Prepared by the Office of Human Resources.
This replaces Administrative Procedure No. A9.720
dated December 1996 and revised July 1999.

February 2001

SAFETY WELFARE AND BENEFITS

A9.720 WORKERS' COMPENSATION

1. Purpose

   To set forth procedures for reporting work-related injuries/illnesses of individuals eligible for coverage pursuant to Chapter 386, HRS, Hawai‘i Workers' Compensation Law, and Title 12, Chapter 10, Hawai‘i Administrative Rules.

2. Objectives

   a. To prescribe the systemwide procedures for reporting work-related injuries/illnesses.

   b. To prescribe and provide the necessary forms and supporting documents to report work-related injuries/illnesses and to support benefit claims.

3. References

   a. Chapter 386, HRS, Hawai‘i Workers' Compensation Law

   b. Title 12, Chapter 10, Hawai‘i Administrative Rules

   c. Chapter 90, HRS, State Policy Concerning the Utilization of Volunteer Services

   d. Administrative Procedure, A9.041, Utilization of Volunteer Services at the University of Hawai‘i

   e. Section 302A-430, HRS, Coverage for Workers’ Compensation

   f. Title 12, Chapter 52, Section 8, Hawai‘i Administrative Rules

   g. Administrative Procedure, A9.750, University Health and Safety Program

   h. Highlights of the Hawai‘i Workers' Compensation Law, Department of Labor,(Rev. 02/95)

4. Applicability/Responsibility

a. This procedure applies, as appropriate, to:

1) All Board of Regents (BOR) and Civil Service employees of the University of Hawai‘i.

2) Official volunteers, as defined in accordance with Administrative Procedure, A9.041, Utilization of Volunteer Services at the University of Hawai‘i, while providing services to the University of Hawai‘i, provided that they have not received any payment for hospital and medical expenses from the State, County or any other person.

3) Students participating in approved school-to-work programs sponsored by the University of Hawai‘i who perform work for private employers as part of the students’ work-based learning programs, whether paid or unpaid, pursuant to Section 302A-430, HRS, Coverage for Workers’ Compensation.

b. The Office of Human Resources (OHR), Workers’ Compensation Section, is responsible for administering the University’s workers' compensation program. The designated administrative or personnel officer of each college shall be authorized to serve as the Workers’ Compensation Coordinator (WC Coordinator) for the respective college.

c. The OHR may utilize the services of a third party administrator (TPA) or insurance carrier (IC), as appropriate.

d. The Supervisor of the Employee shall timely advise and assist the Employee in securing medical attention, filing of the report of injury/illness, notifying the WC Coordinator of the injury/illness, and submitting required documents. (See listing of forms on last page.)

e. The WC Coordinator shall advise the Supervisor and Employee of the Workers’ Compensation Law and applicable administrative rules and University procedures pertinent to the reporting of work-related injury/illness and shall serve as the point of contact for the OHR and the TPA/IC.

5. Guidelines

The purpose of Chapter 386, HRS, Hawai‘i Workers' Compensation Law, is to provide compensation to Employees for economic losses due to occupational injuries/illnesses arising out of and in the course of employment. The injury/illness must be work-related in order to be compensable.

a. Reporting Requirements

1) Under the workers' compensation law, each work-related injury/illness causing an absence of one or more days or which requires medical services other than first aid treatment must be reported by the University within seven (7) working days to the Disability Compensation Division (DCD) of the State Department of Labor and Industrial Relations (DLIR). The seven (7) working days reporting period begins from the first day the Employer has knowledge of the occurrence of the injury/illness. For purposes of reporting work-related injuries/illnesses, the Employer is defined as the Employee's Supervisor.

The WC Coordinator must report the injury/illness to the TPA/IC immediately after the Employee reports the injury/illness in order to permit the TPA/IC to file the report of injury on behalf of the Employer within the mandated seven (7) working days.

2) Title 12, Chapter 52, Section 8 of the Hawai‘i Administrative Rules requires the Employer to report to the State of Hawai‘i Department of Labor and Industrial Relations (DLIR) within eight (8) hours accidents that result in loss of life, injury of three or more employees requiring in-patient hospitalization, or property damage in excess of $25,000.

The WC Coordinator shall report such catastrophic injury/illness to the DLIR within the requisite eight (8) hours of the accident. (Oahu: 586-9102 or Neighbor Islands: 1-800-468-4644).

3) To report an injury/illness of a person other than an Employee, i.e., student or visitor, while on University premises, the person reporting the injury/illness shall complete UH Form 29 (H&S), Accidental Injury and Occupational Illness Report, in accordance with Administrative Procedure, A9.750, University Health and Safety Program, and submit the report directly to the respective Campus Safety Office.

6. Procedures

The following procedures shall apply to the University's Workers' Compensation program.

a. An Employee shall:

1) report any work-related injury/illness to the Supervisor immediately after it occurs, or as soon thereafter as possible.

