AmTrust North America
An AmTrust Financial Company

Hawaii
Worker's Compensation
Claim Kit

AmTrust North America
An AmTrust Financial Company

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EASY ONLINE CLAIMS REPORTING INSTRUCTIONS

By logging into AmTrust's web portal, policyholders can access a wide variety of account information including the ability to report injuries online. The following instructions will help get you started.

First Time Portal Access:

1. Go to www.amtrustnorthamerica.com
2. In the upper right corner of the home page, click "LOGIN"
3. In the subsequent AmTrust *Online* drop-down box, click the word "**Register**"
4. On the following screen, enter your policy number, zip code and the security code that appears on that screen and click "**Enter**" at the bottom right of the screen
5. Enter your email address, user name and password to complete the registration process
6. After completing the registration process, go back to www.amtrustnorthamerica.com and log in

Reporting of New Injuries:

1. Go to www.amtrustnorthamerica.com
2. Log in to "AmTrust ***Online***"
3. Click the "**Claims**" icon in the upper middle of your screen to view the screen that lists your policies
4. Click "**View**" next to the policy for which you wish to enter a claim. This brings you to the policy detail screen
5. Click on "**First Reports**" in the upper left corner
6. On the next screen, click "**Add**" to view the "**New First Report of Injury**" screen
7. Click "**Use WebForm**." This brings you to the screen where you will enter all of the detailed information about the injury/injured worker
8. When finished entering all of the data, click "**Submit**" and this report will channel into our intake center to be set up and assigned to a claims adjuster
9. Return to the "**First Reports"** screen and you will see the claim number for the report entered
10. When finished, click on "**Return to Listing**"

For ID/Password issues or if you receive error messages while using this application, please contact our help desk at help.desk@amtrustgroup.com or call 866.427.6150. Please be sure to specify that you are an AmTrust policyholder and provide your AmTrust Online ID.

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Helpful Hints:

- "**Time Employee Began Work**" and "**Time of Occurrence**" must be entered in military time
- Enter the hours in the first box and the minutes in the second box
- All dates must be entered as two-digit day, two-digit month and four-digit year, i.e.: XX/XX/XXXX
- For PEOs, in the "**Location Address**" box, please include the PEO client name and address of the applicable PEO client location. If there is a location code/number, specify in the "**Location #**" box
- If during the entry of a claim you must exit the application, first click on "S**ave as Draft**" and you may return to it later by going back into the "**First Reports"** screen and clicking on "**In Progress**"

For ID/Password issues or if you receive error messages while using this application, please contact our help desk at help.desk@amtrustgroup.com or call 866.427.6150. Please be sure to specify that you are an AmTrust policyholder and provide your AmTrust Online ID.

Thank you for your attention to this matter.

Sincerely,

AmTrust North
America Claims
Department

CASE NUMBER
DATE RECEIVED

☐ 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

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.

EQUAL OPPORTUNITY EMPLOYER/PROGRAM
Auxiliary aids and services are available upon request to individuals with disabilities.
TDD/TTY Dial 711 then ask for (808) 586-9161.

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		NO	YES
				INPATIENT OVERNIGHT	☐	☐
				EMERGENCY ROOM ONLY?	☐	☐

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

EQUAL OPPORTUNITY EMPLOYER/PROGRAM
Auxiliary aids and services are available upon request to individuals with disabilities.
TDD/TTY Dial 711 then ask for (808) 586-9161.

WC-1 rev. 01/2022

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)

EQUAL OPPORTUNITY EMPLOYER/PROGRAM
Auxiliary aids and services are available upon request to individuals with disabilities.
TDD/TTY Dial 711 then ask for (808) 586-9161.

rev. 01/2022

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.

EQUAL OPPORTUNITY EMPLOYER/PROGRAM
Auxiliary aids and services are available upon request to individuals with disabilities.
TDD/TTY Dial 711 then ask for (808) 586-9161.

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...

TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM® AmTrust North America An AmTrust Financial Company

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
CARRIER/TPA EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

The following entities comprise the Optum Workers Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers Compensation Medical Services, collectively and individually referred as "Optum."

