English

CDI California Department of Insurance

WORKERS COMPENSATION

Insurance

04/05

1-800-927-HELP (800-927-4357)

www.insurance.ca.gov

800-482-4TDD (800-482-4833)

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Workers Compensation Insurance

The Evolution of Workers Compensation

The concept that workers should be protected from and compensated for injury or illness occurring in the workplace came about with the rise of the trade union movement at the beginning of the 20th century. Workers Compensation insurance is a direct result of public awareness and outrage at the poor and often dangerous working conditions people were forced to labor under in order to make a living, and the financially devastating effects of worker injury or illness on the worker and the worker's dependents.

Workers Compensation insurance is the oldest social insurance program in the United States; in fact, it is older than both social security and unemployment compensation.

California adopted Workers Compensation laws in the 1910's along with most other states. Workers Compensation is based on a no-fault system, which means that an injured employee does not need to prove that the injury or illness was someone else's fault in order to receive Workers Compensation benefits for an on-the-job injury or illness.

Since almost every working Californian is protected by Workers Compensation benefits, it is important that employers and employees alike have an understanding of Workers Compensation insurance and how it works.

What Benefits Are Available in a Workers Compensation Policy?

Depending on the circumstances of the injury or illness, injured workers are entitled to specific benefits as structured by Workers Compensation insurance. There are six basic types

of Workers Compensation benefits that include medical care, temporary disability benefits, permanent disability benefits, vocational rehabilitation services, supplemental job displacement benefits, and death benefits. Injured workers may be entitled to one or more of these benefits.

Medical Care

Injured workers are entitled to receive all medical treatment reasonably required to cure or relieve the effects of a work-related injury or illness. Medical care can include physician services, hospitalization, physical restoration, physical therapy, chiropractic treatment, dental care, prescriptions, x-ray, laboratory services, or any other care considered necessary or reasonable by the treating physician and may be subject to applicable treatment guidelines.

Generally, the employer is responsible for arranging medical treatment for the first 30 days from the date the injury or illness is reported. After 30 days the employee is then free to select any treating physician or facility. If an employee, prior to any injury or illness, notifies their employer that they have a personal physician, then that physician may treat the employee from the date of the injury or illness. However, the choice of treating physician differs, if the employer and the employee have opted for a Health Care Organization (HCO).

First Aid Treatment

Firstaid treatment is included as medical care that all employers must provide for their injured employees. In conjunction with the Department of Industrial Relations, Division of Workers Compensation, the California Department of Insurance (CDI) wants to remind all employers, physicians, insurance carriers and self-insurers of the need to comply with Section 6409(a) of the California Labor Code.

Section 6409(a) requires a physician who treats an injured employee to file a "Doctor's First Report of Injury" (DFR) with the claims administrator for every work illness or injury, even first aid cases where there is no lost time from work. Although the Labor Code contains "first aid" exceptions for the Employers Report (Form 5020) and the Employee Claim Form (DWC-1), there is no such exception for the DFR. The insurance carrier (or the employer if the employer is self-insured) must forward these DFR's to the Department of Industrial Relations. There is no "first aid" exception to this statute.

The CDI and Department of Industrial Relations believe there are improper arrangements in place between some medical providers and employers that allow the employer to dictate how injuries are to be classified by the physicians. In some cases, and at the request of the employers, the physicians send the DFR only to the employers and not to the insurance carriers. This arrangement occurs even though the injuries clearly are beyond first aid. This agreement is often marketed to employers as a way to keep premiums from rising or to lower them. Such marketing practices are both improper and may also contribute to possible criminal violations related to premium fraud and the fraudulent denial of Workers Compensation benefits to injured workers.

Temporary Disability

When a worker is unable to return to work within three days of his/her injury or illness, he/she is entitled to temporary disability benefits to help partially replace wages lost as a result of the injury or illness. A physician must verify that an injured employee cannot work because of an on-the-job injury or illness before temporary disability benefits are payable. The benefits are generally designed to replace two-thirds of lost wages, up to the current maximum prescribed by law. Benefits are payable every two weeks until the employee is able to return to work or until the employee's condition becomes permanent and stationary as reported by

the treating physician. Current law limits benefits to a two-year maximum and increases the maximum to four years for certain specified injuries.

Permanent Disability

If a work-related injury or illness results in permanent impairment to an employee, the employee may become eligible for permanent disability benefits. The amount (percentage) the employee receives depends on the extent of the physical injury or disfigurement and consideration being given to an employee's diminished future earning capacity. Other factors that are considered when calculating permanent disability include: the date of injury, the age of the employee when injured, and the employee's occupation. (Due to recent changes in Workers Compensation law, The Department of Workers Compensation [DWC] may institute additional regulations to help calculate permanent disability benefits.) Current Workers Compensation law sets the benefit amount and the maximum amount payable, and the benefits are paid every two weeks until the maximum amount is reached or a lump sum settlement is made.

