



## FACTS ABOUT WORKERS' COMPENSATION

### What Is It

Since 1913, California Workers' Compensation law has guaranteed prompt, automatic benefits to workers who become injured or ill because of their jobs. It is mandatory no-fault insurance, paid entirely by your employer, it pays your medical expenses and helps replace lost wages when you are disabled from work because of a work-related injury or illness.

### Who It Covers

All UCLA employees and registered volunteers are covered for Workers' Compensation.

### What It Covers

Almost any job-related injury or illness is covered. Simple first-aid incidents and serious accidents are both covered. Physical and psychological injuries incurred by victims of violent workplace crime are covered. There are a few injuries that may not be covered depending on how they occur; for instance, injuries that result from voluntary, off-duty recreational, social, or athletic activities are not covered. If you wish more information on the types of injuries not covered by Workers' Compensation, contact the UCLA WC Manager at Insurance and Risk Management 310 794-6954.

This pamphlet is available in Spanish.

Este información esta traducido al español. Para conseguir una copia, favor de llamar: UCLA Insurance & Risk Management 310 794-6948

### EMERGENCY PHONE NUMBERS:

POLICE FIRE AMBULANCE 911

OCCUPATIONAL HEALTH FACILITY 310 825-6771 67-120 Center for Health Sciences  
10833 Le Conte Ave

EMERGENCY MEDICINE CENTER 310 267-8400 757 Westwood Plaza (**ER entrance**  
**Gayley Ave, north of Le Conte**)

### EMPLOYER REPRESENTATIVE:

UCLA Insurance & Risk Management 310 794-6948 860 Wilshire Center

### Claims Administered By:

Sedgwick CMS 310 794-8247 P.O. Box 956914, Los Angeles, Ca 90095  
DWC Information & Assistance 310 482-3820 4720 Lincoln Blvd., Marina Del Rey, CA  
90292

## **How to Report an Injury**

Immediately notify your supervisor of any injury no matter how slight. You may also report your injury to Insurance & Risk Management 310 794-6948. If your injury is more than a simple first aid case, your supervisor will give you a Workers Compensation Claim Form DWC 1, with instructions to complete the form and return it. You can also obtain a Workers' Compensation Claim Form DWC 1 by calling Insurance & Risk Management 310 794-6948 and request a Workers Compensation Claim Form DWC 1 be mailed to you. State law requires employers to authorize medical treatment within one working day of receiving the completed Workers Compensation Claim Form DWC 1 from you. If you delay reporting your injury or delay completing the Workers Compensation Claim Form DWC 1, it may result in a delay in receiving benefits; and too long a delay may even jeopardize your right to obtain benefits altogether.

### **Non- Discrimination**

It is illegal for your employer to fire you or in any way discriminate against you because you file a claim, intend to file a claim, settle a claim, testify or intend to testify for another injured worker. If it is found that UCLA discriminated, UCLA may be ordered to reinstate you to your job, reimburse you for lost wages and employment benefits and pay increased Workers' Compensation benefits, costs and expenses up to a maximum set by law.

### **Benefits**

**Medical Care:** Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by your doctor, hospital services, physical therapy, lab tests, x-rays and medicines. Your claims administrator will pay the costs directly, so that you should never see a bill. For injuries occurring on or after 1/1/04, there is a limit on some medical services. For injuries that require treatment beyond first aid you must complete a claim form. Complete the "Employee" section of the claim form and return it to your employer as soon as possible to insure your medical bills get paid and you get all of the benefits you are entitled you must the. Employers must notify the claims administrator and authorize medical treatment within one working day of receiving a claim form.

### **Temporary Disability:**

If you are disabled for more than three (3) calendar days, temporary disability payments will partially replace your lost wages. The first three (3) calendar days are not paid unless you are disabled for more than 14 days, or are hospitalized overnight. You should receive your first payment within two weeks of reporting your injury. Every two weeks after that, you will receive another payment.