IMP14-1614-109-FFWG

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:

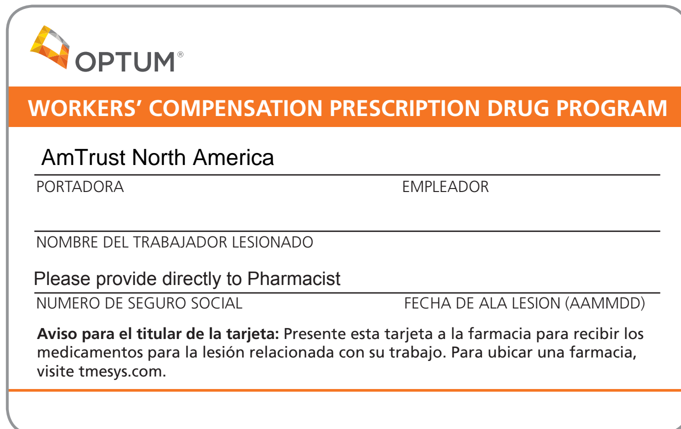
Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias, incluyendo Walgreens, nuestro proveedor preferido, y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta? ¿Necesita ayuda?

1-866-599-5426



OPTUM®

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America

PORTADORA | EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist

NUMERO DE SEGURO SOCIAL | FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

The following entities comprise the Optum Workers Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers Compensation Medical Services, collectively and individually referred as "Optum."

tmesys®

IMP14-1614-109-FFWG

RETURN-TO-WORK; A **GREAT** IDEA

We at the AmTrust Group, are convinced that an employer who provides light, or restricted work for injured employees, enjoys numerous benefits. This is not just an opinion, it's something we see day in and day out. Consider:

- Unless an injured worker returns to the workplace within 60 days, chances of him/her ever returning drop dramatically. (resulting in a very expensive permanent disability situation.)
- After 6 months away from the workplace, only 50% chance of return.
- After 12 months, only a 10% chance of return.

Some Return-to Work Benefits Include:

- "Test" of malingering potential. Injured employees who refuse light duty are more prone to being malingerers.
- Opportunity for employer to demonstrate true concern for workers' well-being.
- Promotion of rehabilitation and recovery.
- Lower medical and rehabilitation costs.
- Productivity.
- Morale improvement for the injured worker.
- Ability for the employer to monitor the injured employee's recovery progress.
- Decrease of WC claims costs, with resultant downstream WC premium savings.

(Notice we're not just talking about 'feel-good' issues, but also hard dollars !)

Some common misconceptions (and truths) about Return-to-Work / Light Duty:

Misconception: *We've already got too many "programs" around here, and don't need any more paper*.

Truth: While it is true a written, planned program works best, in many cases a Light Duty "program" can be nothing more than a management understanding of the benefits and principles of Return-to-Work, how it works, and the commitment to 'just do it', when light-duty recommendations are made by WC physicians.

Misconception: *It will get me into an Americans With Disabilities (ADA) "situation".*

Truth: Light-duty and ADA "reasonable accommodation" are two entirely separate issues. Generally, light duty is a temporary assignment, for a relatively short period. ADA accommodations are made for serious, permanent disabilities that impair major life activities.

Misconception: *I'll have to devise a whole new job each time an employee needs light duty.*

Truth: The vast majority of light-duty restrictions require accommodating only one or two factors, such as "no lifting over 10 pounds", or the like. In many cases, if you break the jobs down into individual **tasks**, you'll see that only one or two tasks within the employee's normal job are affected, and can be handled in some other way.

Misconception: *Once an employee gets into a "cushy" light-duty job, s/he'll never leave it, and I'll be stuck with it.*

Truth: Light duty is always defined by, and monitored by the attending physician. An employee on light duty is periodically monitored by the physician for improvement, and is released for full-duty as soon as medically indicated.

Misconception: *We're a union company. Our union won't allow us to pay lower rates, or move employees between classifications, or between bargaining groups.*

Truth: Any Local that objects to a Return-to-Work program should be referred to its national body for guidance. Return to Work is universally recognized as a very positive influence on an injured worker (as well as benefiting the employer). Labor unions, whose major purpose for existence is the benefit of the workers they represent, should not only "tolerate" Return-to-Work programs, but enthusiastically promote, and assist in such programs' implementation and operation. It is strongly suggested that management approach labor representatives to solicit their input, and assistance in making Return to Work a positive force in your workplace.

Misconception: *I might be willing to place a worker in a light-duty position, but I can't afford pay them their full pay, for the decreased productivity.*

Truth: Talk to your WC insuror's claims professional. In many cases, states' WC plans provide for "make-up" pay to replace some, or all of the injured employees' decreased earnings. The goal of getting them back to the workplace, and doing some productive work is that important!