The percentage of permanent disability is determined by using the Permanent Disability Rating Schedule and an assessment of the injured worker's permanent impairment and limitations. The Permanent Disability Rating Schedule can be accessed through the Department of Industrial Relations Web site at www.dir.ca.gov. Please see the "Resources" section of this brochure for complete Department of Industrial Relations contact information.

The assessment of the injured worker's permanent impairment and limitations is made by either the treating physician, a Qualified Medical Evaluator (QME), or an Agreed Medical Examiner (AME) if the employee is represented by an attorney. The Division of Workers Compensation's Medical Unit appoints and regulates QMEs. (Please see the "Resources" section of this brochure for DWC Medical Unit contact informa-

tion.) If there is a disagreement with the treating physician's opinion, and the worker is not represented by an attorney, then the worker can choose a physician from a three-member panel provided from the DWC Medical Unit to perform a separate evaluation. When a worker is represented by an attorney, the parties must attempt to agree on a physician (AME) to perform the evaluation. If the parties are unable to agree on a physician, a three-member QME panel will be apppointed by the DWC Medical Unit. The parties will then choose a physician from this three-member panel. Each party is allowed to strike off one physician from the panel in order to narrow the selection down to one final physician. In the case that the evaluations are different, the amount of permanent disability will be determined through negotiation or litigation, if necessary.

Vocational Rehabilitation
(for injuries before 01/01/04)

Vocational Rehabilitation Services are offered to injured workers who are unable to return to their former type of work. The services include the development of a suitable plan, the cost of any training, and a maintenance allowance while participating in rehabilitation.

Once an injured worker is determined to be unable to return to his/her previous type of work, the employer and employee together select a rehabilitation counselor who will determine whether vocational rehabilitation is feasible. If rehabilitation is possible, then a suitable rehabilitation plan is developed. The goal of a rehabilitation plan is to return the injured worker to suitable employment or self-employment that offers the opportunity for the worker to be restored to a position of maximum self-support as soon as reasonably possible.

Like temporary disability benefits, the maintenance allowance payable to a worker while in rehabilitation is designed to replace two-thirds of the income for lost wages. The maximum prescribed by law for the maintenance allowance is lower than the maximum payable by temporary disability. The worker may supplement the

maintenance allowance with advances from permanent dis ability benefits up to the level where the worker is receiv ing the same weekly amount as received under temporary disability benefits. Total costs for rehabilitation are now lim ited to a maximum amount prescribed by law for workers injured on or after 01/01/04.

For dates of injury on or after 01/01/03, injured workers with legal representation may settle rehabilitation in a lump sum. Vocational rehabilitation does not apply for dates of injury after 01/01/04.

Supplemental Job Displacement Benefit
(for injuries after 01/01/04)

This benefit is in effect a nontransferable voucher for education-related retraining and/or skill enhancement that is payable to a state approved or accredited school if the worker is injured on or after 01/01/04. To qualify for this benefit, the injury must result in permanent disability, the injured employee does not return to work within 60 days after temporary disability ends, and the employer does not offer modified or alternative work. There is a maximum voucher amount set by law and the amount varies based upon the extent of permanent disability.

Death Benefits

When a worker is fatally injured on the job, reasonable burial expenses are paid up to the current maximum set by law. Additionally, qualified surviving dependents may receive support payments for a period of time. These benefit payments are usually paid at the same weekly rate as the maximum temporary disability benefit. The total death benefit amount of support payments depends on the number of dependents and whether they are partially or totally dependent.

How Is Coverage Structured in a Workers Compensation Policy?

Workers Compensation coverage is offered under Part One of a Workers Compensation insurance policy. In Part One, the insurance company agrees to promptly pay all benefits and compensation due to an injured worker. These payments are imposed on the employer by Workers Compensation law or laws of the state or states listed on the Declarations page of the policy. Workers Compensation insurance is considered the exclusive remedy for injured employees. What this means is that an employer assumes absolute liability for all worker injuries and the Workers Compensation benefits are the remedy and sole source of funds for the injured worker. An injured employee covered under Workers Compensation cannot sue his/her employer for damages.

Despite the fact that Workers Compensation is considered to be the exclusive remedy for employees with work related disabilities, Employers Liability insurance can provide important coverage in addition to Workers Compensation insurance. Employers Liability is offered under Part Two of a Workers Compensation and Employers Liability insurance policy. Employers Liability Part Two protects the employer against instances where an employee's injury or disease is not considered work related. Occupational injuries that do not occur in the course of employment are not covered under Workers Compensation law and are therefore not compensable under Workers Compensation Part One. You may want to contact a licensed commercial broker-agent to discuss Employers Liability coverage as a part of your Workers Compensation policy.

Who Is Required to Purchase Workers Compensation Insurance?

AllCalifornia employers must provide Workers Compensation benefits to their employees under California Labor Code Section 3700. If a business employs one or more employees, then it must satisfy the requirement of the law.

