note that the second option in this section may be used with a subsequent interruption or deferral.

If VRMA payments will terminate, complete the final optional section. This may be used instead of the ending notice of VRMA. If any VRMA was paid at the TD rate while the employer or claims administrator determined eligibility for VR benefits that amount should be listed separately.

When to send:

- **First:** Within 10 days after agreeing to interrupt or defer VR services.
- **Subsequent:** Within 10 days after agreeing to a new or extended interruption or deferral of VR services.

Who to copy with notice:

- Applicant Attorney (if any)

Enclosures / see regulation

- Vocational Rehabilitation Reinstatement Request form
- Payment record
- Other (describe)

VOCATIONAL REHABILITATION REINSTATEMENT REQUEST

Instructions for completing the form.

Complete the Section 9810(c) language (employee, mailing address, etc.). Insert name of claims examiner / individual to whom the Reinstatement Request should be directed.

When to send: Together with each Interruption or Deferral of VR Services.

- Notice of Interruption or Deferral of Vocational Rehabilitation Services
- Subsequent Notice of Interruption or Deferral of Vocational Rehabilitation Services

VR RESUME - 8 CCR §9812(b)
The resumption requirements of §9812(b) apply to all dates of injury through 12/31/2003. If the notice is to advise the employee that vocational rehabilitation maintenance allowance (VRMA) payments are resuming the requirements are in §9812(b). The model notice for start of VRMA payments includes resumption of benefits.

VR CHANGE - 8 CCR §9812(c)
The change requirements of §9812(c) apply to all dates of injury through 12/31/2003. If the notice is to advise the employee that vocational rehabilitation maintenance allowance (VRMA) payments are changing the rate, amount, or scheduled day the requirements are in §9812(c).

VR TERMINATION - 8 CCR §9812(d)
The termination requirements of §9812(d) apply to all dates of injury through 12/31/2003. If the notice is to advise the employee that vocational rehabilitation maintenance allowance (VRMA) payments are ending the requirements are in §9812(d).

Option: If any VRMA is paid at the TD rate (VRTD) because of a delay in providing vocational rehabilitation services which was caused by the employer or the claims administrator, that rate and amount should be listed separately to comply with the requirement to list the dates and amounts of any related penalties. Note that VRTD payments are not part of the $16,000 cap.

NOTE: 8 CCR §10131 Prior to termination of VR, a "Request for Termination of Rehabilitation Benefits" (RU-105) for dates of injury on or after January 1, 1990 must be sent within 10 days of the circumstances set forth in Labor Code section 4644(a).

The model notices presented are in compliance with the benefit notice regulations for dates of injury January 1, 1994 through December 31, 2003. [§9813(d)].

VR 90 AGGREGATE DAYS OF TD - 8 CCR §9813(d)(1)

These notice requirements are found in §9813(d)(1) for dates of injury January 1, 1994 through December 31, 2003. They provide direction for the notice of potential eligibility for vocational rehabilitation services after 90 aggregate days of temporary temporary disability have occurred.

Instructions for completing the form: Complete all non-optional sections of the form. Select and complete the options and delete any option(s) not applicable to the notice.

When to send:

- Within 10 days after the 90th day of aggregate temporary total disability..

Who to copy with notice:

- Applicant Attorney (if any)

Enclosures / see regulation

- Help In Returning to Work pamphlet (w/Rev.date)
- Other (describe)

VR NOTICE OF POTENTIAL ELIGIBILITY - 8 CCR §9813(d)(2)

For dates of injury January 1, 1994 through December 31, 2003, the offer of vocational rehabilitation services notice requirement is found in §9813(d)(2). The model notice provides a selection of options for offer of services. Complete all non-optional sections of the form. Complete/delete the next three options as appropriate to this offer of VR services. Choose one of the options regarding returning to work with the employer. Delete the other option. Insert the date by which the employee must request the VR services.

Situtations that require a Notice of Potential Eligibility:

- Physician determination of medical eligibility for vocational rehabilitation.
- 365 days of aggregate temporary total disability (TTD) has occurred, <u>and</u> a prior Notice of Potential Eligibility has not been sent.

Labor Code §4637 requires that the notice include instructions as to how the employee may apply for vocational rehabilitation services. Accordingly, the Vocational Rehabilitation Reply Form must be enclosed with the Notice of Potential Eligibility, even when there is a delay in determining whether there will be an offer of vocational rehabilitation services. (Instructions for VR Reply form and a model form are provided in this section.)

Labor Code §4636(d) requires that for injuries occurring in 1990 or after, the employee must be provided with the treating physician's final medical report together with notice of the procedures for contesting the treating physician's determination.

Title 8, CCR §10125.1(c) requires that "...the maintenance allowance payable during any delay caused by the employer or claims administrator shall be paid to the injured worker at the temporary disability rate...."

Title 8 CCR §10133.2 provides the language for the "Help in Returning to Work" pamphlet. Other enclosures as required.

When to send:

- Within 10 days after a physician determines the employee is medically eligible for vocational rehabilitation services.
- Within 10 days after the 365th day of aggregate temporary total disability, if a NOPE has not already issued.
- Within 10 days of the claims administrator's determination to offer undisputed VR services.

Who to copy with notice:

- Applicant Attorney (if any)

Enclosures / see regulation:

- Vocational Rehabilitation Reply form
- Help in Returning to Work pamphlet (w/Rev.date)
- Medical Report(s) (w/date)
- Notice of Offer of Modified or Alternate Work (RU-94)
- Request for Dispute Resolution (RU-103)
- Other (describe)

VOCATIONAL REHABILITATION REPLY FORM

Instructions for completing the form.

Complete the Section 9810(c) language (employee, mailing address, etc.). Insert name of claims examiner / individual to whom the Reply should be directed.

When to send: Together with each Notice of Potential Eligibility.

- Notice of Potential Eligibility and Delay of Vocational Rehabilitation
- Subsequent Notice of Potential Eligibility and Delay of Vocational Rehabilitation
- Notice of Potential Eligibility for Vocational Rehabilitation
- Reminder Notice of Potential Eligibility for Vocational Rehabilitation

VR REMINDER NOTICE OF POTENTIAL ELIGIBILITY - 8 CCR §9813(d)(3)

For dates of injury January 1, 1994 through December 31, 2003, the reminder of the offer of vocational rehabilitation services notice requirement is found in §9813(d)(3). The model notice provides a selection of options for offer of services. Complete all non-optional sections of the form. Complete/delete the next three options as appropriate to this offer of VR services. Choose one of the options regarding returning to work with the employer. Delete the other option. Insert the date by which the employee must request the VR services.

Situtations that require a Notice of Potential Eligibility:

- Physician determination of medical eligibility for vocational rehabilitation.
- 365 days of aggregate temporary total disability (TTD) has occurred, and a prior Notice of Potential Eligibility has not been sent.

Special Requirement:
The reminder notice shall be sent by certified mail pursuant to Labor Code §4644(a)(4).

When to send:
- Not earlier than 45 days nor later than 70 days after the employee's receipt of the original Notice of Potential Eligibility.

Who to copy with notice:
- Applicant Attorney (if any)

Enclosures / see regulation:
- Vocational Rehabilitation Reply form
- Help in Returning to Work pamphlet (w/Rev.date)
- Medical Report(s) (w/date)
- Notice of Offer of Modified or Alternate Work (RU-94)
- Request for Dispute Resolution (RU-103)
- Other (describe)

VOCATIONAL REHABILITATION REPLY FORM

Instructions for completing the form.

Complete the Section 9810(c) language (employee, mailing address, etc.). Insert name of claims examiner / individual to whom the Reply should be directed.