Address all inquiries to:

Department of Labor and Industrial Relations
Disability Compensation Division

Oahu: P.O. Box 3769
830 Punchbowl Street, Room 210
Honolulu, Hawaii 96812-3769
Phone: (808) 586-9161

Hawaii: State Office Building
75 Aupuni Street, 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 Street
Wailuku, Hawaii 96793
Phone: (808) 243-5322

Kauai: State Office Building
3060 Eiwa Street, Room 202
Lihue, Hawaii 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 to 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

Form WC-101 (Rev. 5/03)

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.

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 2004 is $596.) 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 self-refer 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, you may request for a hearing. 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.

Workers' Compensation - You have the right to receive workers' compensation benefits and medical care if you suffer a work-related injury. You must report the date, time and circumstance of your injury immediately to your employer or supervisor. Give the name of the insurer to your doctor so that your doctor will know where to send the physician's report. If your employer does not file a report of the injury, you may file a written claim with the Disability Compensation Division. You do not pay for the premium cost; your employer pays the entire amount.

You are entitled to all required medical, surgical and hospital services and supplies including medication; weekly benefits from the fourth day of disability to replace wage loss, representing 66 2/3% of your average weekly wage but not more than the maximum weekly benefit amount annually set by the Department; additional benefits if the injury results in permanent disability or disfigurement; vocational rehabilitation, if appropriate; funeral and burial expenses if the work injury results in death; and additional weekly benefits to the surviving spouse and other dependents.

Temporary Disability Insurance - You have the right to file a claim for temporary disability insurance benefits within 90 days from the date of disability if you suffer a disabling non-work-related injury/illness or inability to work because of your pregnancy. Your employer or insurance carrier should furnish you with a TDI-45 claim form or some other authorized claim form. You may receive TDI benefits if a physician properly certifies your inability to work. Generally, you must have worked for an employer in Hawaii at least two weeks before your disability. During the last 52 weeks, you must have: worked for at least 14 weeks; been paid for at least 20 hours per week; and earned at least $400.

After a 7 consecutive day waiting period, you will be paid 58% of your average weekly wage, not to exceed the maximum in the TDI law. Your employer may have an "equivalent" plan approved by the Department, which may provide different benefits. You should ask your employer for details if they have an "equivalent" plan.

You may be required by your employer to share in the premium cost. Your share cannot be more than one-half of the cost and should not exceed .5% of your weekly wages. Your employer pays the remaining portion exceeding the prescribed limitation. If you are not eligible for benefits (see second paragraph above), your employer cannot deduct any contributions from you to share in the premium cost.

Prepaid Health Care - You have the right to enroll in your employer's prepaid health care insurance plan after 4 consecutive weeks of employment where you have worked at least 20 hours each week. The Department of Labor & Industrial Relations must approve the health care plan and include insurance coverage for hospital, surgical, medical, diagnostic and maternity medical care.

You should claim benefits under this program if a non-work-related injury or illness requires medical care. Give your doctor or hospital the name of your employer's health care contractor and the plan name.

If you are required to share in the premium cost for your coverage, your share cannot be more than 1.5% of your monthly wages or one-half the premium cost (whichever is less). Your employer pays the balance.

Disability Compensation Division:

Oahu	586-9161 (Workers' Compensation)
	586-9188 (Temporary Disability Insurance and Prepaid Health Care)
Hilo	974-6464
Kona	322-4808
Maui	243-5322
Kauai	274-3351

This notice provides general background information on labor laws administered and enforced by DLIR's Disability Compensation Division and is not intended to serve as a substitute for legal counsel. For specific legal advice on individual situations, please consult an attorney.

Anne E. Eustaquio, Director
Department of Labor and Industrial Relations

***You may satisfy Hawaii Labor Laws' posting requirements by posting our official labor law poster.**
For more information: http://labor.hawaii.gov/labor-law-poster/

Equal Opportunity Employer/Program
Auxiliary aids and services are available upon request to individuals with disabilities.
TDD/TTY Dial 711 then ask for (808) 586-8866.

Revised 09/21/2020

You have the right to be notified in writing at least 60 days in advance of possible layoffs or terminations due to certain business transactions taken by your employer. Your employer must also notify the Department of Labor and Industrial Relations in the same manner according to the Dislocated Workers Act (DWA). The DWA applies to businesses which have at least 50 persons employed in the state at any time during the 12 months preceding the event, and are a party to a sale, transfer, merger, business takeover, bankruptcy, or business transaction, which will result in the relocation outside the state or the shutting down of all or a portion of operations.

You have the right to payment of a dislocated worker allowance if you are laid off or terminated due to these transactions and are eligible for unemployment compensation benefits. These payments supplement unemployment benefits for a maximum 4-week period.

