SOI HIRE KIT INSTRUCTIONS

Attached is the electronic version of the New Hire Paperwork; here's the breakdown of what's included:

Page 2 - 8: This are the pages we will need employees to fill out and have those submitted to SOI Payroll.

Page 9: Direct Deposit Enrollment Form; only required if the employee would like to sign up for direct deposit.

Page 10 - 28: New Hire Packet literatures, those are the information flyers and required compliance materials to be hand out to all new hires.

Contacts:

Risk Assessment Manager - Thomas Allen, Thomas.allen@soi.com, or 310-406-5945.

Client Service Representative – Vincent Chou, Vincent.Chou@soi.com, or 866.374.5119 x6725

EMPLOYEE INFORMATION	
Client Number:	
Employee Name:	
Employee SSN:	

NEW HIRE DOCUMENTATION

This document is not intended for use as an application for employment.

The New Hire Documentation (items 1-4 below) must be completed for each Assigned Employee at the time of hire through SOI. The Assigned Employee is not accepted or covered by workers compensation by SOI until all completed forms have been received by SOI. **The New Hire documentation should be submitted before the employee is allowed to work.**

Employee Instructions for Completing New Hire Documentation.

- Please complete the New Hire Documentation in its entirety and do not leave anything blank.
    1. Contact & Resident Information (Section 1 – Employee Data)
    2. W-4 Employee's Withholding Allowance Certificate
    3. I-9 Employment Eligibility Verification
    4. Assigned Employee Acknowledgements (Section 3)

- Instructions for completing the I-9 are available upon request.
- The New Hire Documentation requires your signature in **three** places.

Client Work-site Manager/Supervisor Instructions for completing the New Hire Documentation.

A conditional offer of employment must be made prior to the completion of this package. Please utilize the SOI Application for Employment for pre-employment purposes.

*If you are re-hiring an employee within ninety (90) days of termination, please use the Employee Reactivation Request form located on the SOI portal.
*If you are re-hiring an employee that has been terminated over ninety (90) days, please use this New Hire documentation.

- Complete all required data of SECTION 2 – PAYROLL DATA, sign and date.
- Verify all signature blocks are complete and dated in appropriate sections.
- Verify W-4 Employee's Withholding Allowance Certificate is properly completed.
- Where applicable, state withholding forms are available from SOI. Verify proper completion and forward to SOI.
- Verify I-9 Employment Eligibility. Verification should be completed by your company's authorized representative.
- Fax or Scan & Email the completed New Hire Documentation (items 1-4 above) to your assigned payroll specialist before the employee is allowed to work.
- Retain all originals of the New Hire Documentation (items 1-4 above) for your records.

SECTION 1 –EMPLOYEE DATA
Employee must complete all items in - **PLEASE PRINT**

Social Security# Date of Birth (mm/dd/yyyy)

EMPLOYEE NAME: (as it appears on your Social Security Card)

First ___________________________ Middle ____________________ Last ____

Address ____

City __________________________________ State ____________________________ Zip Code _______________________

Email address: ____

Taxing Jurisdiction Data(if applicable): Resident County Name N/A School District # N/A
Do you live inside or outside the city limits? N/A (Required for residents of KY, OH, and PA)
If you live in a Township or Borough, please list Township or Borough N/A

Home Phone (Include Area Code): ___________________________ Alt No. (Include Area Code) _____________________________

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name: ____ Relationship: _____________________________

Phone (Include Area Code): __________________________________ Alt. Number (Include Area Code) ______________________

EQUAL OPPORTUNITY DATA - you consider yourself:

Race/National Origin: ☐ White ☐ Black or African-American ☐ Hispanic or Latino ☐ Asian ☐ American-Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander ☐ Two or More Races ☐ I choose not to disclose my race/national origin

Gender: ☐ Male ☐ Female

Veteran Status: (check all that apply) ☐ Disabled Vet ☐ Other Protected Vet ☐ Armed Forces Service Medal Vet ☐ Recently Separated Vet
Date separated? :___________

SECTION 2 – PAYROLL DATA
Manager or supervisor must complete all items - **PLEASE PRINT**

THIS INFORMATION MUST BE COMPLETED IN ORDER FOR THE EMPLOYEE TO BE PROCESSED

Client Company Name: ____ Client Number: _______________________

Date of Client Hire: ______________ Effective SOI Hire Date _______________ Check One: ☐ New Hire ☐ Rehire

Location/Branch: ___________________ Department: ________________ Worker's Comp Class Code: ______________

Position: ___________________________________ Job Title: ____

Benefits Employee Type Class: ________________ Job ID: __________________ Check Sort: ____________________

EEO Job Category: ☐ Executive/ Sr Level Officials & Managers ☐ First/Mid-Level Officials &Managers ☐ Professionals ☐ Technicians
☐ Sales Workers ☐ Administrative Support Workers ☐ Craft Workers ☐ Operatives ☐ Laborers and Helpers ☐ Service Workers

Pay Frequency	Pay Type	Rate of Pay	Status
☐Weekly	☐Hourly	☐ Salary $ ____________ per period $ ____________ Annual	☐Full Time
☐Bi-Weekly	☐Salaried Non-Exempt	☐ Standard Rate Rate $ ___________ per hour	☐Part Time
☐Semi-Monthly	☐Salaried Exempt	☐ Shift Pay Rate $ ___________ per ________	
☐Monthly	☐Commissions	☐ Piece Work Rate $ ___________ per ________	☐Temporary
	☐Piece Work	☐ Other_________ Rate $ ___________ per ________	☐Seasonal
		***Please furnish us with information on other applicable rates of pay.	Check all that apply

I understand that the employee status is not active until all completed forms are received by SOI and its affiliates.

Authorized Supervisor or Manager Sign Here ____

Authorized Supervisor or Manager's Title ______________________________ **Date** ________________

 Updated 1/2012

Form W-4 (2013)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2013 expires February 17, 2014. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,000 and includes more than $350 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2013. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . **A** ______

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.

. . . **B** ______

C Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . **C** ______

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . **D** ______

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . . **E** ______

F Enter "1" if you have at least $1,900 of **child or dependent care expenses** for which you plan to claim a credit . . . **F** ______

(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.

- If your total income will be less than $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children.
- If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child . . . **G** ______

H Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶ **H** ______

For accuracy, **complete all worksheets that apply.**
- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------------------------------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------------------------------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2013

1 Your first name and middle initial | Last name | **2 Your social security number**

Home address (number and street or rural route)

3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate.

Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.

City or town, state, and ZIP code

4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ ☐

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) **5** ______

6 Additional amount, if any, you want withheld from each paycheck . . . . . **6** $ ______

7 I claim exemption from withholding for 2013, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . . ▶ **7** ______

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ▶ **Date ▶**

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) | 9 Office code (optional) | 10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2013 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1949) of your income, and miscellaneous deductions. For 2013, you may have to reduce your itemized deductions if your income is over $300,000 and you are married filing jointly or are a qualifying widow(er); $275,000 if you are head of household; $250,000 if you are single and not head of household or a qualifying widow(er); or $150,000 if you are married filing separately. See Pub. 505 for details . . .	1	$
2	Enter: { $12,200 if married filing jointly or qualifying widow(er); $8,950 if head of household; $6,100 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2013 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2013 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2013 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $3,900 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet . . . . 4 ________		
5	Enter the number from line 1 of this worksheet . . . . 5 ________		
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . .	8	$
9	Divide line 8 by the number of pay periods remaining in 2013. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2013. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $8,000	0
5,001 - 13,000	1	8,001 - 16,000	1
13,001 - 24,000	2	16,001 - 25,000	2
24,001 - 26,000	3	25,001 - 30,000	3
26,001 - 30,000	4	30,001 - 40,000	4
30,001 - 42,000	5	40,001 - 50,000	5
42,001 - 48,000	6	50,001 - 70,000	6
48,001 - 55,000	7	70,001 - 80,000	7
55,001 - 65,000	8	80,001 - 95,000	8
65,001 - 75,000	9	95,001 - 120,000	9
75,001 - 85,000	10	120,001 and over	10
85,001 - 97,000	11		
97,001 - 110,000	12		
110,001 - 120,000	13		
120,001 - 135,000	14		
135,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $72,000	$590	$0 - $37,000	$590
72,001 - 130,000	980	37,001 - 80,000	980
130,001 - 200,000	1,090	80,001 - 175,000	1,090
200,001 - 345,000	1,290	175,001 - 385,000	1,290
345,001 - 385,000	1,370	385,001 and over	1,540
385,001 and over	1,540		