When to send: Together with each Notice of Potential Eligibility.
- Notice of Potential Eligibility and Delay of Vocational Rehabilitation
- Subsequent Notice of Potential Eligibility and Delay of Vocational Rehabilitation
- Notice of Potential Eligibility for Vocational Rehabilitation
- Reminder Notice of Potential Eligibility for Vocational Rehabilitation

VR INTENTION TO WITHOLD MAINTENANCE ALLOWANCE FOR FAILURE TO COOPERATE - 8 CCR §9813(d)(4)

For dates of injury January 1, 1994 through December 31, 2003, the intention to withold VRMA for failure to cooperate notice requirement is found in §9813(d)(4). The model notice provides a paragraph to be completed that provides the date the last payment will issue, the explanation of reasons for termination of benefits, and an optional section if there is intention to assert credit. Complete all non-optional sections of the form.

When to send:
- Not later than 15 days before the final payment of VR maintenance allowance

Who to copy with notice:

- Applicant Attorney (if any)

Enclosures / see regulation:

- Request for Dispute Resolution (RU-103)
- Other (describe)

MODEL BENEFIT NOTICES

REGARDING

VOCATIONAL REHABILITATION

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING VOCATIONAL REHABILITATION BENEFITS

Option: **VR MAINTENANCE ALLOWANCE START / RESUME**

Option: **VR TEMPORARY DISABILITY START / RESUME**

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

Payments are ***(option)*** beginning/being resumed for vocational rehabilitation maintenance allowance (VRMA) or ***(option)*** temporary disability (VRTD) for the period from DATE through DATE. The payment is ***(option)*** enclosed/sent separately. Your weekly VRMA/VRTD rate is $ RATE based on your earnings of $ AVERAGE WEEKLY WAGE per week. Payments will be sent to you every two weeks on DAY OF THE WEEK and will continue until further notice.

PD Supplement Option 1: You indicated on DATE you wish to have permanent disability (PD) supplements added to your weekly VRMA rate. The amount of your weekly PD supplement will be $AMOUNT.

PD Supplement Option 2: Because you are entitled to permanent disability (PD) indemnity payments, you have the option of requesting a permanent disability supplement payment that will increase your weekly VRMA rate to the weekly amount you received with your temporary disability (TD) indemnity payments. Your weekly TD rate was $RATE. Should you choose this option, your weekly PD supplement will be $AMOUNT.

Attorney Fee Option: Your attorney has requested INSERT% be withheld from your weekly VRMA payment for attorney fees. Attorney fees at the weekly rate of $RATE will be deducted. Your weekly VRMA rate is $RATE.

If VRTD: PHYSICIAN NAME in the report of REPORT DATE determined your injury is permanent and stationary and because of your injury, you are not able to return to work. Further, you requested vocational rehabilitation services on DATE. A copy of the report is ***(option)*** enclosed/will be sent to you upon receipt. At this time, we are delaying provision of

vocational rehabilitation services because REASON FOR DELAY OF SERVICES. We expect to have this information by DATE. Until we have the information, vocational rehabilitation benefits will be provided to you at the temporary disability rate. The benefit is not part of the $16,000. limit for provision of vocational rehabilitation services.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (insert local I&A number).

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at:

http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to [**choose appropriate option(s)**] the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

cc: Applicant Attorney (if any)

Enc.: **As required by specific regulations**.

- Medical Report (w/date)
- Other

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee
Address
CityStateZip

Empleador:
Fecha de la lesión (accidente):
Número de reclamo:

AVISO SOBRE BENEFICIOS DE REHABILITACIÓN VOCACIONAL

Option: **COMENZAR / REASUMIR PAGOS DE PENSIÓN DE VR**

Option: **COMENZAR / REASUMIR PAGOS DE INCAPACIDAD TEMPORAL DE VR**

CLAIMS ADMINISTRATOR NAME está administrando su reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los beneficios de rehabilitación vocacional para su lesión de compensación de trabajadores de fecha indicada arriba.

Los pagos están ***(option)*** comenzando/siendo reasumidos para la pensión de rehabilitación vocacional (VRMA) o ***(option)*** incapacidad temporal (VRTD) para el período de DATE hasta DATE. El pago está ***(option)*** adjunto/enviado por separado. Su tasa de VRMA/VRTD es de $ RATE basada en sus ingresos de $ AVERAGE WEEKLY WAGE por semana. Pagos le serán enviados cada dos semanas en DAY OF THE WEEK y seguirán hasta nuevo aviso.

PD Supplement Option 1: Usted indicó en DATE que desea tener suplementos de incapacidad permanente (PD) añadidos a su tasa de VRMA semanal. La cantidad de su suplemento de PD semanal será de $AMOUNT.

PD Supplement Option 2: Como usted tiene derecho a los pagos de indemnización por incapacidad permanente (PD), usted tiene la opción de solicitar un pago suplemental de incapacidad permanente que aumentará su tasa semanal de VRMA a la cantidad semanal que usted recibió con sus pagos de indemnización por incapacidad temporal (TD). Su tasa semanal de TD fue $RATE. Si usted elige esta opción, su suplemento de PD semanal será $AMOUNT.

Attorney Fee Option: Su abogado ha solicitado que el INSERT% sea retenido de su pago de VRMA semanal para honorarios de abogado. Los honorarios de abogado a la tasa semanal de $RATE serán descontados. Su tasa semanal de VRMA es de $RATE.

If VRTD: PHYSICIAN NAME en el informe de REPORT DATE determinó que su lesión está permanente y estacionaria y debido a su lesión, usted no puede regresar a trabajar. Además, usted solicitó servicios de rehabilitación vocacional el DATE. Una copia del informe

está***(option)*** adjunto/le será enviado en cuanto se reciba. En este momento estamos demorando la provisión de servicios de rehabilitación vocacional porque REASON FOR DELAY OF SERVICES. Esperamos tener esta información para DATE. Hasta que tengamos la información, los beneficios de rehabilitación vocacional serán proporcionados a la tasa de incapacidad temporal. El beneficio no es parte del límite de $16,000 para la provisión de servicios de rehabilitación vocacional.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al (**insert local I&A number**).

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en:

http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.
Para resolver una disputa, usted puede hacer una solicitud a *[**choose appropriate option(s)**]* la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____

Examinador(a) de Reclamos

cc: Applicant Attorney (if any)

Adjunto: **As required by specific regulations**.

- Informe Médico (w/date)
- Otro

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING VOCATIONAL REHABILITATION BENEFITS

POTENTIAL ELIGIBILITY AND DELAY

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

Option 1: PHYSICIAN NAME in the report of REPORT DATE determined your injury is permanent and stationary and because of your injury, you are not able to return to your regular job duties. A copy of the report is ***(option)*** enclosed/will be sent to you upon receipt.

or

Option 2: You have been temporarily disabled for more than 365 days.

At this time, we are delaying provision of vocational rehabilitation services. In order to make a decision: ***(complete/delete option)***

- We need your treating doctor to make a determination regarding your ability to return to your regular job duties.
- We need clarification of the medical opinion regarding your eligibility for vocational rehabilitation benefits from PHYSICIAN NAME
- We need advice from your employer whether modified or alternative work is available for you. Your employer is attempting to identify a job that meets your work restrictions.
- Other

We expect to have this information by DATE. Enclosed is a vocational rehabilitation reply form. Please complete and return this form advising us of your interest in the potential vocational rehabilitation services.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (insert local I&A number).

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at:

http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to [**choose appropriate option(s)**] the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

cc: Applicant Attorney (if any)

Enc.: **As required by specific regulations**.

- Vocational Rehabilitation Reply Form
- Medical report (w/date)
- Help in Returning to Work pamphlet (w/Rev. date)
- Other

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee
Address
CityStateZip

Empleador:
Fecha de la lesión (accidente):
Número de reclamo:

AVISO SOBRE BENEFICIOS DE REHABILITACIÓN VOCACIONAL

ELEGIBILIDAD POTENCIAL Y DEMORA

CLAIMS ADMINISTRATOR NAME está administrando su reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los beneficios de rehabilitación vocacional para su lesión de compensación de trabajadores de fecha indicada arriba.