Temporary Disability pays two-thirds of your average wage, subject to minimum and maximum amounts set by state law. The payments are tax-free and there are no deductions. For injuries occurring on or after April 19, 2004, Temporary Disability payments for a single injury may not extend for more than 104 weeks within five years from the date of the original injury. Specific catastrophic injuries such as severe burns, amputations or chronic lung disease can be paid TD for up to 240 weeks within five years of the date of injury.

Temporary Disability payments stop when your doctor says you can return to work, or your condition has become Permanent and Stationary (your medical condition has reached maximum foreseeable improvement).

**Permanent Disability:**

If a doctor says your injury or illness will always leave you somewhat limited in your ability to work, you may receive Permanent Disability payments. The amount will depend on the type of injury, your age, occupation, date of injury and how much of the permanent disability was caused by the work injury. There are minimum and maximum amounts set by state law. Payments are made at a regular rate and are spread out over a fixed number of weeks until the total amount has been paid. If you received Temporary Disability payments, the first Permanent Disability payment is due within 14 days after your doctor says your condition has reached maximum foreseeable improvement. Subsequent payments are made every 14 days until the total amount is paid.

**Death Benefits:**

If the injury or illness causes death, payments may be made to your relatives or household members who were financially dependent on you. The amount is set by state law and depends on number of your financial dependents. Payments are made at the same rate as temporary disability; no payments will be less than \$224 per week. A burial allowance is also provided.

**Supplemental Job Displacement Benefit:**

If you have permanent disability and you do not return to work within 60 days after your temporary disability ends and the University does not offer modified or alternative work, you may qualify for a non-transferable voucher payable to a school for retraining and/or skill enhancement. If you qualify the claims administrator will pay the costs up to a maximum set by state law based on your percentage of permanent disability\*. Supplemental Job Displacement Benefit is for injuries on or after 1/1/04.

\*Up to \$4,000 for permanent disability awards of more than 0 but less than 15%

\*Up to \$6,000 for permanent disability awards between 15% and 25%

\*Up to \$8,000 for permanent disability awards between 26% and 49%

\*Up to \$10,000 for permanent disability awards between 50% and 99%

**If Benefits Are Denied:**

You have the right to disagree with any decision affecting your claim. Call your claims administrator first to see if you can resolve any disagreement. For free assistance, you can contact the Information & Assistance Office at the Division of Workers' Compensation (see the section of this pamphlet captioned "If You Have Other Questions").

**If You Have Other Questions**

Please see the telephone numbers listed in this pamphlet. You can contact Insurance & Risk Management 310 794-6948 or Sedgwick CMS at 310 794-8247. You can also contact the Information & Assistance Office at the State Division of Workers' Compensation (DWC) at 310 482-3820.

The Information & Assistance Office provides continuing information on rights, benefits and obligations. They assist in the prompt resolution of misunderstandings and disputes without formal proceedings to the end that full and timely benefits are furnished. Their services are available to you at no cost. You can hear recorded information and a list of local offices by calling 800 736-7401. You can also check the local listing in the phone book under State Government Offices/Industrial Relations/ Workers' Compensation. You may also go to the DWC web site at [www.dir.ca.gov](http://www.dir.ca.gov) and link to Workers' Compensation. There you will find information pamphlets approved by the Division of Workers' Compensation and distributed by the Information & Assistance Officers.

### **Your Treating Physician**

Quality medical care is crucial to making the best recovery from your work injury or illness.

#### **Primary Treating Physician**

Your primary treating physician (PTP) is the doctor with overall responsibility for treating your work injury or illness and for coordinating care with other providers. The PTP decides what type of medical care you need; whether there are temporary or permanent medical limitations or restrictions on your ability to perform work. If the injury results in some degree of permanent disability, the PTP will measure the disability and report the findings to your claims administrator. The PTP will also report whether you will need medical care in the future. As a part of your Workers' Compensation benefits, the University will provide you with a PTP.

