FIRST INSURANCE CO. OF HI, LTD.
WORKERS COMPENSATION CLAIM PACKET
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I. INSTRUCTIONS FOR THE EMPLOYER

A. WORKERS COMPENSATION - EMPLOYER'S FIRST REPORT OF INJURY

Reporting a Workers' Compensation Claim

The speed with which you report an on-the-job injury, illness, or accident has an important bearing upon employee relations, and ultimately can affect the duration and cost of the claim. For this reason, every industrial accident should be promptly reported, regardless of whether or not you feel it is job related.

The current State of Hawaii Workers' Compensation law mandates that disability benefits on any uncontested claim must be paid within 10 days after an injury is reported to you. The Report of Injury should be submitted to Dept. of Labor within seven (7) working days from employer's knowledge of the injury. Timely reporting of claims to the Dept. of Labor will avoid penalties (up to $5,000.00) or delays in servicing. ***Please report claims by calling our Reports Desk at 527-7711.***

If you prefer to complete the Accident Report form, please fax it to:

Fax: **545-3120 (Toll Free: 800-713-3883)**
To: **First Insurance Co. of HI, Ltd.**
Attn: **Reports Desk**

If your employee is disabled from work, please include a photo ID of your injured employee whenever available.

Accidents that result in injuries or illness as listed below, should be reported ***immediately:***

1. Fatality
2. Head injuries
3. Possible blindness
4. Heart Attack or stroke
5. Employee is unconscious
6. Accident caused by a third party
7. Possible injury to spinal cord
8. Amputation of limb
9. Severe burns
10. Multiple fractures
11. An accident involving more than one employee

We transmit the WC-1 to the Dept. of Labor electronically so please ***do not complete a WC-1 form.***

Questionable Claims: There may be occasions where you may doubt the validity or severity of a reported injury. Please report the claim to us as soon as possible, even if compensability is not clear, and inform us of your concerns with a separate memo or a phone call.

Accident Scene Investigation: To fully understand the occurrence and protect your interests, it may be necessary for our representative to conduct an on-the-scene investigation. This may require the assistance of expert consultants specializing in the type of accident which has occurred. If an on-site investigation is necessary, we will provide as much advance notice as possible.

Retention of Evidence: In some cases, particularly where there may be third party involvement, retention of evidence may be critical. It may enable us to recover our loss payments, and since your policy premiums are based on experience, it could help to control your future insurance costs. Even evidence that appears insignificant at the time of the accident could prove important later. For this reason, we ask that you retain all evidence until the claim has been satisfactorily resolved and our claims representative has authorized disposal of the evidence.

CONTROLLING COSTS OF A CLAIM

Investigation and Follow-Through

In the event your employee is unable to return to work, a First Insurance Co. of HI, Ltd. claims representative will be in regular contact with you, the injured employee, the employee's medical providers, and any attorneys or third parties who may be involved. The adjuster may assign a Medical Case Management nurse who will also contact all parties involved to augment the information obtained by our claims adjuster. We will attempt to reach a satisfactory resolution within the shortest possible time and with the least demand upon you and your staff. In some cases, resolution may require the following:

Dept. of Labor Hearing: A hearing may be held to resolve controverted issues such as compensability, appropriateness of treatment plan requests, or permanent partial disability. A copy of the hearing notice will be sent to you. If it is necessary for someone from your company to testify on your firm's behalf, we will provide as much advance notice as possible. We will mail you a copy of the hearing notice in the event that you may want to attend as an observer. Please contact the adjuster to confirm the date and time of the hearing.

Fraud Investigation: T**o** confirm the possibility of symptom exaggeration or if we have reason to suspect fraud, the claim may be referred to our Fraud Investigator. We encourage you to post our "Fraud Hotline Poster" in a conspicuous location. Please let us know if more copies are needed. Any employee may report suspicious activity anonymously. All information is strictly confidential.

Ongoing Communication: Your management staff is an important key to reducing claim cost and improving employee relations. Most injured workers do want to return to work and will do so sooner if they feel you care. This is a time when employees feel insecure and vulnerable and need reassurance. Knowing that you are eager to have them back is a boost to their morale and a deterrent to extended disability and time off from work.

