(4) INSERT EXPLANATION FOR OTHER CHANGE IN BENEFIT (Example: child support or payments to be deducted, etc).]

For injuries occurring from January 1, 2005 through December 31, 2012, include the following for PD benefits if permanent and stationary:

The report advises your injury is permanent and stationary effective DATE.
Select (1) or (2):
(1) Your employer made a timely offer for you to return to ***(choose one)*** regular /modified/alternative work on DATE. The weekly PD rate of $RATE will be reduced by 15% to $REDUCED RATE effective INSERT OFFER DATE, the date of the offer of return to work.

(2) Your employer did not make a timely offer for you to 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.

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

MANDATORY: include for all notices:

Additional information may be found in the publication **Workers' Compensation in California: A Guidebook for Injured Workers**. A complete copy of the Guidebook may be obtained at the website of the Division of Workers' Compensation (see *URL* below) or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation.

Guidebook for Injured Workers:
http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html
[***(Select the 1 or 2 below as appropriate for the notice:)***

(1) Temporary Disability is discussed in chapter 5 of the Guidebook.

Chapter 5: Temporary Disability:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter5.pdf

(2) Permanent Disability is discussed in chapter 7 of the Guidebook.

Chapter 7: Permanent Disability:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter7.pdf]

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

MANDATORY LANGUAGE: Select one of the following:]

[Include the following two paragraphs for all claims not subject to an alternative dispute resolution (ADR) program:]

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call, [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***]. You also have the right to be represented by an attorney of your choice. However, if you are represented by an attorney, you should call your attorney, not [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***].

For information about the workers' compensation claims process and your rights and obligations, go to www.dir.ca.gov or contact an information and assistance (I&A) officer of the State Division of Workers' Compensation. For recorded information and a list of offices, call (800)736-7401.

[For claims subject to an ADR program, include to the extent appropriate according to the ADR agreement:]

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***] or ***(insert name, title and telephone of ombudsperson or mediator)***. However, if you are represented by an attorney, you should call your attorney, not [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***], the ombudsperson or mediator.

[Optional language for claims subject to an ADR program under LC §3201.5 – Include if appropriate under the provisions of the ADR program:]

In accordance with the INSERT UNION NAME *agreement, active participation by an attorney is not allowed in the Ombudsman and Mediation stages of the ADR workers' compensation process. However, you have the right to consult with an attorney and your right to obtain legal advice is not limited and you may obtain such at your own expense at any time. If the Ombudsman and Mediation stages of dispute resolution are unsuccessful and a written request for Arbitration has been timely filed, attorney participation is allowed.*

For information about the workers' compensation claims process and your rights and obligations, contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. Be sure to inform the I&A officer that your claim is subject to an alternative dispute resolution program. For a list of offices, go to www.dwc.ca.gov or call (800) 736-7401.]

[MANDATORY LANGUAGE – required on all notices in bold type.]

Keep this notice. It contains important information about your workers' compensation benefits.

Sincerely,

_____

Claims Examiner

cc: APPLICANT ATTORNEY ***(if any)***
Enc.: 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
[include if available] *Website address*

Date ***[Option]*** SENT VIA E-MAIL TO employee's e-mail address

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING [Choose one: TEMPORARY DISABILITY / PERMANENT 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. ***(If based on a medical report, insert the following)*** *A copy of the report is attached to this notice.*

Benefits paid to you total $ AMOUNT. Benefits were paid to you as ***(select one)*** *temporary total disability / salary continuation / temporary partial disability / permanent disability*: Period(s) paid were from DATE through DATE at $RATE per week. Please see the attached detailed payment record for specific periods and amount paid.

[Complete / delete the following as appropriate:]

- 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.

[If benefit is terminated for medical issue and employee unrepresented, include the following, select (1) or (2).]

(1) The termination of BENEFIT TYPE is based on the comprehensive medical evaluation of QME (***insert name***) dated (***insert date of report***). If you dispute the results of the evaluation, you may file an Application for Adjudication of Claim with the WCAB.

(2) The termination of BENEFIT TYPE is based on the evaluation of treating physician (***insert name***) dated (***insert date of report***)**.** If you disagree with the results of the evaluation of the treating physician, you may obtain an evaluation by a Qualified Medical Evaluator (QME). (***Select (a) if the employee has not previously been evaluated by a QME, or (b) if the employee has previously been evaluated by a QME:)***

(c) To request a QME you must either contact (***insert "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***) to request the form to submit to the state Division of Workers' Compensation (DWC) to request a panel of three Qualified Medical Evaluators (QMEs), or you may download the form from the DWC website: http://www.dir.ca.gov/dwc/FORMS/QMEForms/QMEForm105.pdf. Instructions for completion of the form are found here: http://www.dir.ca.gov/dwc/FORMS/QMEForms/QMEForm105-Instructions.pdf. You must notify me in writing of your objection to the determination of the treating physician within thirty (30) days of the date you received the treating physician's report.

(d) Please contact (***insert*** "me, the ADJUSTER'S NAME" ***or a specific claims department name and telephone number***) to arrange for a new evaluation with QME (***insert name***).

[If benefit terminated for medical issue and employee is represented, include the following:]
If you are represented, you may contact your attorney with any questions.

MANDATORY: include for all notices:

Additional information may be found in the publication ***Workers' Compensation in California: A Guidebook for Injured Workers***. A complete copy of the Guidebook may be obtained on the Division of Workers' Compensation website (see *URL* below) or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation.

Guidebook for Injured Workers:
http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html

[Select the 1 or 2 below as appropriate for the notice:]

(1) Temporary Disability is discussed in chapter 5 of the Guidebook.

Chapter 5: Temporary Disability:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter5.pdf

(2) Permanent Disability is discussed in chapter 7 of the Guidebook.

Chapter 7: Permanent Disability: http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter7.pdf]

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

[MANDATORY LANGUAGE: Select one of the following:]

[Include the following two paragraphs for all claims not subject to an alternative dispute resolution (ADR) program:]

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call, **[*insert either "*me, the ADJUSTER'S NAME*" or a specific claims department name and telephone number***]. You also have the right to be represented by an attorney of your choice. However, if you are represented by an attorney, you should call your attorney, not **[*insert either "*me, the ADJUSTER'S NAME*" or a specific claims department name and telephone number***].

For information about the workers' compensation claims process and your rights and obligations, go to www.dir.ca.gov or contact an information and assistance (I&A) officer of the State Division of Workers' Compensation. For recorded information and a list of offices, call (800)736-7401.

[For claims subject to an ADR program, include to the extent appropriate according to the ADR agreement:]

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call **[*insert either "*me, the ADJUSTER'S NAME*" or a specific claims department name and telephone number***] or ***(insert name, title and telephone of ombudsperson or mediator)***. However, if you are represented by an attorney, you should call your attorney, not **[*insert either "*me, the ADJUSTER'S NAME*" or a specific claims department name and telephone number*],** the ombudsperson or mediator.

[Optional language for claims subject to an ADR program under LC §3201.5 – Include if appropriate under the provisions of the ADR program:]

In accordance with the INSERT UNION NAME *agreement, active participation by an attorney is not allowed in the Ombudsman and Mediation stages of the ADR workers' compensation process. However, you have the right to consult with an attorney and your right to obtain legal advice is not limited and you may obtain such at your own expense at any time. If the Ombudsman and Mediation stages of dispute resolution are unsuccessful and a written request for Arbitration has been timely filed, attorney participation is allowed.*

For information about the workers' compensation claims process and your rights and obligations, contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. Be sure to inform the I&A officer that your claim is subject to an alternative dispute resolution program. For a list of offices, go to www.dwc.ca.gov or call (800) 736-7401.]

[MANDATORY LANGUAGE – required on all notices in bold type.]
Keep this notice. It contains important information about your workers' compensation benefits.

