

**AN OVERVIEW
OF WORKERS' COMPENSATION
IN MICHIGAN**

**Bureau of
Workers' Disability Compensation
Michigan Department of
Consumer & Industry Services
Lansing, Michigan**

November 2000

Portions of material in this booklet are based upon Workers' Compensation in Michigan: Law and Practice, a book written by Edward M. Welch and published by the Institute of Continuing Legal Education, Ann Arbor, Michigan. As the copyright holder of that publication, the Institute of Continuing Legal Education has granted its permission to use the material in this way. The Institute of Continuing Legal Education is located at 1020 Greene Street, Ann Arbor, Michigan 48109-1444, (313) 764-0533.

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An Overview of Workers' Compensation in Michigan

1. INTRODUCTION

What is workers' compensation?

Workers' compensation is the system we use to provide wage replacement, medical, and rehabilitation benefits to men and women who are injured while at work.

What is the purpose of this booklet?

This booklet provides a general outline of workers' compensation law in Michigan. It is not intended to be a legal document and it is not intended to cover every possible situation. We hope, however, that this will provide general guidelines for the majority of problems that arise. In other situations, workers, employers, and insurance companies will need to consult with their attorneys for more specific advice.

Much of this book deals with situations that have resulted (or are likely to result) in disputes and litigation. It should be pointed out, however, that most work-related injuries are resolved without dispute and without the need for litigation. In most cases a worker who is injured receives medical treatment and is paid workers' compensation benefits voluntarily by the employer or its insurance carrier. In time the worker is "rehabilitated" by returning to his or her former job or another one with the same employer. The problem cases—the disputes—are the few that demand the attention of those who manage the workers' compensation system. Only those unusual cases find their way into administrative tribunals and courts and finally result in the interpretations of the law that are discussed here.

Accordingly, while this book will try to define the limits of workers' compensation by describing the extreme cases, the reader is reminded that most cases do not involve extreme or unusual circumstances.

It should also be remembered that the law is often changed by the Legislature and is constantly being interpreted by the courts. Furthermore, there are always new questions about workers' compensation that come up. There are many areas in which the courts have not yet given us a clear interpretation of what the law means. As you read this you will find many instances in which we cannot answer all of the questions that arise. This booklet, however, will do the best it can to provide general guidance.

Where did workers' compensation come from?

Before 1912, a worker who was injured in the course of his or her employment could sue his or her employer in a civil or "tort" action, which was the same remedy available to a person injured under other circumstances. The tort remedy, however, had certain problems. It required the worker to prove that the injury occurred because the employer was negligent and the employer had three important defenses: (1) that the worker was also negligent, (2) that the worker knew of the dangers involved and "assumed the risk," or (3) that the injury occurred because of the negligence of a "fellow employee." Under this system it was very difficult for workers to recover against their employers. If they did win, however, they could receive virtually whatever damages a jury wanted to give them.

In 1912 Michigan, along with most of the other states, adopted a Workmen's Compensation Act. The new remedy is essentially a "no-fault" system under which a worker no longer has to prove negligence on the part of the employer, and the employer's three defenses were eliminated. The intent of the law was to require an employer to compensate a worker for any injury suffered on the job, regardless of the existence of any fault or whose it might be.

In return for this almost automatic liability, the Act limited the amount that a worker could recover. Workers are now entitled only to (1) certain wage loss benefits, (2) the cost of medical treatment, and (3) certain rehabilitation services. Under the old system, workers had been able to recover for pain and suffering, loss of enjoyment of life, and other damages that a jury might award. Recovery under worker's compensation is limited to these three areas, no matter how serious the injury.

What changes have taken place in the Workers' Disability Compensation Act?

Over the years there have been many changes in Michigan's workers' compensation laws. The most important recent changes occurred in 1965, 1982, 1985, and 1987. This booklet talks about the law in effect on May 15, 1987. In some circumstances it will make reference to prior law. You should understand, however, that the law may be somewhat different for cases involving injuries before May 15, 1987.

2. COVERAGE UNDER THE ACT

Who is covered by the Workers' Disability Compensation Act?

Nearly all employers in Michigan are covered by workers' compensation. This includes both public and private employers. In fact, when talking about workers' compensation, it is easier to discuss the exceptions. There are a few classes of workers who are covered by federal laws and are not covered by the Workers' Disability Compensation Act of Michigan. Employees of the federal government (such as postal workers, employees at a veterans administration hospital, or members of the armed forces) are covered by federal laws. People who work on interstate railroads are covered by the Federal Employers Liability Act. Seamen on navigable waters are covered by the Merchant Marine Act of 1920, and people loading and unloading vessels are covered by the Longshoremen's and Harbor Workers' Compensation Act. Virtually all other workers and employers are subject to Michigan's law.

Certain very small employers are exempt. If a private employer has three or more employees at any one time, or employs one or more workers for 35 or more hours per week for 13 or more weeks, the employer is subject to the Workers' Disability Compensation Act. (Section 115)

Are farms and farm workers covered?

Agricultural employees are exempt under certain special circumstances. An agricultural employer, however, may voluntarily cover its workers.

Can a partnership or small business be exempted from the Act?

The **employees** of partnerships and corporations are covered. However, Section 161 of the Act provides that under certain circumstances named partners and officers who are also shareholders of small, closely-held corporations may exempt themselves from the Act. Firms which wish to exclude partners or officers of a corporation but have other employees can do this by making arrangements with their insurance company. Firms in which all of the employees are either partners or owners of a small corporation may obtain a certificate of their exemption under the Act by contacting the Insurance Division of the bureau. Its phone number and address is found in the back of this booklet.

What if a person is self-employed?

A business that is neither a partnership nor a corporation but is owned by one person is called a "sole proprietorship." The owner of that business is "self-employed." **The employees of a sole proprietorship are covered by the Workers' Disability Compensation Act, but the sole proprietor (the person who owns the business) is "self-employed." He or she is not an employee of anyone and accordingly is not covered by the Act.**

Are family members covered?

Section 161(2) of the Act provides that certain family members of an employer may be excluded from the Act.

Are independent contractors exempt from the Workers' Disability Compensation Act?

