State of California
California Public Employees' Retirement System
www.calpers.ca.gov

Workers' Compensation Carrier Request (Local Safety)

If the member has filed a workers' compensation claim for the illness or injury directly related to the application for disability or industrial disability retirement, this Workers' Compensation Carrier Request form must be completed by the employer's workers' compensation insurance carrier.

Section 1: Employer Information

Employer must fill out this section.

Employer Name

Employer Address | **City** | **State** | **Zip Code**

Employer Contact Person | **Job Title**

Contact Person's Phone Number | **Contact Person's Email**

Section 2: Member Information

Employer must fill out this section and then forward the form to the workers' compensation insurance carrier for completion.

Member's Name (First Name, Middle Name, Last Name)

Social Security Number or CalPERS ID

Claim Number 1 | **Date (mm/dd/yyyy)** | **Body Part(s)**

Claim Number 2 | **Date (mm/dd/yyyy)** | **Body Part(s)**

Claim Number 3 | **Date (mm/dd/yyyy)** | **Body Part(s)**

Claim Number 4 | **Date (mm/dd/yyyy)** | **Body Part(s)**

Section 3: To Be Completed By Workers' Compensation Insurance Carrier

Workers' Compensation Insurance Carrier, your help is needed in the evaluation of this member's eligibility for disability or industrial disability retirement. Be sure to send a copy of all medical reports for the claim number(s) listed to the address listed below. Include job descriptions/ job analyses, depositions, investigation reports, videotapes, and approved orders from the Worker's Compensation Appeals Board. Please use additional sheets to supply any additional background, information, or comments.

Claim Number 1 | **WCAB Number** | **Date of Injury (mm/dd/yyyy)**

Body Part(s)

Liability Accepted ☐ **No** ☐ **Yes**

Condition P&S ☐ **No** ☐ **Yes**

Member's name **Social Security Number or CalPERS ID**

Put the member's name and Social Security number or CalPERS ID at the top of every page.

Claim Number 2 **WCAB Number** **Date of Injury (mm/dd/yyyy)**

Body Part(s)

Liability Accepted ☐ **No** ☐ **Yes** **Condition P&S** ☐ **No** ☐ **Yes**

Claim Number 3 **WCAB Number** **Date of Injury (mm/dd/yyyy)**

Body Part(s)

Liability Accepted ☐ **No** ☐ **Yes** **Condition P&S** ☐ **No** ☐ **Yes**

Claim Number 4 **WCAB Number** **Date of Injury (mm/dd/yyyy)**

Body Part(s)

Liability Accepted ☐ **No** ☐ **Yes** **Condition P&S** ☐ **No** ☐ **Yes**

If liability is not accepted, provide reason (Reference Claim Number)

If condition is not permanent and stationary, what is estimated time period or date? (Reference Claim Number)

Has settlement occurred? ☐ **Yes** ☐ **No**

If Yes, ☐ Stipulated Award _____ % Claim Number(s) _____

☐ C&R $ _____ Claim Number(s) _____

☐ F&A _____ % Claim Number(s) _____

Is there a possibility of third party liability? ☐ **Yes** ☐ **No**

Are you in the process of, or have you completed any investigations? ☐ **Yes** ☐ **No** If Yes, provide copies.

Member's name **Social Security Number or CalPERS ID**

Put the member's name and Social Security number or CalPERS ID at the top of every page.

Are further exams scheduled? ☐ **Yes** ☐ **No**

Name of Doctor **Specialty** **Appointment Date**

☐ **AME** ☐ **QME** ☐ **Treating Physician** ☐ **Other**_____

Name of Doctor **Specialty** **Appointment Date**

☐ **AME** ☐ **QME** ☐ **Treating Physician** ☐ **Other**_____

Section 4: Signature of Workers' Compensation Insurance Carrier

After completing this form, please mail it back to the employer's address listed in Section 1.

Signature of Workers' Compensation Representative **Date (mm/dd/yyyy)**

Print Workers' Compensation Representative's Name **Phone Number**

Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose

The information requested is collected pursuant to the Government Code (sections 20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in CalPERS being unable to perform its functions regarding your status.

Please do not include information that is not requested.

Social Security Numbers

Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS' first request for disclosure of your Social Security number, then disclosure is mandatory. If your Social Security number has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction/state contributions
3. Billing of contracting agencies for employee/employer contributions
4. Reports to CalPERS and other state agencies
5. Coordination of benefits among carriers
6. Resolving member appeals, complaints, or grievances with health plan carriers

Information Disclosure

Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights

You have the right to review your membership files maintained by the System. For questions about this notice, our Privacy Policy, or your rights, please write to the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call us at 888 CalPERS (or 888-225-7377).