* If your employee is recuperating at home call your employee within 48 hrs.
* If your employee is hospitalized, a personal visit within 48 hrs. is recommended.
* Periodic phone calls to let your injured employee know that they are missed, and that their job or a modified position is available.
* Encourage your injured employee's co-workers to maintain contact also.

From the outset of a claim, regular communication between the employer, the employee, the treating physician and the insurer is the surest way to prevent malingering and litigation. The more we talk and work together, the better the employee's treatment and mental outlook are likely to be. That will benefit all of us.

Return to Work: Early return to work not only benefits the employee and his or her outlook, but it is also in the employer's best interest:

* It returns an experienced, loyal, worker.
* It saves the time and cost of replacement.
* It helps control your claims costs.

While an injury may require surgery and a period of hospital confinement, recovery and return to work may be enhanced by our aggressive early intervention. If you are unable to provide modified duty, you may want to consider paying your injured employee to do volunteer work on behalf of your company. Please discuss this option with your adjuster.

Medical Cost Containment: Our goal is to provide the best medical care, and manage this care so the injured employee can resume as normal a life as possible, and return to regular or modified work duties.

Rehabilitation: A Medical Case Management Nurse may be assigned to cases where a return to work date is undetermined at the time of reporting the injury. The Case Management Nurse will assist the claims representative in reviewing the appropriateness of treatment, duration of disability, and necessity of referrals to specialists or other providers.

Medical Bill Review: Medical bills are reviewed to ensure charges by providers comply with the Workers Compensation Fee Schedule. Our average cost savings as a result of these reviews is ***25%***. Pharmaceutical Cost Containment program averages cost savings of ***30%*** for prescriptions, medical equipment and supplies.

E M P L O Y E R ' S I N S T R U C T I O N S T O T H E E M P L O Y E E

To expedite processing of your employee's claim for Workers Compensation Benefits, please ask the employee to complete and sign the *Accident Report Form* attached as well as the *Authorization to Release Medical Information.*

Please do not pay for any medical treatment or accept liability for any alleged work related injury reported to you by your employee.

When an employee reports the injury and it seems likely he or she will be disabled from work, you may be asked to complete additional forms included in this packet.

If you would like our Fraud Hotline Poster in hot pink card stock, please call us at 527-7711 or fax your request to us at 527-7511.

The *Highlights of the Workers' Compensation Law brochure is enclosed*, for your information. A copy of this brochure is mailed to the injured employee once our investigation of the accident is completed and compensability is accepted.

An informational brochure regarding *Vocational Rehabilitation* is also enclosed. This is mailed to an injured worker within 120 days of disability. The injured worker may select a vocational rehabilitation provider from the list of certified providers when they are disabled from work.

Our adjuster will be able to answer additional questions you or your employee may have regarding Workers Compensation benefits.

Once a claim is determined to be work related, it is our goal to assist your injured worker to recover from his or her injury. Your employees may call Janice Fukuda, Assistant Vice President of our Workers Compensation Claims Dept. at 527-7535 (for our neighbor islands 1-800-272-5202 ext. 7535) if they have any comments or concerns about our claims service.

ACCIDENT REPORT FORM
FIRST INSURANCE CO. OF HI, LTD.

NAME:			SSN:	-	-
RESIDENT ADDRESS:			DATE OF BIRTH		
			SEX:	☐ MALE	☐ FEMALE
MAILING ADDRESS:			MARITAL STATUS:	☐ SINGLE	☐ MARRIED
☐ SAME AS RESIDENCE					
HOME PHONE:	( ) -		CELLULAR PHONE:	( ) -	
OCCUPATION:			DEPARTMENT:		
DIRECT SUPERVISOR:			YRS IN POSITION:		
DATE OF INJURY:			TIME OF INJURY:		☐ AM ☐ PM
DATE YOU REPORTED THE INJURY TO YOUR EMPLOYER:			TIME SHIFT BEGAN:		☐ AM ☐ PM

Describe what you were doing, how the injury happened and indicate on the checklist and diagram, the body parts injured or affected.

Please describe and note the brand name and model number of any tools or equipment you were using at the time of your injury.