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►**START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name (*Family Name*)	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*

Address (*Street Number and Name)*	Apt. Number	City or Town	State	Zip Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

☐ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): ____________________

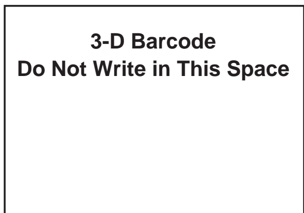
☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) ____________ . Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: ____________________

OR

2. Form I-94 Admission Number: ____________________



If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: ____________________

Country of Issuance: ____________________

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

Signature of Employee:	Date *(mm/dd/yyyy)*:

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:	Date *(mm/dd/yyyy)*:

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	Zip Code

Employer Completes Next Page

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				**3-D Barcode** **Do Not Write in This Space**
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: ________________ **(*See instructions for exemptions.*)**

Signature of Employer or Authorized Representative		Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name	

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	Zip Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)* Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	**B.** Date of Rehire *(if applicable) (mm/dd/yyyy)*:

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title:	Document Number:	Expiration Date *(if any)(mm/dd/yyyy)*:

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A
Documents that Establish Both Identity and Employment Authorization

1. U.S. Passport or U.S. Passport Card
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa
4. Employment Authorization Document that contains a photograph (Form I-766)
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:
   a. Foreign passport; and
   b. Form I-94 or Form I-94A that has the following:
   (1) The same name as the passport; and
   (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI

OR

LIST B
Documents that Establish Identity

1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address
2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
8. Native American tribal document
9. Driver's license issued by a Canadian government authority

For persons under age 18 who are unable to present a document listed above:

10. School record or report card
11. Clinic, doctor, or hospital record
12. Day-care or nursery school record

AND

LIST C
Documents that Establish Employment Authorization

1. A Social Security Account Number card, unless the card includes one of the following restrictions:
   (1) NOT VALID FOR EMPLOYMENT
   (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION
   (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. Native American tribal document
6. U.S. Citizen ID Card (Form I-197)
7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
8. Employment authorization document issued by the Department of Homeland Security

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

SECTION 3 -- ASSIGNED EMPLOYEE NOTICE & ACKNOWLEDGMENTS

The organization for which you perform services (Company) has contracted for SOI to provide services under which you will be paid through SOI for work you perform for and under the direction of Company, and you may also be able to participate in certain benefits offered through SOI. No modification to this page as originally written will be effective. Please sign below:

Illegal discrimination and harassment in employment based on age, race, sex (including sexual harassment), national origin, ethnicity, disability, disabled veteran status, religious or comparable moral belief, union affiliation, or any other legally protected status is prohibited. If I have a disability that impairs my ability to perform the essential functions of my job I may request reasonable accommodations from Company. I cannot be retaliated against for invoking my rights under the law or opposing illegal discrimination and harassment, underpayment of wages, legally-mandated leave and related rights, or any other matter protected by anti-retaliation or "whistle blower" laws.

I will immediately report any illegal discrimination, harassment, retaliation, failure to grant legally-mandated leave (such as FMLA or military leave) and rights in connection with such leave, or error in payment of wages or benefits by or against anyone in my workplace as provided by Company policy (or, in the absence of such a policy, to my supervisor, escalating according to my chain of command and skipping levels if necessary). I also will report such matters to SOI's Human Resources department. SOI cannot determine Company's response, but may facilitate communication between me and Company. I understand that there is never a valid reason not to report such matters. If I do not promptly report a disagreement with the amount of pay I received, Company and SOI may assume that I received the correct amount of pay. I am required to cooperate in investigations of complaints by Company.

If arbitration agreements are forbidden by law with respect to my employment (for example, if I am employed on a federal contract) the agreement to arbitrate below will not apply, and if I am represented by a union and my collective bargaining agreement (CBA) is inconsistent with my agreement to arbitrate in a given case then the agreement to arbitrate will not apply. The other parts of the agreement below will continue to apply in all cases. I and SOI agree that: Any dispute involving SOI, Company, or any benefit plan, insurer, employee, officer, or director of SOI or Company (all of which are Beneficiaries of these Acknowledgments) arising from or relating to my employment, application for employment, or termination from employment will be resolved exclusively through binding arbitration before a neutral arbitrator in the capital or largest city of the state in which I work or another mutually agreed location (SOI may appear by phone); The Arbitrator may grant the same remedies that would be available in a court of law (and no more), and will use the same rules of evidence as a federal court; Unless prohibited by law, costs of arbitration will be shared equally by the parties; If applicable law requires provisions in an arbitration agreement which are different from what is included here, they will be deemed incorporated to the minimum extent required; Disputes will be resolved solely upon applicable law, evidence adduced, and defenses raised, and no other basis, and the arbitrator may grant summary disposition or disposition on the pleadings; The arbitrator will render a reasoned written decision. In addition: **I AND SOI MUTUALLY WAIVE ANY RIGHT TO A JURY TRIAL**, and I agree to participate in any legal dispute with any Beneficiary only in my individual capacity, not as a member or representative of a class or part of a class action. I understand that nothing herein impairs my right to engage in collective action under Section 7 of the National Labor Relations Act and I am not prohibited from complaining to government agencies or cooperating with their investigations. My agreements to arbitrate, waive jury trials, and participate only in my individual capacity are contracts under the Federal Arbitration Act and any other laws validating such agreements and waivers. No failure to strictly enforce these agreements will constitute a waiver or create any future waivers, and no-one other than counsel for SOI (in writing) may waive this agreement for SOI. If any part is unenforceable, the rest will still be enforceable.

I have received or been given access to the SOI Assigned Employee Handbook. Neither this Acknowledgment nor the Handbook is a contract of employment; my relationship with SOI is at will regardless of whether my relationship with Company is at will. SOI can alter, discontinue, and interpret the Handbook at any time without notice or consideration. Nothing herein alters any CBA between Company and any union or limits any rights I may be entitled to from Company under a CBA, such as seniority if applicable. Company, not SOI, is responsible for all matters related to the CBA and the collective bargaining relationship.

If I am a California employee I have received a "Notice to Employees-Injuries Caused by Work (DWC-7)," "Employee Medical Provider Network (MPN) Notice," and "Paid Family Leave Brochure." I am hereby advised that any unresolved complaints regarding SOI in Texas may be addressed to the Texas Department of Licensing & Regulation, (512) 463-6599, P.O. Box 12157, Austin, TX 78711.

If I am injured on the job, even if the injury is minor or I don't want treatment, I must immediately report it to my supervisor and take a post-accident drug/alcohol test at a facility approved by SOI unless prohibited by applicable law or inconsistent with a CBA that covers me. I will be working at a drug free workplace and may be subject to additional testing such as random or reasonable suspicion testing. Refusal to take a required test can result in termination subject to applicable law and CBAs. Being under the influence or in possession of alcohol or illegal controlled substances, being in an unsafe condition, or violating safety standards on the job may result in termination of employment.

SOI is not responsible for any obligation Company has to me such as promises or contracts regarding length or terms of my employment, my pay or other consideration, or benefits. If Company has not provided funds or complied with its agreement with SOI, in no event will SOI be required to pay me more than the minimum wage required by law while the agreement with Company was in effect. Any obligations of SOI cease when its agreement with Company terminates. If I am eligible for any benefits it is my responsibility (and the responsibility of any family members/dependents who wish to participate) to timely submit all required forms and information.