If one company hires another company to come in and do some work for it, the second company is ordinarily an "independent contractor" and not an employee of the first company. Sometimes, however, a company hires one person to come in and perform a specific job and disputes arise as to whether or not that person is an employee or an independent contractor. Section 161(1)(b) of the Act states that if the worker does not maintain a separate business, does not hold himself or herself out to and render service to the public, and does not employ other workers, the worker will be considered an employee.

Where can I get more information about coverage under the Act?

Questions often arise concerning the interpretation of the coverage and exclusion requirements of the law. Information and assistance concerning these issues is available from the **Insurance Division** of the Bureau of Workers' Disability Compensation. That number is listed in the back of this booklet.

The Insurance Division has a booklet which provides more information about employers, employees, and independent contractors. It can be obtained by writing to the Insurance Division at the address listed in the back of this booklet.

Is an employer always better off to avoid coverage under the Workers' Disability Compensation Act?

Many employers believe it is desirable to find some way to be exempt from the Workers' Disability Compensation Act. In many cases this may be correct. It must be remembered, however, that the Act provides protection to employers as well as workers. If an injury occurs in covered employment, the worker is automatically entitled to certain wage loss, medical, and rehabilitation benefits. The worker, however, is **limited** to those benefits. The employer is protected from any other lawsuit by that worker. If a person establishes his or her business in such a way that it is exempt from coverage of the Act, that business is giving up the protection from civil liability that is afforded by the Workers' Disability Compensation Act. This factor should be taken into consideration along with the potential costs of workers' compensation.

3. INSURANCE AND SELF-INSURANCE

Must employers purchase workers' compensation insurance?

The law requires that every employer subject to the Act must provide some way of assuring that it can pay benefits to its workers should they become injured. Most employers in Michigan provide this security by purchasing an insurance policy from a private insurance company. The insurance company then reports to the bureau that it is providing coverage for that employer. Some employers, however, are "self-insured."

What is self-insurance?

Some employers who are financially sound (and usually quite large) are "self-insured." An employer can only be self-insured if it obtains permission from the bureau. The bureau requires employers to demonstrate a very sound financial condition in order to be self-insured.

"Group self-insurance" is another option that is available. Under these plans several small employers which operate the same kind of business and belong to the same trade organization can band together to obtain approval for self-insurance as a group.

Are there penalties if an employer does not obtain insurance or permission to be self-insured?

There are severe penalties for the failure of an employer to provide workers' compensation coverage. First of all, if a worker is injured, he or she may sue the employer for civil damages. If the employer was at fault for the injury, this might result in the payment of a great deal of money by the employer.

Secondly, the Bureau of Workers' Disability Compensation actively enforces the Workers' Disability Compensation Act. It has the authority to go into court and seek an order prohibiting the company from employing any persons in their business until such time as proper workers' compensation insurance coverage is obtained.

Finally, the employer may be subject to a fine of \$1,000 or imprisonment for not less than 30 days nor more than 6 months, or both. Each day for which the employer is uninsured is considered a separate offense.

Are workers protected if an employer or an insurance company goes bankrupt?

There are two provisions in the law to protect workers in the event of bankruptcies. The Self-Insurers' Security Fund is funded by assessments on other self-insured employers. Should a self-insured employer go bankrupt, the Self-Insurers' Security Fund has the responsibility for making payments to injured workers. Should this occur, it is very important that the injured worker give notice of his or her claim to the Self-Insurers' Security Fund immediately. There is also a guaranty fund which assumes responsibility if an insurance carrier becomes bankrupt.

How is the price of workers' compensation insurance set?

Workers' compensation insurance rates are based upon the "classification" of the employees to be covered. The classification refers to the type of work the individuals perform. Insurance companies establish a premium rate for each classification. However, there are often many adjustments to these basic rates.

Since 1983 Michigan has had competitive pricing of workers' compensation insurance. In many states an insurance bureau sets uniform rates that insurance companies are required to follow in selling workers' compensation insurance. In Michigan insurance rates are now set on a competitive basis in the marketplace.

Because insurance companies do not all charge the same rate for the same workers' compensation coverage, it is very important for a business, either directly or through its insurance agent, to shop around for the best price on workers' compensation insurance. In shopping for insurance price is a very important consideration but an employer should also inquire concerning the services that the insurance company will provide. This includes the services concerning claims as well as prevention and loss control.

Where can I get information about insurance?

Information about insurance, self-insurance and group self-insurance is available from the **Insurance Division**. These phone numbers and address can be found in the back of this booklet.

4. COVERAGE

When and where are workers covered?

Of course, to be compensable the injury must happen at work. Workers' compensation is designed to cover only injuries which "arise out of and in the course of the employment." In the majority of cases it is obvious whether an injury happened at work. There are, however, many times when this becomes questionable.

Is a worker covered when he or she is traveling?

Generally speaking, if a worker is injured on the way to or from work, he or she is not covered. If, however, the worker is on the employer's premises when injured, then he or she is covered.

If a job requires a person to travel, he or she is covered while traveling. However, if the worker "deviates" from the business travel, he or she may not be covered.

Is everything that happens at work covered?

The courts have recognized that a certain amount of "horseplay" is to be expected on most jobs and that if a worker is injured as a result of such horseplay, that injury is compensable. The courts have also held, however, that there is a limit to this situation. If the worker is injured as a result of his or her "intentional and willful misconduct," he or she is not entitled to benefits. The courts have held that if an injury results from a violation of a rule which is clearly announced and regularly enforced by the employer, the worker is not entitled to workers' compensation benefits.

What about recreational and social activities?

Section 301(3) of the Act provides that if an injury results from an activity, "the major purpose of which is social or recreational," it is not covered under the Act. If a worker is injured at a company picnic or office Christmas party, he or she is probably not covered. This may, however, depend upon specific circumstances. For example, a salesperson who was entertaining prospective clients might be covered.

5. CIVIL LAWSUITS

Can a worker sue for damages other than workers' compensation?

An individual injured at work can only receive workers' compensation benefits and cannot sue for other damages. This is provided for in Section 131 of the Act. There are a few exceptions to this rule.

When can a worker sue his or her own employer?