Witnesses:

1. NAME: _____ POSITION: _____
   ADDRESS: _____ PHONE: ( ) –
2. NAME: _____ POSITION: _____
   ADDRESS: _____ PHONE: ( ) -

HOSPITAL: _____ PHYSICIAN: _____

WORK SCHEDULE: _____ WAGE: HOURLY: $ _____

HRS WORKED / WEEK: REGULAR _____ OT _____ SALARY: $ _____

DATES OF DISABILITY: _____

DATE RETURNED TO WORK: _____

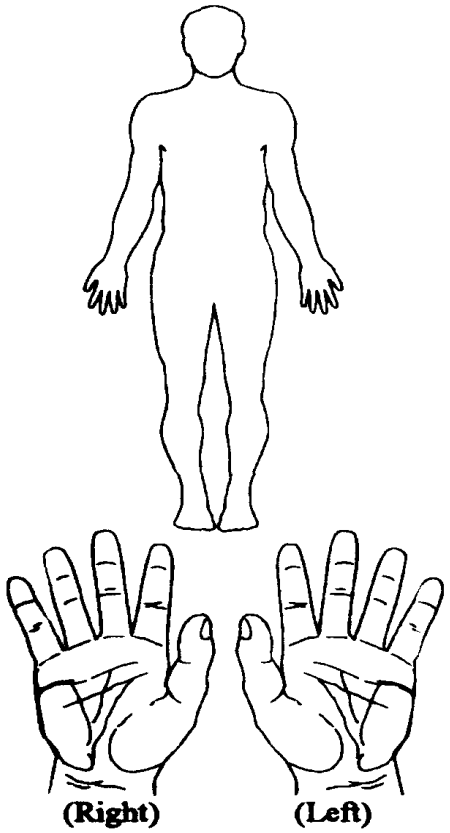
Employer:

1. NAME: _____ POSITION: _____

ADDRESS: _____ PHONE: ( ) –

POLICY: _____ DOL #: _____

ADDRESS WHERE ACCIDENT OCCURRED _____

D. Mark Areas Injured	**Circle Body Part Injured**:	**Circle Injury Description:**
	Head: Forehead - Right - Left Back - Top Eye - Left Right Ear - Left Right Nose Mouth - Teeth Neck Upper Back Chest Arm - Left Right Hand - Left Right Mid back Lower Back Abdomen Thigh - Left Right Knee - Left Right Leg - Left Right Foot - Left Right Other - Respiratory Other -	Abrasion Allergic Reaction Amputation Bruise Burn Contusion Dermatitis/Rash Dizziness/Fainting Foreign Body Fracture Hernia Laceration Repetitive trauma Strain-Sprain Swelling Vision problems Other:

I, _____(name) certify that the statement above is an accurate account of my injury/accident. I also authorize any physician or hospital to release any information to First Insurance Co. of HI, Ltd. in reference to this injury.

Signature: _____ Date: _____

I. C. ACCIDENT REPORT FORM

AUTHORIZATION TO RELEASE INFORMATION & RECORDS

AND

CONSENT TO RELEASE MEDICAL INFORMATION, RECORDS AND REPORTS

TO: **Provider:** _____

Address: _____

_____

SUBJECT:

Claimant: _____

Employer: _____

Carrier: _____

Adjuster: _____

Date of Injury: _____

Claim #: _____

DCD Case #: _____

Authorization: I, the undersigned, authorize the CUSTODIAN OF RECORDS of the above-named provider to release and disclose by way of oral and/or written testimony pertaining to and regarding all information, reports, records, correspondence, notes, evaluations, in its possession concerning diagnosis and treatment of _____. It is understood that this Consent constitutes an express waiver of any rule against disclosure otherwise provided by any confidentiality provision of Federal, State or other applicable law. The information, reports, records, correspondence, notes, and evaluations are to be provided to the following:

1. **Employer, its representatives, employees or consultants who may necessarily review the records released and disclosed; and**
2. **Insurance Carrier/Adjuster, its representatives, employees or consultants who may necessarily review the records released and disclosed. (The Employer and Insurance Carrier/Adjuster are hereinafter collectively referred to as "Employer/Carrier"); and**
3. **The Department of Labor and Industrial Relations, Disability Compensation Division, State of Hawaii; and**
4. **The Labor and Industrial Relations Appeals Board, State of Hawaii; and**
5. **The Supreme Court, State of Hawaii.**

Requested Information: Any and all information and records about my health and/or any other document or records. The requested information and records about my health may be contained in employment and/or personnel records and insurance records, including, but not limited to, no-fault, personal injury protection, optional additional coverage, workers' compensation, and/or bodily injury records.