Sometimes a business owner (sole-proprietor) may desire to purchase Workers Compensation insurance to cover himself/herself only. The inclusion of a sole-proprietor must be clearly stated in the Workers Compensation policy or must be added as a coverage endorsement to the policy. Since Workers Compensation insurance is a type of liability insurance where the employer assumes complete liability for all worker injuries, a Workers Compensation policy for a sole-proprietor may not be the best choice.

Purchasing health, life, and/or disability income insurance can be a viable option to Workers Compensation for a sole-proprietor. Contact a licensed commercial broker-agent or a licensed personal lines broker or agent for further information and consultation.

Executive officers and directors of corporations must be included in Workers Compensation coverage, unless the corporation is fully owned by the directors and officers. If the directors and officers fully own the corporation, then they may elect to be excluded from Workers Compensation benefits. Fully owned corporations may want to discuss the option to include or exclude their officers and directors with a licensed commercial broker-agent.

California Labor Code Section 3351 defines who is an employee, and therefore who can be covered under a Workers Compensation policy. Whether a business is a sole-proprietorship, a partnership, or a corporation, it is beneficial to develop a working relationship with a reliable, competent broker-agent who can explain coverage eligibility issues and present options based on the organization model of a business.

How Is Workers Compensation Insurance Purchased?

Employers must purchase Workers Compensation insurance from either a licensed insurance company or through the State Compensation Insurance Fund (SCIF). Employers may also have the option to self-insure for Workers Compensation.

A commercial broker-agent can assist a business with purchasing Workers Compensation insurance from a licensed insurance company and can assist with information on SCIF and self-insurance. Also, information on insurance companies licensed to sell Workers Compensation insurance and an online rate comparison of the top 50 Workers Compensation insurers can be accessed on the California Department of Insurance (CDI) Web site at www.insurance.ca.gov.

SCIF is a state-operated entity that exists in order to transact Workers Compensation on a non-profit basis. SCIF competes with private Workers Compensation insurance companies for business and also operates as the insurer of last resort if private companies are not willing to offer Workers Compensation insurance. If a business is interested in SCIF, then they can contact SCIF directly by using the information provided in the "Resources" section of this brochure or they can contact a licensed commercial broker-agent.

To become self-insured, a business must obtain a certificate from the California Department of Industrial Relations, Office of Self-Insurance Plans. Private employers have to post security as a condition of receiving a certificate of consent to self-insure. Self-insurance is only a viable option for very large, stable employers. For complete information on Workers Compensation
self-insurance, contact the Department of Industrial Relations, Office of Self-Insurance Plans with the information shown in the "Resources" section.

What Happens to an Employer Who Does Not Purchase Workers Compensation Insurance?

Employers who fail to purchase Workers Compensation insurance are in violation of the California Labor Code. The Director of the Department of Industrial Relations has the authority to issue a stop order against any company who is discovered to be unlawfully uninsured for Workers Compensation. A stop order closes down business operations until Workers Compensation insurance is secured. Besides issuing a stop order, the Director can assess fines based on whether a company has been discovered to be unlawfully uninsured through normal investigation or through the filing of an injured workers claim with the Uninsured Employers Fund. Failure to comply with a stop order can result in a $10,000 fine, while the fine for failure to carry Workers Compensation insurance is $1,000 per employee. Employers can be prosecuted for insurance fraud for willful failure to secure Workers Compensation insurance as prescribed by law. Also, if Workers Compensation is not purchased, an employer opens himself/herself up to liability lawsuits from injured employees. Exclusive remedy protection does not apply if Workers Compensation insurance is not in force at the time of employee injury.

What Is the Uninsured Employers Fund and the Subsequent Injuries Fund?

When a work-related injury or illness occurs to an employee, and the employer is unlawfully uninsured for Workers Compensation, the employee can file a claim with the Uninsured Employers Fund. The Uninsured Employers fund steps in and handles Workers Compensation claims when the employer has secured no insurance or has failed to pay or post a bond in order to pay the compensation owed the employee due to work-related injury or illness. An attempt is made by the Uninsured Employers Fund to recover any amount paid on behalf of an uninsured employer. Please see the "Resources" section of this brochure for contact information regarding the Uninsured Employers Fund.

An employee who has a previous permanent disability or impairment and suffers a subsequent workplace injury or illness may be eligible to receive additional compensation from the Subsequent Injuries Fund. The combined permanent disability must be at least 70 percent to qualify and additional eligibility requirements must be met. It is important to note that employers are not liable under Workers Compensation for the combined disability of an injured worker. An employer is only liable for that portion of compensation that is owed to the worker from the later (not previous) injury. For further information on the Subsequent Injuries Fund, see the contact information located in the "Resources" section of this brochure.

How Is Workers Compensation Premium Calculated?

Classification

Workers Compensation premium calculation is based upon how employees are classified according to their specific work duties and the rate assigned to each corresponding employee classification. Classifications are developed and assigned by the Workers Compensation Insurance Rating Bureau (WCIRB) in most cases. Workers Compensation insurers working with the WCIRB generally use the classification codes the WCIRB provides when rating a workers compensation policy. Insurance companies are allowed to develop and submit their own classification system to the CDI for approval, but this is uncommon due to the strict standards required to file a separate workers compensation classification system. The WCIRB provides a policyholder ombudsman who is available to answer questions from employers on classification, experience modification, and rating issues. Please see the "Resources" section at the end of this brochure for contact information on the WCIRB and their policyholder ombudsman.

Open Rating

Workers Compensation insurers assign a specific rate to each occupational classification code. These rates must be filed with the CDI. Currently, California Workers Compensation insurers operate under an "open" rating system. This open rating system means that individual companies set rates based on their ability to adequately cover losses and expenses in each classification (occupational business class). Open rating requires that all Workers Compensation insurers file their rates and all applicable supplementary rate information to the CDI. Rate approval is based on many factors. One of the most important factors for rate approval is rate adequacy. Rates must be adequate to maintain the solvency of an insurance company. Adequate rates also act to secure the proper surplus monies insurance companies are required to

have in order to meet potential and continuing claim obligations. The Insurance Commissioner will not approve rates if they are inadequate to cover an insurer's losses and expenses, unfairly discriminatory, or create a monopoly in the marketplace. The Commissioner does not have the authority under law to disapprove rates that may be considered excessive only.

Premium Modification

The classification code with its corresponding rate is the first part of the rating formula. The rate itself is expressed in dollars and cents and is multiplied by each $100 of payroll per classification. The payroll for each class is estimated and then multiplied (per each $100 of payroll) by the applicable rates. The sum of the equation is referred to as the "base" premium. The base premium continues to be modified (increased or decreased) using rating plans (usually schedule or judgment rating) and by experience modification. (Please see the "Glossary" section for definitions of schedule and judgment rating.)

Experience Modification

The experience modification is calculated from loss information that an insurance company is required to submit to the WCIRB on an annual basis. The WCIRB uses a mathematical formula approved by the CDI to calculate an experience modification for each employer. The formula takes into account reported paid losses, claim loss reserves, and payroll amounts for a specific experience period (usually the prior three complete years of workers compensation coverage). The experience modification indicates the average loss experience of employers throughout a similar industry and acts as a means of comparison between employers. When the experience modification is applied to the class rate, along with any other modifications (schedule or judgment), the final rate is multiplied per $100 of payroll and the estimated premium is established.

Prospective Rating

The type of basic Workers Compensation rating formula illustrated above is called prospective rating. While Workers Compensation premiums can be calculated using different rating plans (such as dividend plans or retrospective rating), prospective rating is the most common Workers Compensation premium calculation rating method used currently. Businesses interested in learning more about Workers Compensation rating methods should contact a licensed broker-agent for further information and discussion regarding this topic.

Premium Audit

Thefinal premium of a Workers Compensation policy cannot be calculated until the policy term is over and the employer's payroll records have been audited. The final audit of payroll records determines if the initial payroll estimate was either high or low. If the payroll has gone up from the estimate, then the employer will owe additional premium. If the payroll has gone down from the estimate, then the insurance company will owe the employer a return premium. Since many companies experience fluctuating payrolls, some workers compensation insurers offer a monthly payroll reporting option. If an employer does not qualify for monthly reporting (usually due to payroll size), then the employer can work closely with their broker-agent or company underwriter to report any large payroll fluctuations during the policy term. Corrected payroll estimates during the policy term can help minimize the possibility of a large premium audit bill or a large return premium, which can significantly affect the cash flow of a business.

Employers need to be aware that their Workers Compensation company has the right to audit payroll records at anytime. Usually this right is reserved for the final audit, but an insurance company can conduct interim audits as well. Failure to comply with an insurance company audit can lead to cancellation or non-renewal of a policy. Also, insurance compa-

nies can use all legal means at their disposal to collect outstanding premium. It is important to know that deliberate underreporting of payroll is considered insurance fraud and can be prosecuted to the fullest extent of the law. The WCIRB also has the right to conduct an audit of payroll records, which allows them gather information on experience modification and the proper classification categories for a specific employer.

Does the CDI Handle Workers Compensation Claim Issues?

It is important to note that most disputes between injured workers and Workers Compensation insurers do not come under the jurisdiction of the CDI[1]. The California Department of Industrial Relations, Division of Workers Compensation assists employers and employees with Workers Compensation claims. If an employer or employee has a question or concern regarding a Workers Compensation claim he/she can contact the Information and Assistance Unit of the Division of Workers Compensation.

When disputes arise regarding a Workers Compensation claim, the Information and Assistance Unit upon contact will attempt to resolve the dispute. If they are unable to resolve the dispute, then a formal application for adjudication (dispute resolution) can be filed with the Workers Compensation Appeals Board. The Information and Assistance Unit may be able to help filing the application to the Appeals Board unless an attorney has been retained. The Workers Compensation Appeals Board has exclusive jurisdiction over dispute resolution.

An employer or employee can contact the California Department of Industrial Relations, Division of Workers Compensation using the information provided in the "Resources" section of this brochure. The "Resources" section

[1] In specific instances, CDI does investigate the fraudulent submission, or denial, of Workers compensation claims (California Insurance Code Section 1871.4).

includes specific contact information for the Information and Assistance Unit and Workers Compensation Appeals Board. Also, an employer should be able to discuss any general Workers Compensation claim issue with their broker-agent or discuss a specific claim with the claim adjuster that has been assigned to the claim by their Workers Compensation insurer.

What Workers Compensation Issues Does the CDI Handle?

The CDI primarily deals with rating and underwriting issues involving Workers Compensation insurance. Consumers contact the CDI with a variety of Workers Compensation rating and underwriting concerns.

The following is a list of common consumer issues under the jurisdiction of the CDI regarding Workers Compensation insurance:

- Insurer compliance with filed rates
- Rating errors
- Classification and experience modification disputes
- Failure to provide loss history reports
- Cancellation and nonrenewal notice
- Audit disputes
- Dividend plans
- Broker-agent handling
- Insurance fraud

California Code of Regulations (CCR) 2509.40 – 2509.78 lists detailed procedures for appeals regarding experience modification and classification disputes. Please contact the CDI through the information given in the "Talk to Us" section of this brochure when you experience Workers Compensation rating and underwriting difficulties. In most cases, we can assist consumers to resolve workers compensation issues involving rating and underwriting. If it is determined that the CDI does

not have jurisdiction, we can refer the consumer to the appropriate state agency for assistance. Also, it is important to contact the CDI regarding any suspected Workers Compensation fraud. Fraud reports can be filed with the CDI on an anonymous basis. The more complete and credible the information, the greater the chance of apprehending and prosecuting those involved in Workers Compensation fraud.

Frequently Asked Workers Compensation Questions

Q: What is a loss reserve?

A: Insurance companies use loss reserves to evaluate the monetary worth of each claim. A loss reserve is an estimated amount of money that the insurance company sets aside to pay for a claim. It is usually up to a claim adjuster to set the loss reserve, utilizing judgment and experience from prior claims that are similar. Adequate loss reserves help determine how much money an insurance company must have in surplus to meet current, emerging, and future claim obligations. Insurance companies must report Workers Compensation loss reserves along with other claim reporting information to the WCIRB, as this information is used by the WCIRB to calculate experience modifications. Poor loss reserve practices combined with inaccurate claim reporting can put an insurance company in financial jeopardy. Since maintaining insurer solvency is of high importance, loss reserves must be as accurate as possible and revised regularly based on the most current claim information available. While underreserving can effect solvency, overreserving can also cause problems. The practice of overreserving claims results in an inflated experience modification that unfairly raises the premium for the insured.

Q: How does an employer request a Workers Compensation premium and loss history report?

A: Workers Compensation premium and loss history reports (commonly referred to as loss runs) must be requested in writing by the policyholder or by the policyholder's authorized broker-agent. The insurance company has 10 business days to comply with this request under the following circumstances outlined in CIC Section 11663.5: "(1) The policy is cancelled or nonrenewed. (2) The policyholder requests the information within 60 days prior to the renewal date of an existing policy. (3) The policyholder's current insurer's rating is downrated by a nationally recognized insurance rating service to a financial rating below secure or good or to a rating that would negatively impact the ability of the policyholder to contact its business operations. (4) The policyholder's current insurer is conserved by the department…or is ordered to cease writing business…"

If an insurance company fails to comply with a written request for loss runs under the provisions of CIC Section 11663.5, then contact the CDI for assistance by using the information provided in the "Talk to Us" section located at the end of this brochure.

Q: Whatis a minimum premium?

A: Insurance companies have minimum premium amounts in place to cover the expenses involved in issuing and servicing policies. When the payroll of a company is small, it is possible that the premium generated from the premium calculation will be very low. If the calculated premium is so low that the insurer cannot meet even basic expenses, it is not a sound financial practice to insure the risk, as the insurer would be losing money before any claim had occurred. By setting a minimum premium, an insurance company determines the smallest acceptable premium that they are willing to charge in order to accept a risk. Each insurance company must file their minimum premium requirements as part of their rating plan with the CDI.

Q: What happens when an employer cancels a policy during the policy year?

A: When an employer cancels a Workers Compensation policy in the middle of a policy year (mid-term) in order to secure insurance with another company or to close a business, the insurance company will return any premium owed on a short rate basis. A short rate is an administrative penalty assessed to the policyholder for failure to complete the contracted term of insurance.

An insurance company may charge a minimum premium for the cancelled policy if the short rate cancellation amount is less than the minimum premium in order to cover expenses. If an employer experiences problems with a cancellation or a premium refund issue, they can contact the CDI by using the information available in the "Talk to Us" section of this brochure.

Q: Howdoes the insolvency of an insurance company affect outstanding claims?