Intentional torts

Section 131(1) provides that an "intentional tort" is an exception. This means that if an employer deliberately takes an action that is specifically intended to injure a worker, the worker can sue the employer.

Suits based on contract or other statutes

There are other laws that give workers a right to sue their employers. These include Civil Rights statutes, labor laws, and other similar Acts. The workers' compensation law does not deprive a worker of the right to sue under those circumstances. Workers may also have a right to sue their employer if there was a contract between them which the employer breached.

Generally under these circumstances the worker is not suing as a result of a "personal injury or occupational disease." It is lawsuits based on an injury or a disease that the Workers' Disability Compensation Act prohibits.

Uninsured employers

Section 641(2) of the Act provides that if an employer is covered by the Act but fails to provide security for workers' compensation (see Chapters 2 and 3 above), a worker who is injured on the job may sue that employer for civil damages.

Retaliation

Section 301(11) of the Workers' Disability Compensation Act provides that an employer cannot discriminate against an employee because the employee exercised his or her rights under the Workers' Disability Compensation Act.

Can a worker sue someone other than his or her employer if the other party is at fault?

Most civil suits resulting from work-related injuries involve "third parties." If someone other than either the worker, the employer, or a coworker is responsible for an injury, that "third party" can be sued. Thus, if a worker is injured because of the bad design of a machine which the employer purchased from an independent company, the worker can sue the manufacturer of that machine for civil damages.

Since these cases are in civil court, they are often very expensive and time consuming. Accordingly, they are usually only worthwhile if there is a serious injury and some third party is clearly at fault.

If an employer has paid workers' compensation benefits to a worker and the worker later obtains a recovery from a third party, the employer is entitled to be paid back for the workers' compensation benefits it paid to the worker. The employer, however, must pay for its share of the attorney fees and costs in the lawsuit against the third party.

6. DISABILITY

Who is entitled to receive disability benefits?

Sections 301(4) and 401(1) of the Workers' Disability Compensation Act state:

As used in this chapter, "disability" means a limitation of an employee's wage earning capacity in work suitable to his or her qualifications and training resulting from a personal injury or work related disease. The establishment of disability does not create a presumption of wage loss.

In order to receive benefits, a worker must be "disabled" as defined above. However, the fact that a worker is disabled is not enough to obtain benefits. In addition to being disabled, the injury or disability must be **work-related** and there must be a **wage loss**. Benefits can also be denied if the worker has **refused a reasonable offer of employment** or has **established a wage-earning capacity**. All of these factors will be discussed below.

Section 373 of the Act contains a special definition of disability for **retirees**. It makes it harder for a retiree to obtain benefits. A person is considered a "retiree" if he or she is receiving a pension or retirement benefit (but not a disability pension) that was paid for by the employer. To be disabled, a retiree must prove that he or she is unable "to perform work suitable to the employee's qualifications, including training or experience."

Should a worker who has not completely recovered try to return to work?

In most cases of work-related injuries, the most desirable result is a return to work. Indeed in the vast majority of cases the worker gets better and goes back to work and that is the end of the case.

Even if the worker is not completely recovered, it is to the advantage of both the employer and the worker for the worker to return to a job that he or she can perform. The following sections discuss the legal and practical reason why this is so.

Must an injured worker accept the offer of a job?

If the employer or anyone else offers an injured worker a job which he or she can do, the worker must accept the job or face the loss of benefits. Sections 301(5)(a)

and 401(3)(a) provide that if a previous employer, another employer, or the Michigan Employment Security Commission makes an offer of "reasonable employment," the worker must accept the job or lose benefits. Sections 301(9) and 401(7) provide that "reasonable employment" is work that the employee can perform, poses no clear and proximate threat to the employee's health, and is within a reasonable distance from the employee's residence. Reasonable employment is not limited to work suitable to the employee's qualifications and training.

What if the job pays less?

If the job that is offered is a lower paying job, the worker will continue to receive workers compensation benefits based upon the difference in wages. (Benefits are discussed more fully in Chapter 9.)

What if the worker does not think he or she can do the job that is offered?

Disputes often arise concerning whether or not a worker can do the job that is offered. This is a question that can only be answered in individual cases and often requires the expert opinion of a doctor. Of course, a worker should never do a job that will cause injury or harm. In general, however, a worker is always better off to try a job that is offered. If a worker tries the job and is unable to do it, benefits continue or resume; but if the worker refuses to try the job, the employer is likely to challenge that worker's right to continuing benefits.

Does the job have to be the same as the one the worker was previously doing?

The job offered does not have to be at the same skill or pay level that the worker was doing. As mentioned above, however, if it is a lower paying job, the worker continues to receive benefits based upon the difference in wages.

Must an employer offer a job to a worker?

The law does not require the employer to offer a job. Most enlightened employers, however, try to make work available for their injured employees whenever they can. First of all, there is a money factor. An employer is better off to have an individual on the job doing work in return for wages than to have the individual at home receiving workers' compensation. Accordingly, although

there is no legal requirement that an employer offer work, it is financially better off if it does.

Even more important it must be remembered that everyone is better off if the worker goes back to work as soon as possible. Most men and women in our society recognize their responsibility to perform work in return for their wages. Most people want to go back to the job as soon as they can. Most people who have worked and supported themselves and/or their families feel uncomfortable when they are not able to work. If they remain in that unhappy and uncomfortable state longer than is necessary, it becomes harder and harder for them to go back to their jobs.

Many employers in Michigan are finding that disabilities are shorter and the costs lower if they are willing to go out of their way in helping their injured employees get back to the job. Sometimes this requires making a small change in the person's work station. Sometimes it requires moving some people around in order to find a job the person can do. Some employers even create special "transitional workshops" for injured employees to work in temporarily. Whatever it takes, most people find that the sooner an employee can get back to the job, the better off everyone is.

What happens if the worker returns but cannot continue?

If a worker returns to a job, tries and is unable to do it, his or her benefits should be resumed. Of course, in some cases, there may be disputes over whether the worker really tried and whether the job was too hard to do.

If the worker returns to work for a period of time and then leaves, the question of whether benefits resume depends upon whether or not the new work "established a wage-earning capacity." That, in turn, depends upon several factors including (1) how long he or she continued to work after returning, (2) the nature of the work performed, and (3) the reasons for leaving work.