Sincerely,

_____
Claims Examiner

cc: APPLICANT ATTORNEY ***(if any)***

Enc.:
- Payment record
- Medical report ***(if applicable)***
- 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
[include if available] *Website address*

Date ***[Option]*** SENT VIA E-MAIL TO employee's e-mail address

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.

[Include one of the following 4 paragraphs:

(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 future medical care. I expect to have this information by **DATE**. I will notify you of the status of permanent disability at that time.

(2) Subsequent notice - knowledge of P&S, existence of PD and/or need for future medical care unknown:
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.

(3) Subsequent notice – knowledge of P&S and need for future medical care, but existence of PD is unknown:

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 that there is need for further medical care, we do not know if you have 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.

(4) ***Subsequent notice – knowledge of P&S and the existence of PD, but need for future medical care is unknown. Please note that if it is known that the injury has caused PD, a Notice that Permanent Disability Exists as required under Title 8, CCR §9812(e)(2), must be sent at the same time as the last payment of temporary disability or within 14 days after knowledge that the injury has caused permanent disability, whichever is later. This option should only be used to delay the determination of the need for future medical care, if needed.***

On **DATE** a notice issued advising that we would continue to check with your doctor to determine the status of future medical care 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 know 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 future medical care at that time.

Mandatory: include for all notices:

Additional information may be found in the publication **Workers' Compensation in California: A Guidebook for Injured Workers**. A complete copy of the Guidebook may be obtained on the Division of Workers' Compensation website (see *URL* below) or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation. Permanent Disability is discussed in chapter 7 of the Guidebook.

Guidebook for Injured Workers:
http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html

Chapter 7: Permanent Disability:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter7.pdf

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

[MANDATORY LANGUAGE: Select one of the following:]

[Include the following two paragraphs for all claims not subject to an alternative dispute resolution (ADR) program:]

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call, [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***]. You also have the right

to be represented by an attorney of your choice. However, if you are represented by an attorney, you should call your attorney, not [***insert either me, the adjuster's name or a specific claims department name and telephone number***].

For information about the workers' compensation claims process and your rights and obligations, go to www.dir.ca.gov or contact an information and assistance (I&A) officer of the State Division of Workers' Compensation. For recorded information and a list of offices, call (800)736-7401.

[For claims subject to an ADR program, include to the extent appropriate according to the ADR agreement:]

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***] or ***(insert name, title and telephone of ombudsperson or mediator)***. However, if you are represented by an attorney, you should call your attorney, not [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***],** the ombudsperson or mediator.

[Optional language for claims subject to an ADR program under LC §3201.5 – Include if appropriate under the provisions of the ADR program:]

In accordance with the INSERT UNION NAME *agreement, active participation by an attorney is not allowed in the Ombudsman and Mediation stages of the ADR workers' compensation process. However, you have the right to consult with an attorney and your right to obtain legal advice is not limited and you may obtain such at your own expense at any time. If the Ombudsman and Mediation stages of dispute resolution are unsuccessful and a written request for Arbitration has been timely filed, attorney participation is allowed.*

For information about the workers' compensation claims process and your rights and obligations, contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. Be sure to inform the I&A officer that your claim is subject to an alternative dispute resolution program. For a list of offices, go to www.dwc.ca.gov or call (800) 736-7401.]

[MANDATORY LANGUAGE – required on all notices in bold type.]

Keep this notice. It contains important information about your workers' compensation benefits.

Sincerely,

_____

Claims Examiner

cc: APPLICANT ATTORNEY ***(if any)***

Enc.: Medical Report(s) (***As required by specific regulations***)
Claims Administrator Name
Address
City_State_Zip
Telephone Number
[include if available] *Website address*

Date

[Option] SENT VIA E-MAIL TO employee's e-mail address

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 you have permanent disability in the report(s) dated DATE(s) from PHYSICIAN NAME(s) which ***(select one)*** *is/are* enclosed. Based on the information provided in the report(s), your permanent disability rating is PERCENTAGE**%**. This rating is equivalent to $TOTAL AMOUNT, which is paid at the weekly permanent disability rate of $RATE for NUMBER weeks.

[A: Select either (1) or (2) below to address future medical care:]

(1) The report indicates that you ***(select one)*** *are / are not* in need of future medical care.

(2) While your doctor has determined your condition is permanent and stationary on **DATE** and has provided factors of permanent disability, we do not know if there is need for future medical care. We have not received the necessary information and we are therefore extending the determination date regarding future medical care to DATE. I will notify you of the status of future medical care at that time.

[B. For all dates of injury: If LC4650(b)(2) applies, include the following:]
Permanent disability payments are not due at this time because ***[Select (1) or (2)]:***
(1) your employer offered you a position paying at least 85 percent of your wages and compensation at the time of injury. When a settlement or award for benefits is made, your permanent disability payments shall be calculated from the last date of temporary disability payments, or the date you became permanent and stationary, whichever is earlier.
Or:
(2) you have returned to work receiving 100 percent of your wages at the time of injury. When a settlement or award for benefits is made, your permanent disability payments shall be

calculated from the last date of temporary disability payments, or the date you became permanent and stationary, whichever is earlier.

[Mandatory: include for all claims:]

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

[Important: Choose appropriate option below for unrepresented or represented employee:]

[C. If employee unrepresented, include the following:]

[(1) Choose A or B if the determination is based on the findings of a treating physician:]

(A) We ***(select one)*** *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.

(B) 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.

[(2) Choose (A) if determination is based on a comprehensive medical evaluation of QME or B if determination is based upon evaluation of the treating physician.]

(A) The determination of permanent disability is based on the comprehensive medical evaluation of QME (***insert name***) dated ***(insert date of report***). If you dispute the results of the evaluation, you may file an Application for Adjudication of Claim with the WCAB.

(B) The determination of permanent disability is based on the evaluation of treating physician **(*insert name*)** dated ***(insert date of report*).** I ***(select one)*** *agree/disagree* with the results of the evaluation. If you disagree with the results of the evaluation of the treating physician, you may obtain an evaluation by a Qualified Medical Evaluator (QME). You must notify me in writing of your objection to the determination of the treating physician within thirty (30) days of the date you received the treating physician's report. ***(Select 1 if the employee has not previously been evaluated by a QME, or 2 if the employee has previously been evaluated by a QME:)***

(e) To request a QME you must either contact (***insert "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***) to request the form to submit to the state Division of Workers' Compensation (DWC) to request a panel of three Qualified Medical Evaluators (QMEs), or you may download the form from the DWC website: http://www.dir.ca.gov/dwc/FORMS/QMEForms/QMEForm105.pdf. Instructions for completion of the form are found here: http://www.dir.ca.gov/dwc/FORMS/QMEForms/QMEForm105-Instructions.pdf.

(f) Please contact **(*insert* "**me, the ADJUSTER'S NAME*" or a specific claims department name and telephone number*)** to arrange for a new evaluation with QME (***insert name***) if you disagree with the results of the evaluation of the treating physician.

[D. If employee is represented, include the following:]

If you are represented, you may contact your attorney with any questions.

Mandatory: include for all notices:

Additional information may be found in the publication ***Workers' Compensation in California: A Guidebook for Injured Workers***. A complete copy of the Guidebook may be obtained on the Division of Workers' Compensation website (see *URL* below) or by contacting

an Information and Assistance (I&A) Officer of the Division of Workers' Compensation. Permanent Disability is discussed in chapter 7 of the Guidebook.

Guidebook for Injured Workers:
http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html

Chapter 7: Permanent Disability:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter7.pdf

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

[Mandatory Language: Select one of the following:]

[Include the following two paragraphs for all claims not subject to an alternative dispute resolution (ADR) program:]

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call, **[*insert either "*** me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***]. You also have the right to be represented by an attorney of your choice. However, if you are represented by an attorney, you should call your attorney, not **[*insert either "*** me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***]. For information about the workers' compensation claims process and your rights and obligations, go to www.dir.ca.gov or contact an information and assistance (I&A) officer of the State Division of Workers' Compensation. For recorded information and a list of offices, call (800)736-7401.