Option 1: PHYSICIAN NAME en el informe de REPORT DATE determinó que su lesión está permanente y estacionaria y debido a su lesión, usted no puede regresar a trabajar. Una copia del informe está***(option)*** adjunto/le será enviado en cuanto se reciba.

or

Option 2: Usted ha estado temporalmente incapacitado durante más de 365 días.

En este momento estamos demorando la provisión de servicios de rehabilitación vocacional. Para tomar una decisión: ***(complete/delete option)***

- Necesitamos que su médico que le está atendiendo haga una determinación con respecto a su capacidad de regresar a los deberes de su trabajo regular.
- Necesitamos la aclaración de la opinión médica de PHYSICIAN NAME con respecto a su elegibilidad para los beneficios de rehabilitación vocacional.
- Necesitamos consultar con su empleador sobre si tiene un trabajo modificado o alternativo disponible para usted. Su empleador está procurando identificar un trabajo que cumpla con sus restricciones de trabajo.
- Other

Esperamos tener esta información para DATE. Adjunto está un formulario de respuesta para servicios de rehabilitación vocacional. Por favor, rellene y devuelva este formulario para informarnos de su interés en los servicios potenciales de rehabilitación.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al (**insert local I&A number**).

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en:

http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.
Para resolver una disputa, usted puede hacer una solicitud a ***[choose appropriate option(s)]*** la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____

Examinador(a) de Reclamos

cc: Applicant Attorney (if any)

Adjunto: **As required by specific regulations**.

- Formulario de Respuesta para Servicios de Rehabilitación Vocacional
- Informe Médico (w/date)
- Folleto *Ayuda a Regresar al Trabajo* (w/Rev. date)
- Otro

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING VOCATIONAL REHABILITATION BENEFITS

POTENTIAL ELIGIBILITY AND SUBSEQUENT DELAY

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

On DATE a notice issued advising that you may be eligible for vocational rehabilitation services because ***(option)*** a physician has determined you are medically eligible for vocational rehabilitation services ***(or)*** you have been temporarily disabled for more than 365 days however we are delaying provision of those services. In order to make a decision, we need EXPLANATION OF DELAY. We have not received the necessary information and are extending the determination date to DATE. I will notify you of the status of provision of services at that time.

Enclosed is a vocational rehabilitation reply form. If you have not responded to us regarding your interest in potential vocational rehabilitation services, please complete and return this form.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (insert local I&A number).

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at:

http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you

might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to [**choose appropriate option(s)**] the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

cc: Applicant Attorney (if any)

Enc.: **As required by specific regulations**.

- Vocational Rehabilitation Reply Form
- Help in Returning to Work pamphlet (w/Rev. date)

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee
Address
CityStateZip

Empleador:
Fecha de la lesión (accidente):
Número de reclamo:

AVISO SOBRE BENEFICIOS DE REHABILITACIÓN VOCACIONAL

ELEGIBILIDAD POTENCIAL Y DEMORA SUBSECUENTE

CLAIMS ADMINISTRATOR NAME está administrando su reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los beneficios de rehabilitación vocacional para su lesión de compensación de trabajadores de fecha indicada arriba.

En DATE un aviso fue enviado informandole que usted puede ser elegible para servicios de rehabilitación vocacional porque ***(option)*** un médico ha determinado que usted está médicamente elegible para servicios de rehabilitación vocacional ***(or)*** usted ha estado temporalmente incapacitado durante más de 365 días sin embargo estamos demorando la provisión de aquellos servicios. Para tomar una decisión, necesitamos EXPLANATION OF DELAY. No hemos recibido la información necesaria y estamos extendiendo la fecha de determinación a DATE. Le notificaré del estado de provisión de servicios entonces.

Adjunto está un formulario de respuesta para servicios de rehabilitación vocacional. Si usted no nos ha respondido con respecto a su interés a los servicios potenciales de rehabilitación vocacional, por favor rellene y devuelva este formulario.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al **(insert local I&A number)**.

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en:

http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.
Para resolver una disputa, usted puede hacer una solicitud a ***[choose appropriate option(s)]*** la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____
Examinador(a) de Reclamos

cc: Applicant Attorney (if any)

Adjunto: **As required by specific regulations**.

- Formulario de Respuesta para Servicios de Rehabilitación Vocacional
- Folleto *Ayuda a Regresar al Trabajo* (w/Rev. date)

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING VOCATIONAL REHABILITATION BENEFITS

DENIAL

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

After careful consideration of all available information, we conclude that you are not eligible for vocational rehabilitation services at this time. Our decision is based upon the following:

Complete/delete as appropriate:

- You returned to your regular job duties on DATE.
- Your treating doctor reports that you are able to return to your regular job duties. A copy of this report ***(Option)*** is enclosed / will be sent to you as soon as it is received.
- On the basis of EXPLANATION we dispute the findings of your treating doctor who reported that you need vocational rehabilitation. You are entitled to vocational rehabilitation maintenance allowance payments until this dispute is resolved.
- We dispute the findings of PHYSICIAN because EXPLANATION OF DISPUTED ISSUE(S).
- There is no medical evidence available to support your request for vocational rehabilitation services.
- You are not able to benefit from vocational rehabilitation services based on EXPLANATION OF NON-PROVISION OF SERVICES.
- Other:

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your

attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (insert local I&A number).

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at:

http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to [**choose appropriate option(s)**] the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

cc: Applicant Attorney (if any)

Enc.: **As required by specific regulations**.

- DWC fact sheet E – QME/AME (w/Rev. date)
- Medical report (w/date)
- Request for Dispute Resolution (RU-103)
- Help in Returning to Work pamphlet (w/Rev. date)
- Other

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee **Empleador:**
Address **Fecha de la lesión (accidente):**
CityStateZip **Número de reclamo:**

AVISO SOBRE BENEFICIOS DE REHABILITACIÓN VOCACIONAL

NEGACIÓN

CLAIMS ADMINISTRATOR NAME está administrando su reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los beneficios de rehabilitación vocacional para su lesión de compensación de trabajadores de fecha indicada arriba.

Después de la deliberación de toda la información disponible, negamos la responsabilidad de su reclamo para servicios de rehabilitación vocacional en este momento. Nuestra decisión está basada sobre lo siguiente:

Complete/delete as appropriate:

- Usted regresó a los deberes de su trabajo regular el DATE.
- El médico que le está atendiendo indica que usted puede regresar a los deberes de su trabajo regular. Una copia de este informe ***(Option)*** está adjunto / le será enviado tan pronto sea recibido.
- En base a EXPLANATION disputamos las conclusiones de su médico que le está atendiendo que informó que usted necesita rehabilitación vocacional. Usted tiene derecho a pagos de pensión de rehabilitación vocacional hasta que esta disputa sea resuelta.
- Disputamos las conclusiones de PHYSICIAN porque EXPLANATION OF DISPUTED ISSUE(S).
- No hay ninguna evidencia médica disponible para sostener su petición para servicios de rehabilitación vocacional .
- Usted no puede beneficiarse de los servicios de rehabilitación vocacional según EXPLANATION OF NON-PROVISION OF SERVICES.
- Other:

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al **(insert local I&A number)**.

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en:

http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.
Para resolver una disputa, usted puede hacer una solicitud a ***[choose appropriate option(s)]*** la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____

Examinador(a) de Reclamos

cc: Applicant Attorney (if any)

Adjunto: **As required by specific regulations**.

- DWC Hoja de Información E – QME/AME (w/Rev. date)
- Informe médico (w/date)
- Petición para Resolución de Disputa (RU-103)
- Folleto *Ayuda a Regresar al Trabajo* (w/Rev. date)
- Otro

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE OF INTERRUPTION OR DEFERRAL

OF VOCATIONAL REHABILITATION SERVICES

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

This letter documents our agreement to interrupt or defer vocational rehabilitation services from DATE to DATE**.** The reason for this agreement is EXPLANATION.

