# *One good reason to think twice about workers' compensation fraud*

EMPLOYERS® actively investigates suspected workers' compensation fraud and reports such cases to law enforcement authorities.

**fraud costs**

Workers' compensation fraud costs $7.2 billion annually.[1]

Filing a fraudulent workers' compensation claim could lead to serious civil or criminal consequences, such as fines, incarceration and/or restitution.

**If you suspect workers' compensation fraud, please contact EMPLOYERS' Fraud Investigations Department. Call the Fraud Hotline at 1-800-750-3939 or e-mail fraudfighters@employers.com.**

EMPLOYERS®

*America's small business insurance specialist®*



1 Source: http://www.propertycasualty360.com/2015/07/23/3-keys-to-a-successful-workers-compensation-fraud

CM_0077IF_US
REV 09/2015

# *Una buena razón para pensarlo dos veces antes de cometer fraude en una demanda de indemnización laboral*

EMPLOYERS® investiga de manera activa casos sospechosos de cometer fraude en una demanda de indemnización laboral y reporta dichos casos a las autoridades policiales.

## costos del fraude

Fraude en demandas de indemnización laboral cuesta $7.2 mil millones al año.[1]

Presentar una demanda de indemnización laboral fraudulenta puede acarrear graves consecuencias civiles o penales, tales como multas, cárcel y/o indemnizaciones.

**Si sospecha que existe fraude en una demanda de indemnización laboral, póngase en contacto con el Departamento de Investigación de Fraude de EMPLOYERS. Llame a la línea directa de fraude al 1-800-750-3939 o escriba al correo electrónico fraudfighters@employers.com.**

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1 Fuente: http://www.propertycasualty360.com/2015/07/23/3-keys-to-a-successful-workers-compensation-fraud

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

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

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

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

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

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

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

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

Disability Compensation Division:

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

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

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

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

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

Revised 09/21/2020


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

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

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

**Workforce Development Division:**

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

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TDD/TTY Dial 711 then ask for (808) 586-8866.

Revised 09/21/2020


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

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

**Examples of Unlawful Employment Discrimination:**

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

**Filing a Complaint:**

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

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

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

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

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TDD/TTY Dial 711 then ask for (808) 586-8866.

Revised 09/21/2020

# You Have a Right to a Safe and Healthful Workplace

# IT'S THE LAW!

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

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

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

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

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

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


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

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

**Important Information:**

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

**Unemployment Insurance Offices:**

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

**COVID-19-Related Emails:**

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

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

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Revised 09/21/2020

EMPLOYERS®

America's small business insurance specialist®

# Basic Accident Report

Date of Report:_____ Report Completed By:_____

| | | |
|---|---|---|
| Last Name of Injured Person: | First Name: | Job Title: |
| Date of Accident: | Time of Accident: | Location of Accident: |
| Supervisor's Name & Job Title: | Name of Witnesses: | |
| Full Description of Injuries: | | |
| Description of accident/incident or employee's account, including sequence of events preceding the accident: | | |
| Basic cause and contributory causes. Explain fully unsafe act, unsafe condition, personal factor, other: | | |
| Recommended Corrective Measures: | | Action By: |
| Names of Inspection Team Participants: | | |
| Management Review By: | Date to be Completed By: | |

America's small business insurance specialist®

# Informe Básico de Accidentes

Fecha Del Informe:_____Informe Completado Por:_____

| | | |
|---|---|---|
| Apellido De La Persona Lesionada: | Primer Nombre: | Puesto De Trabajo: |
| Fecha Del Accidente: | Hora Del Accidente: | Lugar Del Accidente: |
| Nombre Del Supervisor Y Cargo: | Nombre De Los Testigos: | |
| Descripción Completa De Las Lesiones: | | |
| Descripción del accidente / incidente o versión del empleado, incluyendo la secuencia de eventos que preceden al accidente: | | |
| Causas básicas y causas contributivas. Explique el tipo de situación ya sea si fue una situación insegura, condición insegura, factor personal, otros: | | |
| Medidas Correctivas Recomendadas: | | Acciones Tomadas Por: |
| Nombres De Los Participantes Del Equipo De Inspección: | | |
| Revisión Por Parte De La Gerencia: | Fecha Límite De Entrega: | |

☐ NEW
☐ AMEND

STATE OF HAWAII
DEPARTMENT OF LABOR & INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION

**WC-1 EMPLOYER'S REPORT OF INDUSTRIAL INJURY**
**NOTE: COMPLETE THE FILLABLE-DARK SHADED BLOCKS**

| CASE NUMBER |
|---|
| |
| DATE RECEIVED |
| |

Every work injury/illness to an employee causing absence for one day or more or which requires medical services other than first aid treatment must be reported within 7 working days after the injury/illness. Failure to report promptly is a misdemeanor punishable by not more than a $5,000 fine. (Sec. 386-95, H.R.S. NOTIFY THE DIVISION IMMEDIATELY IF INJURY/ILLNESS RESULTS IN DEATH.) EVERY QUESTION MUST BE ANSWERED FULLY TO AVOID FURTHER CORRESPONDENCE.