Generally if he or she returned for less than 100 weeks, it is most likely that the work will not establish a wage-earning capacity. If the worker returned for between 100 and 250 weeks, the work may or may not have established a wage-earning capacity. If the return was for more than 250 weeks, the work probably will have established the wage-earning capacity.

The nature of the work is also a factor. If the work was a "favored job" especially created for this worker, it probably will not establish a wage-earning capacity. On the other hand, if it was a job regularly performed by other workers, it probably will establish a wage-earning capacity.

Finally, if the worker leaves the job for reasons beyond his or her control, the payment of benefits is more likely to be resumed. If, however, the worker voluntarily leaves the job, benefits will probably not resume.

Must the work cause the injury?

Yes the work must "cause" the disability. If John Doe simply comes down with the flu while on the job, he is probably not entitled to workers' compensation benefits. The work must somehow be the cause of the disability.

What if the work is only one of the causes of an injury?

The work does not have to be the only cause. It is enough if the work **causes, contributes to, or aggravates** a condition which results in disability. Some of us can lift 200 pounds without any difficulty. Some of us, however, would severely hurt our back if we lifted 100 pounds. The law does not make this distinction. If a person does something at work that causes him or her to become disabled, the worker is entitled to benefits. It does not matter if there was some pre-existing weakness or if the worker was born with some condition that made him or her more susceptible to injury. This is an old principle of law that has been applied by the courts to all kinds of damage actions, including workers' compensation.

There are some special rules for certain conditions. In cases of **heart disease, mental disabilities, and conditions of the aging process**, the worker must prove that the employment aggravated or accelerated the condition in a **significant manner**. In cases of **mental disability**, the condition must be caused by actual events of employment. A worker is not entitled to benefits if he or she simply imagined something at work which caused the disability.

Are gradual injuries and occupational diseases covered?

When the workers' compensation law was first passed, there had to be an "accident" in order for benefits to be paid. That has long since been changed. If Mary Smith did not hurt her back by a single incident but her back gradually became painful as the result of lifting over and over, day after day, she can still be entitled to workers' compensation benefits. This is what the law calls "an injury not attributable to a single event."

Another special category is "occupational diseases." At first no diseases were covered by the Act. Then only listed diseases were covered. Then all occupational diseases were covered but certain special conditions were laid down

for the payment of compensation benefits in occupational disease cases. Most of those have been gradually taken out of the law.

Section 431 of the Act provides that if, on an employment application, a worker "willfully and falsely represents in writing that he has not previously suffered from the disease which is the cause of the disability or death,... the employer is not responsible for workers' compensation benefits." There is no similar provision relating to injuries.

There are certain occupational diseases (and now injuries in certain industries) that are treated specially. Silicosis was a very frequent disease among foundry workers. When occupational diseases began to be covered by the law, there was concern that the foundry industry would go out of business if they had to pay full compensation. Accordingly, the law was changed to provide special protection under those circumstances.

Under the present law, if a worker suffers from certain dust diseases or receives an injury while performing certain work in the logging industry, he or she receives exactly the same benefits as if the injury had occurred in some other way, but the employer receives special protection. After the first 104 weeks or the first \$25,000, which ever is greater, weekly benefits are paid by the employer but the employer is reimbursed from a special fund to which all Michigan employers contribute.

7. DEATH BENEFITS

Are death claims treated the same as disability claims?

Generally, the same principles apply to death cases. The issues discussed in Chapter 4 above regarding when and where workers are covered by workers' compensation apply to death cases. In general, the question of causation is treated the same in death cases as in disability cases. A major difference is that in death cases there must be a dependent in order to receive wage loss benefits. It sometimes happens that a childless, unmarried worker is killed on the job leaving no dependents. In that case, his or her estate receives a burial allowance of up to \$6,000 but nothing else.

Who are considered "dependents" of the deceased worker?

Children of a deceased worker are conclusively presumed to have been dependent upon the worker. All other individuals including a spouse must prove that they were, in fact, dependents of the deceased worker. If they were only partially dependent upon the worker, this will reduce the amount of benefits that they can receive.

What is the rate of death benefits?

Generally speaking, the amount of benefits is 80 percent of the after-tax value of the wages the worker was receiving at the time he or she was injured.

Section 356(2) provides for a minimum benefit rate in death cases. The rate is 50 percent of the state average weekly wage as of the date of injury. This is one of the few circumstances in which a benefit rate can actually be higher than 80 percent of the after-tax value of the injured worker's earnings. The calculation of the average weekly wage is discussed more fully in Chapter 9.

Coordination of benefits discussed in Chapter 9 does **not** apply to death cases.

How long are death benefits paid?

Except in the case of minor children, death benefits are paid for a total of 500 weeks. If disability benefits were paid before the worker died, the 500 weeks are reduced accordingly. Assume John Doe contracted silicosis while working in a foundry. Assume that he was disabled and paid disability benefits for 200 weeks at which time he died. His widow would be entitled to 300 weeks of death benefits (500 less 200 weeks of disability benefits).

If there is a dependent child, benefits continue for a longer period of time. If the child is physically or mentally incapacitated, benefits can continue indefinitely.

8. SPECIAL BENEFITS

There are certain special types of injuries or disabilities that are treated differently from others. In this chapter we will discuss several of these.

What are "specific loss" benefits?

Section 361 of the Act provides for compensation for certain specific losses. For example, if John Doe loses his thumb while on the job, he is entitled to 65 weeks of compensation benefits regardless of whether he is disabled and regardless of whether he has a wage loss. Table 1 at the end of this booklet lists the various weeks of benefits payable for specified losses.

If John Doe recovers and returns to work after two weeks, he still continues to receive benefits for the remaining 63 weeks. Assume that John Doe was a skilled watchmaker and is unable to return to work at the end of 65 weeks or assume that he is an ordinary laborer but suffers an infection in his amputation and is unable to work at the end of 65 weeks. Under those circumstances, his situation at the end of 65 weeks is evaluated in the same way as any other "general disability." If he is disabled, has a wage loss, has not refused a reasonable offer of work, and has not established a wage-earning capacity, he will continue to receive benefits.