To start or resume vocational rehabilitation services, you or your attorney, if you have one, must contact me no later than DATE by calling me or returning the enclosed vocational rehabilitation reinstatement request form.

We will not reinstate services unless you contact us. According to state law, you have **five (5)** years from the date of injury to request additional rehabilitation services. Failure to request additional services within this five year period will likely terminate your right to vocational rehabilitation.

The items below also affect your rights to vocational rehabilitation.

Complete / delete as appropriate:

- We have agreed to interrupt your vocational rehabilitation plan which must be completed within 18 months of approval. You must resume services no later than DATE to complete your plan.
- We have agreed to an interruption that extends beyond the five (5) year time limit. If you do not request services by the deadline date shown above, your rights to vocational rehabilitation will likely end.
- Your vocational rehabilitation maintenance allowance (VRMA) payments will stop as of DATE.

Benefits paid to you total $ AMOUNT and were paid from DATE through DATE at $ VRMA RATE per week.

Complete / delete as appropriate:

- Please see the attached payment record for periods paid.
- Additionally, permanent disability supplements totaling $ AMOUNT have been paid.
- Included in this amount is an overpayment totaling $ AMOUNT. We assert credit for the overpayment against EXPLANATION OF INTENTION.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (insert local I&A number).

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at:

http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to [**choose appropriate option(s)**] the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

cc: Applicant Attorney (if any)

Enc.: **As required by specific regulations**.

- Vocational Rehabilitation Reinstatement Request
- Payment Record
- Other

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee
Address
CityStateZip

Empleador:
Fecha de la lesión (accidente):
Número de reclamo:

AVISO DE INTERRUPCIÓN O APLAZAMIENTO DE SERVICIOS DE REHABILITACIÓN VOCACIONAL

CLAIMS ADMINISTRATOR NAME está administrando su reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los beneficios de rehabilitación vocacional para su lesión de compensación de trabajadores de fecha indicada arriba.

Esta carta documenta nuestro acuerdo para interrumpir o aplazar servicios de rehabilitación vocacional desde DATE a DATE. La razón por este acuerdo es EXPLANATION.

Para comenzar o reasumir los servicios de rehabilitación vocacional, usted o su abogado, si usted tiene uno, debe ponerse en contacto conmigo no más tarde que DATE llamándome o devolviendo la petición para el restablecimiento de rehabilitación vocacional que está adjunto.

No restableceremos servicios a menos que usted se ponga en contacto con nosotros. Según la ley estatal, usted tiene cinco (5) años a partir de la fecha de lesión para solicitar servicios de rehabilitación adicionales. La falta de solicitar servicios adicionales dentro de este período de cinco años probablemente terminará su derecho a la rehabilitación vocacional.

Lo siguente también afecta sus derechos a la rehabilitación vocacional.

Complete / delete as appropriate:

- Hemos acordado en interrumpir su plan de rehabilitación vocacional que debe ser completado 18 meses después de la aprobación. Usted debe reasumir los servicios no más tarde que DATE para completar su plan.
- Hemos acordado con una interrupción que se extiende más allá del límite de tiempo de cinco (5) años. Si usted no solicita servicios dentro del plazo indicado arriba, sus derechos a la rehabilitación vocacional probablemente se terminarán.
- Sus pagos por pensión de rehabilitación vocacional (VRMA) terminarán DATE.

Los beneficios pagados a usted totalizan $ AMOUNT y fueron pagados del DATE hasta DATE a $ VRMA RATE por semana.

Complete / delete as appropriate:

- Por favor vea el registro de pago adjunto para períodos pagados.
- Adicionalmente, suplementos de incapacidad permanente que totalizan $ AMOUNT han sido pagados.
- Incluido en esta cantidad está un pago excesivo totalizando $ AMOUNT. Afirmamos un crédito del pago excesivo contra EXPLANATION OF INTENTION.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al **(insert local I&A number)**.

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en:

http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.
Para resolver una disputa, usted puede hacer una solicitud a *[**choose appropriate option(s)**]* la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____

Examinador(a) de Reclamos

cc: Applicant Attorney (if any)

Adjunto: **As required by specific regulations**.

- Petición para el Restablecimiento de Rehabilitación Vocacional
- Registro de Pago
- Otro

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

VOCATIONAL REHABILITATION REINSTATEMENT REQUEST

DIRECTIONS: Complete the information at the bottom of the form. When this form is completed, return it to the address noted above to the attention of your claims examiner, NAME OF CLAIMS EXAMINER.

I am ready to resume vocational rehabilitation services.

Complete the following prior to returning this form.

SIGNATURE		
REQUEST DATE		TELEPHONE
MAILING ADDRESS		

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Employee	**Empleador:**
Address	**Fecha de la lesión (accidente):**
CityStateZip	**Número de reclamo:**

PETICIÓN PARA EL RESTABLECIMIENTO DE REHABILITACIÓN VOCACIONAL

INSTRUCCIONES: Rellene el fondo del formulario. Cuando este formulario sea completado, devuelvalo a la dirección indicada arriba a la atención de su examinador de reclamos, NAME OF CLAIMS EXAMINER.

Estoy listo(a) para reasumir los servicios de rehabilitación vocacional.

Rellene lo siguiente antes de regresar este formulario. NOTE WHEN PRINTED THE "O" AT THE END OF TELÉFONO DROPS TO THE LINE BELOW

FIRMA		
FECHA DE PETICIÓN		TELÉFONO
DIRECCIÓN POSTAL		

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING VOCATIONAL REHABILITATION BENEFITS

90 DAYS OF TOTAL DISABILITY

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

Since you have been off work for more than 90 days, under California law you have potential rights to vocational rehabilitation benefits. You may be eligible for these benefits if you are unable to return to your regular job duties.

A job description, agreed to by you and your employer, must be submitted to your treating physician to help determine your ability to return to your regular duties. You will be notified of your physician's decision. Your prompt response and cooperation is needed to assist us in providing appropriate benefits.

Complete/delete as appropriate:

- You will soon be contacted by NAME/COMPANY to explain your potential eligibility for vocational rehabilitation services and to obtain information regarding your job duties.
- Enclosed is a blank job description form Explanation of Employee's Job Duties (RU-91). Please complete and return the form to us as soon as possible.
- Your employer completed the enclosed job description Explanation of Employee's Job Duties (RU-91). Please review the job description, make any corrections that need to be made, and return the form to us as soon as possible.

Enclosed is a pamphlet for your review explaining the vocational rehabilitation benefits that may be available. Please read it carefully.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and***

telephone number). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (insert local I&A number).

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at:

http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to [**choose appropriate option(s)**] the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

cc: Applicant Attorney (if any)

Enc.: **As required by specific regulations**.

- Help in Returning to Work pamphlet (w/Rev. date)
- Explanation of Employee's Job Duties (RU-91)
- Other

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee
Address
CityStateZip

Empleador:
Fecha de la lesión (accidente):
Número de reclamo:

AVISO SOBRE BENEFICIOS DE REHABILITACIÓN VOCACIONAL

90 DÍAS DE INCAPACIDAD TOTAL

CLAIMS ADMINISTRATOR NAME está administrando su reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los beneficios de rehabilitación vocacional para su lesión de compensación de trabajadores de fecha indicada arriba.

Puesto que usted ha estado fuera del trabajo durante más de 90 días, conforme a la ley de California usted tiene derechos potenciales a beneficios de rehabilitación vocacional. Usted puede ser elegible para estos beneficios si usted no puede regresar a los deberes de su trabajo regular.

Una descripción de trabajo, acordada por usted y su empleador, debe ser presentada a su médico que lo está atendiendo para ayudar a determinar su capacidad de regresar a sus deberes regulares. Usted será notificado de la decisión de su médico. Su respuesta rápida y cooperación son necesarias para asistirnos en proveer los beneficios apropiados.