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

**IDENTIFICATION - SECTION 1**

| EMPLOYEE NAME – LAST | FIRST | M.I. | SUFFIX |
|---|---|---|---|
| | | | |

| SEX/GENDER | MARITAL STATUS | IDENTIFICATION TYPE | IDENTIFICATION NUMBER | DATE OF BIRTH |
|---|---|---|---|---|
| ☐ MALE ☐ FEMALE | ☐ SINGLE ☐ MARRIED | ☐ SSN ☐ PASSPORT | | |

| ADDRESS | ADDITIONAL ADDRESS INFORMATION (C/O) |
|---|---|
| | |

| CITY | STATE | ZIP CODE | EMAIL ADDRESS |
|---|---|---|---|
| | | | |

| PHONE NUMBER | DATE HIRED | YEARS EMPLOYED CODE | OCCUPATION |
|---|---|---|---|
| ( ) – | | | |

| DEPARTMENT | PAYROLL COMP CLASS CODE | SOC CODE | OCC CODE |
|---|---|---|---|
| | | | |

| REGISTERED EMPLOYER | DBA |
|---|---|
| | |

| ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| EMPLOYER POINT OF CONTACT | PHONE NUMBER | EMAIL ADDRESS |
|---|---|---|
| | ( ) – | |

| NATURE OF BUSINESS | PRE-FABRICATED | DEPARTMENT OF LABOR NUMBER | FEDERAL ID NUMBER |
|---|---|---|---|
| | ☐ WC-2 ☐ WC-5 | | |

**DETAIL OF INJURY/ILLNESS (I/I) - SECTION 2**

| DATE OF INJURY/ILLNESS REPORTED | DATE OF INJURY/ILLNESS | TIME OF I/I | TIME OF DAY | ON EMPLOYER'S PREMISE | DID EMPLOYEE WORK A FULL SHIFT? |
|---|---|---|---|---|---|
| | | | ☐ AM ☐ PM | ☐ NO ☐ YES | ☐ NO ☐ YES |

| IF NOT ON EMPLOYER'S PREMISES, INDICATE PLACE WHERE INJURY/ILLNESS OCCURRED | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

A. HOW DID THIS INJURY/ILLNESS OCCUR? - Please describe fully the events that resulted in injury/illness or occupational disease. Explain what happened. Please continue in Supplemental Section if additional space is needed.

| TIME WORK SHIFT BEGAN | TIME OF DAY | TIME WORK SHIFT END | TIME OF DAY | SOURCE OF INJURY/ILLNESS | EVENT |
|---|---|---|---|---|---|
| | ☐ AM ☐ PM | | ☐ AM ☐ PM | | |

| TASK | ACTIVITY | INJURY/ILLNESS FACTOR | AOS |
|---|---|---|---|
| | | | |

B. WHAT WAS THE EMPLOYEE DOING WHEN INJURED? - Please be specific. Identify tools, equipment, or material the employee was using. Please continue in Supplemental Section if additional space is needed.

C. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE - e.g., The machine employee struck against or struck him, the vapor or poison inhaled or swallowed, the chemical that irritated employee's skin. In cases of strains, the object employee was lifting, pulling, etc. Please continue in Supplemental Section if additional space is needed.

CASE NUMBER

**DETAIL OF INJURY/ILLNESS (I/I) - SECTION 2 (continued)**

D. DESCRIBE IN DETAIL THE NATURE OF THE INJURY/ILLNESS AND PART OF THE BODY AFFECTED - Please continue in Supplemental Section if additional space is needed.

| MULTIPLE BODY PARTS? | NATURE OF INJURY/ILLNESS | PART OF BODY CODE |
|---|---|---|
| ☐ NO ☐ YES | | |

| # | SIDE OF INJURY/ILLNESS | | | | PART OF BODY | DISFIGUREMENT | | BURN | |
|---|---|---|---|---|---|---|---|---|---|
| 1. | ☐ LEFT | ☐ RIGHT | ☐ FRONT | ☐ BACK | | ☐ NO | ☐ YES | ☐ NO | ☐ YES |
| 2. | ☐ LEFT | ☐ RIGHT | ☐ FRONT | ☐ BACK | | ☐ NO | ☐ YES | ☐ NO | ☐ YES |
| 3. | ☐ LEFT | ☐ RIGHT | ☐ FRONT | ☐ BACK | | ☐ NO | ☐ YES | ☐ NO | ☐ YES |
| 4. | ☐ LEFT | ☐ RIGHT | ☐ FRONT | ☐ BACK | | ☐ NO | ☐ YES | ☐ NO | ☐ YES |
| 5. | ☐ LEFT | ☐ RIGHT | ☐ FRONT | ☐ BACK | | ☐ NO | ☐ YES | ☐ NO | ☐ YES |