[For claims subject to an ADR program, include to the extent appropriate according to the ADR agreement:]

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call **[*insert either "*** me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***] or ***(insert name, title and telephone of ombudsperson or mediator)***. However, if you are represented by an attorney, you should call your attorney, not **[*insert either "*** me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***]**,** the ombudsperson or mediator.

[Optional language for claims subject to an ADR program under LC §3201.5 – Include if appropriate under the provisions of the ADR program:]

In accordance with the INSERT UNION NAME *agreement, active participation by an attorney is not allowed in the Ombudsman and Mediation stages of the ADR workers' compensation process. However, you have the right to consult with an attorney and your right to obtain legal advice is not limited and you may obtain such at your own expense at any time. If the Ombudsman and Mediation stages of dispute resolution are unsuccessful and a written request for Arbitration has been timely filed, attorney participation is allowed.*

For information about the workers' compensation claims process and your rights and obligations, contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. Be sure to inform the I&A officer that your claim is subject to an alternative dispute resolution program. For a list of offices, go to www.dwc.ca.gov or call (800) 736-7401.]

[Mandatory Language – required on all notices in bold type.]

Keep this notice. It contains important information about your workers' compensation benefits.

Sincerely,

_____

Claims Examiner
cc: APPLICANT ATTORNEY ***(if any)***
Enc.: Medical Reports ***(As required by specific regulations)***

Claims Administrator Name
Address
City_State_Zip
Telephone Number
[include if available] *Website address*

Date ***[Option]*** SENT VIA E-MAIL TO employee's e-mail address

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 ***(choose one)*** *returned to work / were released to return to work / were discharged from care.*

[A. Select 1 or 2]

(1) Based upon the report of DATE from PHYSICIAN'S NAME, ***(select one)*** *your treating physician / a Qualified Medical Evaluator / an Agreed Medical Evaluator*,

(2) Based on (***insert non-medical or other basis for determination)***, you have recovered from your injury with no permanent disability. For this reason, no permanent disability payments are payable. ***(Include if based on a medical report:)*** *A copy of the report is attached to this notice.*

[Mandatory: include for all claims:]

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

[Important: Choose appropriate option below for unrepresented or represented employee:]

[B. If employee unrepresented, include the following:]

[(1) Choose A or B if the determination is based on the findings of a treating physician:]

(A) We ***(select one)*** *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.

(B) 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.

[(2) Choose (A) if determination is based on a comprehensive medical evaluation of QME or B if determination is based upon evaluation of the treating physician.]

(A) The determination of permanent disability is based on the comprehensive medical evaluation of QME (***insert name***) dated ***(insert date of report***). If you dispute the results of the evaluation, you may file an Application for Adjudication of Claim with the WCAB.

(B) The determination of permanent disability is based on the evaluation of treating physician **(*insert name*)** dated ***(insert date of report*).** I ***(select one)*** *agree/disagree* with the results of the evaluation. If you disagree with the results of the evaluation of the treating physician, you may obtain an evaluation by a Qualified Medical Evaluator (QME). You must notify me in writing of your objection to the determination of the treating physician within thirty (30) days of the date you received the treating physician's report. ***(Select 1 if the employee has not previously been evaluated by a QME, or 2 if the employee has previously been evaluated by a QME:)***

(a) To request a QME you must either contact (***insert "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***) to request the form to submit to the state Division of Workers' Compensation (DWC) to request a panel of three Qualified Medical Evaluators (QMEs), or you may download the form from the DWC website: http://www.dir.ca.gov/dwc/FORMS/QMEForms/QMEForm105.pdf. Instructions for completion of the form are found here: http://www.dir.ca.gov/dwc/FORMS/QMEForms/QMEForm105-Instructions.pdf.

(b) Please contact **(*insert* "**me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number*)** to arrange for a new evaluation with QME (***insert name***) if you disagree with the results of the evaluation of the treating physician.

[C. <u>If employee is represented, include the following:</u>]
If you are represented, you may contact your attorney with any questions.

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.

<u>Mandatory: include for all notices:</u>
Additional information may be found in the publication ***Workers' Compensation in California: A Guidebook for Injured Workers***. A complete copy of the Guidebook may be obtained on the Division of Workers' Compensation website (see *URL* below) or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation. Permanent Disability is discussed in chapter 7 of the Guidebook.
Guidebook for Injured Workers:
http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html
Chapter 7: Permanent Disability:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter7.pdf
The State of California requires that you be given the following information:
<u>[Mandatory Language: Select one of the following:]</u>
<u>[Include the following two paragraphs for all claims not subject to an alternative dispute resolution (ADR) program:]</u>

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call, **[*insert either* "**me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***]. You also have the right to be represented by an attorney of your choice. However, if you are represented by an attorney, you should call your attorney, not **[*insert either* "**me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***]. For information about the workers' compensation claims process and your rights and obligations, go to www.dir.ca.gov or contact an information and assistance (I&A) officer of the State Division of Workers' Compensation. For recorded information and a list of offices, call (800)736-7401.

[For claims subject to an ADR program, include to the extent appropriate according to the ADR agreement:]

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call **[*insert either* "**me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***] or ***(insert name, title and telephone of ombudsperson or mediator)***. However, if you are represented by an attorney, you should call your attorney, not **[*insert either* "**me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***]**,** the ombudsperson or mediator.

[Optional language for claims subject to an ADR program under LC §3201.5 – Include if appropriate under the provisions of the ADR program:]

In accordance with the INSERT UNION NAME *agreement, active participation by an attorney is not allowed in the Ombudsman and Mediation stages of the ADR workers' compensation process. However, you have the right to consult with an attorney and your right to obtain legal advice is not limited and you may obtain such at your own expense at any time. If the Ombudsman and Mediation stages of dispute resolution are unsuccessful and a written request for Arbitration has been timely filed, attorney participation is allowed.*

For information about the workers' compensation claims process and your rights and obligations, contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. Be sure to inform the I&A officer that your claim is subject to an alternative dispute resolution program. For a list of offices, go to www.dwc.ca.gov or call (800) 736-7401.

[Mandatory Language – required on all notices in bold type.]

Keep this notice. It contains important information about your workers' compensation benefits.

Sincerely,

_____

Claims Examiner

cc: APPLICANT ATTORNEY ***(if any)***

Enc.: Medical Report(s) ***(As required by specific regulations)***

Claims Administrator Name
Address
City_State_Zip
Telephone Number
[include if available] *Website address*

Date ***[Option]*** SENT VIA E-MAIL TO employee's e-mail address

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING PERMANENT DISABILITY BENEFITS

PAYMENT START

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 starting for permanent disability and is ***(select 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 for NUMBER weeks until $TOTAL DUE has been paid. These payments will be deducted from any award you may receive. The amount of permanent disability to be paid is based upon:

[Select (1) or (2)]
(1) the report dated DATE from PHYSICIAN NAME. A copy of the report is attached to this notice. The report indicates that you ***(select one)*** *are / are not* in need of future medical care.

(2) EXPLANATION OF ESTIMATED PERMANENT DISABILITY DUE.

MANDATORY: include for all notices:
Additional information may be found in the publication ***Workers' Compensation in California: A Guidebook for Injured Workers***. A complete copy of the Guidebook may be obtained on the Division of Workers' Compensation website (see *URL* below) or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation. Permanent Disability is discussed in chapter 7 of the Guidebook.

Guidebook for Injured Workers:
http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html

Chapter 7: Permanent Disability:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter7.pdf

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

[MANDATORY LANGUAGE: Select one of the following:]

[Include the following two paragraphs for all claims not subject to an alternative dispute resolution (ADR) program:]

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call, **[*insert either "*me, the ADJUSTER'S NAME*" or a specific claims department name and telephone number*]**. You also have the right to be represented by an attorney of your choice. However, if you are represented by an attorney, you should call your attorney, not **[*insert either "*me, the ADJUSTER'S NAME*" or a specific claims department name and telephone number*]**.