Complete/delete as appropriate:

- Usted pronto será contactado por NAME/COMPANY para explicarle su elegibilidad potencial para servicios de rehabilitación vocacional y para obtener información con respecto a sus deberes de trabajo.
- Adjunto está un formulario de descripción de trabajo en blanco Explicación de los Deberes de Trabajo del Empleado (Explanation of Employee's Job Duties) (RU-91). Por favor rellene y devuélvanos el formulario cuanto antes.
- Su empleador completó la descripción de trabajo adjunto Explicación de los Deberes de Trabajo del Empleado (Explanation of Employee's Job Duties) (RU-91). Por favor revise la descripción de trabajo, haga cualquier corrección que tenga que ser hecha, y regresenos el formulario cuanto antes.

Adjunto está un folleto para su revisión que explica los beneficios de rehabilitación vocacional que pueden estar disponibles. Por favor léalo detenidamente.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al **(insert local I&A number)**.

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en:

http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.
Para resolver una disputa, usted puede hacer una solicitud a ***[choose appropriate option(s)]*** la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____

Examinador(a) de Reclamos

cc: Applicant Attorney (if any)

Adjunto: **As required by specific regulations**.

- Folleto *Ayuda a Regresar al Trabajo* (w/Rev. date)
- Explicación de los Deberes de Trabajo do Empleado (RU-91)
- Otro

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING VOCATIONAL REHABILITATION BENEFITS

POTENTIAL ELIGIBILITY

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

We are advising you that you may be eligible for vocational rehabilitation benefits.

Complete/delete as appropriate

- PHYSICIAN reports that you cannot return to your regular job duties. A copy of the report ***(option)*** is enclosed/will be sent to you when it is received.
- You have been totally temporarily disabled for more than 365 days.
- We have determined that your medical condition will prevent return to your regular job duties.

Complete/delete as appropriate

- Your employer has a job for you that meets your work restrictions. You will be contacted with more information about this job soon.
- Your employer does not have a job available within your work restrictions.

Please let us know if you wish to participate in vocational rehabilitation by returning the enclosed Vocational Rehabilitation Reply form as soon as possible, but **no later than 90 days** from the date you receive this letter. If you choose to participate in vocational rehabilitation services:

1. You have the right to participate in selecting a vocational counselor who will assist you with your vocational rehabilitation.
2. You have the right to request an evaluation to help you decide whether you will benefit from vocational rehabilitation services. If your injury occurred on or after 1/1/94, the fees for this evaluation will be paid from the $4,500 maximum allowed for counselor fees.

3. You will be eligible to receive benefit payments as described in the enclosed pamphlet. You should read this pamphlet carefully.

The time period for you to request vocational rehabilitation services is limited. If you do not advise this office by DATE you could lose all rights to the vocational rehabilitation benefit.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (insert local I&A number).

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at:

http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to [**choose appropriate option(s)**] the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

cc: Applicant Attorney (if any)

Enc.: **Enclose/delete as required by specific regulations**,

- Vocational Rehabilitation Reply form
- Help in Returning to Work pamphlet (w/Rev. date)
- Medical Report (w/date)
- Notice of Offer of Modified or Alternate Work (RU-94)
- Request for Dispute Resolution (RU-103)
- Other

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee
Address
CityStateZip

Empleador:
Fecha de la lesión (accidente):
Número de reclamo:

AVISO SOBRE BENEFICIOS DE REHABILITACIÓN VOCACIONAL

ELEGIBILIDAD POTENCIAL

CLAIMS ADMINISTRATOR NAME está administrando su reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los beneficios de rehabilitación vocacional para su lesión de compensación de trabajadores de fecha indicada arriba.

Le estamos informando que usted puede ser elegible para beneficios de rehabilitación vocacional.

Complete/delete as appropriate

- PHYSICIAN indica que usted no puede regresar a los deberes de su trabajo regular. Una copia de este informe ***(option)*** está adjunto/le será enviado tan pronto sea recibido.
- Usted ha estado temporalmente incapacitado durante más de 365 días.
- Hemos determinado que su condición médica impedirá el regreso a los deberes de su trabajo regular.

Complete/delete as appropriate

- Su empleador tiene un trabajo para usted que satisface sus restricciones de trabajo. Usted será contactado pronto con más información sobre este trabajo.
- Su empleador no tiene un trabajo disponible dentro de sus restricciones de trabajo.

Por favor avísenos si usted desea participar en rehabilitación vocacional devolviendo cuanto antes el formulario de Respuesta de Rehabilitación Vocacional adjunto, pero **no más tarde que 90 días** a partir de la fecha que usted recibe esta carta. Si usted decide participar en los servicios de rehabilitación vocacional:

1. Usted tiene el derecho de participar en la selección de un consejero vocacional que le asistirá con su rehabilitación vocacional.
2. Usted tiene el derecho de solicitar una evaluación para ayudarle a decidir si usted se beneficiará de los servicios de rehabilitación vocacional. Si su lesión ocurrió en o después del 1/1/94, los honorarios de esta evaluación serán pagados del máximo de 4,500 dólares permitido para los honorarios de consejero.

3. Usted será elegible para recibir pagos de beneficios como descrito en el folleto adjunto. Usted debería leer este folleto detenidamente.

El período de tiempo para que usted solicite servicios de rehabilitación vocacional está limitado. Si usted no informa a esta oficina para el DATE usted podría perder todos los derechos al beneficio de rehabilitación vocacional.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al **(insert local I&A number)**.

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en:

http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.
Para resolver una disputa, usted puede hacer una solicitud a ***[choose appropriate option(s)]*** la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____

Examinador(a) de Reclamos

cc: Applicant Attorney (if any)

Adjunto: **Enclose/delete as required by specific regulations**,

- Formulario de Respuesta para Servicios de Rehabilitación Vocacional
- Folleto *Ayuda a Regresar al Trabajo* (w/Rev. date)
- Informe Médico (w/date)
- Aviso de Oferta de Trabajo Modificado o Alternativo (RU-94)
- Petición para Resolución de Disputa (RU-103)
- Otro

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date
Certified Mail Receipt #: _____

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING VOCATIONAL REHABILITATION BENEFITS

REMINDER OF POTENTIAL ELIGIBILITY

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

On DATE, a Notice of Potential Eligibility issued to your attention. As we have received no response to our initial Notice, we are reminding you that you may be eligible for vocational rehabilitation benefits.

Complete/delete as appropriate

- PHYSICIAN/COMPANY reports that you cannot return to your regular job duties. A copy of the report ***(option)*** is enclosed/will be sent to you when it is received.
- You have been totally temporarily disabled for more than 365 days.
- We have determined that your medical condition will prevent return to your regular job duties.

Complete/delete as appropriate

- Your employer has a job for you that meets your work restrictions. You ***(option)*** will be/have been contacted with more information about this job.
- Your employer does not have a job available within your work restrictions.

Please let us know if you wish to participate in vocational rehabilitation by returning the enclosed Vocational Rehabilitation Reply form as soon as possible. **You have no more than 90 days from the date of receipt of our first Notice to respond**. If you choose to participate in vocational rehabilitation services:

1. You have the right to participate in selecting a vocational counselor who will assist you with your vocational rehabilitation.
2. You have the right to request an evaluation to help you decide whether you will benefit from vocational rehabilitation services. If your injury occurred on or after 1/1/94, the fees for this evaluation will be paid from the $4,500 maximum allowed for counselor fees.

3. You will be eligible to receive benefit payments as described in the enclosed pamphlet. You should read this pamphlet carefully.

The time period for you to request vocational rehabilitation services is limited. If you do not advise this office by DATE you could lose all rights to the vocational rehabilitation benefit.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (insert local I&A number).

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at:

http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to [**choose appropriate option(s)**] the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

cc: Applicant Attorney (if any)

Enc.: **As required by specific regulations**.