2) complete and submit to the Supervisor the UH Form 79 (OHR), Report of Work-Related Injury/Illness (Attachment 1) immediately or as soon thereafter as possible.

3) timely submit to the Supervisor any disability certification from the treating physician to support the request for sick/vacation leave or leave without pay.

4) review the copies of the "Highlights of the Hawai‘i Workers' Compensation Law" brochure (Attachment 2) and "What To Do For Work-Related Injury/Illness" information sheet (Attachment 3).

5) upon return to work submit, as appropriate, the UH Form 83 (OHR), Time-Off for Treatment of Work-Related Injury/Illness (Attachment 4) for medical services during work time when unable to schedule such appointments during non-work time.

6) timely inform the WC Coordinator and TPA/IC of any changes in address; failure to do so may delay the receipt of benefits.

7) timely submit the UH Form 1, Application for Leave of Absence, as appropriate.

b. When notified of the injury/illness, the Supervisor shall:

1) provide to the Employee the UH Form 79 (OHR), Report of Work-Related Injury/Illness (Attachment 1).

2) as appropriate, facilitate the reporting by assisting the Employee in the completion of the Employee's statement on the UH Form 79 (OHR), Report of Work-Related Injury/Illness (Attachment 1).

3) encourage the Employee to seek medical attention, if necessary.

4) complete the Supervisor's statement on the UH Form 79 (OHR), Report of Work-Related Injury/Illness (Attachment 1), and forward it immediately to the respective WC Coordinator.

c. The WC Coordinator shall:

1) file the report of injury/illness either telephonically or by FAX to the TPA/IC.

Note: If the injury/illness does not involve medical treatment beyond first aid and/or lost work time, do not submit the report to the TPA/IC; submit the UH Form 79 (OHR), Report of Work-Related Injury/Illness (Attachment 1) to the OHR for "records only" documentation.

2) inform the Employee of the basic rights and benefits under Workers' Compensation Law by providing the Employee with copies of the "Highlights of the Hawai'i Workers' Compensation Law" brochure (Attachment 2) and "What To Do For Work-Related Injury/Illness" information sheet (Attachment 3).

3) be cognizant of the statutory requirement that the TPA/IC must file on behalf of the University the WC-1 Employer's Report of Industrial Injury (Attachment 5) with the State Department of Labor and Industrial Relations no later than seven (7) working days after the Employee notifies the Supervisor of the injury/illness and that the

failure of the University to report promptly is a misdemeanor punishable by not more than a $5,000 fine. The WC Coordinator will, therefore, make every effort to comply with the law. A copy of the WC-1, Employer's Report of Industrial Injury (Attachment 5) is attached for reference purposes only; do not complete this form.

4) ensure that copies of all forms submitted to the TPA/IC are submitted to the OHR. Additionally, ensure that the following forms and supporting documents are accurately prepared and submitted to the OHR immediately after filing the report of the injury to the TPA/IC:

   a) Copy of the employment document in effect at the time of injury/illness; e.g., UH Payroll Notification Form (PNF), State DHRD Form 5 Employee Personnel Action Report (SF-5), UH Form 6, FMIS-36 (for those receiving stipends), Student Employment Work Agreement (SEWA), Volunteer Application Form, etc.

   b) UH Form 41 (OHR), Sick/Vacation Pay During Receipt of Workers' Compensation Disability Benefits (Attachment 6).

   c) UH Form 42 (OHR), Computation of Average Weekly Wages for Temporary Disability Payments (Attachment 7).

5) maintain the accuracy of the leave accounting reports by timely submitting the UH Form 1, Application for Leave of Absence

6) ensure that the Employee timely receives authorized sick/vacation pay by completing and submitting the UH Form 78 (OHR), Authorization for Sick/Vacation Pay While Receiving Workers' Compensation Replacement Benefits (Attachment 8) to the UH Payroll Office

7) ensure that the UH Form 83, Time-Off for Treatment of Work-Related Injury/Illness (Attachment 4) is appropriately and timely completed and filed.

d. The Office of Human Resources shall facilitate, coordinate and oversee the comprehensive University

systemwide workers' compensation program. The designated TPA/IC shall, on behalf of the University, timely file the Form WC-1, Employer's Report of Industrial Injury (Attachment 5) and determine the compensability of the claim.

e. The responsibility of the TPA/IC shall include, but not be limited to, initiating, maintaining and updating a comprehensive systemwide case management and claims adjustment program to ensure prompt compensation of benefits to eligible Employees under the Hawai'i Workers' Compensation Law.

7. Forms

a. UH Form 79 (OHR), rev. 02/01, Report of Work-Related Injury/Illness (Attachment 1)

b. "Highlights of the Hawai'i Workers' Compensation Law", rev. 02/01, (Attachment 2)

c. "What To Do For Work-Related Injury/Illness", rev. 02/01, information sheet (Attachment 3)

d. UH Form 83 (OHR), rev. 02/01, Time-Off for Treatment of Work-Related Injury/Illness (Attachment 4)

e. Form WC-1, Employer's Report of Industrial Injury (Attachment 5)

f. UH Form 41 (OHR), rev. 02/01, Sick/Vacation Pay During Receipt of Workers' Compensation Disability Benefits (Attachment 6)

g. UH Form 42 (OHR), rev. 02/01, Computation of Average Weekly Wages for Temporary Disability Payments (Attachment 7)

h. UH Form 78 (OHR), rev. 02/01, Authorization for Sick/Vacation Pay While Receiving Workers' Compensation Replacement Benefits (Attachment 8)

i. Leave and Additional Bargaining Unit Codes for Workers' Compensation Purposes (Attachment 8A)

j. Sample Letter to Employee (Attachment 9)

University of Hawai‘i
REPORT OF WORK-RELATED INJURY/ILLNESS

I. Employee's Statement (to be completed by Employee or WC Coordinator in consultation with Employee)

Name: _____ Dept/College: _____
Last First M.I.

Home Address: _____ Marital Status: Married ( ) Single ( )
Street/P.O.Box

_____ Home Phone: _____ Work Phone: _____
City State Zip

Date of Birth: _____ Social Security No.: _____
mo day year

Date of Injury: _____ Time of Injury: _____ a.m. _____ p.m.
mo day year

Time Began Work on Day of Injury: _____ a.m. _____ p.m.

Date injury/illness reported to Supervisor or WC Coordinator (College Personnel Officer): _____

Name of Supervisor: _____

List names and phones numbers of any witnesses to injury/illness: _____

_____

Any outside employment? Yes [ ] No [ ] If yes, list name and address of employer:

_____

Did you lose any time off from work? Yes [ ] No [ ] If yes, indicate dates: From _____ To _____

Fully describe how, when and where the injury occurred (e.g., I was in Hawai‘i Hall Room 5 moving a 60# box of copier paper from the bottom shelf to the hand truck when I felt a sharp pain.):

_____

_____

_____

_____

Identify body part and extent of injury/illness (e.g., muscle strain in lower back): _____

_____

_____

Identify the tools, equipment, or materials, if any, you were using at the time of the accident: _____

_____

Identify any protective equipment you were using at the time of the accident: _____

_____

If you received medical treatment other than first aid, provide name and address of medical provider:

_____

If you were hospitalized for this injury/illness, provide name and address of hospital: _____

_____

Have you ever had a similar injury/illness? Yes [ ] No [ ] If yes, please explain and list names and addresses of previous medical providers who have treated you: _____

_____

_____

I hereby certify that the statements on this form are true and correct to the best of my knowledge.

_____ _____
Employee's Signature Date

II. Supervisor's Statement

Date on which the injury/illness described above was reported to you: _____

Reason for delay, if any, in informing WC Coordinator: _____
_____

Is the Employee's description of his/her work assignment at the time of injury/illness accurate? Yes [ ] No [ ]
If no, explain: _____
_____

Was the Employee performing the assigned duties and responsibilities at the time of injury/illness?
Yes [ ] No [ ] If no, explain: _____
_____

Additional information (provide relevant information; e.g., special circumstances relating to the injury/illness, contextual information, etc.) _____
_____
_____

_____ _____ _____
Supervisor's Name (Print) Supervisor's Signature Phone No.

II. Authorized Workers' Compensation Coordinator (Designated College PO/AO)

Employee-Claimant Employment Information:

Position Title: _____ Class Code: _____ Gender: ____ Male ____ Female

Date of Hire: _____ BU: _____ Pay: $_____hourly $_____ monthly

Type of Appointment: ____ Regular ____ Temporary ____ Casual/Emergency ____ Part-time (Hrs worked per week:

If injury/illness is fatal, date of death: _____ Date DLIR - OSH Notified: _____

Employing Agency Code: 22-_____

14-digit payroll account code and % at time of injury: _____ _____%
_____ _____%
_____ _____%
_____ _____%
_____ _____%

Reason for delay, if any, in submitting report to FICOH: _____
_____

Additional Information (Provide any other relevant information; e.g., knowledge of concurrent employment if not otherwise indicated by Employee; special circumstances relating to the injury/illness) : _____
_____
_____
_____
_____

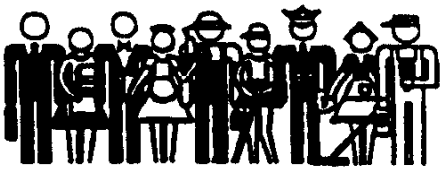
I understand that the Employer's Report of Injury/Illness must be submitted to DLIR by First Insurance Company of Hawai'i within seven (7) days of the Employee's notice to Employer in compliance with Chapter 386, HRS. The UH Form 79 (OHR) Report of Work-Related Injury/Illness and UH Form 42 (OHR), Computation of Average Weekly Wages for Temporary Disability Payments were timely submitted to First Insurance Company of Hawai'i by FAX to ***527-7511*** *by*:

