

****CSRMA ALERT******WORKERS' COMPENSATION ALERT:****Critical Requirement for Employers to save 15%**

One of the most positive benefits for employers that came out of the 2004 SB899 reforms is the ability for employers to take a financial credit for returning injured workers to their employment. ***Unfortunately many employers are missing out on this savings because they are failing to take one necessary step.***

How Do I Take Advantage Of This 15% Savings?

When an injured worker's condition is found to be at Maximum Medical Improvement (MMI) and there is some level of permanent benefits owed, Bragg & Assoc. will send the employer a letter to complete and give to the injured employee presenting him/her with a job "offer". The letter must be completed and sent to the injured worker within 60 days for the employer to have the ability to take a 15% reduction in the permanent disability benefits.

The purpose of this component of SB899 was to encourage and reward employers for bringing permanently disabled workers back to their work place.

But Wait, There's More!

Even if the employee continued to work without temporary disability or restricted duty, employers can still take advantage of this 15% reduction, **but the employer must send the "offer letter" and it must be done timely.**

More often than not, employers will be offering the injured worker their regular job, the job they have already returned to or even a permanent modified or alternate job. It may seem counterintuitive to send an offer letter when the employee may have already come back to work, but, the letter must be sent and sent timely in order to take the 15% reduction as a reward for bringing them back to work. This is the reason so many employers fail to get the financial credit they are entitled to.

Sample "Offer" Letters Are Attached

The first letter is to be used when the injured worker is returning to his/her regular job and the second is to be used when returning them to a modified or alternate job. Remember these letters are to be used in **permanent job situations**, NOT in TEMPORARY job re-assignments.

We know that sometimes these form letters may seem a little bit strange or confusing. If you have any questions about a specific claims situation, contact your Sr. Claims Examiner at Gregory B. Bragg & Assoc., Nancy Hutton at: 916-960-0939.

You may also call Heather Truro, CSRMA Workers' Compensation/Return to Work Advisor to help you through the process at 925-922-0305 or htruro@comcast.net.

***For More Information, Please Contact David Patzer, CSRMA Risk Control Advisor at
707.373.9709 or at losscontrol@sbcglobal.net***

DWC-AD 10003 NOTICE OF OFFER OF REGULAR WORK
For injuries occurring on or after 1/1/05

THIS SECTION TO BE COMPLETED BY EMPLOYER OR CLAIMS ADMINISTRATOR:

Claims Administrator: Gregory B. Bragg & Associates, Inc.

Claim Number: _____

Based on the opinion of treating physician _____ OME _____ AME _____,
(Name of Physician)

usual occupation or to the position you held at the time of your injury on _____ (Date).

Date you are eligible to return to job: _____ (as stated in the above physician's report)

Employer: _____

Job Title: _____

Starting Date: _____

____ This position is at the same location and shift as your pre-injury position.

____ This position is at a different location than your pre-injury position, as follows :

____ This position is for a different shift than your pre-injury position, as follows:

(start time)

(end time)

You may contact _____ concerning this position. Phone No.: _____
(Name of Contact Person)

You must return the completed form to the employer or claims administrator listed here:

(Name of Employer or Claims Administrator)

(Mailing address)

This position is expected to last for a total of at least 12 months of work. If this position does not last for a total of at least 12 months of work, you may be entitled to an increase in your permanent disability benefit payments.

This position provides wages and compensation of \$ _____, that are equivalent to or more than the wages and compensation paid to you at the time of your injury.

I, Gregory B. Bragg & Associates, Inc., have obtained the above job offer information from your employer.
(Name of Claims Administrator)

If the job offered is at a different location than the job you held at the time of your injury, and you believe the commuting distance to this job from the residence where you lived at the time of your injury is not reasonable, you may object to the job offer as not being within a reasonable commuting distance. You may also waive this commuting distance requirement. You will be considered to have waived this requirement if you accept the above offer of work or do not reject the offer within twenty calendar days of receipt of this notice.

THIS SECTION TO BE COMPLETED BY EMPLOYEE:

Claim Number _____

The employee must accept, reject, or object to this offer for regular work and return this form to the employer or claims administrator listed on page one within 20 calendar days of receipt of the offer or it will be deemed that the employee has waived the right to object to the location or shift. The employee should keep a copy of this form for his or her records.

Name of employee: _____ Date offer received: _____

I understand that if my disability is permanent and stationary and the employer has fulfilled its legal obligations related to this offer, my remaining permanent disability payments will be decreased by 15% whether I accept or reject this offer.

Offer of Regular Work at Same Location and/or Shift

_____ I accept this offer of regular work.

_____ I reject this offer of work. Reason: _____

Note: If either party has a dispute or objection regarding the offer of regular work, or if the employee rejects the offer of regular work, that party may file a Declaration of Readiness with the local district office of the Workers' Compensation Appeals Board (WCAB).

Offer of Regular Work at a Different Location and/or Shift

_____ I understand that I have the right to object to a work offer when the location or shift is different than what I had at the time of my injury.

_____ I accept the offer and waive my right to object to the job location as not being within a reasonable commuting distance from the residence where I lived at the time of my injury.