Generally speaking, the amount of benefits paid is calculated in the same way as for any other injury (see Chapter 9). The exception is that Section 356(3) of the Act provides a **minimum** rate of 25 percent of the state average weekly wage for a specific loss. Thus a worker with a very low wage could receive benefits higher than 80 percent of the after-tax value of his or her average weekly wage.

What is "total and permanent disability"?

This is a special category of disability. Workers who meet certain requirements can get additional benefits.

Which workers can benefit if they qualify as totally and permanently disabled?

Until 1982, relatively low maximums limited the benefits of many disabled workers whose earnings would otherwise have entitled them to a higher rate. Workers who can qualify as totally and permanently disabled, however, may be entitled to have their benefits increase each year as the maximums increase while other disabled workers are limited to the maximum that was in effect on their date of injury.

The number of cases in which there is a large discrepancy between total and permanent disability benefits and regular benefits has greatly lessened over the years. There are, however, still some workers with high wage rates who can receive increases in benefits because they are classified as totally and permanently disabled.

Also, coordination of benefits (discussed in Chapter 9) does not apply in the case of total and permanent disability. Most individuals who receive workers' compensation benefits will have those benefits reduced if they are receiving a pension or other benefits from their employer. This reduction or "coordination" does not apply if the worker is totally and permanently disabled.

Finally, the presumption of disability is "conclusive" for the first 800 weeks. This means that if Jane Smith loses an arm and a leg, she is considered totally and permanently disabled for 800 weeks and she receives benefits whether she works or not. After 800 weeks, however, it becomes a question of fact. If because of some skill that she has, Jane has been able to return to work, and is in fact earning a living at the end of 800 weeks, her benefits will be stopped or reduced. If, however, she is still not able to work at the end of 800 weeks, benefits will continue.

Who is considered totally and permanently disabled?

Section 361(3) provides that a worker is totally and permanently disabled if he or she has suffered:

- (a) Total and permanent loss of sight of both eyes.
- (b) Loss of both legs or both feet at or above the ankle.
- (c) Loss of both arms or both hands at or above the wrist.
- (d) Loss of any 2 of the members or faculties in subdivisions (a),(b), or (c).
- (e) Permanent and complete paralysis of both legs or both arms or of 1 leg and 1 arm.
- (f) Incurable insanity or imbecility.
- (g) Permanent and total loss of industrial use of both legs or both hands or both arms or 1 leg and 1 arm; for the purpose of this subdivision such permanency shall be determined not less than 30 days before the expiration of 500 weeks from the date of injury.

It is relatively easy to determine whether a person has lost a leg or an eye (in the case of an eye, vision of 20/200 or less is considered a loss). Questions sometimes arise, however, concerning other categories. For the category of incurable insanity or imbecility, the worker must have a mental condition so severe that it affects the quality of the worker's personal non-vocational life in a significant manner comparable to the loss of two members or sight of both eyes, and it must be likely that normal functioning cannot be restored.

"Loss of industrial use" is another area that is sometimes difficult to determine. In general, the loss must be so severe as to prevent the use of the two extremities in industrial activity.

How much does a totally and permanently disabled worker receive?

In the case of a totally and permanently disabled worker, the employer pays the same benefit it would in the ordinary case. In addition, however, the worker is allowed to take advantage of changes in the minimum and maximum rates of benefit. The additional benefits paid to the worker are the responsibility of the Second Injury Fund and are called **differential benefits**.

Also, a totally and permanently disabled worker is entitled to the minimum benefit available. This is equal to 25 percent of the state average weekly wage. A worker with an ordinary disability is not entitled to any minimum benefit.

Finally, a totally and permanently disabled worker is not subject to coordination of benefits. As discussed in Chapter 9 below, most workers have their workers compensation benefits reduced as a result of other benefits they receive from their employer. This does not apply to workers who are totally and permanently disabled.

More information concerning those is available from the **Second Injury Fund**. Their address and phone number is listed in the back of this booklet.

What are "second injury" cases?

The Second Injury Fund was originally created to deal with the situation in which an individual suffers first one specific loss and then another specific loss that results in total and permanent disability. Assume for example that Mary Doe lost the sight of one eye as a child. Then later as a result of an industrial injury, lost her left arm. She would be considered totally and permanently disabled and entitled to the benefits described above. However, the employer would only have to pay for the first 269 weeks. This is the amount of specific loss benefits paid for the loss of an arm. All other wage loss benefits would be paid to Mary by the Second Injury Fund.

If a worker loses one bodily member and later suffers the loss of another member that results in total and permanent disability, the employer must only pay for the specific loss of the second member. The Second Injury Fund then pays all other wage loss benefits. (Medical and rehabilitation benefits are still the responsibility of the employer.) It does not matter whether the first member is lost at work or at home or even if the loss occurred at birth. The second loss, however, must be at work. If Mary Smith lost her arm at work and later lost her eye as a result of an injury not related to her work, she would not be entitled to total and permanent disability benefits.

Is there any special incentive under the Workers' Disability Compensation Act to hire handicapped workers?

Chapter 9 of the Workers' Disability Compensation Act provides special protection for employers who hire certified vocationally handicapped workers.

To be certified a worker must suffer from a back or heart impairment, epilepsy, or diabetes. The worker must be certified as vocationally handicapped by the Michigan Rehabilitation Service before he or she is employed. The employer must report the hiring of the handicapped worker to the Michigan Rehabilitation Services of the Michigan Department of Education within 60 days from the time the employment starts unless such information is filed before an injury for which benefits are payable under the Act.

If this is done, the employer then has special protection should that worker later suffer a compensable injury. Should that occur, the employer is responsible for only the first 52 weeks of workers' compensation benefits. Any subsequent benefits are reimbursed to the employer by the Second Injury Fund.

This provision does not in any way jeopardize the rights of the worker but provides this special protection to the employer.

The claims history of the vocationally handicapped law demonstrates that the hiring of certified vocationally handicapped workers is an extremely low risk proposition for employers. More than 86,000 employer certificates have been issued since the law went into effect but the Second Injury Fund is currently reimbursing employers in only about 180 cases. This shows that there have been very few serious injuries among the individuals involved.

