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

Reporting a Workers' Compensation Claim

The speed with which you report an on-the-job injury, illness, or accident has an important bearing upon employee relations, and ultimately can affect the duration and cost of the claim. For this reason, every industrial accident should be promptly reported, regardless of whether or not you feel it is job related. In addition, the current State of Hawaii Workers' Compensation law mandates that disability benefits on any uncontested claim must be paid within 10 days after an injury is reported to you.

We ask that the WC-1 Employer's Report of Injury form be sent to us within three (3) working days or less. Timely reporting of claims to the Dept. of Labor will avoid penalties (up to $5,000.00) or delays in servicing. **Please report claims by calling our Reports Desk at 527-7711 (Toll Free: 808-272-5202) or by Fax to 545-3120 (Toll Free: 800-713-3883)**

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

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

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

We transmit the WC-1 to the Dept. of Labor electronically so please do not submit the WC-1 form directly to the Department of Labor.

For your convenience, here is the address for the Department of Labor, Disability Compensation Division's website that will allow you complete the WC-1 Employer's Report of Injury form.

https://labor.hawaii.gov/dcd/

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

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

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

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

Once a claim is determined to be work related, it is our goal to assist your injured worker to recover from his or her injury.

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

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

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

CONTROLLING COSTS OF A CLAIM

Investigation and Follow-Through

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

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

Fraud Investigation: To confirm the possibility of symptom exaggeration or if we have reason to suspect fraud, the claim may be referred to our Fraud Investigator. We encourage you to post our “Fraud Hotline Poster” in a conspicuous location. Any employee may report suspicious activity anonymously. All information is strictly confidential.

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

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

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

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

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

While an injury may require surgery and a period of hospital confinement, recovery and return to work may be enhanced by our aggressive early intervention. If you are unable to provide modified duty, we will continue to pay time loss benefits to your employee.

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

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

Medical Bill Review: Medical bills are reviewed to ensure charges by providers comply with the Workers Compensation Fee Schedule. Our average cost savings as a result of these reviews is ***40%***. Pharmaceutical Cost Containment program averages cost savings of ***35%*** for prescriptions, medical equipment and supplies.

JOB ANALYSIS

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

PHYSICAL REQUIREMENTS:

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

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

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

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

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

OTHER PHYSICAL REQUIREMENTS:_____

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

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

PHYSICIAN SIGNATURE:_____
DATE:_____

EMPLOYEE ACKNOWLEDGEMENT:

(Signature)_____ DATE:_____

PHYSICAL REQUIREMENTS:

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

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

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

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

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

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

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

OTHER PHYSICAL REQUIREMENTS:_____

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

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

PHYSICIAN SIGNATURE:_____
DATE:_____

EMPLOYEE ACKNOWLEDGEMENT:

(Signature)_____ DATE:_____

WORKERS COMP FRAUD HOTLINE

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

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

Please post for your employees

Courtesy of First Insurance Company of HI, Ltd.

II. DEPT. OF LABOR FORMS

A. WC-1 EMPLOYERS REPORT OF INJURY FORM
B. HIGHLIGHTS OF THE WORKERS COMPENSATION LAW
C. WC-14 EMPLOYEE WAGE FORM

NEW
AMEND

STATE OF HAWAII
DEPARTMENT OF LABOR & INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION

WC-1 EMPLOYER'S REPORT OF INDUSTRIAL INJURY

NOTE: COMPLETE THE FILLABLE-DARK SHADED BLOCKS

CASE NUMBER
DATE RECEIVED

Every work injury/illness to an employee causing absence for one day or more or which requires medical services other than first aid treatment must be reported within 7 working days after the injury/illness. Failure to report promptly is a misdemeanor punishable by not more than a $5,000 fine. (Sec. 386-95, H.R.S. NOTIFY THE DIVISION IMMEDIATELY IF INJURY/ILLNESS RESULTS IN DEATH.) EVERY QUESTION MUST BE ANSWERED FULLY TO AVOID FURTHER CORRESPONDENCE.

The law requires the employer to furnish the injured/ill employee a copy of this report.

IDENTIFICATION - SECTION 1

EMPLOYEE NAME – LAST	FIRST	M.I.	SUFFIX

SEX/GENDER	MARITAL STATUS	IDENTIFICATION TYPE	IDENTIFICATION NUMBER	DATE OF BIRTH
MALE FEMALE	SINGLE MARRIED	SSN PASSPORT		

ADDRESS	ADDITIONAL ADDRESS INFORMATION (C/O)