_____ I object to this offer because the job location that has been offered is different than the job location I held at the time of my injury, and I do not believe this job allows a reasonable commute from my residence. I understand if the claims administrator does not agree with this objection, my remaining permanent disability weekly benefit payment may be decreased by 15%.

_____ I object to this offer because the job shift that has been offered is different than the job shift I held at the time of my injury. I understand if the claims administrator does not agree with this objection, my remaining permanent disability weekly benefit payment may be decreased by 15%.

Note: If either party has a dispute or objection regarding the offer of regular work, or if the employee rejects the offer of regular work, that party may file a Declaration of Readiness with the local district office of the Workers' Compensation Appeals Board (WCAB).

Date: _____

Signature

Proof of Service By Mail or Hand Delivery

I am a resident of the County of _____ . I am over the age of eighteen years and not a party to the within matter. My business address is: P.O. Box 619058, Roseville CA 95661-9058.

On _____ , I served the **Notice of Offer of Regular Work** on the party/parties listed below by either method of service described below:

A. Placing a true copy of the **Notice of Offer of Regular Work** in a sealed envelope with postage fully prepaid addressed to each person whose name and address is given below by depositing the envelope in the United States mail.

Or

B. Personally serving a true copy of the **Notice of Offer of Regular Work** on each person whose name and address is given below.

Enter the name of the party and indicate the type of service in the box (either A or B as described above.)

Name of Party:	Type of Service
_____	A.
_____	A.
_____	A.
_____	A.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on June 20, 2007, at Roseville, CA.

Nancy Hutton Sr. Workers' Compensation Claims Examiner

Signature: _____

DWC-AD 10133.53 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK
For injuries occurring on or after 1/1/04

THIS SECTION COMPLETED BY CLAIMS ADMINISTRATOR:

Employer (name of firm) _____ is offering you the position of a

(name of job) _____.

You may contact _____ concerning this offer. Phone No.: _____

Date of offer: _____ Date job starts: _____.

Claims Administrator: Gregory B. Bragg & Associates, Inc. Claim Number: _____

NOTICE TO EMPLOYEE

Name of employee: _____ >

Date of Injury: _____ Date offer received: _____

You have 30 calendar days from receipt to accept or reject the attached offer of modified or alternative work. Regardless of whether you accept reject this job offer, the remainder of your permanent disability payments may be decreased by 15%. However, if you fail to respond within 30 days you will not be entitled to the supplemental job displacement benefit unless:

Modified Work **or** **Alternate Work**

- A. You cannot perform the essential functions of the job; or
- B. The job is not a regular position lasting at least 12 months; or
- C. Wages and compensation offered are less than 85% paid at the time of injury; or
- D. The job is beyond a reasonable commuting distance from residence at time of injury.

THIS SECTION TO BE COMPLETED BY EMPLOYEE

_____ I accept this offer of Modified or Alternative work.

_____ I reject this offer of Modified or Alternative work and understand that I am not entitled to the Supplemental Job Displacement Benefit.

I understand that if I voluntarily quit prior to working in this position for 12 months, I am not entitled to the Supplemental Job Displacement Benefit.

Signature

Date

I feel I cannot accept this offer because:

NOTICE TO THE PARTIES

If the offer is not accepted or rejected within 30 days of the offer, the offer is deemed to be rejected by the employee.

The employer or claims administrator must forward a completed copy of this agreement to the Administrative Director within 30 days of acceptance or rejection. (A.D., "SJDB," Division of Workers' Compensation, P.O. Box 420603, San Francisco, CA 94142-0603)
If a dispute occurs regarding the above offer or agreement, either party may request the Administrative Director to resolve the dispute by filing a Request for Dispute Resolution (Form DWC-AD 10133.55) with the Administrative Director.

DWC-AD 10133.53 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK

For injuries occurring on or after 1/1/04

Actual job title: _____

Wages: \$ _____ per Hour ___ Week ___ Month ___

Is salary of modified/alternative work the same as pre-injury job? Yes ___ No ___

Is salary of modified/alternative work at least 85% of pre-injury job? Yes ___ No ___

Will job last more than 12 months? Yes ___ No ___

Is the job a regular position required by the employer's business? Yes ___ No ___

Work location: _____

Duties required of the position:

Description of activities to be performed (if not stated in job description):

Physical requirements for performing work activities (include modifications to usual and customary job):

Name of doctor who approved job restrictions (optional): _____ Date of report: _____

Date of last payment of temporary disability:

Preparer's Name:

Preparer's Signature: _____ Date _____

DWC-AD 10133.53 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK
For injuries occurring on or after 1/1/04

Proof of Service By Mail

I am a citizen of the United States and a resident of the County of _____ . I am over the age of eighteen years and not a party to the within matter.

My business address is:

On _____, I served the **Notice of Offer of Modified or Alternative Work** on the parties listed below by placing a true copy thereof enclosed in a sealed envelope with postage fully prepaid, and thereafter deposited in the U. S. Mail at the place so addressed.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed at _____ on _____.

Signature: _____

Copies Served On: