



Northern California Conference  
**HUMAN RESOURCES**  
Connections With A Purpose

# Workers' Compensation

## For ALL NCC employees

## Workers' Compensation

Workers' Compensation is an insurance program for employees who are injured or become ill as the result of something that occurred while on-the-job.

State law mandates that certain steps be taken by the employee's supervisor almost immediately when the supervisor learns of a work injury or illness.



## What you should know:

- If treated for a work related illness/injury – Do not use your personal health insurance card when being treated.
- Report your work injury or illness to your supervisor immediately. HR may be who you report to.



## The employers' role:

(this could be you)

Please follow these steps when an employee reports a workplace injury/illness:

### 1. DWC1

Give the employee an Employee's Claim for Workers' Compensation Benefits form (Form DWC 1) within 24 hours of notification of the work injury/illness. Instruct them to complete, sign and return the Employee Section of the form ASAP.



# DWC 1 Form (Sample)

State of California  
Department of Industrial Relations  
DIVISION OF WORKERS' COMPENSATION



Estado de California  
Departamento de Relaciones Industriales  
DIVISION DE COMPENSACION AL TRABAJADOR

**WORKERS' COMPENSATION CLAIM FORM (DWC 1)**

**PETITION DEL EMPLEADO PARA DE COMPENSACION DEL TRABAJADOR (DWC 1)**

**Employee:** Complete the "Employee" section and give the form to your employer. Keep a copy and mark it "Employee's Temporary Receipt" until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at (800) 736-7401. An explanation of workers' compensation benefits is included as the cover sheet of this form.

**Empleado:** Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al (800) 736-7401 para oír información grabada. En la hoja cubierta de esta forma esta la explicación de los beneficios de compensación al trabajador.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonía".

**Employee—complete this section and see note above**    **Empleado—complete esta sección y note la notación arriba.**

1. Name. *Nombre.* \_\_\_\_\_ Today's Date. *Fecha de Hoy.* \_\_\_\_\_
2. Home Address. *Dirección Residencial.* \_\_\_\_\_
3. City. *Ciudad.* \_\_\_\_\_ State. *Estado.* \_\_\_\_\_ Zip. *Código Postal.* \_\_\_\_\_
4. Date of Injury. *Fecha de la lesión (accidente).* \_\_\_\_\_ Time of Injury. *Hora en que ocurrió.* \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde ocurrió el accidente.* \_\_\_\_\_
6. Describe injury and part of body affected. *Describe la lesión y parte del cuerpo afectada.* \_\_\_\_\_
7. Social Security Number. *Número de Seguro Social del Empleado.* \_\_\_\_\_
8. Signature of employee. *Firma del empleado.* \_\_\_\_\_

**Employer—complete this section and see note below.**    **Empleador—complete esta sección y note la notación abajo.**

9. Name of employer. *Nombre del empleador.* \_\_\_\_\_
10. Address. *Dirección.* \_\_\_\_\_
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* \_\_\_\_\_
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* \_\_\_\_\_
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* \_\_\_\_\_
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* \_\_\_\_\_
15. Insurance Policy Number. *El número de la póliza de Seguro.* \_\_\_\_\_
16. Signature of employer representative. *Firma del representante del empleador.* \_\_\_\_\_
17. Title. *Título.* \_\_\_\_\_ 18. Telephone. *Teléfono.* \_\_\_\_\_

**Employer:** You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within one working day of receipt of the form from the employee.

**Empleador:** Se requiere que Ud. feche esta forma y que proporcione copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de un día hábil desde el momento de haber sido recibida la forma del empleado.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

- Employer copy/Copia del Empleador     Employee copy/Copia del Empleado     Claims Administrator/Administrador de Reclamos     Temporary Receipt/Recibo del Empleado



## The employer's role:

(this could be you)

2. Once the DWC1 is received back, complete and sign the Employer's Section of the form.
3. Report the claim to Sedgwick CMS by calling 1-855-572-5966



## HR's role:

- The completed DWC<sub>1</sub> form should be submitted to HR.
- Any treating physician reports should also be submitted to HR.
- HR works with the claims adjuster.



## Keep in Mind

- If you will miss work due to a work injury, inform your supervisor and provide a copy of the physician's instruction.
- You will be permitted back to work once a doctor's note is provided releasing you to duty whether it be full or modified work.