Purpose: I am a party to the above-referenced claim, whose medical condition is at issue. The medical information and records may be used to evaluate my medical condition or claim(s) related thereto by anyone involved with this claim, and may be used for the following purposes: (1) for evaluation of my injuries, care, and treatment; (2) for evaluation and payment of my claim for medical benefits and/or indemnity benefits; (3) for disclosure to and use by an independent medical examination physician or other health care provider, who will report on the evaluation of my injuries, care, and treatment; (4) for disclosure to and use by the appropriate tribunal, adjudicator, and fact-finder in any administrative hearing, mediation, arbitration, and/or court proceeding involving my claim for benefits; (5) for submission as exhibits in any such administrative hearing, mediation, arbitration, and/or court proceeding; (6) for disclosure to and use by any attorney or law firm in such evaluation, administrative hearing, mediation, arbitration, and/or court proceeding; and (7) for disclosure to a third-party and the third-party's insurance carrier, if any, that is or who may be responsible for my injuries arising out of and related to my claim for benefits in the above-

referenced claim and against whom the Employer/Carrier is pursuing for contribution, indemnification or reimbursement.

Authorization to Employer/Carrier: I, the undersigned, authorize Employer/Carrier's Custodian of Records to release and disclose by way of oral and/or written testimony pertaining to and regarding all information, reports, records, correspondence, notes, evaluations in Employer/Carrier's possession concerning my diagnosis and treatment in pursuit of any claims, including but not limited to subrogation claims, against a third-party and the third-party's insurance carrier, if any, that is or who may be responsible for my injuries arising out of and related to my claim for benefits in the above-referenced claim and against whom the Employer/Carrier is pursuing for contribution, indemnification or reimbursement. This consent encompasses any and all information and records about my health and/or any other document or records. The requested information and records about my health may be contained in employment and/or personnel records and insurance records, including, but not limited to, no-fault, personal injury protection, optional additional coverage, workers' compensation, and/or bodily injury records. It is further understood that this Consent constitutes an express waiver of any rule against disclosure otherwise provided by any confidentiality provision of Federal, State or other applicable law. The information, reports, records, correspondence, notes, and evaluations may be provided to the following:

1. **Third-Party, its representatives, employees or consultants who may necessarily review the records released and disclosed;**
2. **Third-Party's Insurance Carrier, its representatives, employees or consultants who may necessarily review the records released and disclosed;**

Eligibility Determination: This authorization is voluntary. I understand that I can refuse to sign this authorization. If the above-indicated records provider is a medical provider, they will not condition my treatment, payment, enrollment or eligibility for benefits on the signing of this authorization except as allowed under Federal privacy laws for: (i) research-related treatment; or (ii) health care provided solely for disclosure to a third party or (iii) health plan initial enrollment/eligibility determinations, underwriting or risk rating determinations.

Waiver: With respect to anyone involved with this claim, I waive any applicable State or Federal requirement that may apply to the receipt, use, or dissemination of such information and records. Information released may be subjected to re-disclosure by the recipient and may no longer be protected under Federal privacy regulations.

Revocation of Authorization: It is understood that this information is required in connection with the undersigned's application for compensation benefits, and that this Consent is revocable at any time except to the extent that action has been taken in reliance thereon. I understand that I may revoke this authorization at any time upon my written notice. I understand that the revocation will not apply to any information that has already been released in reliance on this authorization. Unless otherwise revoked, this authorization will be valid until the conclusion of the above-referenced claim. A copy of this authorization shall be deemed to be as valid and as effective as an original authorization.

Expiration Date: This authorization and consent will expire upon the conclusion or resolution of the above-referenced claim.

Reference: Standards for Privacy of Identifiable Health Information (HIPAA), 45 C.F.R., Subtitle A, Subchapter C. § 164.508.