A: Fortunately, there is protection for both employers and employees when a Workers Compensation company becomes insolvent. The Insurance Commissioner oversees the conservation and liquidation of an insurance company under appointment of the courts. The Conservation and Liquidation Office (CLO) of the CDI is responsible for handling the details of conservation and liquidation. Because claim payments for workers compensation can be so crucial, CLO works very closely with the California Insurance Guarantee Association (CIGA) to help ensure timely payment of claims with no excessive time delays. This helps to relieve the burden employers and employees experience when an insurance company becomes insolvent. CIGA acts as a safety net and guarantees that claim payments will continue to be made whether or not the insolvent insurance company's liquidated assets are enough to cover claims. For more information on conservation and liquidation process, contact the CDI

through the information available in the "Talk to Us" section of this brochure. The "Resources" section of this brochure also contains contact information for CIGA.

Q: Whatexactly is a dividend plan?

A: A dividend plan is a type of rating plan that allows an employer to share in the profits of their Workers Compensation carrier, in the form of a dividend. Because the employer participates in the profits of the insurer, dividend plans are often referred to as participating policies of insurance. There are various types of dividend plans with different provisions and requirements. An employer interested in pursuing other options to prospective rating (please see the "Prospective Rating" paragraph under the "How Is Workers Compensation Premium Calculated?" section), should contact their broker-agent for discussion and further information. All dividend plans must be submitted along with all other rating plan information to the CDI for approval.

Q: Can an insurance broker-agent or insurance company guarantee the amount of a future Workers Compensation dividend?

A: The California Code of Regulations (CCR) clearly states that broker-agents or insurance companies cannot guarantee or in any way promise the payment amount of future Workers Compensation dividends (see Title 10, Chapter 5, Subchapter 3, Article 9, Section 2505). A broker-agent or other company representative can provide past dividend payment amounts for illustration purposes, but the policyholder dividend statement cannot directly or indirectly imply the amount of future dividend payments. If an employer feels that a broker-agent or company representative is in any way misrepresenting their dividend plan, especially by directly or indirectly promising future dividend results, then they should contact the CDI immediately through the information provided in the "Talk to Us" section of this brochure.

Q: What can an employer do if there is a dispute on a Workers Compensation classification code?

A: If an employer questions the assignment of a classification code, the broker-agent or company underwriter should be contacted for a discussion and/or explanation of the specific classification code in question. If a company underwriter

changes a classification code that results in an increased premium (unless the reclassification is the result of a CDI regulation or under the authority of the Insurance Commissioner), the company must inform the employer or the broker-agent of the change in writing within 30 days. If there continues to be a dispute regarding an existing or reclassified code, then the employer can file a written complaint with the CDI. (Please see the contact information listed in the "Talk to Us" section.) Similarly, if an employer wants to dispute a classification decision made by the WCIRB, then the employer can file a written dispute with the WCIRB. If the request is rejected or not acted upon within 30 days, then the employer can contact the CDI and file a written complaint. (Please note the contact information for the WCIRB can be found in the "Resources" section of this brochure.) Finally, refer to the "What Workers Compensation Issues does the CDI Handle?" section of this brochure for related information on the appeals process for classification and experience modification issues.

Resources

California Department of Industrial Relations
Location Address:
455 Golden Gate Avenue
San Francisco, CA 94102
Mailing Address:
PO Box 420603
San Francisco, CA 94142
Phone: 415-703-5070
Web site: www.dir.ca.gov

Division of Workers Compensation (DWC)
Location Address:
455 Golden Gate Avenue, 9th Floor
San Francisco, CA 94102
Mailing Address:
PO Box 420603
San Francisco, CA 94142
Phone: 415-703-4600
Web site: www.dir.ca.gov

Division of Workers Compensation (DWC)
Information and Assistance Unit
Phone: 800-736-7401

Division of Workers Compensation (DWC)
Uninsured Employers Fund and Subsequent Injuries Fund
Los Angeles Claims Unit: 213-576-7300
San Francisco Claims Unit: 415-703-4955

Division of Workers Compensation (DWC)
Medical Unit (formerly Industrial Medical Council)
PO Box 8888
San Francisco, CA 94128
Phone: 650-737-2700
800-794-6900
Complaint Line: 800-999-1041
Web site: www.dir.ca.gov

California Department of Industrial Relations
Office of Self Insurance Plans (SIP)
2265 Watt Avenue, Suite 1
Sacramento, CA 95825
Phone: 916-483-3392
Web site: www.dir.ca.gov

California Department of Industrial Relations
Workers Compensation Appeals Board
Location Address:
455 Golden Gate Avenue
San Francisco, CA 94102
Mailing Address:
PO Box 429459
San Francisco, CA 94142
Phone: 415-703-4580
Web site: www.dir.ca.gov

California Insurance Guarantee Association (CIGA)

PO Box 29066
Glendale, CA 91209
Phone: 818-844-4300
Web site: www.caigo.org

State Compensation Insurance Fund (SCIF)

1275 Market Street
San Francisco, CA 94103
Phone: 415-565-1234
877-405-4545
Web site: www.scif.com

Workers Compensation Insurance Rating Bureau (WCIRB)

525 Market Street, Suite 800
San Francisco, CA 94105-2716
Phone: 415-777-0777
Web site: www.wcirbonline.org
Attn: Customer Service
Phone: 888-229-2472
Attn: Policyholder Ombudsman
Phone: 415-778-7159

Glossary

Agent
A licensed individual or organization authorized to sell and service insurance policies for an insurance company.