- Vocational Rehabilitation Reply form
- Help in Returning to Work pamphlet (w/Rev. date)
- Medical Report (w/date)
- Notice of Offer of Modified or Alternate Work (RU-94)
- Request for Dispute Resolution (RU-103)
- Other

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date
Certified Mail Receipt #: _____

Employee **Empleador:**
Address **Fecha de la lesión (accidente):**
CityStateZip **Número de reclamo:**

AVISO SOBRE BENEFICIOS DE REHABILITACIÓN VOCACIONAL

RECORDATORIO DE ELEGIBILIDAD POTENCIAL

CLAIMS ADMINISTRATOR NAME está administrando su reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los beneficios de rehabilitación vocacional para su lesión de compensación de trabajadores de fecha indicada arriba.

El DATE, un Aviso de Elegibilidad Potencial fue enviado para su atención. Como no hemos recibido ninguna respuesta a nuestro Aviso inicial, le recordamos que usted puede ser elegible para beneficios de rehabilitación vocacional.

Complete/delete as appropriate

- PHYSICIAN/COMPANY indica que usted no puede regresar a los deberes de su trabajo regular. Una copia de este informe ***(option)*** está adjunto/le será enviado tan pronto sea recibido.
- Usted ha estado temporalmente incapacitado durante más de 365 días.
- Hemos determinado que su condición médica impedirá el regreso a los deberes de su trabajo regular.

Complete/delete as appropriate

- Su empleador tiene un trabajo para usted que satisface sus restricciones de trabajo. Usted ***(option)*** será/ ha sido contactado con más información sobre este trabajo.
- Su empleador no tiene un trabajo disponible dentro de sus restricciones de trabajo.

Por favor avísenos si usted desea participar en rehabilitación vocacional devolviendo cuanto antes el formulario de Respuesta de Rehabilitación Vocacional adjunto. **Usted tiene no más de 90 días a partir de la fecha que recibio nuestro primer Aviso para responder**. Si usted decide participar en los servicios de rehabilitación vocacional:

1. Usted tiene el derecho de participar en la selección de un consejero vocacional que le asistirá con su rehabilitación vocacional.
2. Usted tiene el derecho de solicitar una evaluación para ayudarle a decidir si usted se beneficiará de los servicios de rehabilitación vocacional. Si su lesión ocurrió en o después

del 1/1/94, los honorarios de esta evaluación serán pagados del máximo de 4,500 dólares permitido para los honorarios de consejero.

3. Usted será elegible para recibir pagos de beneficios como descrito en el folleto adjunto. Usted debería leer este folleto detenidamente.

El período de tiempo para que usted solicite servicios de rehabilitación vocacional está limitado. Si usted no informa a esta oficina para el DATE usted podría perder todos los derechos al beneficio de rehabilitación vocacional.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al (**insert local I&A number**).

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en:

http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.
Para resolver una disputa, usted puede hacer una solicitud a [***choose appropriate option(s)***] la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____

Examinador(a) de Reclamos

cc: Applicant Attorney (if any)

Adjunto: **As required by specific regulations**.

- Formulario de Respuesta para Servicios de Rehabilitación Vocacional
- Folleto *Ayuda a Regresar al Trabajo* (w/Rev. date)
- Informe Médico (w/date)
- Aviso de Oferta de Trabajo Modificado o Alternativo (RU-94)
- Petición para Resolución de Disputa (RU-103)
- Otro

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING VOCATIONAL REHABILITATION BENEFITS

INTENTION TO WITHOLD MAINTENANCE ALLOWANCE FOR FAILURE TO COOPERATE

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

We intend to stop payments of vocational rehabilitation maintenance allowance. We will stop these payments on DATE because you have unreasonably failed to participate in vocational rehabilitation services by EXPLANATION OF REASONS FOR INTENTION TO TERMINATE VRMA BENEFITS. ***Option:*** We intend to assert a credit against future benefits in the amount of $ AMOUNT for the period from DATE through DATE.

If you disagree with this decision, you may request a conference with the State Division of Workers' Compensation Retraining and Return to Work Unit to resolve this dispute. YOU HAVE TEN (10) DAYS FROM THE DATE YOU RECEIVE THIS NOTICE TO MAKE THIS REQUEST.

Enclosed is a Request for Dispute Resolution (DWC-RU-103) which is used to request a conference. There are instructions for completion at the top of the form. The completed form should be sent to the nearest State Division of Workers' Compensation Retraining and Return to Work Unit.

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

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call: (***insert adjuster's name and telephone number***). However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (insert local I&A number).

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at:

http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to [**choose appropriate option(s)**] the Workers' Compensation Appeals Board, the Vocational Rehabilitation Unit, or the Administrative Director.

Sincerely,

_____

Claims Examiner

cc: Applicant Attorney (if any)

Enc.: **As required by specific regulations**.

- Help in Returning to Work pamphlet (w/Rev. date)
- Request for Dispute Resolution (DWC-RU-103)

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Date

Employee
Address
CityStateZip

Empleador:
Fecha de la lesión (accidente):
Número de reclamo:

AVISO SOBRE BENEFICIOS DE REHABILITACIÓN VOCACIONAL
INTENCIÓN DE RETENER PAGOS DE PENSIÓN POR FALTA DE COOPERAR

CLAIMS ADMINISTRATOR NAME está administrando su reclamo de compensación de trabajadores en nombre de EMPLOYER NAME. Este aviso es para informarle sobre el estado de los beneficios de rehabilitación vocacional para su lesión de compensación de trabajadores de fecha indicada arriba.

Pensamos suspender los pagos de pensión de rehabilitación vocacional. Pararemos estos pagos el DATE porque usted ha dejado sinrazón de participar en los servicios de rehabilitación vocacional en EXPLANATION OF REASONS FOR INTENTION TO TERMINATE VRMA BENEFITS. ***Option:*** Tenemos la intención de afirmar un crédito contra futuros beneficios en cantidad de $ AMOUNT para el período del DATE hasta DATE.

Si usted no está de acuerdo con esta decisión, usted puede solicitar una conferencia con la División Estatal de Compensación de Trabajadores Unidad de Reentrenamiento y Regreso al Trabajo para resolver esta disputa. USTED TIENE DIEZ (10) DÍAS A PARTIR DE LA FECHA QUE USTED RECIBE ESTE AVISO PARA HACER ESTA PETICIÓN.

Adjunto está una Petición de Resolución de Disputa (DWC-RU-103) que es usado para solicitar una conferencia. Hay instrucciones en como rellenarla a lo alto del formulario. El formulario completado deberá ser enviado a la División Estatal de Compensación de Trabajadores Unidad de Reentrenamiento y Regreso al Trabajo más cercana.

El estado de California requiere que le den la siguente información:

Usted tiene derecho a no estar de acuerdo con decisiones que afectan su reclamo. Si usted tiene alguna pregunta sobre la información proporcionada a usted en este aviso, por favor llame a: (***insert adjuster's name and telephone number***). Sin embargo, si usted está representado por un abogado, usted debería llamar a su abogado, no al ajustador de reclamos. Si usted quiere información adicional sobre sus derechos a beneficios o no está de acuerdo con nuestra decisión, usted puede ponerse en contacto con su Oficina de Información y Asistencia estatal local de la División de la Compensación de Trabajadores llamando al (**insert local I&A number**).

Para información grabada y una lista de oficinas, llame al (800) 736-7401. Usted también puede visitar la página web de la DWC en:

http://www.dir.ca.gov/DWC/dwc_home_page.htm.

Usted también tiene el derecho de consultar con un abogado de su elección. Si usted decide ser representado por un abogado, usted puede o puede no recibir una indemnización más grande, pero, a menos que usted sea determinado no ser elegible para una indemnización, los honorarios del abogado serán descontados de cualquier indemnización que usted podría recibir para beneficios de incapacidad. La decisión de ser representado por un abogado es suya para hacer, pero es voluntaria y puede no ser necesaria para que usted reciba sus beneficios.
Para resolver una disputa, usted puede hacer una solicitud a ***[choose appropriate option(s)]*** la Junta de Apelaciones de Compensación de Trabajadores, la Unidad de Rehabilitación Vocacional, o al Director Administrativo.