I may request a copy of these Acknowledgments for my records, and I have read them (or had them read to me) and agree:

Signature Printed Name Date

Authorization for Payroll Direct Deposit

TO BE COMPLETED BY SOI	
Client Number:	
Pay Specialist:	
Date Entered:	

Please complete, sign and return this form along with proof of account(s) to SOI for processing.

Client Name ________________________________ **Client Number** ______ **Client Location** ________

Employee Name ________________________________ **Social Security Number** _____-____-______

As an Assigned Employee of SOI, you have the option and convenience of having all, or a portion of your paycheck deposited directly into your bank account(s).

You may direct deposit your pay in up to six designated accounts which can vary into checking, savings or investment accounts. In order to direct deposit your pay check, your financial institution must be a member of the Automated Clearinghouse (ACH) system and you must be an owner on the accounts into which the funds will be deposited. We may request you provide additional information to validate account ownership.

The following section requires the designation of your pay into your accounts. This designation remains the same for each pay period; a change would require a new form. Indicate the type and the specific account information.

Type: ☐ **New** ☐ **Add an additional Acct.** ☐ **Change in amount** ☐ **Change in Financial Institution** ☐ **Discontinue/stop**

***Account 1*: Financial Institution Name** ____________________ ☐ **Checking/Investment** ☐ **Net Pay or** ______**%**
Routing/ABA # **Account #** ☐ **Savings** ☐ **Amount $**

Type: ☐ **New** ☐ **Add an additional Acct.** ☐ **Change in amount** ☐ **Change in Financial Institution** ☐ **Discontinue/stop**

***Account 2*: Financial Institution Name** ____________________ ☐ **Checking/Investment** ☐ **Net Pay or** ______**%**
Routing/ABA # **Account #** ☐ **Savings** ☐ **Amount $**

Type: ☐ **New** ☐ **Add an additional Acct.** ☐ **Change in amount** ☐ **Change in Financial Institution** ☐ **Discontinue/stop**

***Account 3*: Financial Institution Name** ____________________ ☐ **Checking/Investment** ☐ **Net Pay or** ______**%**
Routing/ABA # **Account #** ☐ **Savings** ☐ **Amount $**

Type: ☐ **New** ☐ **Add an additional Acct.** ☐ **Change in amount** ☐ **Change in Financial Institution** ☐ **Discontinue/stop**

***Account 4*: Financial Institution Name** ____________________ ☐ **Checking/Investment** ☐ **Net Pay or** ______**%**
Routing/ABA # **Account #** ☐ **Savings** ☐ **Amount $**

Type: ☐ **New** ☐ **Add an additional Acct.** ☐ **Change in amount** ☐ **Change in Financial Institution** ☐ **Discontinue/stop**

***Account 5*: Financial Institution Name** ____________________ ☐ **Checking/Investment** ☐ **Net Pay or** ______**%**
Routing/ABA # **Account #** ☐ **Savings** ☐ **Amount $**

Type: ☐ **New** ☐ **Add an additional Acct.** ☐ **Change in amount** ☐ **Change in Financial Institution** ☐ **Discontinue/stop**

***Account 6*: Financial Institution Name** ____________________ ☐ **Checking/Investment** ☐ **Net Pay or** ______**%**
Routing/ABA # **Account #** ☐ **Savings** ☐ **Amount $**

Please attach one of the following preprinted documents as verification for account ownership and routing information:

- **Preprinted check (No Starter Checks)**
- **Preprinted Financial Institute Card**
- **Copy of a Bank Statement**
- **Letter on Bank Letterhead**

** *The Financial Institution's name, the employee's name and account number must all be preprinted on the document. Routing/ABA numbers must be included but can be handwritten.*

NOTE: If you are indicating a change to account(s), you will receive a live check until the new account(s) prenote and direct deposit begins.

*Routing/ABA numbers can not start with a 5 or an 8 as sometimes found on internal deposit slips.

Incomplete or unacceptable information will delay the activation of your direct deposit. Direct deposit may take up to two pay periods for activation due to the prenote process. Once activated, direct deposit will occur each pay period. Failure to notify SOI promptly of a closed account may result in the rejection of the deposit and a delay in your pay. SOI may need to reissue your pay in another form of payment.

When making changes to your current direct deposit information it may cause you to receive a live check until the prenote process is complete, which may take up to two pay periods for activation.

I hereby authorize SOI to deduct from my paycheck the designated amounts noted above and direct deposit those funds each pay period. All paychecks will be deposited (regular payroll, commission, bonus, vacation, per diem, etc.) In the event of an error, SOI is authorized to make corrections and initiate adjustments. I understand that a request for change is required in writing and that it may take up to 30 days before the new request is activated.

Employee Signature **Date**

Employee Discounts Flyer

You can find more information for following vendors at **www.soi.com** "***resources***" then click the vendor's icon.
Contact the **SOI Customer Care Department** at **(800) 572-2412** for additional questions.

SOI members can save up to 10% off your car rental with Hertz. Your discount CDP#1849869 is the key!

Wherever your travel takes you, close to home or around the world, your CDP#1849869 is the key to special savings. Be sure to include it in all of your reservations. Click here for the lowest rates, special offers and information about Hertz locations, vehicles and services. Or call Hertz at 1-800-654-2200 and be sure to mention your CDP#1849869.

SOI Discount Card

LifeLock is the industry leader in the rapidly growing field of Identity Theft Protection. We are based in Tempe, Arizona. Our company is led by experienced and successful entrepreneurs and industry experts. We are backed by Bessemer Venture Partners, one of the leading venture capital firms in the world. We serve tens of thousands of consumers in every state of the union, Puerto Rico and the US Virgin Islands. Take a moment to browse and learn about the team that will work for you. Victims of identity theft have new resource for support through LifeLock's partnership with the National Organization for Victim Assistance.

Sears Commercial offers special pricing on major kitchen appliances for SOI clients and employees. Kenmore is the best value, however other brands are available such as Bosch, LG, Maytag, KitchenAid and Jenn-air. In addition you can choose from other great products for your home such as Craftsman garage storage, exercise equipment, mattresses, Craftsman lawn tractors, Kenmore outdoor grills and televisions.

For a complete selection of products you can go to www.sears.com. Obtain the model numbers of the products you are interested in purchasing. Email the information to: Jeff Shaver at jshave1@searshc.com for a price quote. Please allow up to 48 hours for a response. Please list SOI on the subject line.
This program is a special offer exclusively through Sears Commercial and completely separate from Sears retail stores. It is valid only in continental USA. If you have already received a written appliance quote from a Sears retail store you would not be eligible for this program.

Appliances included in the program: dishwashers, cooking, laundry, refrigeration.

SOI Employees SAVE 15%* at www.1800flowers.com® & **www.1800baskets.com**®

For more than 30 years, 1-800-FLOWERS.COM Inc. has been providing customers around the world with the freshest flowers and finest selection of plants, gift baskets, gourmet foods, confections and plush stuffed animals perfect for every occasion. Go to www.1800flowers.com or call (800) 356-9377

As a member of the 1800Flowers.com® family of brands, 1800Baskets.com® truly completes your online gift shopping experience. When you need a special gift, think of us. We'd love to build a basket for you! Go to www.1800baskets.com or call (800)356-9377

For BOTH vendors use PROMOTION CODE: SOI

Theme Park and Entertainment Discounts

SOI clients and employees can now take advantage of discounts to popular theme parks and entertainment attractions in Florida, California and other locations nationwide! Discounts are available for the Walt Disney World® Resort, Universal Orlando and more!

To take advantage of these savings select the link above and you will be directed to the TicketsAtWork.com website.