_____ _____ _____ _____
Authorized WC Coordinator (print) WC Coordinator Signature Phone Date

FAX to: First Insurance Company of Hawai'i <u>and</u> OHR-WC
Original: WC Coordinator (do <u>not</u> file in employee's personnel folder)

AP A9.720
Attachment 2

HIGHLIGHTS OF THE HAWAII WORKERS' COMPENSATION LAW



STATE OF HAWAII
Department of Labor and Industrial Relations
DISABILITY COMPENSATION DIVISION
P.O. Box 3769
Honolulu, Hawaii 96812

Rev. 2/95

This is an information brochure.
Secure full text from Workers' Compensation coordinator
or
University of Hawaii, Office of Human Resources

University of Hawai‘i
WHAT TO DO FOR WORK-RELATED INJURY/ILLNESS

- You need to immediately notify your supervisor or your college personnel office about your injury/illness, if you will be seeking medical attention beyond basic first aid, and intend to file for workers' compensation. You must provide complete and accurate information, including outside (non-University) employment and prior similar injury/illness . You must obtain and submit the following forms to the Workers' Compensation Coordinator (WC Coordinator) in your college personnel office :

  - UH Form 79 (OHR), Report of Work-Related Injury/Illness - Section I
  - UH Form 41 (OHR), Sick/Vacation Pay During Receipt of Workers' Compensation Disability Benefits (If you do not complete and submit this form, you will be placed on LWOP - Industrial Injury and receive only wage loss benefits, as applicable.)

- Have your medical providers submit billings and reports directly to the third party administrator (TPA)/insurance carrier (IC). For claims filed on or after February 1, 2001:

  First Insurance Company of Hawai‘i, Ltd.
  P.O. Box 2866
  Honolulu, Hawai‘i 96803

- If you are unable to return to work, you are responsible for providing your supervisor or WC Coordinator with a certificate of disability from your attending physician for each period of disability and for notifying your supervisor or WC Coordinator of the estimated date of return to work. Supervisors must immediately forward to the WC Coordinator any certificates of disability received from injured employees.

- In accordance with Section 386-31, HRS, Total Disability, there is a three (3) calendar days wait period during which Workers' Compensation wage replacement benefits are not paid. You need to submit a leave request (UH Form 1, Request for Leave) to your supervisor to request sick and/or vacation leave or leave without pay (LWOP) to cover your absence from work for these days.

- If you will be absent from work due to your work-related injury/illness, account for your absence as sick/vacation leave or leave without pay. There is a three-day wait period during which you are not eligible for wage loss replacement benefits. For those cases requiring additional review before determination of compensability, you will need to similarly account for your absence during the period for which you are not yet receiving wage replacement benefits.

- If your claim is deemed compensable and you require time-off during working hours for medical treatment, submit via your supervisor to your WC Coordinator a completed UH Form 83 (OHR), Time-Off for Treatment of Work-Related Injury/Illness.

- You may select for treatment of your injury/illness any physician who is practicing on the island where the injury/illness was incurred. However, should you decide to change to another physician, you must:

  - inform your physician and claim adjuster, **prior to making a first change**, of your desire to change and furnish both with the name of the selected physician.
  - receive the approval of the claim adjuster or the Director of Labor, upon application and justification, **prior to making any subsequent change** after the first change.

  Note: The TPA/IC may also appoint a physician of its choice, for purpose of examination.

- Read the copy of the "Highlights of the Hawai‘i Workers' Compensation Law" brochure provided by your WC Coordinator.

- Notify your WC Coordinator and the TPA/IC of any change in mailing address or phone number; failure to do so may delay receipt of benefits.

University of Hawai‘i
TIME-OFF FOR TREATMENT OF WORK-RELATED INJURY/ILLNESS

An employee returning to duty following a work-related injury/illness who requires follow-up medical treatments shall be provided duty time off to keep such appointments which cannot be scheduled during off-duty hours. Time-off for such treatment is provided only for work-related injury/illness deemed compensable and treatment must be directly related to a specific Worker's Compensation claim. This time-off includes reasonable travel time to and from the medical appointment.

Part I (Employee-Claimant to Complete)

Employee-Claimant: _____ Date of Injury: _____

Position Title: _____ Dept./Div.: _____

Address (Work Site): _____

Work Phone No.: _____ APPOINTMENT: DATE: _____ TIME: _____

Employee's Signature: _____ Date: _____

Part II (Supervisor to Complete) On date of appointment, Employee gives to Supervisor to have departure time entered and signed. Employee takes this form to the physician for completion of Part III. Upon Employee's return to work, the Employee must give this form to the Supervisor to have the time returned entered and signed.