For general information about the Dislocated Workers Act or the Dislocated Workers Allowance, please call the Workforce Development Division at 586-8877. For information about assistance to employers and employees facing a business closure, please contact the following Workforce Development Division offices:

Workforce Development Division:

Oahu:	Honolulu:	586-8700
	Waipahu:	675-0010
Hawaii:	Kona:	327-4770
	Hilo:	981-2860
Maui:		984-2091
Kauai:		274-3056
Molokai:		553-1755

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Revised 09/21/2020

You have the right to be free from unlawful discrimination in your employment. All applicants and employees of private and public employers (except the federal government), union members, and job seekers in employment agencies are protected by Hawaii law against employment discrimination.

You cannot be denied a job, fired, or subjected to unequal terms and conditions of employment because of your race, sex, including gender identity or expression, reproductive choices, refusing to enter into a nondisclosure agreement that prevents you from discussing workplace sexual harassment or assault sexual orientation, age, religion, color, ancestry/national origin, disability, marital status, civil union status, credit history, credit report, arrest and court record (except in limited circumstances), or domestic or sexual violence victim status. Sexual harassment by a supervisor or coworker is a form of sex discrimination. Employers are prohibited from retaliating against you for disclosing sexual harassment or sexual assault.

Examples of Unlawful Employment Discrimination:

- If you are a pregnant employee and are denied leave recommended by a doctor or are denied reinstatement to the same or comparable position after giving birth.
- If you are subjected to unwanted sexual advances or demands, offered benefits in exchange for sexual favors, threatened with demotion, firing, or loss of benefits for refusing sexual advances, or subjected to unwelcome sexual conduct.
- If you are denied a job or a promotion because of your race, sex, including gender identity or expression, sexual orientation, age, religion, color, ancestry, disability, marital status, civil union status, credit history, credit report, arrest and court record (except in limited circumstances), or domestic or sexual violence victim status.

Filing a Complaint:
You have the right to file a complaint if you have been subjected to discrimination because of your race, sex, including gender identity or expression, reproductive choices, refusing to enter into a nondisclosure agreement that prevents you from discussing workplace sexual harassment or assault, sexual orientation, age, religion, color, ancestry, disability, marital status, credit history, credit report, arrest and court record, or domestic or sexual violence victim status.

You can file a complaint by calling the Hawaii Civil Rights Commission. Under state law, you must file your complaint within 180 days of the act of discrimination.

You have the right to be free from discriminatory or retaliatory action from your employer for filing a complaint, participating in an investigation, or opposing a discriminatory practice.

Hawaii Civil Rights Commission:
Oahu: 586-8636
Hawaii: 974-4000, ext.68636
Maui: 984-2400, ext.68636
Kauai: 274 -3141, ext.68636
Molokai/Lanai: 1-800-468-4644, ext.68636 TDD/TTY 586-8692

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Revised 09/21/2020

You Have a Right to a Safe and Healthful Workplace

IT'S THE LAW!

- You have the right to notify your employer or HIOSH (808-586-9092) about workplace hazards. HIOSH will keep your name and identity confidential.
- You have the right to request a HIOSH inspection if you believe that there are unsafe and/or unhealthful conditions at your workplace. You or your representative may participate in the inspection.
- You have a right to see HIOSH citations issued to your employer. Your employer must post the citations at or near the place of the alleged violation.
- Your employer must correct workplace hazards by the date indicated on the citation and must certify that these hazards have been reduced or eliminated.
- You have the right to copies of your medical records or records of your exposure to toxic and harmful substances or conditions.
- Your employer may not discriminate against you for making a safety and health complaint or for exercising your rights under the law, some of which are detailed above. You can file a discrimination complaint with HIOSH within 60 days of the discriminatory act. ***Private sector employees** must also file a discrimination complaint with the OSHA Regional Office below within 30 days of the discriminatory act or they will lose their rights to pursue a federal claim under section 11(c) of the federal Occupational Safety and Health Act of 1970 after the conclusion of the HIOSH investigation.*
- Report to OSHA all work-related fatalities within 8 hours, and all inpatient hospitalizations, amputations, and losses of an eye within 24 hours.
- Provide required training to all workers in a language and vocabulary they can understand.
- Your employer must post this notice in the workplace in a prominent location or where such notices are customarily located.