**TIME LOST INFORMATION - SECTION 3**

| DATE DISABILITY BEGAN | WAS EMPLOYEE FURNISHED MEALS, TIPS, OR LODGINGS? | AVERAGE WEEKLY WAGE | IF EMPLOYEE IS BACK TO WORK, GIVE DATE | WAS EMPLOYEE PAID IN FULL FOR DAY OF INJURY/ILLNESS? |
|---|---|---|---|---|
| | ☐ NO ☐ YES | | | ☐ NO ☐ YES |

| IF EMPLOYEE DECEASED, GIVE DATE | HOURLY WAGE | MONTHLY SALARY | HRS WORKED/WEEK | WEIGHING FACTOR |
|---|---|---|---|---|
| | | | | |

**DECEDENT'S DEPENDENTS - SECTION 4**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | DEPENDENT 1 – LAST NAME | FIRST NAME | M.I. | SUFFIX | RELATION TO DECEASED | |
| | DEPENDENT 1 - ADDRESS | CITY | STATE | ZIP CODE | PHONE NUMBER ( ) - | |
| 2. | DEPENDENT 2 – LAST NAME | FIRST NAME | M.I. | SUFFIX | RELATION TO DECEASED | |
| | DEPENDENT 2 - ADDRESS | CITY | STATE | ZIP CODE | PHONE NUMBER ( ) - | |
| 3. | DEPENDENT 3 – LAST NAME | FIRST NAME | M.I. | SUFFIX | RELATION TO DECEASED | |
| | DEPENDENT 3 - ADDRESS | CITY | STATE | ZIP CODE | PHONE NUMBER ( ) - | |
| 4. | DEPENDENT 4 – LAST NAME | FIRST NAME | M.I. | SUFFIX | RELATION TO DECEASED | |
| | DEPENDENT 4 - ADDRESS | CITY | STATE | ZIP CODE | PHONE NUMBER ( ) - | |

**TREATMENT (OBTAIN NAME OF TREATING PHYSICIAN FROM EMPLOYEE) - SECTION 5**

| NAME OF PHYSICIAN | PHONE NUMBER | EMAIL ADDRESS |
|---|---|---|
| | ( ) - | |

| ADDRESS | CITY | STATE | ZIP CODE | | NO | YES |
|---|---|---|---|---|---|---|
| | | | | INPATIENT OVERNIGHT | ☐ | ☐ |
| | | | | EMERGENCY ROOM ONLY? | ☐ | ☐ |

| NAME OF MEDICAL FACILITY | ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|---|
| | | | | |

**INSURANCE CARRIER - SECTION 6**

| NAME OF WC INSURANCE CARRIER | CARRIER ID |
|---|---|
| | |

| IS LIABILITY DENIED? | IF LIABILITY DENIED, WHY? |
|---|---|
| ☐ NO ☐ YES | |

| NAME OF ADJUSTING COMPANY | ADJUSTER NAME |
|---|---|
| | |

| EMAIL ADDRESS | PHONE NUMBER | ADJUSTER ID NUMBER |
|---|---|---|
| | ( ) - | |

| POLICY NUMBER | POLICY PERIOD | MEDICAL DEDUCTIBLE | CARRIER CLAIM NUMBER |
|---|---|---|---|
| | FROM: TO: | | |

**SIGNATURE - SECTION 7**

| SIGNATURE | TITLE | DATE |
|---|---|---|
| | | |

CASE NUMBER

**SUPPLEMENTAL - SECTION 8**

A. HOW DID THIS INJURY/ILLNESS OCCUR? (continued from Section 2.A)

B. WHAT WAS THE EMPLOYEE DOING WHEN INJURED? (continued from Section 2.B)

C. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (continued from Section 2.C)