If you would like more information about Chapter 9, contact your local office of the Michigan Rehabilitation Services of the Michigan Department of Education or the **Second Injury Fund** at the number listed in the back of this booklet.

Is there any special help for a young worker with high earnings potential who is injured at a low-paying job?

Section 356(1) of the Act provides special help for individuals who are earning a very low wage at the time of their injury and can demonstrate that at the time of their injury they had a potential for higher earnings.

It applies to individuals whose rate of compensation is less than 50 percent of the state average weekly wage as of the time of their injury. After two years of continuous disability, such a person may petition for a hearing and demonstrate that "by virtue of the employee's age, education, training, experience, or other documented evidence which would clearly reflect the employee's earning capacity,

the employee's earnings would have been expected to increase." If the employee can demonstrate this, then the magistrate may order an increase in compensation up to 50 percent of the state average weekly wage for the year of injury.

This one-time adjustment and the higher rate of benefits is paid only from the time a claim is made under this section. The cost of the increased payments comes from the Second Injury Fund and not the employer.

Are there special provisions for police officers and fire fighters?

The Workers' Disability Compensation Act contains two special provisions dealing with police officers and fire fighters. Section 161(1) says that if an employer provides "like benefits" to police officers or fire fighters, an injured worker must elect to receive either those benefits or workers' compensation benefits. Thus, if Jane Smith is a police officer and is injured in the course of her employment, she will want to determine if there is a duty disability pension. She will then want to determine whether the benefits under that pension are better than the benefits under workers' compensation. She can elect to receive benefits under the most beneficial plan. However, she cannot receive benefits under both plans.

Section 405 of the Act provides that in the case of a police officer or fire fighter, there is a rebuttable presumption that respiratory or heart disease is caused by the employment if the disease first manifests itself during a period while the individual is in the active service of a police or fire department. Thus, if John Doe works as a fire fighter and begins to experience symptoms of respiratory disease, it will be assumed that his work as a fire fighter caused the respiratory disease. In virtually all other cases the burden of proof is on the worker to prove that the work caused the disability. In this circumstance it is assumed that the work caused the disability. If, however, the employer can show that some other factor caused the respiratory disease, then it is not responsible for workers' compensation.

9. WAGE-LOSS BENEFITS

What benefits can a worker receive?

As discussed at the beginning of this booklet, the workers' compensation law provides a strict limit on the benefits that an individual can receive as the result of a job-related injury. A worker can only receive certain specified (1) wage loss benefits, (2) medical benefits, and (3) rehabilitation benefits. Each of those benefits will be discussed in the following sections.

How are wage-loss benefits calculated?

In the ordinary case a worker receives 80 percent of the after-tax value of his or her wage loss. It does not matter whether the worker is "totally" or "partially" disabled. Benefits are based on the wage loss and set at 80 percent of the after-tax value of the loss. (Total and permanent disability is a special category and discussed in Chapter 8.)

Thus, if Jane Smith is unable to work, a determination would be made of her "average weekly wage" before her injury and she would be paid benefits equal to 80 percent of the after-tax value of that amount. If she returned to work and because of her injury received wages less than her average weekly wage, she would receive benefits equal to 80 percent of the after-tax value of the difference.

Prior to 1982 the basic rate of benefits was two-thirds of the worker's gross average weekly wages rather than 80 percent of the after-tax value of his or her wages. When this law was changed, it was also provided that if the two-thirds formula subject to the 1981 maximum limitation would result in a higher rate, the worker is entitled to receive that rate. The tables published by the bureau for calculating the compensation rate indicate when this situation applies.

How is a person's average weekly wage determined?

The provisions dealing with the average weekly wage are found in Section 371 of the Act. The basic method of calculation provides that the average weekly wage is based on the highest 39 of the last 52 weeks before the injury.

If John Doe received a wage of \$500 per week for each week for the last year before the injury, there is no problem. His average weekly wage is \$500.

If he worked for each of the 52 weeks before the injury but earned a different rate for each of those weeks, we would look at the 39 highest weeks. We would then

determine the average by taking the total wages for those 39 weeks and dividing them by 39.

If John worked less than 39 weeks during the year prior to his injury, we divide the total earnings by the number of weeks he actually worked. Weeks in which no work was performed are not included in this calculation. Thus, if he worked for only 30 weeks during the year prior to his injury and earned a total of \$9,000, the average weekly wage would be \$300 (\$9,000 divided by 30).

Are fringe benefits included?

Under certain circumstances the value of fringe benefits may be included in determining the average weekly wage. "Fringe benefits" include things such as the cost of health insurance, employer contributions to a pension plan, and vacation and holiday pay. Sometimes when a worker is injured, the company continues to provide fringe benefits. There is nothing in the law that requires the company to do this.

However, if benefits are not continued, the worker has suffered a greater loss of income. The value of fringe benefits that are not continued is added to the value of the cash wages to determine the worker's average weekly wage. There is a limit, however. Fringe benefits cannot be used to raise the benefit to more than two-thirds of the state average weekly wage.

How do you determine 80 percent of the after-tax value of a given wage?

The bureau publishes tables that do this for you. Many factors are included in this calculation including the tax filing status, the number of dependents, and the state and federal tax rates. For each year since 1982 the bureau has published a table which translates a given average weekly wage into an amount equal to 80 percent of the after-tax value of that wage earned. The law provides that the determinations made by this table are conclusive and binding upon the parties.

Are there maximums and minimums?

Yes. The law provides that the maximum rate of benefits is 90 percent of the state average weekly wage for the year prior to the injury. A worker does not receive benefits higher than this amount regardless of how high his or her earnings might have been.

For the ordinary injury there is no minimum benefit. However, a worker who suffers a specific loss, as discussed in Chapter 8, is entitled to a minimum benefit

equal to 25 percent of the state average weekly wage. The same applies to a worker who is totally and permanently disabled as discussed in Chapter 8. In the case of death, the dependents of a deceased worker are entitled to a minimum benefit equal to 50 percent of the state average weekly wage.

A listing of the state average weekly wage and the various percentages can be found on Table 2.

Must a worker pay income tax on workers' compensation benefits?