_____	_____	_____	_____
Date & Time Left	Supervisor's Signature	Date & Time Returned	Supervisor's Signature

Part III (Medical Provider to Complete)

Medical Provider: _____ Specialty: _____
Address: _____ Phone No.: _____
Approximate Time Patient Arrived: _____ Completed Treatment at: _____
Brief Description of Treatment Provided: _____

Date/Time of Next Scheduled Appointment: _____

_____ _____
Signature of Medical Provider Date

Every work injury 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. 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 RESULTS IN DEATH.) EVERY QUESTION MUST BE ANSWERED FULLY TO AVOID FURTHER CORRESPONDENCE.

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

WC-1 EMPLOYER'S REPORT OF INDUSTRIAL INJURY

(NOTE: DO NOT WRITE IN SHADED BLOCKS)

CASE NUMBER

IDENTIFICATION SECTION

EMPLOYEE NAME - LAST	FIRST	M.I.	SOC SEC NO	DATE OF BIRTH MO / DAY / YR	SEX ☐ MALE FEMALE ☐	MARITAL STATUS MARRIED ☐ ☐ SINGLE	DATE RECEIVED MO / DAY / YR

ADDRESS	ADDITIONAL ADDRESS INFORMATION (C/O)	CITY	STATE	ZIP CODE

PHONE	OCCUPATION	HOW LONG EMPLOYED BY YOU IN THIS OCCUPATION?	YRS EMP'S CODE	DEPARTMENT	PAYROLL COMP CLASS CODE	OCC CODE

REGISTERED EMPLOYER	DBA

ADDRESS	CITY	STATE	ZIP CODE

PHONE	NATURE OF BUSINESS	DATE INJURY/ILLNESS REPORTED MO / DAY / YR	DATE OF INJURY/ILLNESS MO / DAY / YR	FORMS ☐ WC-2 ☐ WC-5	DOL NUMBER	DBA

DETAIL OF INJURY/ILLNESS

TIME OF INJURY/ILLNESS ____ A.M. ____ P.M.	TIME OF W CODE	PLACE OF I/I IF DIFFERENT FROM EMPLOYERS MAILING ADDRESS	CITY	STATE	ON EMPLOYER'S PREMISES ☐ YES ☐ NO	SIC	OWNERSHIP CODE

HOW DID THIS ACCIDENT OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened. Please use separate sheet if necessary.)

SOURCE OF INJURY | ACCIDENT TYPE

WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using.)

TASK | ACTIVITY | ACCIDENT FACTOR

AOB

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 injured his skin; in case of strains, the thing he was lifting, pulling, etc.)

DESCRIBE IN DETAIL THE NATURE OF THE INJURY ILLNESS AND PART OF THE BODY AFFECTED		YES	NO	NATURE OF INJURY	PART OF BODY
	DISFIGUREMENT	☐	☐		
	BURNS	☐	☐		

TIME LOST INFORMATION

DATE DISABILITY BEGAN MO / DAY / YR	WAS EMPLOYEE FURNISHED MEALS OR LODGING? YES NO	AVG WKLY WAGE	IF EMPLOYEE IS BACK TO WORK GIVE DATE MO / DAY / YR	WAS EMPLOYEE PAID IN FULL FOR DAY OF INJURY-ILLNESS? YES NO	IF EMPLOYEE DIED GIVE DATE MO / DAY / YR	HOURLY WAGE	MONTHLY SALARY	HRS WORKED/WK	WEIGHING FACTOR

GIVE NAME AND ADDRESS OF SURVIVORS ON BACK

TREATMENT

OBTAIN NAME OF TREATING PHYSICIAN FROM EMPLOYEE

NAME OF PHYSICIAN	ADDRESS	PHYSICIAN I.D. CODE

NAME OF HOSPITAL (IF HOSPITALIZED)	ADDRESS

CARRIER I.D.

INSURANCE

NAME OF WC INSURANCE CARRIER	NAME OF ADJUSTING COMPANY	IF LIABILITY DENIED, WHY?	IS LIABILITY DENIED? ☐ YES ☐ NO

POLICY NO	POLICY PERIOD	ADJUSTER NAME	CARR. CASE NO

ADJUSTER I.D. | MEDICAL DEDUCTIBLE

SIGNATURE

SIGNATURE	TITLE	DATE MO / DAY / YR

(Rev. 2/94)

MEMORANDUM

TO: WC Coordinator

FROM: _____ Date of Injury: _____
Employee-Claimant Name (print)

SUBJECT: Sick/Vacation Pay During Receipt of Workers' Compensation Disability Benefits