Date: _____ **Signature** _____

Print Name: _____

Address: _____

_____ **, HI** _____

DOB: _____

SSN: _____

JOB ANALYSIS

Employee:	Date Of Injury:
Employer:	
Address:	
Contact Person (Form Prepared by):	Phone:
Current Job Title and Description:	Supervisor: Phone:

PHYSICAL REQUIREMENTS:

☐ Standing _____ Hrs. at one time _____ Total Hrs. Per Day
☐ Sitting _____ Hrs. at one time _____ Total Hrs. Per Day
☐ Walking _____ Hrs. at one time _____ Total Hrs. Per Day

Lifting MAXIMUM lbs.	80+	70	60	50	40	30	20	10
Frequently (34-66%)	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally (0-33%)	☐	☐	☐	☐	☐	☐	☐	☐

Carrying MAXIMUM lbs.	80+	70	60	50	40	30	20	10
Frequently (34-66%)	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally (0-33%)	☐	☐	☐	☐	☐	☐	☐	☐

Movements: ☐ Bend ☐ Reach ☐ Squat ☐ Kneel - Duration_____ hrs.
☐ Climb ☐ Push/Pull _____ Lbs.

Operate Machinery: ☐ *NO* ☐ *YES* **TYPE:**

OTHER PHYSICAL REQUIREMENTS:_____

PHYSICIAN APPROVAL - I REVIEWED THE JOB ANALYSIS AND BELIEVE THE EMPLOYEE:

☐ Is Currently Able to Perform this job
☐ Is Currently Able to Perform a MODIFIED job
☐ Will Be Able to Perform this job on (date)_____
☐ Will Be Able to Perform a MODIFIED job on (date)_____

PHYSICIAN SIGNATURE:_____ DATE:_____

EMPLOYEE ACKNOWLEDGEMENT:

(Signature)_____ DATE:_____

PHYSICAL REQUIREMENTS:

☐ Standing _____ Hrs. at one time _____ Total Hrs. Per Day

☐ Sitting _____ Hrs. at one time _____ Total Hrs. Per Day

☐ Walking _____ Hrs. at one time _____ Total Hrs. Per Day

Lifting MAXIMUM lbs.	80+	70	60	50	40	30	20	10
Frequently (34-66%)	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally (0-33%)	☐	☐	☐	☐	☐	☐	☐	☐

Carrying MAXIMUM lbs.	80+	70	60	50	40	30	20	10
Frequently (34-66%)	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally (0-33%)	☐	☐	☐	☐	☐	☐	☐	☐

Movements: ☐ Bend ☐ Reach ☐ Squat ☐ Kneel - Duration_____ hrs.
☐ Climb ☐ Push/Pull _____ Lbs.

Operate Machinery: ☐ *NO* ☐ *YES* **TYPE:**

OTHER PHYSICAL REQUIREMENTS:_____

PHYSICIAN APPROVAL - I REVIEWED THE JOB ANALYSIS AND BELIEVE THE EMPLOYEE:

☐ Is Currently Able to Perform this job
☐ Is Currently Able to Perform a MODIFIED job
☐ Will Be Able to Perform this job on (date)_____
☐ Will Be Able to Perform a MODIFIED job on (date)_____

PHYSICIAN SIGNATURE:_____ DATE:_____

EMPLOYEE ACKNOWLEDGEMENT:

(Signature)_____ DATE:_____

I. E. Job Analysis

WORKERS COMP FRAUD HOTLINE

Fraudulent claims hurt the company's bottom line. Report any suspicious behavior or potential insurance fraud *anonymously* – call:

1-888-98-FRAUD 1-888-983-7283

Please post for your employees

Courtesy of First Insurance Company of HI, Ltd.

II. DEPT. OF LABOR FORMS

A. Highlights of the Workers Compensation Law

B. Vocational Rehabilitation

We provide these brochures to your injured employee. These are two-sided brochures that are printed on legal size paper.

Address all inquiries to:

Department of Labor and Industrial Realtions
Disability Compensation Division

Oahu: P.O. Box 3769
830 Punchbowl St. Room 210
Honolulu, Hawaii 96812-3769
Phone: (808) 586-9171

Hawaii: State Office Building
75 Aupuni St. Room 108
Hilo, Hawaii 96720
Phone: (808) 974-6464

West Hawaii: P.O. Box 49
Kealakekua, Hawaii 96750
Phone: (808) 322-4808

Maui: State Office Building, #2
2264 Aupuni St.
Wailuku HI 96793
Phone: (808) 243-5322

Kauai: State Office building
3060 Eiwa St. Room 202
Lihue Hi 96766
Phone: (808) 274-3351

Auxiliary aids and services are available upon request. Please call the above listed telephone numbers, (808) 586-8847 (TTY), OR 1-888-569-6859 (TTY neighbor islands). A request for a reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

It is the policy of the Department of Labor and Industrial Relations that no person shall on the basis of race, color, sex, marital status, religion, creed, ethnic origin, national origin, age, disability, ancestry, arrest/court record, sexual orientation, and National Guard participation be subjected discrimination, excluded from participation in, or denied the benefits of the department's services, programs, activities, or employment.