Atentamente,

_____

Examinador(a) de Reclamos

cc: Applicant Attorney (if any)

Adjunto: **As required by specific regulations**.

- Folleto *Ayuda a Regresar al Trabajo* (w/Rev. date)
- Petición para Resolución de Disputa (DWC-RU-103)

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

VOCATIONAL REHABILITATION REPLY FORM

DIRECTIONS: Please review the four options given below. Circle the option you choose. Complete any items as appropriate to your selection. Complete the information at the bottom of the form. When this form is completed, return it to the address noted above to the attention of your claims examiner, NAME OF CLAIMS EXAMINER.

- **YES,** I want vocational rehabilitation. Please contact me now about the next step. Circle one: **I <u>want</u>** or **I <u>do not want</u>** the Permanent Disability supplement described in the enclosed pamphlet. I understand this supplement will be deducted from any permanent disability benefits due me. Please advise me if I am eligible for this supplement and what the amount will be.
- **YES**, I want vocational rehabilitation, but not right now. The reason I am not ready is

  _____

  _____

  I expect to be ready to participate by the following date: _____

  I understand that I may lose my right to rehabilitation if I do not request services within 5 years of the date of this work injury.
- **I AM NOT SURE** if I am ready for vocational rehabilitation. Please contact me to arrange an evaluation to help me decide whether I will benefit from vocational rehabilitation services.
- **NO,** I do not want vocational rehabilitation services. I understand that if I change my mind, I have only 90 days from the date I received the Notice of Potential Eligibility to request vocational rehabilitation. If I do not submit a request within 90 days, my right to rehabilitation services will end.

Complete the following prior to returning this form.

SIGNATURE		
REQUEST DATE		TELEPHONE
MAILING ADDRESS		

Claims Administrator Name
Address
City_State_Zip
Telephone Number

Employee	**Empleador:**
Address	**Fecha de la lesión (accidente):**
CityStateZip	**Número de reclamo:**

FORMULARIO DE RESPUESTA DE REHABILITACIÓN VOCACIONAL

INSTRUCCIONES: Por favor revise las cuatro opciones dadas abajo. Marque con un círculo la opción que usted elige. Complete cualquier artículo como apropiado para su selección. Rellene la información en el fondo del formulario. Cuando este formulario sea completado, regreselo a la dirección indicada arriba a la atención de su examinador de reclamos, NAME OF CLAIMS EXAMINER.

- **Sí,** quiero rehabilitación vocacional. Por favor póngase en contacto conmigo ahora sobre el siguiente paso. Marque con un círculo: **Yo <u>quiero</u>** or **Yo <u>no quiero</u>** el suplemento de Incapacidad Permanente descrito en el folleto adjunto. Entiendo que este suplemento será descontado de cualquier indemnización por incapcidad permanente debida a mí. Por favor aviseme si soy elegible para este suplemento y cual será la cantidad.
- **Sí**, quiero la rehabilitación vocacional, pero no en este momento. La razón que no estoy listo(a) es:

  _____

  _____

  Espero estar listo(a) a participar para la fecha siguiente: _____

  Entiendo que puedo perder mi derecho a rehabilitación si no solicito servicios dentro de 5 años a partir de la fecha de esta lesión de trabajo.
- **NO ESTOY SEGURO(A)** si estoy lista para rehabilitación vocacional. Por favor póngase en contacto conmigo para hacer una evaluación para ayudarme a decidir si me beneficiaré de servicios de rehabilitación vocacional.
- **NO,** No quiero servicios de rehabilitación vocacional. Entiendo que si cambio de opinión, tengo sólo 90 días a partir de la fecha que recibí la Noticia de la Elegibilidad Potencial para solicitar rehabilitación vocacional. Si no someto una petición dentro de 90 días, mi derecho a servicios de rehabilitación terminará.

Rellene lo siguiente antes de regresar este formulario.NOTE LINE IN FORMATTING DROPPED.

FIRMA	
FECHA DE PETICIÓN	TELÉFONO
DIRECCIÓN POSTAL	

MANDATORY NOTICES
FOR VOCATIONAL TRAINING & RETURN TO WORK

For injuries occurring on or after January 1, 2004

Information about the DWC Retraining and Return to Work Unit may be accessed on the DWC website at: http://www.dir.ca.gov/dwc/rehab.html

Access to the mandatory forms (2 and 3) may be accessed on the DWC website at: http://www.dir.ca.gov/dwc/forms.html

1. **Potential Right to Supplemental Job Displacement Benefit Notice DWC-AD 10133.52**
2. **Notice of Offer of Modified or Alternative Work Benefit Notice DWC-AD 10133.53**
3. **Notice of Offer of Regular Work DWC AD 10118**

NOTICE OF POTENTIAL RIGHT TO SUPPLEMENTAL JOB DISPLACEMENT BENEFIT - (DWC-AD 10133.52)

Requirements for the notice are in Section 9813.1 (a) for dates of injury occurring on or after January 1, 2004.

Instructions for completing the form: The employer shall use the mandatory form as it is presented in Section 10133.52. There shall be no modification of this form. Requirements for the notice are in §9813.1. Complete the last section of the notice prior to sending the notice via certified mail.

When to send:

- Within 10 days of the last payment of temporary disability, if not previously provided.

Special Actions:

- The notice shall be sent by certified mail.

Who should be copied with the notice:

- Applicant Attorney (if any)

Authority, Reference, and Regulation: Labor Code Sections 133, 4658.5, and 5307.3 and 8 CCR Section 10133.51

NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK (DWC-AD 10133.53)

Requirements for the notice are in Section 9813.1(b) for dates of injury occurring on or after January 1, 2004 and **Section 9813.2(c)** for dates of injury occurring on or after January 1, 2005.

Instructions for completing the form: The employer shall use the mandatory form as it is presented in Section 10133.53. There shall be no modification of this form.

- The employer may offer modified work lasting at least 12 months accommodating the employee's work restrictions as defined by Section 10133.53.
- The employer may offer alternative work meeting all of the conditions of Section 10133.53.
- Complete all portions of the form with the exception of the portions designated to be completed by the employee.

When to send:

- Within 30 calendar days of the termination of temporary disability indemnity payments.

and/or

- Within 60 calendar days from the date that the condition of an injured employee with PD becomes P&S.

Who should be copied with the notice:

- Applicant Attorney (if any)

NOTICE OF OFFER OF REGULAR WORK - (DWC-AD 10003)

Requirements for the notice are in Section 9813.2 for dates of injury occurring on or after January 1, 2005.

Instructions for completing the form: The employer shall use the mandatory form as it is presented in Section 10118. There shall be no modification of this form. Requirements for the notice are in Section 9813.2 and Section 10117.

Complete all portions of the form with the exception of the portions designated to be completed by the employee.

When to send:

- Within 60 calendar days from the date that the condition of an injured employee with permanent partial disability becomes permanent and stationary.

Special actions:

- The notice must be served either with a Proof of Service by mail or hand delivery.

Who should be copied with the notice:

- Applicant Attorney (if any)

MANDATORY BENEFIT NOTICES
REGARDING

POTENTIAL RIGHT TO
SUPPLEMENTAL JOB DISPLACEMENT BENEFIT

OFFER OF
MODIFIED OR ALTERNATIVE WORK

OFFER OF
REGULAR WORK

Notice of Potential Right to Supplemental Job Displacement Benefit Form
(Mandatory Form)

If your injury causes permanent partial disability, which prevented you from returning to work within 60 days of the last payment of temporary disability, and the claims administrator has not provided you with a Form DWC-AD 10133.53 "Notice of Offer of Modified or Alternative Work," you may be eligible for a supplemental job displacement benefit in the form of a nontransferable voucher for education-related retraining or skill enhancement, or both, at state approved or accredited schools.