I understand that there is a three (3) calendar day wait period, pursuant to Chapter 386, HRS, before I am eligible for receipt of workers' compensation (WC) wage loss replacement benefits. Therefore, I must account for these days of absence due to work-related injury/illness by using personal leave (sick, vacation, or leave without pay). I further understand that the WC wage loss replacement shall be paid only for those periods of authorized temporary total disability (TTD) or temporary partial disability (TPD) at the rate of 2/3 of my average weekly wage (AWW) which shall not be more than the specified State maximum AWW and not less than the specified State minimum AWW. I further understand that the University permits me to use my sick and vacation leave with the intent to provide me with income additional to my WC wage loss replacement. Finally, I understand that WC wage loss replacement will be sent directly to me at the mailing address shown on the UH Form 79, Report of Work-Related Injury/Illness, or as otherwise reported. With this understanding, I hereby make the following election which shall be effective to the date my disability ends, unless superseded by a subsequent UH Form 41 (OHR), Sick/Vacation Pay During Workers' Compensation Disability Benefits:

Option 1: _____ WC Benefits Only (66 ⅔% of weekly wages, not to exceed the specified State maximum)

I elect ***not*** to supplement my TTD or TPD benefits with availalbe accrued sick and/or vacation leave while absent due to work-related disability. I understand that I will be placed on Leave Without Pay status for the duration of authorized absence due to work-related disability. I understand that no voluntary deductions can be made from my workers' compensation wage replacement benefits, and I will be responsible for making direct payments to the respective payees.

Option 2: _____ WC Benefits + Sick/Regular Pay = Regular Salary (100%)

I elect to supplement my WC wage loss replacement benefits with available accrued sick leave credits. The total of my WC wage replacement benefits ***plus*** salary payments (supplemental sick leave credits and/or regular pay) shall equal my regular salary. I understand that my sick leave credits will used on a pro-rata basis. Do not use my available accrued vacation leave credits. If I do not have sufficient accrued sick leave credits to receive a sum equal to my full salary, I will receive an amount equal to workers' compensation benefits plus regular pay for any days worked plus available sick leave pay.

Option 3: _____ WC Benefits + Sick/Vacation/Regular Pay = Regular Salary (100%)

I elect to supplement my WC wage replacement benefits with available accrued sick and vacation leave credits. The total of my WC wage replacement benefits ***plus*** salary payments (supplemental sick and/or vacation leave credits and/or regular pay) shall equal my regular salary. I understand that my sick and/or vacation leave credits will be used on a pro-rata basis. I further understand that my vacation leave credits will ***only*** be used if my available accrued sick leave credit balance is insufficient.

I understand that no deductions can be made from my WC benefit payments, other than for ERS contributions as indicated below. All voluntary deductions and reductions shall be from my vacation/sick leave payments. As such, should my vacation/sick leave payments be insufficient to cover all voluntary deduction items, I shall make payments directly to the respective payees.

ERS Option: I am a member of the **ERS contributory retirement plan** and hereby *(initial one)* _____ **direct or** _____ **do not direct** the Employer and/or TPA/IC to deduct my statutory ERS contributions from my wage loss replacement benefits and to appropriately deposit such amounts to the ERS. I understand that without this specific directive, there shall be no contributions to the ERS from my wage loss replacement benefits.

I understand that I am responsible for timely notifying my department and the TPA/ IC of any changes to my mailing address. With my signature below, I hereby authorize the WC Coordinator of my college to process applicable UH Form(s) 1, Request for Leave of Absence, in compliance with my election as shown above. A photocopy of this form shall be considered as effective and valid as the original.

_____ _____
Signature of Employee-Claimant Date
(*Invalid without signature)*

Original: WC Coordinator <u>UNLESS</u> employee selects ERS Option; then original to FICOH and copy to WC Coordinator
Copies: UH Payroll (to be attached to first submission of UH Form 78) & OHR-WC
UH Form 41 (OHR), rev. 02/01

A9.720
Attachment 7

University of Hawai'i
COMPUTATION OF AVERAGE WEEKLY WAGES FOR
TEMPORARY DISABILITY PAYMENTS

Under the provisions of Section 386-51, HRS, Computation of average weekly wages (AWW), and Section 12-10-23, Chapter 10, Title 12, Department of Labor and Industrial Relations, the AWW of an employee for temporary total disability (TTD) and/or temporary partial disability (TPD) payments must be computed so as to include overtime, temporary assignments and differentials during the 52 weeks, or portions thereof, preceding the week in which the work-related injury/illness occurred. Instruction: Access the on-line the FHMR Screen 751 Payroll Inquiry by SSN/Name and specify 52-week period immediately prior to the date of injury/illness (actual payments made or owed during this period) , then add amounts shown for the following object codes and enter below. WC Coordinators who do not have access to this on-line report should seek the immediate assistance of the appropriate fiscal officer. ***It is imperative that this information be provided to the TPA/IC to permit the proper calculation and payment of benefits as required by law.***

Name of Employee-Claimant: _____
Date of Injury/Illness: _____
Regular Salary/Wage at Time of Injury: _____per month _____per hour
If Student Assistant or Casual Hire: _____ total earned (paid or owed) wages for work performed during prior 52 weeks

In the 52 weeks preceding the week in which the date of injury occurred, the named employee received the following in addition to regular/normal wages/salary: **If no additional compensation was received, check here _____.**