For information about the workers' compensation claims process and your rights and obligations, go to www.dir.ca.gov or contact an information and assistance (I&A) officer of the State Division of Workers' Compensation. For recorded information and a list of offices, call (800)736-7401.

[For claims subject to an ADR program, include to the extent appropriate according to the ADR agreement:]

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call **[*insert either "*me, the ADJUSTER'S NAME*" or a specific claims department name and telephone number*]** or ***(insert name, title and telephone of ombudsperson or mediator)***. However, if you are represented by an attorney, you should call your attorney, not **[*insert either "*me, the ADJUSTER'S NAME*" or a specific claims department name and telephone number*],** the ombudsperson or mediator.

[Optional language for claims subject to an ADR program under LC §3201.5 – Include if appropriate under the provisions of the ADR program:]

In accordance with the INSERT UNION NAME *agreement, active participation by an attorney is not allowed in the Ombudsman and Mediation stages of the ADR workers' compensation process. However, you have the right to consult with an attorney and your right to obtain legal advice is not limited and you may obtain such at your own expense at any time. If the Ombudsman and Mediation stages of dispute resolution are unsuccessful and a written request for Arbitration has been timely filed, attorney participation is allowed.*

For information about the workers' compensation claims process and your rights and obligations, contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. Be sure to inform the I&A officer that your claim is subject to an

alternative dispute resolution program. For a list of offices, go to www.dwc.ca.gov or call (800) 736-7401.

[MANDATORY LANGUAGE – required on all notices in bold type.]
Keep this notice. It contains important information about your workers' compensation benefits.

Sincerely,

_____
Claims Examiner

cc: APPLICANT ATTORNEY ***(if any)***

Enc.: Medical Report(s) (***As required by specific regulations)***

Claims Administrator Name
Address
City_State_Zip
Telephone Number
[include if available] *Website address*

Date ***[Option]*** SENT VIA E-MAIL TO employee's e-mail address

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.

Select 1 or 2:

(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. ***(If denial is based on a medical report, insert the following):*** A copy of the report is attached to this notice.

(2) PARTIAL DENIAL: After careful consideration of all available information, we are accepting liability only for your claim of injury to LIST ACCEPTED BODY PART(S). Liability is being denied for LIST DENIED BODY PART(S) because EXPLANATION FOR PARTIAL DENIAL OF BENEFIT. ***(If denial is based on a medical report, insert the following):*** A copy of the report is attached to this notice.

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 immediately 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 that liability for the claim is rejected.

If employee unrepresented and determination based on a medical report, select (1), (2) or (3) below:

(1)(Choose if the employee has not previously received a comprehensive medical evaluation:)

If you disagree with the decision to deny your claim and wish to obtain a comprehensive medical evaluation, enclosed is a form that you must submit to the state Division of Workers' Compensation (DWC) within **10 days** to request a panel of three Qualified Medical Evaluators (QMEs). If you do not submit the form within **10 days** we will have the right to submit the form. In addition, within **10 days** after the DWC sends you a panel, you must choose a QME from the panel, make an appointment to be examined by the QME, and inform me of your choice and appointment time. If you inform us of your choice but you do not arrange the appointment, we will arrange the appointment. If you do not inform us of your choice, we may choose the QME who will examine you and arrange the appointment.

Choose (2) or (3) if the employee has already received a comprehensive medical evaluation:

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

(3) Since you have already received a comprehensive medical evaluation, if you disagree with the decision to deny your claim, please contact (*insert* ***"me, the ADJUSTER'S NAME"*** *or a specific claims department name and telephone number*) to arrange to return to the same medical evaluator for a new evaluation.

If employee is represented, include the following:

If you are represented, you may contact your attorney with any questions.

MANDATORY: include for all notices:

Additional information may be found in the publication **Workers' Compensation in California: A Guidebook for Injured Workers**. A complete copy of the Guidebook may be obtained at the website of the Division of Workers' Compensation (see *URL* below) or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation. Chapters 2, 4 and 9 of the Guidebook contain information addressing the determination of liability for a workers' compensation claim and the QME process.

Guidebook for Injured Workers:
http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html

Chapter 2: After You Get Hurt on the Job

http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter2.pdf

Chapter 4: Resolving Problems with Medical Care and Medical Reports:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter4.pdf

Chapter 9: For More Information and Help
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter9.pdf

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

[MANDATORY LANGUAGE: Select one of the following:]

[Include the following two paragraphs for all claims not subject to an alternative dispute resolution (ADR) program:]

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call, [***insert "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***]. You also have the right to be represented by an attorney of your choice. However, if you are represented by an attorney, you should call your attorney, not [***insert either me, the adjuster's name or a specific claims department name and telephone number***].

For information about the workers' compensation claims process and your rights and obligations, go to www.dir.ca.gov or contact an information and assistance (I&A) officer of the State Division of Workers' Compensation. For recorded information and a list of offices, call (800)736-7401.

[For claims subject to an ADR program, include to the extent appropriate according to the ADR agreement:]

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***] or ***(insert name, title and telephone of ombudsperson or mediator)***. However, if you are represented by an attorney, you should call your attorney, not [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***],** the ombudsperson or mediator.

[Optional language for claims subject to an ADR program under LC §3201.5 – Include if appropriate under the provisions of the ADR program:]

In accordance with the INSERT UNION NAME *agreement, active participation by an attorney is not allowed in the Ombudsman and Mediation stages of the ADR workers' compensation process. However, you have the right to consult with an attorney and your right to obtain legal advice is not limited and you may obtain such at your own expense at any time. If the Ombudsman and Mediation stages of dispute resolution are unsuccessful and a written request for Arbitration has been timely filed, attorney participation is allowed.*

For information about the workers' compensation claims process and your rights and obligations, contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. Be sure to inform the I&A officer that your claim is subject to an alternative dispute resolution program. For a list of offices, go to www.dwc.ca.gov or call (800) 736-7401.]

[MANDATORY LANGUAGE – required on all notices in bold type.]
Keep this notice. It contains important information about your workers' compensation benefits.

Sincerely,

_____
Claims Examiner

cc: APPLICANT ATTORNEY ***(if any)***
SERVICE PROVIDERS ON FILE
LIEN CLAIMANT(S)

Enc.: ***(Choose enclosures as appropriate.)***
- Medical Report(s) ***(if applicable)***
- QME Panel form (QME Form 105 and attachment) ***(to unrepresented employees)***

Claims Administrator Name
Address
City_State_Zip
Telephone Number
[include if available] *Website address*

Date ***[Option]*** SENT VIA E-MAIL TO employee's e-mail address

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.

Select (1), (2)or (3):

(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.

(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.

(3) Subsequent notice(s): On DATE a notice was 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.

[*(Include if the delay is related to a medical issue and the claims administrator is requesting a comprehensive medical evaluation for an unrepresented employee:)]*

To resolve this issue and allow me to make a determination on your entitlement to benefits, a comprehensive medical evaluation is needed. Enclosed is a form that you must submit to the state Division of Workers' Compensation (DWC) within **10 days** to request a panel of three Qualified Medical Evaluators (QMEs). If you do not submit the form within **10 days** we will have the right to submit the form. In addition, within **10 days** after the DWC sends you a panel, you must choose a QME from the panel, make an appointment to be examined by the QME, and inform me of your choice and appointment time. If you inform us of your choice but you do not arrange the appointment, we will arrange the appointment. If you do not inform us of your choice, we may choose the QME who will examine you and arrange the appointment.

If employee is represented, include the following:

If you are represented, you may contact your attorney with any questions.

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 medical treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide such 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).

MANDATORY: include for all notices:

Additional information may be found in the publication ***Workers' Compensation in California: A Guidebook for Injured Workers.*** A complete copy of the Guidebook may be obtained at the website of the Division of Workers' Compensation (see *URL* below) or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation. Chapters 2, 4 and 9 of the Guidebook contain information addressing the determination of liability for a workers' compensation claim and the QME process.