Agreed Medical Examiner (AME)
A physician who may be selected by the parties together, when an injured worker is represented by an attorney, to assess any disputed medical-legal issues.

Binder
A short-term agreement that provides temporary insurance coverage until the policy can be issued or delivered.

Broker
A licensed individual or organization who sells and services insurance polices on your behalf.

Broker-agent
A licensed individual who can act as an agent representing one or more insurers, and also as a broker dealing with one or more insurers representing your interests.

Cancellation
The termination of an in-force insurance contract by either the insured or the insurer before its normal expiration date.

Claim
Notice to an insurance company that a loss has occurred that may be covered under the terms and conditions of the policy.

Claim Adjuster
The person who evaluates the damage caused by a covered loss and determines the amount to be paid under the policy terms.

Commercial Lines

Insurance coverages for businesses, commercial institutions, and professional organizations, as contrasted with personal insurance.

Commission

A portion of the policy premium that is paid to an agent by the insurance company as compensation for the agent's work.

Conditions

The portion of an insurance contract that sets forth the rights and duties of the insured and the insurer.

Consequential Bodily Injury

In Workers Compensation, special circumstances can arise when a work-related injury causes some sort of non-work related injury. (Please see Loss of Consortium, Dual Capacity, and Third Party Over glossary definitions.)

Coverage

Protection that is provided under an insurance policy.

Declarations (DEC) Page

Usually the first page of an insurance policy that contains the full legal name of the insurance company, the policy number, effective and expiration dates, premium payable, the amount and types of coverage, and the deductibles.

Deductible

The amount of the loss that the insured is responsible to pay before benefits from the insurance policy are payable.

Dual Capacity

In Workers Compensation, an employer may be liable two ways to an employee who incurs bodily harm on the job as a result of using a product or service produced by that employer. The employee is eligible for Workers Compensation benefits and may also sue the employer because of the defectiveness of the injuring product or service.

Earned Premium

The portion of the policy premium paid by an insured that has been allocated to the insurance company's loss experience, expenses, and profit year to date.

Endorsement

A written agreement that changes the terms of an insurance policy by adding or subtracting coverage.

Effective Date

The starting date of an insurance policy: the date the policy goes into force.

Exclusion

A contractual provision in an insurance policy that denies or restricts coverage for certain perils, persons, property, or locations.

Experience Modification

The adjustment of premium resulting from the use of experience rating. Experience rating plans reflect an insured's past loss experience (usually from the past three years) and use this experience to modify and determine the premium for the current policy year.

Expiration Date

The termination date of coverage as indicated on an insurance policy.

First Party

The policyholder (insured) in an insurance contract.

Flat Cancellation

Cancellation that takes place on the policy effective date. No premium charge is made; however, other charges (i.e. service) may apply.

Fraud

An intentionally deceptive act committed to obtain an unfair or unlawful advantage. Fraud usually involves monetary gain.

Frequency
The number of times a loss occurs.

Hazard
A circumstance that increases the likelihood or potential severity of a loss.

Indemnity
In a property and casualty contract, the objective is to restore an insured to the same financial position after the loss that the insured had prior to the loss. In the most basic sense, indemnity is compensation for a loss.

Independent Adjuster
A person or organization that provides claim adjusting services to different insurers on a contract basis.

Insurance
A method of shifting risk from a person, business, or organization to an insurance company in exchange for the payment of premium. The insurance company commits to be responsible for covered losses.

Insured
The policyholder(s) entitled to coverage under an insurance policy.

Insurer
The insurance company who issues insurance and agrees to pay for losses and provide covered benefits.

Judgment Rating
A rating modification (either decrease or increase) that is based on the underwriter's experience, best judgment, and analysis in classifying and underwriting a particular type of risk.

Lapse
In property and casualty insurance, a lapse is the termination of a policy because of a failure to pay premium when due.

Liability Insurance

Coverage for a policyholder's legal liability resulting from injuries to other persons or damage to their property.

License

A certificate of authority issued by the CDI to an insurer, agent, broker, or broker-agent to transact insurance business.

Limits of Insurance

The maximum amount of benefits the insurance company agrees to pay in the event of a loss.

Loss of Consortium

A potential situation in any bodily injury claim (including Workers Compensation claims) where a spouse contends that the bodily injury of their partner deprives them of the natural affection (spousal duties), help, and companionship of said spouse.

Managing General Agent (MGA)

An agent contractually authorized by an insurance company to manage all or part of the insurer's business activities. An MGA can manage the marketing, underwriting, policy issuance, premium collection, appointing and supervision of other agents, claims payments, and reinsurance negotiations of an insurance company.