HIGHLIGHTS OF THE HAWAII WORKERS' COMPENSATION LAW

STATE OF HAWAII
Department of Labor and Industrial Relations
DISABILITY COMPENSATION DIVISION

HIGHLIGHTS OF THE HAWAII WORKERS' COMPENSATION LAW

INTRODUCTION

Your safety and well being on the job are important to the employer. However, accidents and illnesses can arise from work and when they do, you are covered under the workers' compensation law. This brochure has been prepared to help explain your benefits and responsibilities under the workers' compensation law.

PURPOSE

The purpose of the workers' compensation law is to provide an employee who suffers an industrial injury or illness with medical care, wage loss replacement, and permanent disability benefits. It also provides death benefits for dependents.

WHO CAN RECEIVE WORKERS' COMPENSATION BENEFITS?

Most full-time and part-time employees who suffer from any injury or disease, which results from work or working conditions, are covered. Under the law, certain kinds of employees are not covered.

WHAT SHOULD I DO IF I AM INJURED?

1. Immediately report the injury to your immediate supervisor or employer. You can do this orally or in writing.

2. Obtain appropriate treatment for the injury.

DO I HAVE TO FILE ANY PAPERS TO MAKE A CLAIM?

If your employer fails to file an "Employer's Report of Industrial Injury/Illness"(WC-1) with their workers' compensation insurance carrier you should contact your nearest Disability Compensation Division office and file an "Employee's Claim for Workers' Compensation Benefits" (WC-5).

WHAT DO I TELL MY PHYSICIAN IF I AM INJURED?

If you are injured as a result of your work, you should tell the person treating you that this is an industrial injury. Ask the physician to send the medical reports and bills to your employer's insurance carrier. The physician should call the employer for the name of the insurance carrier.

Your employer's workers compensation carrier is FIRST INSURANCE COMPANY OF HAWAII, LTD.

Policy #:_____

FROM WHOM CAN I OBTAIN TREATMENT?

You may obtain treatment from a physician of your choice. However, you may be under the care of only one attending physician. Your attending physician may refer you to other specialist(s) with the approval of the employer's insurance carrier.

You may change your attending physician once, but you must notify the insurance carrier before making the change. Any other changes in physician require approval from the insurance carrier before the change.

IF I AM INJURED, WHAT MEDICAL BENEFITS WILL WORKERS' COMPENSATION PAY FOR?

If your claim is accepted, workers' compensation should pay for the following:

1. Treatments for the injury.
2. Hospital charges.
3. Prescription drugs ordered by your doctor.
4. X-rays as prescribed.
5. Physical therapy as ordered by your doctor.
6. Reasonable transportation expense incidental to treatment. (Keep track of your expenses and mileage.)

WHAT TYPES OF DISABILITY BENEFITS AM I ELIGIBLE FOR?

You are eligible for the following types of disability benefits:

1 **TEMPORARY TOTAL DISABILITY (TTD)**

If you are unable to work because of an industrial injury, you may receive temporary wage replacement benefits after a three-day waiting period. You may receive 2/3 of your weekly wages up to a specified maximum. (For example, the maximum for 2003 is $580.) TTD is paid for periods a physician certifies you are unable to work.

If your workers' compensation claim is disputed and you are not paid benefits, you may file a temporary disability insurance (TDI) claim with your employer's TDI carrier. If eligible, you will be paid benefits at rates allowed by the TDI law. The TDI carrier may recover the amount they paid from your workers' compensation benefits.

If you have two or more jobs you may be eligible for concurrent benefits. You must notify the nearest Disability Compensation Division Office.

2 **PERMANENT PARTIAL DISABILITY (PPD)**

After you reach the point of stability or maximum medical recovery, you may be sent to a physician to be evaluated on the extent of your permanent impairment. The evaluation will be used to determine the amount of your PPD award.

3 **PERMANENT TOTAL DISABILITY (PTD)**

If you are unable to do any kind of work, you may be eligible for PTD benefits. Whether you are eligible for PTD benefits is determined at a hearing held by the Department of Labor and Industrial Relations.