D. DESCRIBE IN DETAIL THE NATURE OF THE INJURY/ILLNESS AND PART OF THE BODY AFFECTED (continued from Section 2.D)

| | |
|---|---|
| ENGLISH | This document contains important information. If you need language assistance at no cost to you, please contact us by telephone or in person immediately. |
| ILOKANO | Daytoy nga dokumento ket addaan ti importante nga impormasyon. No masapul mo ti mangipatarus nga libre, pangngaasim ta awagan na kami ti telepono wenno umay na kami kitaen nga daras. |
| TAGALOG | Ang dokumentong ito ay naglalaman ng importanteng impormasyon. Kung nangangailangan kayo ng libreng tulong para maintindihan ito, mangyaring makipag-ugnay sa amin sa pamamagitan ng telepono o makipagkita kagaad sa amin. |
| CHINESE SIMPLIFIED | 此文件有重要信息。如果您需要免费的语言协助服务，请您立刻给我们打电话或来我们办公室请求帮助。 |
| CHINESE TRADITIONAL | 此文件有重要信息。如果您需要免費的語言協助服務，請您立刻給我們打電話或來我們辦公室請求幫助。 |
| SPANISH | Este documento contiene información importante. Si necesita los servicios de un intérprete sin costo alguno para usted, por favor llame de inmediato por teléfono o contacte con alguna persona de nuestra oficina. |
| JAPANESE | この書類には重要な情報が含まれています。無償で日本語の支援を受けたい場合は、早急に電話あるいは直接窓口にて申込を行ってください。 |
| CHUUKESE | Mei auchea met masowan ei taropwe. Ika pwe ke mochen aninis ren noumw chon chiaku esap kamo, kose mochen kokori kich won tengwa ika fen pusin chuto rech. |
| MARSHALLESE | Ilo pepa in ewor melele ko aorok. Ne kwoj aikuj jiban na ukok ilo ejjelok wonen, jouj im kokkeitaak kem ilo talboon ak ilo wobij e ien eo emakaaj tata. |
| KOREAN | 이 문서는 중요한 정보가 포함되어 있습니다. 무료로 언어 도움이 필요하시면, 바로 전화 하시거나 오셔서 상담하십시오. |
| VIETNAMESE | Tài liệu này bao gồm các thông tin quan trọng. Nếu bạn cần hỗ trợ ngôn ngữ miễn phí, xin vui lòng đến gặp trực tiếp chúng tôi hoặc liên lạc qua điện thoại ngay lập tức. |

STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

# INSTRUCTION SHEET FOR FORM WC-14
# EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS

## Instructions

**Please completely fill out the WC-14 EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS FORM.**

The **Delivery Information** section below lists various delivery options. Please select the most convenient method and submit the completed form accordingly.

**Please remember to sign and date the form before submitting it.**

## Delivery Information

**Delivery by U.S. Mail**
Department of Labor and Industrial Relations, Disability Compensation Division
P.O. Box 3769, Honolulu, Hawaii 96812-3769

**Delivery In-Person**
Department of Labor and Industrial Relations, Disability Compensation Division
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

**Delivery via Fax**
Department of Labor and Industrial Relations, Disability Compensation Division
(808) 586-9219

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

STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

# FORM WC-14 EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS

## EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS PRIOR TO DATE OF INJURY

| Employee: | SS No.: | Case No.: - - | Date of Injury: |
|---|---|---|---|

The above employee reported employment with your firm Under the Hawaii Workers' Compensation Law; an employee's benefits are calculated based on wages earned. Please assist us in determining benefits by completing this form

| Employer: | Employee's Occupation: | Hourly Rate: |
|---|---|---|
| Date Employed: | Presently Employed? | If terminated, date: |
| Disabled from: | through: | Returned to Work: |
| Indicate the days and hours normally worked: | | |
| Sunday: ☐ | Monday: ☐ | Tuesday: ☐ |
| Wednesday: ☐ | Thursday: ☐ | Friday: ☐ |
| Saturday: ☐ | | |
| If other than the above, please indicate: | | |

*Please call Records and Claims Branch at 586-9161 if you have Questions*

| Employer: | Telephone: ( ) |
|---|---|
| Address | |
| Date: | By: |

(To be signed in ink)

Auxiliary aids and services are available upon request. Please call: (808) 586-9161; TTY (808) 586-8847; and for neighbor islands, TTY 1-888-569-6859. A request for reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

It is the policy of the Department of Labor and Industrial Relations that no person shall, on the basis of race, color, sex, marital status, religion, creed, ethnic origin, national origin, age, disability, ancestry, arrest/court record, sexual orientation, and National Guard participation, be subjected to discrimination, excluded from participation in, or denied the benefits of the Department's services, programs, activities, or employment.

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

| Employee: | SS No.: | Case No.: - - | Date of Injury: |
|---|---|---|---|

| | Dates (inclusive) of each period paid for | | | Hours, Days, Weeks or month each Payment Covers | Total amount paid Employee for each period | | Amount paid excluding overtime or extra work | | Overtime or extra work | |
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| | From | To | Year | | | | | | | |
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| | Total | | | | | | | | | |

This statement of Employee's earnings is taken from our Payroll Records.

| | Dates (inclusive) of each period paid for | | | Hours, Days, Weeks or month each Payment Covers | Total amount paid Employee for each period | | Amount paid excluding overtime or extra work | | Overtime or extra work | |
|---|---|---|---|---|---|---|---|---|---|---|
| | From | To | Year | | | | | | | |
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| | Total | | | | | | | | | |

This statement of Employee's earnings is taken from our Payroll Records.