Description (Code)	Amount	Description (Code)	Amount
Ordinary Overtime (2002)	_____	Overseas Pay (2018)	_____
Holiday Overtime (2003)	_____	Stipend (2019)	_____
Split Shift Overtime (2004)	_____	Standby Pay, Call Back(2025)	_____
Split Shift Differential (2005)	_____	Hazardous Duty (2026)	_____
Night Shift Differential (2006)	_____	Emergency Work (2027)	_____
Temporary Assignment Pay (2007)	_____	Casual Overtime (2102)	_____
Overload (2008)	_____	Student Assistant Overtime (2202)	_____
Retroactive Pay (2009)*	_____	Lecturer Regular Retroactive Pay (2309)*	_____
Hazard Differential / High Altitude Differential (2011)	_____	Lecturer Casual Overtime (2402)	_____
Wages In Kind (2015)	_____	Lecturer Casual Retroactive Pay (2409)*	_____
Sabbatical Leave Differential (2017)	_____	Lecturer Overload (2508)	_____
		TOTAL	_____

***Only if retroactive to pre-injury/illness date.**

Has the employee earned and not been paid for any overtime, standby, or shift differentials as of the date of the injury/illness?
____ yes ___ no If yes, what is the total amount earned, but not yet paid. $_____

Was the employee performing service on a temporary assignment at a rate of pay higher than employee's regular rate at the time of the injury/illness? ___ yes ___ no If yes, what is the employee's regular rate? $_____

I have reviewed all available records, including the UH FHMR 751 Detail Payroll Feed Report by Fiscal Officer and/or FHMR Screen 751 Payroll Inquiry by SSN/Name, and have provided all pertinent information relative to regular and premium pay.

_____ _____ _____
Signature of WC Coordinator Phone E-mail Address

[ ] CORRECTION for Disability Date(s): _____

Authorization for Sick/Vacation Pay While Receiving Workers' Compensation Wage Replacement Benefits

Employee (Last, First, MI): _____ Soc. Sec. No.: _____ Payroll No.: _____ Dist. Code: _____
Dept./College/Office: _____ BU: _____ FTE: _____
Full-Time Monthly Salary: $_____/ Hourly Rate: $_____ Acct. Code*: _____ _____%
Date of Injury: _____ Disability Dates _____ Days Off: _____
Year: _____ Date Returned to Work: _____

1st Half ___	2ND Half ___	Absence Due to WC Claim	(1) Hrs Worked	(2) Hrs WC Sick**	(3) Hrs Personal Sick**	(4) Hrs WC Vacation**	(5) Hrs Personal Vacation**	(6) Hrs Other Paid Leave**	(7) Hrs LWOP **	Total of Row for Columns 1 to 7 Must Not Exceed 8
1	16									
2	17									
3	18									
4	19									
5	20									
6	21									
7	22									
8	23									
9	24									
10	25									
11	26									
12	27									
13	28									
14	29									
15	30									
	31									
	Totals:									

* If multiple account codes, list additional account codes and percentages: _____
** Complete and process Form(s) 1 as authorized by proper authority within policy

I certify that the above information is correct and the employee has sufficient accumulated sick/vacation leave available for use. I hereby authorize payment of _____ hours of sick/vacation leave:

_____ _____ _____
Signature of WC Coordinator Date Phone No.

Original: Payroll xc: OHR-WC

INSTRUCTIONS

- The UH Form 78 is the document which authorizes Payroll to make payment to the Employee of sick/vacation hours.

- If the Employee elects not to supplement the WC wage loss replacement benefits, the UH Form 41 serves as notice to Payroll that the Employee is to receive no salary payments for the duration of the wage loss replacement benefit period. The UH Form 78 is to be submitted to Payroll for each applicable pay period.

- The UH Form 78 must be timely submitted to Payroll (copy to OHR) for each pay period during which disability leave was authorized.

- For Employees on a work schedule other than M-F, the Employee's days off must be indicated on the UH Form 78.

- All applicable hours must be accounted for on the UH Form 78.

- The WC Coordinator must ensure that the UH Form 1, Application for Leave of Absence, for hours indicated in columns 2 and 4 is completed and processed for timely recordation in the leave accounting system.