The Hawaii Occupational Safety and Health Law of 1972, Chapter 396, Hawaii Revised Statutes, assures safe and healthful working conditions for every worker in the State. The Hawaii Occupational Safety and Health Division (HIOSH) of the state Department of Labor & Industrial Relations, has the primary responsibility

for administering the HIOSH Law. HIOSH does not cover those hired for domestic service in or about a private home, maritime or shipbuilding employees, employees covered by a federal agency, and employees working on military installations. The Occupational Safety and Health Administration (OSHA) monitors the HIOSH program to ensure its effectiveness. If you believe HIOSH is not meeting its responsibilities, you may file a Complaint About State Program Administration (CASPA) directly to the OSHA Regional Office:

Regional Administrator
U.S. Department of Labor
Occupational Safety and Health Administration 90 7th Street, Suite 18100
San Francisco, California 94103

Copies of the State law, the HIOSH rules and Standards or other program information may be obtained at:

HIOSH
830 Punchbowl St
Rm 423
Honolulu, HI 96813
Tel. (808) 586-9100
http://labor.hawaii.gov/hiosh/

UNEMPLOYMENT INSURANCE LAW
NOTICE TO EMPLOYEES

You have the right to unemployment benefits if you lose your job or your work hours are substantially reduced through no fault of your own. You may file your claim for unemployment insurance benefits online or in-person at a local claims office.

Go to **uiclaims.hawaii.gov** between 6:30 am to 11:00 pm, Monday through Friday and between 9:00 am to 11:00 pm on weekends & holidays (Hawaii Standard Time). You will need a valid email address to create an online account.

Important Information:

- When you file, you must provide your social security number.
- If you are not a U.S. citizen, you should have your alien registration number available.
- You will need to provide information for all of your employers in the past 18 months, such as the employer's name, address, zip code, phone number, dates of employment, and the reason for separation. Ex-military servicepersons should have their DD214 (member 4) available. Former federal employees should have their Standard Form 8, Standard Form 50, or pay stubs available.
- File your claim promptly. Your claim will begin only from the week that you file with the Unemployment Insurance Office.
- If benefits are payable, you must receive your payments by direct deposit. You must provide your account type (savings or checking), financial institution routing number, and your account number.

Unemployment Insurance Offices:

General Unemployment……………..(833) 901-2275
Oahu Claims Office…....................586-8970……………………................dlir.ui.oahu@hawaii.gov
Hilo Claims Office............................974-4086..dlir.ui.hilo@hawaii.gov
Kona Claims Office ....322-4822………...................................dlir.ui.kona@hawaii.gov
Maui Claims Office.........................984-8400 ....dlir.ui.maui@hawaii.gov
Kauai Claims Office........................274-3043 .... dlir.ui.kauai@hawaii.gov
Liable Interstate Unit ....(808) 586-8970....................................dlir.ui.oahu@hawaii.gov

COVID-19-Related Emails:

Request Language Services……………………………………dlir.ui.languageassistance@hawaii.gov

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Anne E. Eustaquio, Director
Department of Labor and Industrial Relations

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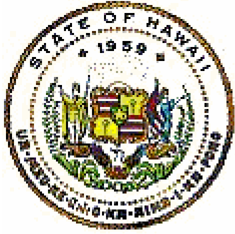
Revised 09/21/2020



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-5
EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

Injured Person

Name	
Address	
Occupation	
Telephone No. ( )	Social Security No.

Employer

Name	
Address	
Nature of Business	Telephone No. ( )

Insurance Carrier

Name
Address P.O. BOX 89404, CLEVELAND, OH 44101-6404

Injury

Date of Accident	Time of Injury a.m. p.m.	Date Disability Began
If not on employer's premises, indicate place where accident occurred		
Describe how accident occurred		
Describe injury/illness		

Reason for filing:

- ☐ Employer has not filed WC-1
- ☐ Reopening of old claim
- ☐ Insurance carrier has not paid benefits
- ☐ Others (explain)

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

FORM WC-5 EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

Witness

Name	Work Phone ( )	Home Phone ( )
Address		

Name	Work Phone ( )	Home Phone ( )
Address		

Notice

Did you notify the employer of the injury? ☐ Yes ☐ No If so, when:
How: ☐Oral ☐Written To whom:

Attending Physician

Name	Telephone No. ( )
Address	

I hereby present my claim for compensation for disability resulting from the foregoing injury arising out of and in the course of my employment and not caused by my intoxication nor by my willful intention to injure myself or another individual.

I hereby authorize any physician and/or hospital to release any information related to any treatment rendered to me.