Generally not. Workers' compensation benefits are not subject to either state or federal income tax.

Sometimes, however, when benefits have been delayed for a long period of time and an employer or insurance company pays a worker interest in addition to the workers' compensation benefits, those payments of interest may be subject to both state and federal income tax.

When and for how long are benefits paid?

Section 311 of the Act provides that no compensation is paid for an injury which does not last for at least one week. If the disability lasts beyond one week, the worker is entitled to benefits as of the eighth day after the injury. If a disability continues for two weeks or longer, then the worker is entitled to be paid compensation for the first week of disability.

Benefits continue so long as the worker is disabled. This could be for the rest of his or her life. Benefits are reduced 5 percent each year beginning with the year of the worker's 65th birthday. This reduction continues until the worker is 75 years of age. At that time benefits have been reduced to 50 percent. They continue at that level for the rest of his or her life. (This 5 percent reduction only applies if the worker is receiving social security benefits and is not subject to coordination as discussed below.)

Are any adjustments made in the rate of benefits?

Under ordinary circumstances there are no adjustments in the level of benefits. The worker is paid benefits based upon his or her wage and/or the state average weekly wage at the time of injury. There are no increases even though the worker might have received increased wages had he or she continued to work.

There are a few exceptions to this circumstance. As discussed in Chapter 8, workers who qualify as "totally and permanently disabled" can receive some increases. Also, as discussed in Chapter 8, low-wage earning workers who are continuously disabled for more than two years may be entitled to an increase. Workers with dates of injury between 1965 and 1979 were given a one-time increase effective January 1, 1982.

Adjustments are also made based on changes in the number of dependents of the worker.

Is there a penalty for the illegal employment of minors?

Section 161(1)(b) provides that if an illegally employed minor is injured, he or she is entitled to double compensation. This does not apply if the minor fraudulently uses permits or certificates of age in order to obtain the job.

Are workers' compensation benefits affected by other benefits a worker receives?

Section 354 provides for the "coordination" or reduction of workers' compensation benefits to the extent the worker receives other benefits paid for by the employer. Thus if a worker receives sick and accident benefits, pension benefits, or other similar benefits, his or her workers' compensation rate will be reduced by one dollar for each dollar in other benefits that are received.

If the other benefits are taxable, such as a pension benefit might be, there is an adjustment to represent the after-tax value of the benefit received.

Social security benefits are paid 50 percent by the employer and 50 percent by the worker. Accordingly there is a 50 percent reduction for social security **retirement** benefits.

Social security **disability** benefits are already reduced if an individual receives workers' compensation. Accordingly, there is no reduction in workers' compensation for social security disability benefits.

What if a worker is employed on more than one job?

If a worker is employed by more than one employer at the time of injury, the earnings from both employers are added together to calculate the average weekly wage. The worker's benefits are based on the total wages from all employments. If the job in which the worker was injured accounts for more than 80 percent of the worker's wages, that employer is responsible for all the benefits owing. If,

however, that employer was responsible for less than 80 percent of the worker's wages, it pays the entire benefits, but is reimbursed a proportional amount by the Second Injury Fund.

What is an "advance lump sum"?

Under special circumstances a worker may request an advance payment of his or her weekly benefits. The worker is paid the "lump sum" and future benefits are stopped or reduced until the amount is recovered. In computing the recovery, the employer is given credit for the interest it could have earned on the money.

10. MEDICAL BENEFITS

What medical benefits is a worker entitled to receive?

Section 315 of the Workers' Disability Compensation Act provides that a worker is entitled to all reasonable and necessary medical care. This includes medical, surgical, and hospital services, dental services, crutches, hearing apparatus, chiropractic treatment and nursing care. The responsibility to provide medical care continues indefinitely so long as the need for the care is related to the industrial injury.

How is the doctor chosen?

During the first ten days of treatment the employer has the right to choose the doctor. After that the worker is free to change doctors if he or she so desires. The worker, however, must notify the employer of the change.

In practice, many large employers have company doctors. The worker ordinarily seeks treatment from the company doctor first. If the assistance of a specialist is necessary, the company doctor refers the worker to such a specialist. Small employers, on the other hand, often tell their workers that they should go to their family doctor or some other physician in the community.

Can a worker refuse medical treatment?

In certain circumstances if a worker refuses medical treatment or fails to follow medical advice, he or she may lose the right to continuing benefits. The courts, however, are reluctant to apply this principle and it must be a very serious case before it is applied.

How are medical bills handled?

For the most part, the doctors and other medical providers send their bills directly to the employer or its insurance carrier. If for some reason the worker pays the doctor directly, he or she is entitled to be reimbursed by the employer or insurance company.

The law provides that medical providers such as doctors and hospitals cannot charge more than the amount specified in a fee schedule. If they attempt to charge more, the insurance company will pay only the maximum allowed by the schedule. The provider is not allowed to collect the difference from the worker. More information about the workers' compensation health care rules is available from the Health Care Services Division whose address is listed at the end of this booklet.

11. VOCATIONAL REHABILITATION BENEFITS

What rights does a worker have to vocational rehabilitation?

Section 319 of the Act provides that a worker has a right to vocational rehabilitation benefits. Vocational rehabilitation can include a whole variety of things. It might simply mean that the employer makes some minor change in the worker's job station so that he or she can return to the work in spite of some continuing problem. It might mean that an outside rehabilitation counselor will work with the employer and the employee to aid in a return to work at the same job or a similar job with the same employer.

It might mean that a vocational rehabilitation agency, either a state agency or private agency, will help the worker find a job with some other employer.

It might involve short-term training to help the worker find a new job or in some unusual circumstances, long-term re-education. In the appropriate circumstance an employer can be required to provide up to two years of vocational rehabilitation services.

Must a worker take part in vocational rehabilitation?

In certain circumstances if the company offers vocational rehabilitation services and the worker refuses to cooperate, wage loss benefits can be terminated.

Are vocational rehabilitation benefits offered automatically?

As with medical benefits, in most cases the employer will offer to provide rehabilitation services and will pay the rehabilitation agency directly. If these services are not offered, the worker can request them from the employer or seek assistance from the bureau.