Guidebook for Injured Workers:
http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html

Chapter 2: After You Get Hurt on the Job
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter2.pdf

Chapter 4: Resolving Problems with Medical Care and Medical Reports:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter4.pdf

Chapter 9: For More Information and Help
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter9.pdf

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

[MANDATORY LANGUAGE: Select one of the following:]

[Include the following two paragraphs for all claims not subject to an alternative dispute resolution (ADR) program:]

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call, [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***]. You also have the right to be represented by an attorney of your choice. However, if you are represented by an attorney, you should call your attorney, not [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***].

For information about the workers' compensation claims process and your rights and obligations, go to www.dir.ca.gov or contact an information and assistance (I&A) officer of the State Division of Workers' Compensation. For recorded information and a list of offices, call (800)736-7401.

[For claims subject to an ADR program, include to the extent appropriate according to the ADR agreement:]

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***] or ***(insert name, title and telephone of ombudsperson or mediator)***. However, if you are represented by an attorney, you should call your attorney, not [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***],** the ombudsperson or mediator.

[Optional language for claims subject to an ADR program under LC §3201.5 – Include if appropriate under the provisions of the ADR program:]

In accordance with the INSERT UNION NAME *agreement, active participation by an attorney is not allowed in the Ombudsman and Mediation stages of the ADR workers' compensation process. However, you have the right to consult with an attorney and your right to obtain legal advice is not limited and you may obtain such at your own expense at any time. If the Ombudsman and Mediation stages of dispute resolution are unsuccessful and a written request for Arbitration has been timely filed, attorney participation is allowed.*

For information about the workers' compensation claims process and your rights and obligations, contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. Be sure to inform the I&A officer that your claim is subject to an alternative dispute resolution program. For a list of offices, go to www.dwc.ca.gov or call (800) 736-7401.]

[MANDATORY LANGUAGE – required on all notices in bold type.]

Keep this notice. It contains important information about your workers' compensation benefits.

Sincerely,

_____

Claims Examiner

cc: APPLICANT ATTORNEY ***(if any)***

Enc.: QME Panel form (QME Form 105 and attachment) ***(if applicable)***

Claims Administrator Name
Address
City_State_Zip
Telephone Number
[include if available] *Website address*

Date ***[Option]*** SENT VIA E-MAIL TO employee's e-mail address

Employee
Address
City_State_Zip

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.

[Include one or both of the following:]

(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 ***(select one:)*** *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.

(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 ***(select one:)*** *enclosed / sent separately*. The weekly compensation rate is $INSERT RATE based on EXPLANATION.]

MANDATORY: include for all notices:

Additional information may be found in the publication **Workers' Compensation in California: A Guidebook for Injured Workers**. A complete copy of the Guidebook may be obtained at the website of the Division of Workers' Compensation (see *URL* below) or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation.

Guidebook for Injured Workers:
http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html

(1) Death Benefits are discussed in chapter 1 of the Guidebook.
Chapter 1: The basics of workers' Compensation:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter1.pdf

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

[MANDATORY LANGUAGE: Select one of the following:]

[Include the following two paragraphs for all claims not subject to an alternative dispute resolution (ADR) program:]
You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call, [***insert either "***me, the ADJUSTER'S NAME***"or a specific claims department name and telephone number***]. You also have the right to be represented by an attorney of your choice. However, if you are represented by an attorney, you should call your attorney, not [***insert either "***me, the ADJUSTER'S NAME***" or a specific claims department name and telephone number***].

For information about the workers' compensation claims process and your rights and obligations, go to www.dir.ca.gov or contact an information and assistance (I&A) officer of the State Division of Workers' Compensation. For recorded information and a list of offices, call (800)736-7401.

[For claims subject to an ADR program, include to the extent appropriate according to the ADR agreement:]
You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call [***insert either "***me, the ADJUSTER'S NAME***"or a specific claims department name and telephone number***] or ***(insert name, title and telephone of ombudsperson or mediator)***. However, if you are represented by an attorney, you should call your attorney, not [***insert either "***me, the ADJUSTER'S NAME***"or a specific claims department name and telephone number***],** the ombudsperson or mediator.

[Optional language for claims subject to an ADR program under LC §3201.5 – Include if appropriate under the provisions of the ADR program:]
In accordance with the INSERT UNION NAME *agreement, active participation by an attorney is not allowed in the Ombudsman and Mediation stages of the ADR workers' compensation process. However, you*

have the right to consult with an attorney and your right to obtain legal advice is not limited and you may obtain such at your own expense at any time. If the Ombudsman and Mediation stages of dispute resolution are unsuccessful and a written request for Arbitration has been timely filed, attorney participation is allowed.

For information about the workers' compensation claims process and your rights and obligations, contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. Be sure to inform the I&A officer that your claim is subject to an alternative dispute resolution program. For a list of offices, go to www.dwc.ca.gov or call (800) 736-7401.]

[MANDATORY LANGUAGE – required on all notices in bold type.]

Keep this notice. It contains important information about your workers' compensation benefits.

Sincerely,

_____

Claims Examiner

cc: APPLICANT ATTORNEY ***(if any)***
DEPENDENT(S)

Claims Administrator Name
Address
City_State_Zip
Telephone Number
[include if available] *Website address*

Date ***[Option]*** SENT VIA E-MAIL TO employee's e-mail address

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING DEPENDENCY BENEFITS
CHANGE IN PAYMENT OR BENEFIT ENDING

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.

[Include one or more of the following]:
(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.

(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.

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

(4) INSERT EXPLANATION FOR OTHER CHANGE IN BENEFIT.

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

MANDATORY: include for all notices:

Additional information may be found in the publication ***Workers' Compensation in California: A Guidebook for Injured Workers***. A complete copy of the Guidebook may be obtained at the website of the Division of Workers' Compensation (see *URL* below) or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation.

Guidebook for Injured Workers:
http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html

Death Benefits are discussed in chapter 1 of the Guidebook.
Chapter 1: The basics of workers' Compensation:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter1.pdf

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

[MANDATORY LANGUAGE: Select one of the following:]

[Include the following two paragraphs for all claims not subject to an alternative dispute resolution (ADR) program:]
You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call, [***insert either me, the adjuster's name or a specific claims department name and telephone number***]. You also have the right to be represented by an attorney of your choice. However, if you are represented by an attorney, you should call your attorney, not [***insert either me, the adjuster's name or a specific claims department name and telephone number***].

For information about the workers' compensation claims process and your rights and obligations, go to www.dir.ca.gov or contact an information and assistance (I&A) officer of the State Division of Workers' Compensation. For recorded information and a list of offices, call (800)736-7401.

[For claims subject to an ADR program, include to the extent appropriate according to the ADR agreement:]
You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call [***insert either me, the adjuster's name or a specific claims department name and telephone number***] or ***(insert name, title and telephone of ombudsperson or mediator)***. However, if you are represented by an attorney, you

should call your attorney, not **[*insert either me, the adjuster's name or a specific claims department name and telephone number*],** the ombudsperson or mediator.

[Optional language for claims subject to an ADR program under LC §3201.5 – Include if appropriate under the provisions of the ADR program:]

In accordance with the INSERT UNION NAME *agreement, active participation by an attorney is not allowed in the Ombudsman and Mediation stages of the ADR workers' compensation process. However, you have the right to consult with an attorney and your right to obtain legal advice is not limited and you may obtain such at your own expense at any time. If the Ombudsman and Mediation stages of dispute resolution are unsuccessful and a written request for Arbitration has been timely filed, attorney participation is allowed.*

For information about the workers' compensation claims process and your rights and obligations, contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. Be sure to inform the I&A officer that your claim is subject to an alternative dispute resolution program. For a list of offices, go to www.dwc.ca.gov or call (800) 736-7401.