4 **DISFIGUREMENT**

If an injury results in a permanent disfigurement, you may be entitled to additional compensation. Disfigurement includes scars, deformity, and discoloration. Laceration scars and surgical scars are reviewed six months from date of occurrence, however, burn scars are evaluated after one year.

5 **DEATH BENEFITS**

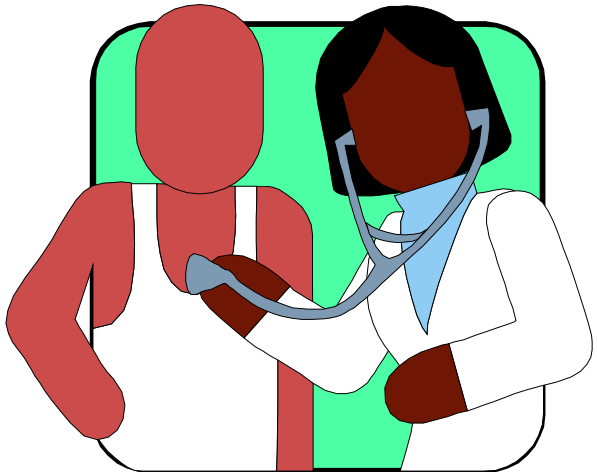
Where an industrial injury results in death, the surviving spouse and dependent minor children (including full-time students up to 21 years of age) are entitled to weekly benefits as provided in the workers' compensation law. Funeral expenses up to 10 times the maximum weekly benefit rate and burial expenses up to 5 times the maximum weekly benefit rate are also allowed.

6 **VOCATIONAL REHABILITATION**

When an industrial injury has or may have caused permanent disability and prevents you from returning to your usual job, you may be referred for vocational rehabilitation services to assist you in returning to suitable work.

WHAT IS THE PROCESS?

If there are any issues, which cannot be resolved by agreement, a hearing will be held, and a decision will be rendered. If you or the employer/insurance carrier disagrees with the decision, the decision may be appealed by filing a notice of appeal with the department within 20 calendar days from the date stamped on the decision.



Auxiliary aids and services are available upon request. Please call the above listed telephone numbers, (808) 586-8847 (TTY), OR 1-888-569-6859 (TTY neighbor islands). A request for a reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

It is the policy of the Department of Labor and Industrial Relations that no person shall on the basis of race, color, sex, marital status, religion, creed, ethnic origin, national origin, age, disability, ancestry, arrest/court record, sexual orientation, and National Guard participation be subjected to discrimination, excluded from participation in, or denied the benefits of the department's services, programs, activities, or employment.

HIGHLIGHTS OF YOUR VOCATIONAL REHABILITATION BENEFITS OF THE HAWAII WORKERS' COMPENSATION LAW

STATE OF HAWAII
Department of Labor and Industrial Relations
DISABILITY COMPENSATION DIVISION
P.O. Box 3769
Honolulu, Hawaii 96812

HIGHLIGHTS OF YOUR VOCATIONAL REHABILITATION BENEFITS OF THE HAWAII WORKERS' COMPENSATION LAW

INTRODUCTION

This brochure has been prepared to help explain your vocational rehabilitation benefits and responsibilities under the Hawaii Workers' Compensation law.

PURPOSE

The primary purpose of Vocational Rehabilitation is to restore an employee to suitable gainful employment.

WHO CAN RECEIVE VOCATIONAL REHABILITATION BENEFITS?

If you suffered a work-related injury and you have or may have suffered permanent disability, you may be eligible for Vocational Rehabilitation benefits.

If eligible, your employer or employer's insurance carrier pays for this benefit.

WHAT ARE VOCATIONAL REHABILITATION SERVICES?

State Registered Vocational Rehabilitation Counselors are trained to assist you in making the best possible decisions about your future work. Your vocational rehabilitation counselor will work closely with your doctor, employer, insurance adjuster, and other professionals to provide the best possible outcome for ***you.***

Your Vocational Rehabilitation Counselor will
take into consideration your:

Limitations
Skills and
Experience

HOW DO I LEARN MORE ABOUT THIS BENEFIT?