CITY	STATE	ZIP CODE	EMAIL ADDRESS

PHONE NUMBER	DATE HIRED	YEARS EMPLOYED CODE	OCCUPATION
( ) -			

DEPARTMENT	PAYROLL COMP CLASS CODE	SOC CODE	OCC CODE

REGISTERED EMPLOYER	DBA

ADDRESS	CITY	STATE	ZIP CODE

EMPLOYER POINT OF CONTACT	PHONE NUMBER	EMAIL ADDRESS
	( ) -	

NATURE OF BUSINESS	PRE-FABRICATED	DEPARTMENT OF LABOR NUMBER	FEDERAL ID NUMBER
	WC-2 WC-5		

DETAIL OF INJURY/ILLNESS (I/I) - SECTION 2

DATE OF INJURY/ILLNESS REPORTED	DATE OF INJURY/ILLNESS	TIME OF I/I	TIME OF DAY	ON EMPLOYER'S PREMISE	DID EMPLOYEE WORK A FULL SHIFT?
			AM PM	NO YES	NO YES

IF NOT ON EMPLOYER'S PREMISES, INDICATE PLACE WHERE INJURY/ILLNESS OCCURRED	CITY	STATE	ZIP CODE

A. HOW DID THIS INJURY/ILLNESS OCCUR? - Please describe fully the events that resulted in injury/illness or occupational disease. Explain what happened. Please continue in Supplemental Section if additional space is needed.

TIME WORK SHIFT BEGAN	TIME OF DAY	TIME WORK SHIFT END	TIME OF DAY	SOURCE OF INJURY/ILLNESS	EVENT
	AM PM		AM PM		

TASK	ACTIVITY	INJURY/ILLNESS FACTOR	AOS

B. WHAT WAS THE EMPLOYEE DOING WHEN INJURED? - Please be specific. Identify tools, equipment, or material the employee was using. Please continue in Supplemental Section if additional space is needed.

C. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE - e.g., The machine employee struck against or struck him, the vapor or poison inhaled or swallowed, the chemical that irritated employee's skin. In cases of strains, the object employee was lifting, pulling, etc. Please continue in Supplemental Section if additional space is needed.

CASE NUMBER

DETAIL OF INJURY/ILLNESS (I/I) - SECTION 2 (continued)

D. DESCRIBE IN DETAIL THE NATURE OF THE INJURY/ILLNESS AND PART OF THE BODY AFFECTED - Please continue in Supplemental Section if additional space is needed.

MULTIPLE BODY PARTS? NO YES	NATURE OF INJURY/ILLNESS	PART OF BODY CODE

#	SIDE OF INJURY/ILLNESS				PART OF BODY	DISFIGUREMENT		BURN	
1.	LEFT	RIGHT	FRONT	BACK		NO	YES	NO	YES
2.	LEFT	RIGHT	FRONT	BACK		NO	YES	NO	YES
3.	LEFT	RIGHT	FRONT	BACK		NO	YES	NO	YES
4.	LEFT	RIGHT	FRONT	BACK		NO	YES	NO	YES
5.	LEFT	RIGHT	FRONT	BACK		NO	YES	NO	YES

TIME LOST INFORMATION - SECTION 3

DATE DISABILITY BEGAN	WAS EMPLOYEE FURNISHED MEALS, TIPS, OR LODGINGS? NO YES	AVERAGE WEEKLY WAGE	IF EMPLOYEE IS BACK TO WORK, GIVE DATE	WAS EMPLOYEE PAID IN FULL FOR DAY OF INJURY/ILLNESS? NO YES

IF EMPLOYEE DECEASED, GIVE DATE	HOURLY WAGE	MONTHLY SALARY	HRS WORKED/WEEK	WEIGHING FACTOR

DECEDENT'S DEPENDENTS - SECTION 4

1.	DEPENDENT 1 – LAST NAME	FIRST NAME	M.I.	SUFFIX	RELATION TO DECEASED	
	DEPENDENT 1 - ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER ( ) -	
2.	DEPENDENT 2 – LAST NAME	FIRST NAME	M.I.	SUFFIX	RELATION TO DECEASED	
	DEPENDENT 2 - ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER ( ) -	
3.	DEPENDENT 3 – LAST NAME	FIRST NAME	M.I.	SUFFIX	RELATION TO DECEASED	
	DEPENDENT 3 - ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER ( ) -	
4.	DEPENDENT 4 – LAST NAME	FIRST NAME	M.I.	SUFFIX	RELATION TO DECEASED	
	DEPENDENT 4 - ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER ( ) -	

TREATMENT (OBTAIN NAME OF TREATING PHYSICIAN FROM EMPLOYEE) - SECTION 5

NAME OF PHYSICIAN	PHONE NUMBER ( ) -	EMAIL ADDRESS

ADDRESS	CITY	STATE	ZIP CODE	INPATIENT OVERNIGHT EMERGENCY ROOM ONLY? NO YES

NAME OF MEDICAL FACILITY	ADDRESS	CITY	STATE	ZIP CODE

INSURANCE CARRIER - SECTION 6

NAME OF WC INSURANCE CARRIER	CARRIER ID

IS LIABILITY DENIED? NO YES	IF LIABILITY DENIED, WHY?