Material Misrepresentation

A factual falsification made in such a manner that the insurance company would have refused to insure the risk if the truth had been known at policy issuance. A material misrepresentation gives an insurance company grounds to rescind a contract.

Misquote

An incorrect estimate of an insurance premium.

Nonpayment of Premium

Failure by the policyholder to pay the premium on a policy or pay the installment premium payments due on a policy.

Nonrenewal

The termination of an insurance policy on its normal expiration date.

Occupational Accident

A work-related accident that injures an employee.

Occupational Disease

An illness contracted as a result of employment-related exposures and conditions.

Occupational Hazard

A condition in an occupation and surrounding work environment that increases the peril of accident, illness, or death.

Occurrence

A liability insurance policy that covers claims arising out of occurrences that take place during the policy period, regardless of when the claim is filed.

Permanent Disability Rating Schedule

The schedule that is used to determine and modify the percentage of permanent disability of an injured worker.

Personal Line

Insurance written on the personal and real property of an individual (or individuals) to include such policies as Homeowners insurance and personal auto insurance, as contrasted with commercial lines.

Policy

A contract that states the rights and duties of the insurance company and the insured.

Premium

The monetary payment that an insured makes to an insurance company in exchange for the contract indemnifying the insured against potential loss. Simply put, this is the payment made by the insured to keep an insurance policy in effect.

Producer

A term used by the insurance industry to refer to agent, brokers, broker-agents, and solicitors.

Pro Rata Cancellation

A cancellation of a policy by an insurance company that returns the unearned premium to the policyholder (the portion of the premium for the remaining time period that the policy will not be in force).

Provisions

The statement of policy conditions in an insurance policy.

Qualified Medical Evaluator (QME)

Appointed and regulated by the DWC Medical Unit, a QME assesses an injured worker's permanent impairment and limitations and evaluates a wide variety of disputed medical-legal issues. Often, a QME performs a separate medical evaluation when the treating physicians assessment is disputed.

Quotation

An estimate of the cost of insurance based on the information supplied to the agent, broker, broker-agent, or the insurance company.

Recision (or Rescission)

The cancellation of an insurance policy back to its effective date resulting in a return of all premium charged.

Regulations

Requirements developed by the CDI that implement laws

passed by the legislature. Regulations go through a public comment process and must be approved by the state Office of Administrative Law.

Reinstatement

The restoration of a lapsed or canceled policy.

Renewal

The continuation of an insurance policy (offer of renewal) into a new term from the same insurance company that issued the existing policy.

Schedule Rating

A method of pricing property and liability insurance. Schedule Rating uses debits and credits to modify a base rate figured by the special characteristics of the risk exposure. Insurers develop Schedule Rating because actuarial experience shows a direct relationship between certain physical characteristics and the possibility of loss. Most schedule rating plans must be filed and approved by the CDI.

Second Party

The insurance company in an insurance contract.

Self-Insured Retention (SIR)

The portion of a property or liability loss retained by a policyholder.

Severity

The size of a loss. Loss severity is used as a factor in establishing premium rates.

Short Rate Cancellation

A cancellation initiated by policyholder request in which the premium returned is subject to an administrative penalty.

Subrogation

The process of recovering the amount of claim damages paid out to a policyholder from the legally liable party. When a company pursues the legally liable third party, they are

required to include the policyholder's deductible in the recovery process.

Third Party

An individual other than the policyholder or the insurance company who has suffered a loss and may be able to collect compensation under the policy due to the negligent acts or omissions of the policyholder.

Third Party Over

The legal doctrine that involves an injured employee bring suit against a third party who (for one reason or another) is able to bring an action against the employer.

Underwrite

The process to evaluate the insurance application and independent sources in order to verify the information provided and to determine the acceptability of the risk.

Underwriter

The person who performs the underwriting process to accept, reject, or modify risks on behalf of the insurer.

Unearned Premium

The portion of the written premium applicable to the unexpired or unused part of the policy period for which the premium has been paid. For example, in an annual premium policy 11/12 of the premium is unearned at the end of the first month of the policy.

Waiver

The relinquishment of a known right, which may be expressed or implied.

Written Premium

The total premium on all policies written by an insurer during a specified period of time, regardless of what portion has been earned.

Talk to Us

Do you have a question, comment or concern?
There are several ways to talk to us:

- Call our Consumer Hotline at (800) 927-HELP
- Telecommunication Device for the Deaf dial (800) 482-4TDD
- Telephone lines are open from 8:00 AM to 5:00 PM Pacific Time, Monday through Friday, excluding holidays

- Write: California Department of Insurance
  300 South Spring St., South Tower
  Los Angeles, CA 90013

- E-mail us through our Web site at: www.insurance.ca.gov

- Visit us in person on the 9th Floor at the address above. Office Hours: Monday through Friday 8:00 AM to 5:00 PM Pacific Time, excluding holidays

Personal Notes