Represented by ______________________________ ______________________________
ATTORNEY/UNION AGENT SIGNATURE OF CLAIMANT

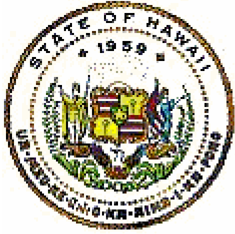
Address____ Date ____________

____

____

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.



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-5
EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

Instructions

IMPORTANT:
If information provided is incomplete, this claim will not be processed and will be returned to the employee. Please complete the form in triplicate. Please distribute the form as follows: original and one copy to the appropriate District Office (see next page) and one copy for employee's records.

Ensure information indicated is CLEAR, LEGIBLE, COMPLETE AND ACCURATE.

INJURED PERSON:
Name: Enter full, complete name shown on injured person's social security identification card (no nicknames). Address: Enter mailing address.

EMPLOYER:
Name: Enter the complete business name of the employer.
Address: Enter full address of employer including city, state and zip code.

INSURANCE CARRIER:
Name: Enter the name of the insurance company that handles workers' compensation for the employer.

INJURY:
Date of Accident: Enter specific date injury occurred.
Time: Specify time and include a.m. or p.m.
Describe Injury/Illness: How and where did the accident occurred?
Reason for Filing: Specify reason(s) for filing this claim.

WITNESS:
Enter name and address of someone who saw accident, if any.

NOTICE:
Indicate whether you notified your employer of the injury.

ATTENDING PHYSICIAN:
Enter name and address of the physician who treated you for this injury and attach available medical reports to this claim.

REPRESENTED BY:
You may leave this part blank, but if you are represented, enter the name and address of attorney/union agent, or other representative.

Address: Enter full address of your representative to include city, state and zip code.

SIGNATURE OF CLAIMANT:
Sign your name and date.

ATTACHMENTS: (if available)
(i.e. Physician medical reports, Attorney letter of representation, etc.)

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

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, In-Person, or via Fax

Department of Labor and Industrial Relations, Disability Compensation Division

Oahu	Kauai	Maui
Princess Keelikolani Building 830 Punchbowl Street, Room 209 Honolulu, Hawaii 96813 Mailing Address: P.O. Box 3769 Honolulu, Hawaii 96812-3769 Phone: (808) 586-9161 Fax: (808) 586-9219	3060 Eiwa Street, Room 202 Lihue, Hawaii 96766 Phone: (808) 274-3351 Fax: (808) 274-3355	2264 Aupuni Street, #2 Wailuku, Hawaii 96793 Phone: (808) 984-2072 Fax: (808) 984-2071
Hawaii	**West Hawaii**	
75 Aupuni Street, Room 108 Hilo, Hawaii 96720 Phone: (808) 974-6464 Fax: (808) 974-6460	Ashikawa Building 81-990 Halekii Street, Room 2087 Kealakekua, Hawaii 96750 If Mailing, Please Mail to This Address: P.O. Box 49, Kealakelua, Hawaii 96750 Phone: (808) 322-4808 Fax: (808) 322-4813	

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

STATEMENT OF WAGES/SALARY

IMPORTANT: PLEASE COMPLETE ALL INFORMATION REQUESTED

Employee: Employer: Claim Number:
Social Security Number: Date of Hire: Position/Job Title

EMPLOYMENT TYPE: Full Time____Part Time____Seasonal____Temp_____
If Temporary or Seasonal worker, last day of season or job end date _________________
WAGE TYPE: Hourly____Salary____Commission____
WAGE INFORMATION:
$______ per hour ; Monthly Wage $_________ ; Does monthly wage include commission ____Yes ___No
Hours per Week ______ ; Overtime Rate $_____per hour ; Overtime Hours Regularly Worked per week ____
Tips reported: $_______ per week

If employees' compensation package includes an allowance for any of the following, please indicate the actual or estimated value:
Meals: $_____per week Auto: $__________ Rent/Lodging: $_________per week Bonus $_______ per __wk__mth__yr

PLEASE COMPLETE THE BELOW FOR THE PERIOD _________________________ TO ___________________________________

WK	Pay Rate	Hrs Worked	Begin Date	End Date	Gross Salary	WK	Pay Rate	Hrs Worked	Begin Date	End Date	Gross Salary
1						27					
2						28					
3						29					
4						30					
5						31					
6						32					
7						33					
8						34					
9						35					
10						36					
11						37					
12						38					
13						39					
14						40					
15						41					
16						42					
17						43					
18						44					
19						45					
20						46					
21						47					
22						48					
23						49					
24						50					
25						51					
26						52					