You can order your tickets directly from this website or by calling 800-331-6483.

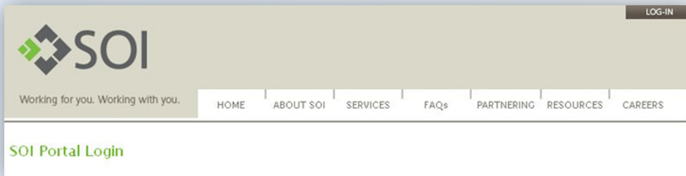
We have partnered with Wild at Work to help our employees save money and get exciting discounts on theme parks, hotels, restaurants, and many more. Some featured offers include Disneyland, Universal Studios, SeaWorld, LEGOLAND, Knott's Berry Farm, T-Mobile, Marriot Hotels, Starwood Hotels, Grand Canyon Railway, over 15,000 restaurants and thousands of other money-saving deals to help you stretch your paycheck.

Go to www.WildatWork.com, click New User Sign Up (Blue Box - Upper right-hand corner of the page), and enter SOI when prompted for the company name. Fill in the short registration form and log in within 48 hours with your password to validate your membership. **Make sure to put Wild at Work on your approved senders list on your email program.**

Some e-mail accounts may block the automated e-mail containing your password as spam. If you do not receive your password within 5 minutes, please call Wild at Work Customer Service at 858-558-6890 ext 110.

Portal Self Registration

Follow these simple steps to register your own user name and password and start using our suite of employee applications available from the SOI Portal.

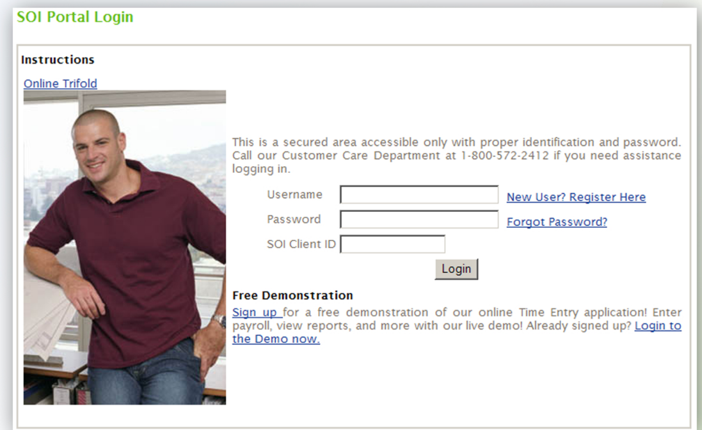


Log On

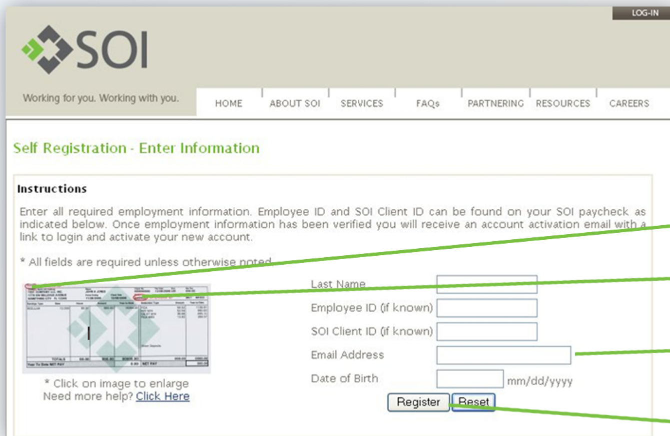
Log on to our website at www.soi.com and click the Login button at the top of the screen

Enter

Select “New User? Register Here” to access the registration form screen



Sign Up



Enter the following information available from your paycheck as shown:

SOI Client ID

Employee ID

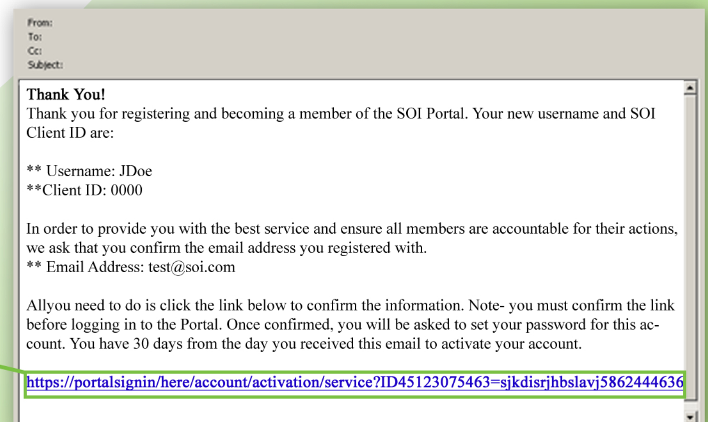
Name, Email and DOB

Click the Register button to submit the application

Finish

An activation email will be sent to the email address provided containing the SOI Portal login information

Click the link to verify the new account and complete registration



From:
To:
Cc:
Subject:

Thank You!
Thank you for registering and becoming a member of the SOI Portal. Your new username and SOI Client ID are:

** Username: JDoe
**Client ID: 0000

In order to provide you with the best service and ensure all members are accountable for their actions, we ask that you confirm the email address you registered with.
** Email Address: test@soi.com

Allyou need to do is click the link below to confirm the information. Note- you must confirm the link before logging in to the Portal. Once confirmed, you will be asked to set your password for this account. You have 30 days from the day you received this email to activate your account.

https://portalsignin/here/account/activation/service?ID45123075463=sjkdisrjhbslavj5862444636

SOI SIGN UP!

Paid Family Leave Insurance Program

Paid Family Leave insurance benefits for California workers

There are times in the life of every working person when they need to care for a loved one. Maybe it's a working parent who needs more time to bond with and care for a newborn. Maybe it's an employee who needs to care for a seriously ill parent, child, spouse, or registered domestic partner. California's Paid Family Leave insurance benefit was created for times like these. (**Note**: Registered domestic partners must meet requirements and register with the California Secretary of State to be eligible for benefits.)

A program that benefits you and your family

California is leading the nation as the first state to make it easier for employees to balance the demands of the workplace and family care needs at home. Paid Family Leave insurance benefits are based on the claimant's (care provider's) past quarterly earnings. For more information regarding maximum benefit amounts paid, view the link to the *Disability Insurance (DI) & Paid Family Leave (PFL) Weekly Benefit Amounts in Dollar Increments* form, DE 2589, at **www.edd.ca.gov**.

Paid Family Leave for California employees

Paid Family Leave insurance does not provide job protection or return rights. Your job **may** be protected **if** your employer is subject to the federal Family Medical Leave Act and the California Family Rights Act. You must notify your employer of your reason for taking leave in a manner consistent with your company's leave policy.

To qualify for Paid Family Leave compensation, you must meet the following requirements:

- Be covered by State Disability Insurance (SDI) (or a voluntary plan in lieu of SDI) and have earned at least $300 in your base period from which deductions were withheld.
- Complete your claim forms accurately, completely, truthfully, and timely.
- Submit your claim no earlier than 9 days, but no later than 49 days after the first day your family care leave began.
- Supply medical information that supports your claim that the care recipient has a serious health condition and requires your care.
- Provide documentation to support a claim for bonding with a new biological, adopted, or foster child.
- Use up to two weeks of any earned but unused vacation leave or paid time off (PTO) prior to the initial receipt of benefits if required by your employer prior to the initial receipt of benefits.
- Serve a 7-day unpaid waiting period before benefits begin for each different care recipient within the 12-month period.

You may not be eligible for benefits if:

- You receive State Disability Insurance, Unemployment Insurance, or Workers' Compensation.
- You are not working or looking for work at the time you begin your family care leave.
- You are not suffering a loss of wages.
- The need for care is not supported by the certificate of a treating physician or practitioner.
- You are in custody due to conviction of a crime.

You are entitled to:

- Know the reason and basis for any decision that affects your benefits.
- Appeal any decision about your eligibility for benefits. (Appeals must be sent to Paid Family Leave in writing.)
- A hearing of your appeal before an Administrative Law Judge (ALJ). You may further appeal the ALJ's decision to the California Unemployment Insurance Appeals Board and the courts.
- Privacy — Information about your claim will be kept confidential except for the purposes allowed by law.

Fast facts about Paid Family Leave

- Provides benefits but does not provide job protection or return rights.
- Provides eligible workers partial wage replacement when taking time off work to care for parents, children, spouses, and registered domestic partners or to bond with a new minor child.
- Covers all employees who are covered by SDI (or a voluntary plan in lieu of SDI).
- Offers up to 6 weeks of benefits in a 12-month period.
- Provides benefits of approximately 55 percent of lost wages.

Contact Paid Family Leave

If you have any questions about these benefits or would like to request a claim form, contact us today. If you are a woman currently receiving SDI pregnancy-related benefits, it is not necessary to request a Claim for Paid Family Leave Benefits. You will automatically be sent a Claim for Paid Family Leave (PFL) Benefits - New Mother, DE 2501FP, when your preganancy-related disability claim ends.

1-877-238-4373 (English) **1-877-379-3819 (Español)**
1-866-692-5595 (Cantonese) **1-866-692-5596 (Vietnamese)**
1-866-627-1567 (Armenian) **1-866-627-1568 (Punjabi)**
1-866-627-1569 (Tagalog) **1-800-445-1312 (TTY)**

For more information, visit:
www.edd.ca.gov

Claim forms should be mailed to
Paid Family Leave at:
P.O. Box 997017
Sacramento, CA 95799-7017

EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and/or alternate formats need to be made by calling 877-238-4373 (voice), or TTY 800-445-1312.

This pamphlet is for general information only and does not have the force and effect of law, rule or regulation.

PO Box 241448
Charlotte, NC 28224
1.800.572.2412

On the web: http://www.soi.com

We are here to serve your employees and you!

The SOI Customer Care Department

Hours of Operation:

7:30 a.m. – 9:00 p.m. EST Monday – Friday

(Spanish speaking representatives are available)

Give us a call at (800) 572-2412

or

E-mail us at ccd@soi.com

The SOI Customer Care Department can help with many inquiries such as:

Address Changes
Forms Assistance
Payroll and YTD Reports
ID Card Requests
Government Employment Verifications
Health Plan Eligibility Questions
Creditable Coverage Letters
Check History Reports
Website Navigation
Payroll Tracking
W-2 Reprints

We look forward to hearing from you!

WORKERS' COMPENSATION - WRITTEN NOTICE TO NEW EMPLOYEES

This notice includes some of your rights, benefits and obligations under the workers' compensation law.

EVENTS, INJURIES AND ILLNESSES COVERED BY WORKERS' COMPENSATION

You may be entitled to workers' compensation benefits if you are injured or become ill because of your job. Workers' compensation covers most work related physical or mental injuries and illnesses. An injury or illness can be caused by one event (such as hurting your back in a fall) or by repeated exposures (such as hurting your wrist from doing the same motion over and over). You may not be entitled to workers' compensation benefits for any injury that arises from your voluntary participation in any off-duty, recreational, social or athletic activity that is not part of your work-related duties.

RIGHTS AND BENEFITS

You may have the right to the following:

- Medical Care Benefits which include: Doctor visits, hospital services, physical therapy, lab tests, x-rays, and medicines as reasonably necessary to treat your injury.
- Temporary Disability (TD) Benefits: Payments if you lose wages while recovering. For most injuries that occur on or after Jan 1, 2008, temporary disability (TD) benefits may not extend for more than 104 compensable weeks within five years from the date of injury. For a few long term injuries, such as severe burns or chronic lung disease, benefits may not extend for more than 240 weeks within five years from the date of injury. Filing a timely Employment Development Department claim may result in additional state disability benefits when TD benefits terminate.
- Permanent Disability (PD) Benefits: Payments if your injury causes a permanent disability.
- Supplemental Job Displacement Benefits: A nontransferable voucher payable to a state approved school if you are injured on or after 1/1/04, the injury results in a permanent disability, you don't return to work within 60 days after TD ends, and your employer does not offer modified or alternative work.
- Death Benefits: Paid to dependents of a worker who dies from a work-related injury or illness.

Temporary disability, permanent disability, vocational rehabilitation maintenance allowance and death benefits are all payable based on 2/3 of your average weekly wage subject to state minimum and maximum rates in effect on your date of injury. Your benefits are paid every two weeks while you are eligible.

CHOOSING YOUR OWN DOCTOR

You may be able to choose the doctor who will treat you for a job injury or illness during the first 30 days after the injury. If eligible, you must tell your employer, in writing, the name and address of your personal physician **before** you are injured. You may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- your employer offers group health coverage;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- **prior** to the injury your doctor agrees to treat you for work injuries or illnesses;
- **prior** to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

Pages 3 and 4 of this notice are forms which can be used for this purpose.

If you do not choose a doctor, your employer has the right to select the physician who will treat you for the first 30 days. You may be able to switch to a doctor of your choice after 30 days, which may include your personal chiropractor or personal acupuncturist. Special rules apply if your employer offers a Health Care Organization (HCO) or after 1/1/05, has a medical provider network (MPN).

Contact your employer for more information.

ROLE OF THE PRIMARY TREATING PHYSICIAN

Your Primary Treating Physician will decide what type of medical care you will receive for your injury or illness, determine when you can return to work, help identify the kinds of work you can do safely while recovering, refer you to specialists, if necessary, and write medical reports that will affect the benefits you receive. It is important to get good medical care to help you recover. You should be

treated by a doctor who understands your particular type of injury or illness. Tell the doctor about your symptoms and the events at work that you believe caused them. Also, describe your job and your work environment.

IF YOU GET HURT – GET MEDICAL CARE. If you need first aid, contact your employer. If you need emergency medical treatment, call 911 or one of the numbers listed below. Tell the health care provide who treats you that your injury or illness is job related.

Ambulance ______________________
Fire Dept. ______________________
Police ______________________
Doctor ______________________
Hospital ______________________

REPORT YOUR INJURY OR ILLNESS

Report the injury immediately to your supervisor or to:

Employer Representative ______________
Phone Number ______________

Tell your supervisor right away. If your injury or illness developed gradually, report it as soon as you learn it was caused by your job. Reporting promptly helps prevent problems and delays in receiving benefits, including medical care you may need to avoid further injury. If your employer does not learn of your injury within 30 days, you could lose your right to receive workers' compensation benefits.

Your employer is required to provide you a claim form within one working day after learning about your injury. Within one working day after an employee files a claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars ($10,000).

ADDITIONAL INFORMATION

You can get free information from a State of Workers' Compensation Information & Assistance Officer. To hear recorded information including a list of local offices, call toll-free (800) 736-7401. Learn more online: http://www.dir.ca.gov

The nearest Information & Assistance Officer is at:

Address ______________________
City ______________________
Phone ______________________

Your employer's compensation carrier at the time of your hire is:

____

DISCRIMINATION

It is illegal for your employer to punish or fire you for having a work injury or illness, for filing a claim, or testifying in another person's workers' compensation case. If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to the limits set by the state.

MEDICAL PROVIDER NETWORKS

Your employer may be using an MPN, which is a selected network of health care providers to provide treatment to workers injured on the job. If you have pre-designated a personal physician prior to your work injury, then you may receive treatment from your pre-designated doctor. If you have not pre-designated and your employer is using a MPN, you are free to choose an appropriate provider from the MPN list after the first medical visit directed by your employer. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN. Contact your employer for more information.