[MANDATORY LANGUAGE – required on all notices in bold type.]

Keep this notice. It contains important information about your workers' compensation benefits.

Sincerely,

_____

Claims Examiner

cc: APPLICANT ATTORNEY ***(if any)***
DEPENDENT(S)

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 benefit type of resuming indemnity payments. For TPD or PD, include and complete the applicable paragraphs.

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)

§9810(d) requires all notices to refer the employee (by chapter number and url) to the appropriate chapter of the publication "Workers' Compensation in California: A Guidebook for Injured Workers" that addresses the benefit(s) to which the notice pertains, and to advise the employee that a complete copy of the Guidebook may be obtained on the Division of Workers' Compensation's website at http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation.

Enclosures as appropriate to benefit:

- An explanation of the salary continuation plan specific to the employer is included (if applicable)

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, and permanent disability indemnity benefit rate, payment amount, or schedules. **Section 9812(f)(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).

§9810(d) requires all notices to refer the employee (by chapter number and url) to the appropriate chapter of the publication "Workers' Compensation in California: A Guidebook for Injured Workers" that addresses the benefit(s) to which the notice pertains, and to advise the employee that a complete copy of the Guidebook may be obtained on the Division of Workers' Compensation's website at

http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation.

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 TERMINATION

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(f)(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 must 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.

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 together with 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.

§9810(d) requires all notices to refer the employee (by chapter number and url) to the appropriate chapter of the publication "Workers' Compensation in California: A Guidebook for Injured Workers" that addresses the benefit(s) to which the notice pertains, and to advise the employee that a complete copy of the Guidebook may be obtained on the Division of Workers' Compensation's website at http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation.

Who to copy with notice:

- Applicant Attorney (if any)

Required enclosures /see specific regulations:

- An explanation of the salary continuation plan specific to the employer is included (if appropriate);
- Payment record

Every benefit notice shall contain the following statement in bold font at the end of the notice: **"Keep this notice. It contains important information about your workers' compensation benefits."**

Claims Administrator Name
Address
City_State_Zip
Telephone Number
[include if available] *Website address*

Date ***[Option]*** SENT VIA E-MAIL TO employee's e-mail address

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING
DELAY OF WORKERS' COMPENSATION DEPENDENCY BENEFITS

CLAIMS ADMINISTRATOR NAME is handling your workers' compensation claim 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.

[*Select one of the following:*]

(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.

(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.

(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.

(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.

MANDATORY: include for all notices:

Additional information may be found in the publication ***Workers' Compensation in California: A Guidebook for Injured Workers***. A complete copy of the Guidebook may be obtained at the website of the Division of Workers' Compensation (see *URL* below) or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation.

Guidebook for Injured Workers:
http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html

Death Benefits are discussed in chapter 1 of the Guidebook.
Chapter 1: The basics of workers' Compensation:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter1.pdf

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

[MANDATORY LANGUAGE: Select one of the following:]

[Include the following two paragraphs for all claims not subject to an alternative dispute resolution (ADR) program:]
You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call, [***insert either me, the adjuster's name or a specific claims department name and telephone number***]. You also have the right to be represented by an attorney of your choice. However, if you are represented by an attorney, you should call your attorney, not [***insert either me, the adjuster's name or a specific claims department name and telephone number***].

For information about the workers' compensation claims process and your rights and obligations, go to www.dir.ca.gov or contact an information and assistance (I&A) officer of the State Division of Workers' Compensation. For recorded information and a list of offices, call (800)736-7401.

[For claims subject to an ADR program, include to the extent appropriate according to the ADR agreement:]
You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call [***insert either me, the adjuster's name or a specific claims department name and telephone number***] or ***(insert name, title and telephone of ombudsperson or mediator)***. However, if you are represented by an attorney, you should call your attorney, not [***insert either me, the adjuster's name or a specific claims department name and telephone number***], the ombudsperson or mediator.

[Optional language for claims subject to an ADR program under LC §3201.5 – Include if appropriate under the provisions of the ADR program:]

In accordance with the INSERT UNION NAME *agreement, active participation by an attorney is not allowed in the Ombudsman and Mediation stages of the ADR workers' compensation process. However, you have the right to consult with an attorney and your right to obtain legal advice is not limited and you may obtain such at your own expense at any time. If the Ombudsman and Mediation stages of dispute resolution are unsuccessful and a written request for Arbitration has been timely filed, attorney participation is allowed.*

For information about the workers' compensation claims process and your rights and obligations, contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. Be sure to inform the I&A officer that your claim is subject to an alternative dispute resolution program. For a list of offices, go to www.dwc.ca.gov or call (800) 736-7401.

[MANDATORY LANGUAGE – required on all notices in bold type.]

Keep this notice. It contains important information about your workers' compensation benefits.

Sincerely,

_____

Claims Examiner

cc: APPLICANT ATTORNEY ***(if any)***
DEPENDENT(S)

Claims Administrator Name
Address
City_State_Zip
Telephone Number
[include if available] *Website address*

Date ***[Option]*** SENT VIA E-MAIL TO employee's e-mail address

Employee
Address
City_State_Zip

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.

[***Select one of the following:***]

(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.

(2) ***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.

MANDATORY: include for all notices:

Additional information may be found in the publication **Workers' Compensation in California: A Guidebook for Injured Workers**. A complete copy of the Guidebook may be obtained at the website of the Division of Workers' Compensation (see *URL* below) or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation.

Guidebook for Injured Workers:
http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html

(1) Death Benefits are discussed in chapter 1 of the Guidebook.
Chapter 1: The basics of workers' Compensation:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter1.pdf

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

[MANDATORY LANGUAGE: Select one of the following:]

[Include the following two paragraphs for all claims not subject to an alternative dispute resolution (ADR) program:]
You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call, **[*insert either me, the adjuster's name or a specific claims department name and telephone number*]**. You also have the right to be represented by an attorney of your choice. However, if you are represented by an attorney, you should call your attorney, not **[*insert either me, the adjuster's name or a specific claims department name and telephone number*]**.

For information about the workers' compensation claims process and your rights and obligations, go to www.dir.ca.gov or contact an information and assistance (I&A) officer of the State Division of Workers' Compensation. For recorded information and a list of offices, call (800)736-7401.

[For claims subject to an ADR program, include to the extent appropriate according to the ADR agreement:]
You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call **[*insert either me, the adjuster's name or a specific claims department name and telephone number*]** or ***(insert name, title and telephone of ombudsperson or mediator)***. However, if you are represented by an attorney, you should call your attorney, not **[*insert either me, the adjuster's name or a specific claims department name and telephone number*]**, the ombudsperson or mediator.

[Optional language for claims subject to an ADR program under LC §3201.5 – Include if appropriate under the provisions of the ADR program:]
In accordance with the INSERT UNION NAME *agreement, active participation by an attorney is not allowed in the Ombudsman and Mediation stages of the ADR workers' compensation process. However, you have the right to consult with an attorney and your right to obtain legal advice is not limited and you may obtain such at your own expense at any time. If the Ombudsman and Mediation stages of dispute resolution are unsuccessful and a written request for Arbitration has been timely filed, attorney participation is allowed.*

For information about the workers' compensation claims process and your rights and obligations, contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. Be sure to inform the I&A officer that your claim is subject to an

alternative dispute resolution program. For a list of offices, go to www.dwc.ca.gov or call (800) 736-7401.

[MANDATORY LANGUAGE – required on all notices in bold type.]
Keep this notice. It contains important information about your workers' compensation benefits.

Sincerely,

_____
Claims Examiner

cc: APPLICANT ATTORNEY ***(if any)***
DEPENDENT(S)

Claims Administrator Name
Address
City_State_Zip
Telephone Number
[include if available] *Website address*

Date ***[Option]*** SENT VIA E-MAIL TO employee's e-mail address

Employee
Address
City_State_Zip

Employer:
Date of Injury:
Claim Number:

NOTICE REGARDING

QME PANEL REQUEST FORM

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.