- Additional Instructions:

Column #	Column Heading	Instruction
(1)	Hrs Worked	Enter the number of hours worked by the Employee
(2)	Hrs WC Sick	Enter the number of authorized sick hours per day used to supplement WC wage replacement benefits. UH Form 1 to be completed using Code 03.
(3)	Hrs Personal Sick	Enter the applicable number of authorized non-WC sick leave hours; i.e., while on TPD, Employee needs to take sick leave due to reasons other than work-related injury/illness on scheduled work days. UH Form 1 to be completed using Code 02.
(4)	Hrs WC Vacation	Enter the number of authorized vacation hours per day used to supplement the workers' compensation wage replacement benefits. UH Form 1 to be completed using Code W1.
(5)	Hrs Personal Vacation	Enter the applicable number of non-WC vacation hours per day; i.e., while on TPD, Employee is granted vacation leave on scheduled work days. UH Form 1 to be completed using Code 01.
(6)	Hrs Other Paid Leave	Enter the applicable authorized number of hours. Also enter the narrative description of Other Paid Leave; e.g., sabbatical/professional improvement leave with pay, bereavement, military, comp time, jury/witness duty. UH Form 1 to be completed using appropriate code: 04, 05, 06, 11, 12.
(7)	Hrs LWOP	Enter the applicable number of hours. Also enter the narrative description of LWOP; e.g., child care, health, professional improvement leave, family leave, industrial injury. UH Form 1 to be completed using appropriate code: 07, 08, 09, 10, 27, 37, 47, W8. Note: Code W8 permits continued accrual of leave when the Employee is not receiving sick/vacation pay to supplement WC wage loss replacement benefits.

Note: Leave Codes printed on the UH Form 1 represents only a partial listing, reflective of the most common leave codes used. Attachment 9 is a complete listing of leave codes.

A9.720
Attachment 8A

Leave Codes

Code	Description
01	vacation
02	sick
03	sick - industrial injury
04	sabbatical/professional improvement leave with pay
05	bereavement
06	military
07	LWOP - child care
08	LWOP - health
09	LWOP - professional improvement leave
10	LWOP - other
11	compensatory time off
12	jury/witness duty
13	strike
21	vacation - family leave - birth of child
22	sick - family leave - birth of child
27	LWOP - family leave - birth of child
31	vacation - family leave - adoption of child
32	sick - family leave - adoption of child
37	LWOP - family leave - adoption of child
41	vacation - family leave - care of family member
42	sick - family leave - care of family member
47	LWOP - family leave - care of family member
W1	vacation - industrial injury
W8	sick - industrial injury

Additional Bargaining Unit Codes for Workers' Compensation Purposes

Code	Description
GA	Graduate Assistant
ST	Student Assistant
CH	Casual Hire
VL	Volunteer
NC	Non-compensated
PD	Post-Doctoral
FE	Former Employee

Attachment 9

*** SAMPLE ***

MEMORANDUM

TO: *(employee name)*
(employee title)

FROM: (*name of WC Coordinator)*

SUBJECT: Salary Payments Related to Absences Due to Work-related Injuries

I regret that you are temporarily unable to perform your duties and responsibilities due to your recent injury/illness. We wish you well in your recovery. Please be advised of the following:

While Awaiting a Determination of Compensability

While you await a determination of eligibility for workers' compensation benefits, you must take appropriate action to avoid salary overpayments. Please be reminded that a three-day wait period is required before wage replacement benefits can be authorized, as appropriate. Wage replacement benefits are payments from the workers' compensation administrator or insurance carrier to replace the regular wages/salaries from the University of Hawai'i, which you are unable to receive due to your absence.

You must account for any and all absences while you await determination of compensability of your reported injury/illness and authorization of applicable wage replacement benefits. If you have sufficient sick or vacation leave, you must use such leave during this time and any subsequent periods of absence due to total disability. You will be placed on leave without pay should you not have a sufficient leave balance or you elect a leave without pay in lieu of sick/vacation pay. In all cases, the University cannot pay your regular full salary for days not worked. The University can, with proper notice and authorization apply your sick or vacation leave for those days of absence.

There may be instances of salary overpayment when there are insufficient leave balances. As the determination of workers' compensation benefits is not instantaneous and as payroll deadlines must be timely met, there will likely be a period of salary overpayment; i.e., you are not at work but continue to receive regular salary which cannot be attributed to the use of sick or vacation leave.

In instances wherein the claim is "denied pending investigation," there will be no benefit payments until the review of the case is completed (e.g., investigation may involve review of medical reports). Please ensure that you utilize available sick or vacation leave for any resulting absence(s) to avoid a leave without pay situation. Subsequently,

should the claim be deemed compensable and you begin receiving wage replacement benefits, you may need to "buy back" leave by returning a portion of the sick/vacation pay already received; the equivalent leave time will be credited to your leave account.

<u>After Your Injury/Illness is Determined to be Compensable</u>

Your wage replacement benefits are paid for days of absence due to disability arising from the compensable injury/illness. Additionally, University employees are permitted to utilize sick leave to supplement these benefits. Should you exhaust your available sick leave, you may utilize your available vacation balance. If you have not yet completed an UH Form 41, you will be placed on Leave Without Pay.

Upon receipt of your wage replacement benefits and return of a portion of the sick and/or vacation pay already received; the University will credit to your leave account the appropriate leave credits.

Should you have questions about your workers' compensation benefits, please feel free to contact your case manager at First Insurance Company of Hawai‘i. Should you have questions about your sick/vacation pay during periods of absences relating to your injury/illness, please contact me at _____.