- Within 120 days of disability, *contact any of the State Registered Vocational Rehabilitation Counselors from the list provided inside this brochure.*

- The Vocational Rehabilitation Counselor you select shall submit to your employer (insurance carrier) and to the Director of the Dept. of Labor and Industrial Relations, a copy of an Employee Selection Form (WCRP-23) within 7 days.

- Within 45 days of the date of referral or selection, the Enrollment form and Statement of Worker's Rights and Responsibilities form (WCRP-39) shall be submitted to your employer

WHERE CAN I GET ADDITIONAL INFORMATION?

OAHU:

P.O. Box 3769
830 Punchbowl St. Room 209
Honolulu, HI 96813
Phone: 586-9171

HAWAII:

State Office Building
75 Aupuni St. Room 108
Hilo, HI 96720
Phone: 974-6464

WEST HAWAII:

P.O. Box 49
Kealakekua, HI 96750
Phone: 322-4808

MAUI:

State Office Building, #2
2264 Aupuni St.
Wailuku, HI 96793
Phone: 243-5322

KAUAI:

State Office Building
3060 Eiwa St. Room 202
Lihue, HI 96766
Phone: 274-3351

II. DEPT. OF LABOR FORMS

C. WC-14 Employer's Wage Report

AVERAGE WEEKLY WAGE

Form WC-14 is the Employee's Wage Report for Fifty-Two Weeks Prior to Date of Injury. This form is usually requested for:

Part Time Employees
Salaried Employees with commissions
Hourly salaried employees with tips
Hourly salaried employees with overtime

Our claims representative will advise you if a WC-14 is required.

STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

INSTRUCTION SHEET FOR FORM WC-14
EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS

Instructions

Please completely fill out the WC-14 EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS FORM.

The **Delivery Information** section below lists various delivery options. Please select the most convenient method and submit the completed form accordingly.

Please remember to sign and date the form before submitting it.

Delivery Information

Delivery by U.S. Mail
Department of Labor and Industrial Relations, Disability Compensation Division
P.O. Box 3769, Honolulu, Hawaii 96812-3769

Delivery In-Person
Department of Labor and Industrial Relations, Disability Compensation Division
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

Delivery via Fax
Department of Labor and Industrial Relations, Disability Compensation Division
(808) 586-9219

Visit our Website at www.hawaii.gov/labor for ALL interactive and downloadable forms.

(3 pages including instruction sheet) (Rev. 10/05)

STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

FORM WC-14 EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS

EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS PRIOR TO DATE OF INJURY

Employee:	SS No.:	Case No.: - -	Date of Injury:

benefits are calculated based on wages earned. Please assist us in determining benefits by completing this form

Employer:	Employee's Occupation:	Hourly Rate:
Date Employed:	Presently Employed?	If terminated, date:
Disabled from:	through:	Returned to Work:
Indicate the days and hours normally worked:		
Sunday: ☐	Monday: ☐	Tuesday: ☐	Wednesday: ☐	Thursday: ☐	Friday: ☐	Saturday: ☐
If other than the above, please indicate:		

Please call Records and Claims Branch at 586-9174 if you have Questions

Employer:	Telephone: ( )
Address	
Date:	By:

(To be signed in ink)

Auxiliary aids and services are available upon request. Please call: (808) 586-9174; TTY (808) 586-8847; and for neighbor islands, TTY 1-888-569-6859. A request for reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

It is the policy of the Department of Labor and Industrial Relations that no person shall, on the basis of race, color, sex, marital status, religion, creed, ethnic origin, national origin, age, disability, ancestry, arrest/court record, sexual orientation, and National Guard participation, be subjected to discrimination, excluded from participation in, or denied the benefits of the Department's services, programs, activities, or employment.

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(3 pages including instruction sheet) (Rev. 10/05)

Employee:	SS No.:	Case No.: - -	Date of Injury:

	Dates (inclusive) of each period paid for			Hours, Days, Weeks or month each Payment Covers	Total amount paid Employee for each period		Amount paid excluding overtime or extra work		Overtime or extra work	
	From	To	Year							
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25										
26										
	Total									

This statement of Employee's earnings is taken from our Payroll Records.

	Dates (inclusive) of each period paid for			Hours, Days, Weeks or month each Payment Covers	Total amount paid Employee for each period		Amount paid excluding overtime or extra work		Overtime or extra work	
	From	To	Year							
27										
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52										
	Total									

This statement of Employee's earnings is taken from our Payroll Records.