We have received your objection to the medical determination of PHYSICIAN'S NAME regarding ***(choose one or more of the following:)*** temporary disability / permanent disability / the need for future medical care / INSERT NATURE OF OTHER OBJECTION(S).

If you wish to obtain a comprehensive medical evaluation, enclosed is a form that you must submit to the state Division of Workers' Compensation (DWC) within **10 days** to request a panel of three Qualified Medical Evaluators (QMEs). If you do not submit the form within **10 days** we will have the right to submit the form. In addition, within **10 days** after the DWC sends you a panel, you must choose a QME from the panel, make an appointment to be examined by the QME, and inform me of your choice and appointment time. If you inform us of your choice but you do not arrange the appointment, we will arrange the appointment. If you do not inform us of your choice, we may choose the QME who will examine you and arrange the appointment.

Additional information may be found in the publication **Workers' Compensation in California: A Guidebook for Injured Workers**. A complete copy of the Guidebook may be obtained at the website of the Division of Workers' Compensation (see *URL* below) or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation. Chapter 4 of the Guidebook contains information regarding how to obtain a medical evaluation with a qualified medical evaluator (QME).

Guidebook for Injured Workers:
http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html

Chapter 4: Resolving Problems with Medical Care and Medical Reports:
http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter4.pdf

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

[MANDATORY LANGUAGE: Select one of the following:]

[Include the following two paragraphs for all claims not subject to an alternative dispute resolution (ADR) program:]

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call, [***insert either me, the adjuster's name or a specific claims department name and telephone number***]. You also have the right to be represented by an attorney of your choice. However, if you are represented by an attorney, you should call your attorney, not [***insert either me, the adjuster's name or a specific claims department name and telephone number***].

For information about the workers' compensation claims process and your rights and obligations, go to www.dir.ca.gov or contact an information and assistance (I&A) officer of the State Division of Workers' Compensation. For recorded information and a list of offices, call (800)736-7401.

[For claims subject to an ADR program, include to the extent appropriate according to the ADR agreement:]

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call [***insert either me, the adjuster's name or a specific claims department name and telephone number***] or ***(insert name, title and telephone of ombudsperson or mediator)***. However, if you are represented by an attorney, you should call your attorney, not [***insert either me, the adjuster's name or a specific claims department name and telephone number***], the ombudsperson or mediator.

[Optional language for claims subject to an ADR program under LC §3201.5 – Include if appropriate under the provisions of the ADR program:]

In accordance with the INSERT UNION NAME *agreement, active participation by an attorney is not allowed in the Ombudsman and Mediation stages of the ADR workers' compensation process. However, you have the right to consult with an attorney and your right to obtain legal advice is not limited and you may obtain such at your own expense at any time. If the Ombudsman and Mediation stages of dispute resolution are unsuccessful and a written request for Arbitration has been timely filed, attorney participation is allowed.*

For information about the workers' compensation claims process and your rights and obligations, contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. Be sure to inform the I&A officer that your claim is subject to an alternative dispute resolution program. For a list of offices, go to www.dwc.ca.gov or call (800) 736-7401.

[MANDATORY LANGUAGE – required on all notices in bold type.]
Keep this notice. It contains important information about your workers' compensation benefits.

Sincerely,

_____
Claims Examiner

Enc.:
- QME Panel form (QME Form 105 and attachment)
- Workers' Compensation Claim form (DWC-1) ***(if not previously provided)***

NOTICE OF DENIAL OF CLAIM FOR WORKERS' COMPENSATION BENEFITS

8 CCR §9812(h)

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(h). This regulation applies to all dates of injury. Section 9812(f)(4) provides requirements for denial of dependency (death) benefits for all dates of injury.

If denying all 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 denial. Delete inappropriate options.

If denying 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 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."

If the claim is denied for a medical issue, one of the four paragraphs addressing the employee's remedies must be included. Choose (1) if the employee is not represented by an attorney and the determination is based on a comprehensive medical evaluation; choose (2) or (3) if the unrepresented employee has already received a comprehensive medical evaluation; choose (4) if the employee is represented.

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).

§9810(d) requires all notices to refer the employee (by chapter number and url) to the appropriate chapter of the publication "Workers' Compensation in California: A Guidebook for Injured Workers" that addresses the benefit(s) to which the notice pertains, and to advise the employee that a complete copy of the Guidebook may be obtained on the Division of Workers' Compensation's website at http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation.

Required copy: All lien claimants, all claim for costs claimants, and all persons or entities that have been authorized by the claims administrator to furnish benefits, goods or services for which a lien or claim for costs 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, claim for costs claimants, authorized providers of benefits, goods or services for which a lien or claim for costs may be filed

Enclosures / see regulation:

- Medical report(s) ***[If the determination s based on a medical report, a copy of the medical report(s) shall be provided with the notice, except for psychiatric reports that the psychiatrist has recommended not to be provided to the employee.]***
- Workers' Compensation claim form (DWC-1) if not previously provided

NOTICE OF DELAY IN DETERMINING LIABILITY
FOR WORKERS' COMPENSATION BENEFITS

8 CCR §9812(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.

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

If delaying all 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 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. Attach a copy of the Request for QME Panel (QME) to the notice.

If the claims administrator wishes to request a comprehensive medical evaluation for an unrepresented employee, include the paragraph requesting the employee to submit the form to request the Panel.

For represented employees, include the appropriate paragraph.

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).

§9810(d) requires all notices to refer the employee (by chapter number and url) to the appropriate chapter of the publication "Workers' Compensation in California: A Guidebook for Injured Workers" that addresses the benefit(s) to which the notice pertains, and to advise the employee that a complete copy of the Guidebook may be obtained on the Division of Workers' Compensation's website at

http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation.

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:

- 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 TO PROVIDE PANEL QME REQUEST FORM
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.

Complete all non-optional sections of the form. Complete the date and choose the option best suited to your notice. Delete inappropriate options.

§9810(d) requires all notices to refer the employee (by chapter number and url) to the appropriate chapter of the publication "Workers' Compensation in California: A Guidebook for Injured Workers" that addresses the benefit(s) to which the notice pertains, and to advise the employee that a complete copy of the Guidebook may be obtained on the Division of Workers' Compensation's website at http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation.

When to send:

- Within ten business days of receipt of the unrepresented employee's objection to the medical determination of the treating physician.

Enclosures:

- QME Panel Request (QME Form 105 and attachment)
- Workers' Compensation claim form (DWC-1) if not previously provided

NOTICES REGARDING WORKERS' COMPENSATION DEPENDENCY BENEFITS

Title 8, CCR §§9812(f)(1) through (f)(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(f) 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(f)(1) through (f)(4). These notices are sent to each dependent. 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(f)(1).

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

Include paragraphs (1) **(For the first payment of death benefits)**

and/or

(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)**

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

§9810(d) requires all notices to refer the employee (by chapter number and url) to the appropriate chapter of the publication "Workers' Compensation in California: A Guidebook for Injured Workers" that addresses the benefit(s) to which the notice pertains, and to advise the employee that a complete copy of the Guidebook may be obtained on the Division of Workers' Compensation's website at http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation.

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; BENEFITS ENDING - §9812(f)(2)

Requirements for the notice are in §9812(f)(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.

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 when penalties were paid. An attachment detailing the payment record must 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.

§9810(d) requires all notices to refer the employee (by chapter number and url) to the appropriate chapter of the publication "Workers' Compensation in California: A Guidebook for Injured Workers" that addresses the benefit(s) to which the notice pertains, and to advise the employee that a complete copy of the Guidebook may be obtained on the Division of Workers' Compensation's website at http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation.

When to send:

- For change to rate, amount or schedule: before or with the changed payment, but not later than 14 days after the last payment made before the change.
- For payment ending: 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. ***(For benefits ending.)***

DEPENDENCY DELAY - §9812(f)(3)

Requirements for the notice are in Section 9812(f)(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.