False Claims and False Denials. Any person who makes or causes to be made any knowingly false of fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payment is guilty of a felony and may be fined and imprisoned.

PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.) or doctor of osteopathic medicine (D.O.) or medical group if:

- your employer offers group health coverage;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related in injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work – related injury or illness and the above requirements are met.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee: Complete this section.

To: ___________________________ **(name of employer**). If I have a work-related injury or illness, I choose to be treated by:

____

(name of doctor)(M.D., D.O., or medical group)

____ **(street address, city, state, zip)**

____ **(telephone number)**

Employee Name **(please print):**

____

Employee's Address:

____

Employee's Signature ____ **Date:** _________________________

Physician: I agree to this Predesignation:

Signature: ____ **Date:** _________________________

(Physician or Designated Employee of the Physician or Medical Group)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

Title 8, California Code of Regulations, section 9783.

NOTICE OF PERSONAL CHIROPRACTOR OR PERSONAL ACUPUNCTURIST

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

You may use this form to notify your employer of your personal chiropractor or acupuncturist.

Your Chiropractor or Acupuncturist's Information:

____

(name of chiropractor or acupuncturist)

____

(street address, city, state, zip code)

____

(telephone number)

Employee Name **(Please Print):**

____

Employee's address:

____

Employee's
Signature ______________________________ Date: ________________

SEGURO CONTRA ACCIDENTES LABORALES - NOTIFICACIÓN ESCRITA PARA NUEVOS EMPLEADOS

Esta notificación incluye algunos de sus derechos, beneficios y obligaciones según la ley del seguro contra accidentes laborales.

EVENTOS, LESIONES Y ENFERMEDADES CUBIERTOS POR EL SEGURO CONTRA ACCIDENTES LABORALES

Usted tendrá derecho a los beneficios del seguro contra accidentes laborales en caso de sufrir una lesión o contraer una enfermedad relacionada con su trabajo. El seguro contra accidentes laborales cubre gran parte de las enfermedades y lesiones físicas o mentales relacionadas con el trabajo. La lesión o enfermedad puede ser causada por un solo evento (como lesionarse la espalda en una caída) o por exposición reiterada (como lesionarse la muñeca por realizar un mismo movimiento repetidas veces). Usted no tendrá derecho a los beneficios del seguro contra accidentes laborales por una lesión que surja de la participación voluntaria en cualquier actividad fuera del trabajo, recreativa, social o deportiva, que no forme parte de sus obligaciones laborales.

DERECHOS Y BENEFICIOS

Usted podrá tener derecho a lo siguiente:

- Beneficios de atención médica que incluyen: consultas a médicos, servicios hospitalarios, fisioterapia, pruebas de laboratorio, radiografías y medicamentos que sean razonablemente necesarios para tratar la lesión.
- Beneficios por incapacidad temporal (TD): pagos en caso de perder el salario durante la recuperación. En la mayoría de las lesiones producidas después del 1 de enero de 2008 inclusive, los beneficios por incapacidad temporal (temporary disability, TD) no podrán extenderse por más de 104 semanas compensables en un plazo de cinco años a partir de la fecha de la lesión. Para algunas lesiones de largo plazo, tales como quemaduras graves o enfermedad pulmonar crónica, los beneficios no podrán extenderse por más de 240 semanas en un plazo de cinco años a partir de la fecha de la lesión. Cuando los beneficios por TD terminan, puede obtener beneficios por incapacidad adicionales del estado si presenta en forma oportuna una reclamación ante el Departamento de Desarrollo del Empleo.
- Beneficios por incapacidad permanente (PD): pagos cuando la lesión causa una incapacidad permanente.
- Beneficios complementarios por desplazamiento del trabajo: vale no transferible pagadero a una escuela autorizada por el estado por una lesión ocurrida después del 1/1/04 inclusive, cuando dicha lesión causa una incapacidad permanente, usted no regresa al trabajo en el plazo de 60 días luego de finalizar la TD y su empleador no le ofrece un puesto de trabajo modificado o alternativo.
- Beneficios por fallecimiento: se pagan a los dependientes de un empleado que fallece a causa de una enfermedad o lesión relacionada con el trabajo.

Los beneficios por incapacidad temporal, incapacidad permanente, rehabilitación profesional, pensión alimenticia y fallecimiento se pagan sobre la base de 2/3 de su salario promedio semanal, sujeto a tasas máximas y mínimas, vigentes a la fecha de la lesión. Los beneficios se pagan cada dos semanas mientras usted sea elegible.

ELECCIÓN DEL MÉDICO PERSONAL

Usted podrá elegir el médico que tratará su enfermedad o lesión laboral durante los primeros 30 días posteriores a la lesión. Si es elegible, deberá informar por escrito el nombre y la dirección del médico personal a su empleador, **antes** de sufrir la lesión. Podrá ser tratado por dicha lesión o enfermedad por su médico personal (M.D.), osteópata (D.O.) o grupo médico si:

- su empleador ofrece cobertura médica colectiva;
- el médico es su médico habitual, quien deberá ser médico general o médico de familia, ginecólogo obstetra, pediatra o internista elegible por la junta médica o certificado por dicha junta, y que haya coordinado su tratamiento médico con anterioridad y conserve sus registros médicos;
- su "médico personal" puede ser un grupo médico si se trata de una única sociedad o asociación formada por médicos u osteópatas con licencia, que opera como un grupo médico integrado con múltiples especialidades, que brinda servicios médicos amplios, especialmente para lesiones y enfermedades no ocupacionales;
- **antes** de la lesión, el médico acepta tratarlo por enfermedades o lesiones laborales;
- **antes** de la lesión, usted suministra a su empleador lo siguiente por escrito: (1) notificación del deseo de que su médico personal lo trate por enfermedades o lesiones relacionadas con el trabajo, y (2) el nombre y la dirección comercial de su médico personal.

Para tal fin, puede utilizar los formularios de las páginas 3 y 4 de esta notificación.

Si no elige un médico, el empleador tendrá derecho a seleccionar el médico que lo tratará durante los primeros 30 días. Después de 30 días, usted podrá cambiar de médico según desee; este cambio podrá incluir a su

quiropráctico o acupunturista personal. Si su empleador ofrece una Organización de Atención Médica (Health Care Organization, HCO) o a partir del 1/1/05 tiene una red de proveedores de atención médica (medical provider network, MPN), se aplicarán normas especiales.

Contacte a su empleador para obtener más información.

FUNCIÓN DEL MÉDICO DE ATENCIÓN PRIMARIA

El médico de atención primaria decidirá qué tipo de atención médica recibirá usted para su lesión o enfermedad, determinará cuándo podrá regresar a trabajar, contribuirá a identificar el tipo de tareas que puede realizar en forma segura durante la recuperación, lo referirá a especialistas, si es necesario, y escribirá informes médicos que afectarán los beneficios que usted reciba. Es importante obtener una buena atención médica para poder recuperarse. El médico que lo trate deberá conocer el tipo de lesión o enfermedad específica. Informe al médico sobre los síntomas y los eventos laborales que usted cree que los ocasionaron. También describa su trabajo y entorno laboral.

SI SE LESIONA, OBTENGA ATENCIÓN MÉDICA. Si necesita primeros auxilios, contacte a su empleador. Si necesita tratamiento médico de emergencia, llame al 911 o a uno de los números indicados debajo. Informe al proveedor de atención médica que la lesión o enfermedad está relacionada con su trabajo.

Ambulancia ______________________

Bomberos ______________________

Policía ______________________

Médico ______________________

Hospital ______________________

INFORMAR SOBRE LA LESIÓN O ENFERMEDAD

Informe de inmediato sobre la lesión a su supervisor o:

Representante del empleador ______________________

Número de teléfono ______________________

Hable con su supervisor de inmediato. Si la lesión o enfermedad se desarrolló en forma gradual, informe sobre esta tan pronto advierta que fue causada por su trabajo. Si se comunica de inmediato, evitará problemas y retrasos en la recepción de beneficios, incluida la atención médica necesaria para evitar lesiones mayores. Si el empleador no toma conocimiento de su lesión en un plazo de 30 días, usted puede perder el derecho a recibir los beneficios del seguro contra accidentes laborales.