The amount of the voucher for the supplemental job displacement benefit will be as follows:

- Up to four thousand dollars ($4,000) for a permanent partial disability award of less than 15%.
- Up to six thousand dollars ($6,000) for a permanent partial disability award between 15 and 25 %.
- Up to eight thousand dollars ($8,000) for a permanent partial disability award between 26 and 49 %.
- Up to ten thousand dollars ($10,000) for a permanent partial disability award between 50 and 99 %.

A permanent partial disability award is issued by a Workers' Compensation Administrative Law Judge or the Workers' Compensation Appeals Board. You may also settle your potential eligibility for a voucher as part of a compromise and release settlement for a lump sum payment. Any settlement must be reviewed and approved by a Workers' Compensation Administrative Law Judge.

The voucher may be used for payment of tuition, fees, books, and other expenses required by the school for retraining or skill enhancement. Not more than 10 percent of the voucher moneys may be used for vocational or return to work counseling. A list of vocational return to work counselors is available on the Division of Workers' Compensation's website www.dir.ca.gov or upon request.

If you are eligible, and you have not already settled the benefit, you will receive the voucher from the claims administrator within 25 calendar days from the date the permanent partial disability award is issued by the Workers' Compensation Administrative Law Judge or the Workers' Compensation Appeals Board.

If modified or alternative work is available, you will receive a Form DWC-AD 10133.53 "Notice of Offer of Modified or Alternative Work" from the claims administrator within 30 days of the termination of temporary disability indemnity payments. The claims administrator will not be required to pay for supplemental job displacement benefits if the offer for modified or alternative work meets the following conditions:

(1) You have the ability to perform the essential functions of the job provided;
(2) The job provided is in a regular position lasting at least 12 months;
(3) The job provided offers wages and compensation that are at least 85 percent of those paid to you at the time of the injury; and

(4) The job is located within reasonable commuting distance of your residence at the time of injury.

If there is a dispute regarding the Supplemental Job Displacement Benefit, the employee or claims administrator may file Form DWC-AD 10133.55 "Request for Dispute Resolution before the Administrative Director."

If you have a question or need more information, you can contact your employer or the claims administrator listed below. You can also contact a State Division of Workers' Compensation Information and Assistance Officer.

Date:

Name of Claims Administrator: Phone No.:

Address of Claims Administrator:

Email (optional):

DWC-AD 10133.53 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK

For injuries occurring on or after 1/1/04

MANDATORY FORM (Four Pages)
STATE OF CALIFORNIA

DWC-AD 10118 NOTICE OF OFFER OF REGULAR WORK For injuries occurring on or after 1/1/05

MANDATORY FORM (Four Pages)
STATE OF CALIFORNIA

Aviso de Derecho Potencial al Beneficio Suplemental por Desplazamiento de Trabajo
(Formulario Mandatorio)

Si su lesión causó incapacidad permanente parcial, que le impidió regresar a trabajar 60 días después del último pago de incapacidad temporal, y el administrador de reclamos no le ha proveído el Formulario DWC-AD 10133.53 "Aviso de Oferta de Trabajo Modificado o Alternativo" (Notice of Offer of Modified or Alternative Work) usted puede ser elegible para un beneficio suplemental por desplazamiento de trabajo en la forma de un vale no transferible para el reentranamiento o el mejoramiento de las habilidades, o ambas cosas, en instituciones educativas aprobadas o acreditadas por el estado.

La cantidad del vale para el beneficio suplemental por desplazamiento de trabajo será lo siguente:

- Hasta cuatro mil dólares ($4,000) para una indemnización por incapacidad permanente parcial de menos de 15 %.
- Hasta seis mil dólares ($6,000) para una indemnización por incapacidad permanente parcial entre 15 y 25 %.
- Hasta ocho mil dólares ($8,000) para una indemnización por incapacidad permanente parcial entre 26 y 49 %.
- Hasta diez mil dólares ($10,000) para una indemnización por incapacidad permanente parcial entre 50 y 99 %.

La indemnizacion por incapacidad permanente parcial es otorgada por un Juez de Derecho Administrativo de Compensación de Trabajadores o la Junta de Apelaciones de Compensación de Trabajadores. Usted también puede resolver extrajudicialmente su elegibilidad potencial para un vale con un pago de suma global como parte de una finalizacion de compromiso y liberacion. Cualquier finalización debe ser revisada y aprobada por un Juez de Derecho Administrativo de Compensación de Trabajadores.

El vale puede ser utilizado para el pago de matrícula, honorarios, libros, y otros gastos requeridos por la escuela para reentrenamiento o mejoramiento de habilidades. No más del 10 por ciento de las suma de dinero del vale puede ser utilizado para servicios de orientacion profesional o regreso al trabajo. Una lista de consejeros vocacionales de regreso al trabajo está disponible en el sitio web de la División de Compensación de Trabajadores en www.dir.ca.gov o a petición.

Si usted es elegible, y no ha resuelto extrajudicialmente el beneficio, usted recibirá el vale del administrador de reclamos dentro de 25 días naturales a partir de la fecha de cuando la indemnización por incapacidad permanente parcial es otorgada por un Juez de Derecho Administrativo de Compensación de Trabajadores o la Junta de Apelaciones de Compensación de Trabajadores.

Si trabajo modificado o alternativo está disponible, usted recibirá el Formulario DWC-AD 10133.53 "Aviso de Oferta de Trabajo Modificado o Alternativo" (Notice of Offer of Modified or Alternative Work) del administrador de reclamos 30 días después de la terminación de pagos por indemnidad de incapacidad temporal. No se requerirá que el administrador de

reclamos pague los beneficios suplementales por desplazamiento de trabajo si la oferta de trabajo modificado o alternativo llena las siguentes condiciones:

(1) Usted tiene la capacidad de realizar las funciones esenciales del trabajo proporcionado;
(2) El trabajo proporcionado está en una posición regular que dura por lo menos 12 meses;
(3) El trabajo proporcionado ofrece sueldo y compensación que son por lo menos el 85 por ciento de aquellos pagados a usted en el momento de la lesión; y
(4) El trabajo está localizado dentro de una distancia de conmutación razonable de su residencia en el momento de la lesión.

Si hay alguna disputa en cuanto al Beneficio Suplemental por Desplazamiento de Trabajo, el empleado o administrador de reclamos puede presentar el Formulario DWC-AD 10133.55 "Petición de Resolución de Disputa antes del Director Administrativo" (Request for Dispute Resolution before the Administrative Director)

Si usted tiene alguna pregunta o necesita más información, usted puede ponerse en contacto con su empleador o el administrador de reclamos indicado abajo. También puede ponerse en contacto con un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores.

Fecha:

Nombre del Administrador de Reclamos: Teléfono:

Dirección del Administrator de Reclamos:

Email (opcional):

DWC-AD 10133.53 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK

For injuries occurring on or after 1/1/04

MANDATORY FORM (Four Pages)
STATE OF CALIFORNIA

DWC-AD 10118 NOTICE OF OFFER OF REGULAR WORK For injuries occurring on or after 1/1/05

MANDATORY FORM (Four Pages)
STATE OF CALIFORNIA

DIVISION OF WORKERS' COMPENSATION
FACT SHEETS & QME REQUEST

DWC Fact Sheets may be accessed on the DWC Information and Assistance website at: http://www.dir.ca.gov/dwc/IandA.html. For Spanish-language fact sheets go to http://www.dir.ca.gov/dwc/iwguides_Spanish.html.

The notice "Request For QME panel under Labor Code Section 4062.1 - unrepresented" (QME Form-105) may be accessed on the DWC website at http://www.dir.ca.gov/dwc/forms.html#1

1. DWC Fact sheet C: Temporary Disability – Fact sheet C in Spanish
2. DWC Fact sheet D: Permanent Disability – Fact sheet D in Spanish
3. DWC Fact sheet E: QME / AME – Fact sheet E in Spanish
4. Request for QME panel under Labor Code §4062.1 – unrepresented – - (QME Form 105 and attachment) QME Form 105 in Spanish