§9810(d) requires all notices to refer the employee (by chapter number and url) to the appropriate chapter of the publication "Workers' Compensation in California: A Guidebook for Injured Workers" that addresses the benefit(s) to which the notice pertains, and to advise the employee that a complete copy of the Guidebook may be obtained on the Division of Workers' Compensation's website at http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation.

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 (f)(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."

§9810(d) requires all notices to refer the employee (by chapter number and url) to the appropriate chapter of the publication "Workers' Compensation in California: A Guidebook for

Injured Workers" that addresses the benefit(s) to which the notice pertains, and to advise the employee that a complete copy of the Guidebook may be obtained on the Division of Workers' Compensation's website at http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation.

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

Every benefit notice shall contain the following statement in bold font at the end of the notice: **"Keep this notice. It contains important information about your workers' compensation benefits."**

NOTICES REGARDING PERMANENT DISABILITY BENEFITS

8 CCR §§9812(e)

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, (1) "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, except as provided in paragraph (2). 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. (2) Prior to an award of permanent disability indemnity, a permanent disability indemnity payment shall not be required if the employer has offered the employee a position that pays at least 85 percent of the wages and compensation paid to the employee at the time of injury or if the employee is employed in a position that pays at least 100 percent of the wages and compensation paid to the employee at the time of injury, provided that when an award of permanent disability indemnity is made, the amount then due shall be calculated from the last date for which temporary disability indemnity was paid, or the date the employee's disability became permanent and stationary, whichever is earlier."

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

The model notices presented are in compliance with the benefit notice regulations [§9812(e)].

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 §9810(e). For claims subject to an alternative dispute resolution program, choose the alternate suggested language and modify as need to fit the ADR.

§9810(d) requires all notices to refer the employee (by chapter number and url) to the appropriate chapter of the publication "Workers' Compensation in California: A Guidebook for Injured Workers" that addresses the benefit(s) to which the notice pertains, and to advise the employee that a complete copy of the Guidebook may be obtained on the Division of Workers' Compensation's website at http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html or by contacting an Information and Assistance (I&A) Officer of the Division of Workers'

Compensation.

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 sections which can be used in different combinations to provide necessary information to the injured worker.

Every benefit notice shall contain the following statement in bold font at the end of the notice: **"Keep this notice. It contains important information about your workers' compensation benefits."**

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(e)(1)

Notice is due when TD terminates and the injury may result in permanent disability. Choose and complete the appropriate 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.

- **Paragraph 1:** Include for first notice with the termination of temporary disability (TD) when the injury is not permanent and stationary (P&S) and may cause permanent disability. If employee is not yet P&S by the determination date stated in the first notice, this paragraph should be included in the subsequent notice, with a new determination date stated.
- **Paragraph 2:** Include for 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**.**
- **Paragraph 3:** Include for subsequent notice when there is knowledge that the injury is P&S and advice regarding future medical care, but no factors for PD.
- **Paragraph 4:** Include for subsequent notice when there is knowledge that the injury is P&S, and factors for PD, but no advice regarding future medical care**. Important note: this option should only be used to delay the determination regarding future medical care. Notice that the employee has PD is required under Title 8, CCR §9812(e)(2) at the same time as the last payment of temporary disability or within 14 days after knowledge that the injury has caused permanent disability, whichever is later.**

§9810(d) requires all notices to refer the employee (by chapter number and url) to the appropriate chapter of the publication "Workers' Compensation in California: A Guidebook for Injured Workers" that addresses the benefit(s) to which the notice pertains, and to advise

the employee that a complete copy of the Guidebook may be obtained on the Division of Workers' Compensation's website at http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation.

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)

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

Notice is due at the same time as the last payment of temporary disability or within 14 days after knowledge that the injury has caused permanent disability, whichever is later. Complete all non-optional sections of the form. Complete the report date and physician's name. Complete the section(s) addressing the PD and future medical.

If the need for future medical care has not yet been determined, a follow-up notice addressing the need for future medical care should be sent once the determination has been made. See PD delay notice, option for paragraph 4 above.

Select the appropriate options advising employee of the right to disagree. Sections 9812(e)(2)(A) and (B) 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".

[The following optional language may be included if desired, for injuries occurring from January 1, 2005 through December 31, 2012, include the following if permanent and stationary:

The report advises your injury is permanent and stationary effective DATE.
Select (1), (2), or (3)]
(1) Your employer made a timely offer for you to return to ***(choose one)*** *regular /modified/alternative work* on DATE. The weekly PD rate of $RATE will be reduced by 15% to $REDUCED RATE effective INSERT OFFER DATE, the date of the offer of return to work.

(2) Your employer did not make a timely offer for you to return to regular, modified, or 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.

(3) Your employer is investigating whether or not regular, modified or alternative work may be offered to you. You will be advised within 60 days after INSERT P&S DATE whether your employer is able to offer you the opportunity to return to work.]

If PD payments will be delayed pursuant to LC§4650(b)(2), complete section B.

For unrepresented employees, complete section C.

For represented employees, complete section D.

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.

§9810(d) requires all notices to refer the employee (by chapter number and url) to the appropriate chapter of the publication "Workers' Compensation in California: A Guidebook for Injured Workers" that addresses the benefit(s) to which the notice pertains, and to advise the employee that a complete copy of the Guidebook may be obtained on the Division of Workers' Compensation's website at http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation.

When to send:

- At the same time as 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:

- Medical Report(s) (w/date)

PD DENIAL - Title 8, CCR §9812(e)(3)

Notice is due in cases where the employee has sustained compensable lost time from work, if the claims administrator alleges that the injury has caused no permanent disability in a case where either the employee has received payment of temporary disability indemnity or the employee claims permanent disability. 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(e)(3)(A) and (B) 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".

Complete section A, choosing either (1) or (2).

Where the employee is not represented by an attorney, choose the appropriate paragraphs from section B:

(1)(a) or (1)(b) if the determination is based on a treating physician's report (in which case, include 2(b)1. or 2. also);

(2)(a) if the determination is based on a QME report or 2(b)1. or 2. if the determination is based on a treating physician's report.

If the employee is represented, include paragraph C.

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.

§9810(d) requires all notices to refer the employee (by chapter number and url) to the appropriate chapter of the publication "Workers' Compensation in California: A Guidebook for Injured Workers" that addresses the benefit(s) to which the notice pertains, and to advise the employee that a complete copy of the Guidebook may be obtained on the Division of Workers' Compensation's website at http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation.

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:

- Medical Report(s) (w/date)

PD START - Title 8, CCR §9812(e)(4)

Notice is due at the same time as the first payment of permanent disability indemnity. 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.

[The following optional language may be included if desired, for injuries occurring from January 1, 2005 through December 31, 2012, include the following if permanent and stationary:

The report advises your injury is permanent and stationary effective DATE.
Select (1), (2), or (3)]
(1) Your employer made a timely offer for you to return to ***(choose one)*** *regular /modified/alternative work* on DATE. The weekly PD rate of $RATE will be reduced by 15% to $REDUCED RATE effective INSERT OFFER DATE, the date of the offer of return to work.

(2) Your employer did not make a timely offer for you to return to regular, modified, or 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.

(3) Your employer is investigating whether or not regular, modified or alternative work may be offered to you. You will be advised within 60 days after INSERT P&S DATE whether your employer is able to offer you the opportunity to return to work.]

§9810(d) requires all notices to refer the employee (by chapter number and url) to the appropriate chapter of the publication "Workers' Compensation in California: A Guidebook for Injured Workers" that addresses the benefit(s) to which the notice pertains, and to advise the employee that a complete copy of the Guidebook may be obtained on the Division of Workers' Compensation's website at http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation.

When to send:

- **At the same time as the first payment or first resumed payment of PD.**

Who to copy with notice:

- Applicant Attorney (if any)

Enclosures / see regulation:

- 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).