El empleador deberá proporcionarle un formulario de reclamación en el plazo de un día laboral después de enterarse de la lesión. En el plazo de un día laboral tras la presentación del formulario de reclamación por parte del empleado, el empleador deberá autorizar la prestación del tratamiento, conforme a las pautas de tratamiento aplicables, para la supuesta lesión, y deberá continuar suministrando tratamiento hasta la fecha en que se acepte o rechace la responsabilidad por la reclamación. Hasta la fecha de rechazo o aceptación de la reclamación, la responsabilidad por el tratamiento médico se limitará a diez mil dólares ($10,000.

INFORMACIÓN ADICIONAL

Podrá obtener información gratuita a través de un Funcionario Estatal de Asistencia e Información sobre el Seguro contra Accidentes Laborales. Para escuchar información grabada, incluida una lista de oficinas locales, llame sin cargo al 1 (800) 736-7401. Información en línea: http://www.dir.ca.gov

Funcionario de Asistencia e Información más cercano se encuentra en:

Dirección ______________________

Ciudad ______________________

Teléfono ______________________

Compañía aseguradora contra accidentes laborales de su empleador al momento de su contratación:

____

DISCRIMINACIÓN

La sanción o despido por sufrir una enfermedad o lesión laboral, presentar una reclamación o testificar en un caso de seguro contra accidentes laborales de otra persona, constituye un acto ilegal por parte del empleador. Si esto se demuestra, usted podrá recibir salarios perdidos, reincorporación al trabajo, aumento en los beneficios, más costos y gastos hasta el límite establecido por el estado.

RED DE PROVEEDORES MÉDICOS (MPN)

Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación hablando al número de la MPN debajo descrito. Si usted ha hecho una designación previa de un médico personal antes de leionarse en el trabajo, entonces usted puede recibir tratamiento de su medico previamente designado. Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede esoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Contacte a su empleador para obtener más informatión.

Reclamaciones y negaciones falsas. Toda persona que realice o motive una declaración o manifestación sustancial falsa o fraudulenta en forma intencional, con el fin de obtener o negar el pago o los beneficios del seguro contra accidentes laborales, será culpable de delito grave y quedará sujeta a la pena de multa o prisión.

DESIGNACIÓN PREVIA DE MÉDICO PERSONAL

En caso de sufrir una lesión o enfermedad relacionada con su trabajo, podrá ser tratado para dicha lesión o enfermedad por su médico personal (M.D.), osteópata (D.O.) o grupo médico si:

- su empleador ofrece cobertura médica colectiva;
- el médico es su médico habitual, quien deberá ser médico general o médico de familia, ginecólogo obstetra, pediatra o internista elegible por la junta médica o certificado por dicha junta, y que haya coordinado su tratamiento médico con anterioridad y conserve sus registros médicos;
- su "médico personal" puede ser un grupo médico si se trata de una única sociedad o asociación formada por médicos u osteópatas con licencia, que opera como un grupo médico integrado con múltiples especialidades, que brinda servicios médicos amplios, especialmente para lesiones y enfermedades no ocupacionales;
- antes de la lesión, el médico acepta tratarlo por enfermedades o lesiones laborales;
- antes de la lesión, usted suministra al empleador lo siguiente por escrito: (1) notificación del deseo de que su médico personal lo trate por enfermedades o lesiones relacionadas con el trabajo, y (2) el nombre y la dirección comercial de su médico personal.

Si cumple con los requisitos anteriores y desea que su médico u osteópata personal lo trate por una lesión o enfermedad relacionada con el trabajo, podrá usar el siguiente formulario para notificar a su empleador.

NOTIFICACIÓN DE DESIGNACIÓN PREVIA DE MÉDICO PERSONAL

Empleado: complete esta sección.

Para: __________________________ **(nombre del empleador**). Si sufro una lesión o enfermedad relacionada con mi trabajo, elijo ser tratado por:

____

(nombre del médico) (M.D., D.O. o grupo médico)

____ **(dirección, ciudad, estado, código postal)**

____ **(número de teléfono)**

Nombre del empleado **(en letra de imprenta):**

____

Dirección del empleado:

____

Firma del empleado ____ **Fecha:** ________________________

Médico: acepto esta designación previa:

Firma: ____ **Fecha:** ________________________

(Médico o empleado designado del médico o grupo médico)

No es obligatorio que el médico firme este formulario; no obstante, si el médico o empleado designado del médico o el grupo médico no lo firma, se exigirá otra documentación en la que conste la aceptación del médico a ser designado previamente conforme al Título 8 del Código de Reglamentaciones de California, sección 9780.1(a)(3).

Título 8 del Código de Reglamentaciones de California, sección 9783.

NOTIFICACIÓN DE QUIROPRÁCTICO O ACUPUNTURISTA PERSONAL

Si su empleador o la compañía aseguradora de su empleador no tienen una Red de Proveedores de Atención Médica, usted podrá cambiar el médico que lo trata por su quiropráctico o acupunturista personal tras una lesión o enfermedad relacionada con el trabajo. A fin de ser elegible para realizar este cambio, deberá informar por escrito a su empleador el nombre y la dirección comercial del quiropráctico o acupunturista personal, antes de la lesión o enfermedad. Por lo general, el administrador de reclamaciones tiene derecho a seleccionar el médico que lo trata durante los primeros 30 días después de que el empleador se entere de la lesión o enfermedad. Después de que el administrador de reclamaciones inicie el tratamiento con otro médico durante dicho período, usted podrá solicitar que el tratamiento se transfiera a su quiropráctico o acupunturista personal.

Para notificar al empleador sobre su quiropráctico o acupunturista personal, puede usar el siguiente formulario.

Información del quiropráctico o acupunturista:

____

(nombre del quiropráctico o acupunturista)

____

(dirección, ciudad, estado, código postal)

____

(número de teléfono)

Nombre del empleado **(en letra de imprenta):**

____

Dirección del empleado:

____

Firma del empleado ______________________________ Fecha: ______________

Time of Hire
Pamphlet

This pamphlet may be given to all newly hired employees in the State of California. Employers and claims administrators may use the content of this document and put their logos and additional information on it.

What is *workers' compensation?*

If you get hurt on the job, your employer is required by law to pay for workers' compensation benefits. You could get hurt by:

One event at work. Examples: hurting your back in a fall, getting burned by a chemical that splashes on your skin, getting hurt in a car accident while making deliveries.

—or—

Repeated exposures at work. Examples: hurting your wrist from doing the same motion over and over, losing your hearing because of constant loud noise.

—or—

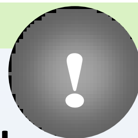
Workplace crime. Examples: you get hurt in a store robbery, physically attacked by an unhappy customer.

What are *the benefits?*

MEDICAL CARE: Paid for by your employer to help you recover from an injury or illness caused by work. Doctor visits, hospital services, physical therapy, lab tests and x-rays are some of the medical services that may be provided. These services should be necessary to treat your injury. There are limits on some services such as physical therapy and chiropractic care.

TEMPORARY DISABILITY BENEFITS: Payments if you lose wages because your injury prevents you from doing your usual job while recovering. The amount you may get is up to two-thirds of your wages. There are minimum and maximum payment limits set by state law. You will be paid every two weeks if you are eligible. For most injuries, payments may not exceed 104 weeks within five years from your date of injury. Temporary disability (TD) stops when you return to work, or when the doctor releases you for work, or says your injury has improved as much as it's going to. You may file a claim with the Employment Development Department to get additional state disability benefits when TD benefits are delayed, denied or have ended.