NAME OF ADJUSTING COMPANY	ADJUSTER NAME

EMAIL ADDRESS	PHONE NUMBER ( ) -	ADJUSTER ID NUMBER

POLICY NUMBER	POLICY PERIOD FROM: TO:	MEDICAL DEDUCTIBLE	CARRIER CLAIM NUMBER

SIGNATURE - SECTION 7

SIGNATURE	TITLE	DATE

CASE NUMBER

SUPPLEMENTAL - SECTION 8

A. HOW DID THIS INJURY/ILLNESS OCCUR? (continued from Section 2.A)

B. WHAT WAS THE EMPLOYEE DOING WHEN INJURED? (continued from Section 2.B)

C. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (continued from Section 2.C)

D. DESCRIBE IN DETAIL THE NATURE OF THE INJURY/ILLNESS AND PART OF THE BODY AFFECTED (continued from Section 2.D)

ENGLISH	This document contains important information. If you need language assistance at no cost to you, please contact us by telephone or in person immediately.
ILOKANO	Daytoy nga dokumento ket addaan ti importante nga impormasyon. No masapul mo ti mangipatarus nga libre, pangngaasim ta awagan na kami ti telepono wenno umay na kami kitaen nga daras.
TAGALOG	Ang dokumentong ito ay naglalaman ng importanteng impormasyon. Kung nangangailangan kayo ng libreng tulong para maintindihan ito, mangyaring makipag-ugnay sa amin sa pamamagitan ng telepono o makipagkita kagaad sa amin.
CHINESE SIMPLIFIED	此文件有重要信息。如果您需要免费的语言协助服务，请您立刻给我们打电话或来我们办公室请求帮助。
CHINESE TRADITIONAL	此文件有重要信息。如果您需要免費的語言協助服務，請您立刻給我們打電話或來我們辦公室請求幫助。
SPANISH	Este documento contiene información importante. Si necesita los servicios de un intérprete sin costo alguno para usted, por favor llame de inmediato por teléfono o contacte con alguna persona de nuestra oficina.
JAPANESE	この書類には重要な情報が含まれています。無償で日本語の支援を受けたい場合は、早急に電話あるいは直接窓口にて申込を行ってください。
CHUUKESE	Mei auchea met masowan ei taropwe. Ika pwe ke mochen aninis ren noumw chon chiaku esap kamo, kose mochen kokori kich won tengwa ika fen pusin chuto rech.
MARSHALLESE	Ilo pepa in ewor melele ko aorok. Ne kwoj aikuj jiban na ukok ilo ejjelok wonen, jouj im kokkeitaak kem ilo talboon ak ilo wobij e ien eo emakaaj tata.
KOREAN	이 문서는 중요한 정보가 포함되어 있습니다. 무료로 언어 도움이 필요하시면, 바로 전화 하시거나 오셔서 상담하십시오.
VIETNAMESE	Tài liệu này bao gồm các thông tin quan trọng. Nếu bạn cần hỗ trợ ngôn ngữ miễn phí, xin vui lòng đến gặp trực tiếp chúng tôi hoặc liên lạc qua điện thoại ngay lập tức.

Address all inquiries to:

Department of Labor and Industrical Realtions
Disability Compensation Division

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

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

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

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

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

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

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

HIGHLIGHTS OF THE HAWAII WORKERS' COMPENSATION LAW

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

HIGHLIGHTS OF THE HAWAII WORKERS' COMPENSATION LAW

INTRODUCTION

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

PURPOSE

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

WHO CAN RECEIVE WORKERS' COMPENSATION BENEFITS?

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

WHAT SHOULD I DO IF I AM INJURED?

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

2. Obtain appropriate treatment for the injury.

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

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

WHAT DO I TELL MY PHYSICIAN IF I AM INJURED?

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

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

Policy #:_____

FROM WHOM CAN I OBTAIN TREATMENT?

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

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

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

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

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

WHAT TYPES OF DISABILITY BENEFITS AM I ELIGIBLE FOR?

You are eligible for the following types of disability benefits:

1 **TEMPORARY TOTAL DISABILITY (TTD)**

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

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

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

2 **PERMANENT PARTIAL DISABILITY (PPD)**

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

3 **PERMANENT TOTAL DISABILITY (PTD)**

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

4 **DISFIGUREMENT**

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

5 **DEATH BENEFITS**

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

6 **VOCATIONAL REHABILITATION**

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

WHAT IS THE PROCESS?

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

AVERAGE WEEKLY WAGE

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

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

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

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

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

Instructions

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

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

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

Delivery Information

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

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

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

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

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

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

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

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

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

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

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

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

Employer:	Telephone: ( )
Address	
Date:	By:

(To be signed in ink)

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

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

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

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

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

	Dates (inclusive) of each period paid for			Hours, Days, Weeks or month each Payment Covers	Total amount paid Employee for each period		Amount paid excluding overtime or extra work		Overtime or extra work	
	From	To	Year							
1										
2										
3										
4										
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22										
23										
24										
25										
26										
	Total									

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

	Dates (inclusive) of each period paid for			Hours, Days, Weeks or month each Payment Covers	Total amount paid Employee for each period		Amount paid excluding overtime or extra work		Overtime or extra work	
	From	To	Year							
27										
28										
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51										
52										
	Total									

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