#### **Personal Physician (M.D. or D.O.)**

If you have a personal M.D. or D.O. and you wish to designate the physician to be your PTP, you must do so in writing before the injury occurs. In addition, before the injury occurs, the physician must agree to treat you for a work related injury or illness.

#### **One Time Right To Change PTP**

You have the right to change your PTP one time. You can request this change at any time.

#### **Change of PTP: First 30 days**

If you make your request to change PTP during the first 30 days after reporting your injury, you can change to your personal chiropractor or acupuncturist if you have predesignated this physician.

#### **Change of PTP: After 30 days**

If you have not already used your one-time change of PTP, then thirty (30) days after reporting your injury, you may change to the PTP of your own choice. This can be your personal chiropractor, personal acupuncturist, or any physician of your choice within a reasonable geographic area.

#### **Physician Predesignation Form**

You may use the Physician Predesignation Form in this pamphlet to predesignate your personal physician, chiropractor or acupuncturist. After the form is completed, give a copy to your supervisor and mail a copy to UCLA Insurance & Risk Management Suite 860, UCLA Wilshire Center, mail code 135248. If you have questions about the form or how to complete it, call the WC Manager at 310 794-6954.

**WORKERS' COMPENSATION FRAUD IS A FELONY**

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

**PHYSICIAN PREDESIGNATION FORM**

Your personal medical physician (M.D. or D.O.) chiropractor (D.C.)

- Is this your regular treatment provider?
- Has directed your treatment in the past
- Retains your treatment records and history

If you give your employer the name and address of your personal physician in writing before the injury, then

- You can treat with your personal M.D. or D.O. immediately after the injury.
- You can change to your personal D.C. or L.A.C. if you exercise your right to one change of treating physician.

Your personal M.D. or D.O. must agree to treat you for work injuries or illnesses before one occurs.

**PREDESIGNATION OF PERSONAL PHYSICIAN**

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.) or doctor of osteopathic medicine (D.O.) if:

- your employer offers group health coverage;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing:

(1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor’s name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work- related injury or illness and the above requirements are met.

**NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN**

**Employee: Complete this section.**

To: \_\_\_\_\_ (name of employer) If I have a work-related injury or illness, I choose to be treated by:

\_\_\_\_\_  
 (name of doctor)(M.D., D.O.)  
 \_\_\_\_\_(street address, city, state, ZIP)  
 \_\_\_\_\_(telephone number)

Employee Name (please print):

Employee’s Address: \_\_\_\_\_

Employee’s

Signature \_\_\_\_\_ Date: \_\_\_\_\_

**Physician: I agree to this Predesignation:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Physician or Designated Employee of the Physician)  
The physician is not required to sign this form, however, if the physician or designated employee of the physician does not sign, other documentation of the physician’s agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).  
Title 8, California Code of Regulations, section 9783.

**Section 9783.1. DWC Form 9783.1 Notice of Personal Chiropractor or Personal Acupuncturist.**

**Employee: Complete this section.**

To: \_\_\_\_\_ (name of employer) If I have a work-related injury or illness, I choose to be treated by:

\_\_\_\_\_  
(name of **Personal Chiropractor or Personal Acupuncturist**)

\_\_\_\_\_  
(street address, city, state, ZIP)

\_\_\_\_\_  
(telephone number)

Employee Name (please print):

Employee's Address:

\_\_\_\_\_  
Employee's

Signature \_\_\_\_\_ Date: \_\_\_\_\_

**Physician: I agree to this Predesignation:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**(Personal Chiropractor or Personal Acupuncturist)**

The **Personal Chiropractor or Personal Acupuncturist** is not required to sign this form, however, if the **Personal Chiropractor or Personal Acupuncturist** or designated employee does not sign, other documentation of the **Personal Chiropractor or Personal Acupuncturist** agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).