DISCRIMINATION IS ILLEGAL



It is illegal under Labor Code section 132a for your employer to punish or fire you because:

- You file a workers' compensation claim
- Intend to file a workers' compensation claim
- Settle a workers' compensation claim
- Testify or intend to testify for another injured worker.

If it is found that your employer discriminated against you, he or she may be ordered to return you to your job. Your employer may also be made to pay for lost wages, increased workers' compensation benefits, costs and expenses set by state law.

PERMANENT DISABILITY BENEFITS: Payments if you don't recover completely. The amount of payment is based on:

- Your doctor's medical reports
- Your age
- Your occupation
- How much you can earn in the future.

You will be paid every two weeks if you are eligible. There are minimum and maximum weekly payment rates.

SUPPLEMENTAL JOB DISPLACEMENT BENEFITS:

Vouchers to help pay for retraining or skill enhancement if you don't recover completely and don't return to work for your employer. The vouchers range from $4,000 to $10,000 depending on your level of permanent disability. This voucher is for you to use at a state approved school if:

- You have a permanent disability
- Your employer does not offer modified or alternative work and
- You don't return to your employer within 60 days after your TD ends.

DEATH BENEFITS: Payments to your spouse, children or other dependents if you die from a job injury or illness. The amount of payment is based on the number of dependents. The benefit is paid every two weeks at a rate of at least $224 per week. In addition, workers' compensation provides a burial allowance.

WORKERS' COMPENSATION FRAUD IS A CRIME

Any person who makes or causes to be made any knowingly false statement in order to obtain or deny workers' compensation benefits or payments is guilty of a felony. If convicted, the person will have to pay fines up to $150,000 and/or serve up to five years in jail.

What should I do *if I have an injury?*

REPORT YOUR INJURY TO YOUR EMPLOYER

Tell your supervisor right away no matter how slight the injury may be. Don't delay — there are time limits. You could lose your right to benefits if your employer does not learn of your injury within 30 days. If your injury or illness is one that develops over time, report it as soon as you learn it was caused by your job.

WHO IS MY CLAIMS ADMINISTRATOR?

Workers' compensation claims administrator, or if employer is self-insured, person responsible for handling the claim is:

____

Address:________________________________

____

____

Phone:______________________________

GET EMERGENCY TREATMENT IF NEEDED

If it's a medical emergency, go to an emergency room right away. Tell the medical provider who treats you that your injury is job related. Your employer may tell you where to go for follow up treatment.

EMERGENCY TELEPHONE NUMBER:

Call 911 for an ambulance, fire department or police. For non-emergency medical care, contact your employer, the workers' compensation claims administrator or go to this facility:

____

FILL OUT DWC 1 CLAIM FORM AND GIVE IT TO YOUR EMPLOYER Your employer must give you a DWC 1 claim form within one working day after learning about your injury or illness. Complete the employee portion, sign and give it back to your employer. Your employer will then file your claim with the claims administrator. Your employer must authorize treatment within one working day of receiving the DWC 1 claim form.

If the injury is from repeated exposures, you have one year from when you realized your injury was job related to file a claim.

In either case you may receive up to $10,000 in employer-paid medical care until your claim is either accepted or denied. The claims administrator has up to 90 days to decide whether to accept or deny your claim. Otherwise your case is presumed payable.

Your employer or the claims administrator will send you "benefit notices" that will advise you of the status of your claim.

What is a *primary treating physician (PTP)?*

This is the doctor with overall responsibility for treating your injury or illness. He or she may be:

- The doctor you name in writing *before* you get hurt on the job
- A doctor from the medical provider network (MPN)
- The doctor chosen by your employer during the first 30 days of injury if your employer does not have an MPN or
- The doctor you chose after the first 30 days if your employer does not have an MPN.

What is a *medical provider network (MPN)?*

An MPN is a select group of health care providers who treat injured workers. Each MPN includes a mix of doctors specializing in work-related injuries and doctors with expertise in general areas of medicine. Check with your employer to see if they are using an MPN.

If you have not named a doctor before you get hurt and your employer is using an MPN, you will see an MPN doctor. After your first visit, you are free to choose another doctor from the MPN list. A complete MPN notice must be posted in a work area used by employees and near the "Notice to Employees" poster. For more information, see the MPN contact on the "Notice to Employees" poster.

What is *predesignation?*

Predesignation is when you name your regular doctor to treat you if you get hurt on the job. The doctor must be a medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or a medical group with an M.D. or D.O. You must name your doctor in writing *before* you get hurt or become ill.

You may predesignate a doctor if your employer offers group health coverage and the doctor must have:

- Treated you
- Maintained your medical history and records before your injury and
- Agreed to treat you for a work-related injury or illness before you get hurt or become ill.

You may use the "predesignation of personal physician" form included with this pamphlet. After you fill in the form, be sure to give it to your employer.

If your employer does not have an approved MPN, you may name your chiropractor or acupuncturist to treat you for work related injuries. The notice of personal chiropractor or acupuncturist must be in writing *before* you get hurt. You may use the form included in this pamphlet. After you fill in the form, be sure to give it to your employer.

What if there is a *problem with my benefits?*

If you have a concern, speak up. Talk to your employer or the claims administrator handling your claim and try to solve the problem. If this doesn't work, get help by trying the following:

CONTACT THE DIVISION OF WORKERS' COMPENSATION (DWC) INFORMATION AND ASSISTANCE (I&A) UNIT

All 24 DWC offices throughout the state provide information and assistance on rights, benefits and obligations under California's workers' compensation laws. I&A officers help resolve disputes without formal proceedings. Their goal is to get you full and timely benefits. Their services are free.

To contact the nearest I&A Unit, go to www.dwc.ca.gov in the top bar, click on "I&A." At this site you will find fact sheets, guides and information to help you.

THE NEAREST I&A UNIT IS LOCATED AT:

Address:________________________________

____

____

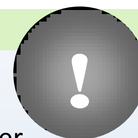
Phone:__________________________________

CONSULT WITH AN ATTORNEY

Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fees may be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their Web site at www.californiaspecialist.org. You may get a list of attorneys from your local I&A Unit or look in the yellow pages.

WARNING

Your employer may not pay workers' compensation benefits if you get hurt in a voluntary off-duty recreational, social or athletic activity that is not part of your work-related duties.



ADDITIONAL RIGHTS

You may also have other rights under the Americans with Disabilities Act (ADA) or the Fair Employment and Housing Act (FEHA). For additional information, contact FEHA at (800) 884-1684 or the Equal Employment Opportunity Commission (EEOC) at (800) 669-4000.

The information contained in this pamphlet conforms to the informational requirements found in Labor Code sections 3551 and 3553 and California Code of Regulation, Title 8, sections 9880 and 9883. This document is approved by the Division of Workers' Compensation administrative director.

PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- your employer offers group health coverage;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work- related injury or illness and the above requirements are met.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee: Complete this section.

To: ____________________________ (name of employer) If I have a work-related injury or illness, I choose to be treated by:

____

(name of doctor)(M.D., D.O., or medical group)

____(street address, city, state, ZIP)

____(telephone number)

Employee Name (please print):

____

Employee's Address:

____

Employee's
Signature____Date:_____________

Physician: I agree to this Predesignation:

Signature:____Date:__________

(Physician or Designated Employee of the Physician or Medical Group)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

Title 8, California Code of Regulations, section 9783.
(Optional DWC Form 9783 March 1, 2007)

NOTICE OF PERSONAL CHIROPRACTOR OR PERSONAL ACUPUNCTURIST

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

You may use this form to notify your employer of your personal chiropractor or acupuncturist.

Your Chiropractor or Acupuncturist's Information:

____

(name of chiropractor or acupuncturist)

____

(street address, city, state, zip code)

____

(telephone number)

Employee Name **(please print)**:

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Employee's address:

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Employee's
Signature____Date:_____________