If disputes arise concerning rights or responsibilities for vocational rehabilitation, a petition can be filed with the bureau and a hearing will be scheduled before a representative of the director.

Is vocational rehabilitation important?

Vocational rehabilitation is very important. A return to work should be the ultimate goal of everyone concerned with workers' compensation. The employee is certainly better off to be back on the job and earning wages, and an employer

is better off to have a day's work in return for payment to an injured employee rather than to pay workers' compensation benefits. All of the research about rehabilitation suggests two things. One, rehabilitation efforts are most likely to be successful if they are begun early; and two, the most likely avenue of successful rehabilitation is a return to work with the same employer.

Many progressive employers are implementing an entire system of "disability management." Under such a program they do everything they can to bring disabled employees back to productive work as soon after the injury as possible.

Effective disability management can lower costs for employers and reduce the suffering of injured workers at the same time. More information about disability management is available from the **Rehabilitation Division** of the Bureau of Workers' Disability Compensation. Their address and phone number can be found in the back of this booklet.

12. PROCEDURES

Are workers' compensation claims usually disputed?

No. In the sections that follow we will devote much attention to the disputed case and the unusual case. It is, of course, the problem cases that require the most explanation. Unfortunately, it is also these cases that receive the most attention.

The fact is that in about 75 percent of the cases, there is no problem and no dispute. Accordingly, we will begin this chapter with an outline of what happens in the ordinary case, then we will turn to a more detailed discussion that applies to problem situations.

What happens in the ordinary case?

In the ordinary case, the worker immediately reports an injury to his or her immediate supervisor. If the problem is not the result of a single event but rather caused by exposures or repeated events that happen over a period of time, the injury is reported to the immediate supervisor as soon as the worker is aware that there is any problem and that the problem might be caused or related to the employment.

Depending upon the facilities available, the worker is either seen at the company first aid station or medical department or referred to a private physician or other medical facility. At this point the company doctor or the private physician takes responsibility for the ongoing medical care of the injured worker. If the help of a specialist or hospitalization is needed, the proper arrangements are made.

If it appears that the disability will last for more than one week, the employer files an Employer's Basic Report of Injury (Form 100) with the Bureau of Workers' Disability Compensation.

If the employer is insured, its insurance company is informed of the situation. If it is a self-insured employer, it may handle the problem through its workers' compensation department—either at the local plant or at the company headquarters—or it may refer the case for management to a "third-party administrator." This is a separate company that specializes in handling workers' compensation claims for self-insured employers.

When the worker has been off for a week, the company begins the payment of workers' compensation disability benefits. The payments are made by the self-insured employer or the insurance carrier to the injured worker. Payments are **not** made by the state or the Bureau of Workers' Disability Compensation. The

employer or insurance company does report to the bureau that it has begun paying benefits.

If disability lasts for an extended period of time, the employer may request that the worker be examined by special physicians to evaluate his or her condition. The employer may offer, or the worker may request, vocational rehabilitation services.

Payments to the doctors and hospitals are ordinarily made directly by the employer or its insurance company to those providers of medical services.

When the worker recovers sufficiently, he or she returns to work. In many cases the worker is given some restrictions when he or she first goes back. Often this will be a limitation on how much the worker can lift but many other factors can be involved.

When the worker returns to full wages, benefits stop and the employer files a form with the bureau reporting that benefits have ended.

In what way is a worker required to give notice of an injury or make a claim for benefits?

Whenever a worker is injured on the job, he or she should immediately report the injury to the immediate supervisor. If a problem does not result from a single event but instead results from an exposure over a long period of time, the worker should report the injury as soon as he or she knows there is a problem that may be related to the work.

The law does not require that either notice or claim be in writing. However, most employers provide forms upon which to report an accident or injury. Workers should use such forms. The failure to report an injury in writing will not in itself mean that the worker is not entitled to compensation. However, if there is any doubt about the situation, it will be much easier for the worker to prove that he or she reported the injury (and that the injury happened) if a written report is made and if the worker keeps a copy of the report.

Section 381 of the Act requires that the employee give his or her employer notice of an injury within 90 days after the injury or within 90 days after the employee knew or should have known of the injury. If the worker fails to give such notice, however, the employer does not escape responsibility unless it can show that it was somehow harmed by the worker's failure to give notice.

Section 381 also requires that a worker must make a claim for compensation benefits within two years after the injury. The claim to the employer need not be in writing, but as discussed above, there are good reasons why it should be. In the vast majority of cases, the claim is made with the employer. The law, however,

does provide the alternative that a worker can make a claim by filing it in writing with the bureau on Form 117 available from the bureau.

What other time limitations apply?

Circumstances can arise under which a worker has given the proper notice and made a proper claim but for various reasons benefits were not paid. Sometimes many years go by before a worker files an application for hearing. Section 381(2) provides that in those cases the worker cannot receive past due benefits for more than two years back from the date he or she filed an application for hearing.

Section 833(l) deals with the situation in which a worker receives benefits which are then stopped and the worker later files an application for hearing to have benefits started again. Ordinarily a worker would do this shortly after benefits were stopped. Sometimes, however, this is delayed for a long period of time. Section 833(l) provides that under these circumstances the employer cannot be ordered to pay benefits for more than one year back from the date the application is filed with the bureau.

Sometimes, for various reasons, an employer pays a worker more benefits than he or she is entitled to. Under those circumstances the employer has a right to recover that overpayment from the worker. Usually this is done by reducing future benefits by a specified amount until the overpayment is recovered.

Section 833 provides that the employer cannot recover for an overpayment which was made more than one year prior to the date it takes action to recover that overpayment.

What reports is an employer required to file concerning workers' compensation?

As mentioned above, benefits are ordinarily paid by the employer or its insurance carrier to the worker. Unless there is a dispute, the Bureau of Workers' Disability Compensation does not get involved. Sections 801, 805, and Rules 1 and 2, however, require that certain events be reported to the bureau.

If an injury results in death, a specific loss, or a disability of seven days or more, the employer is required to report that injury to the bureau on a Form 100. (Injuries that require medical treatment but do not result in a disability of seven days do not need to be reported.) In the case of death, a Form 106 must also be filed.

When an employer begins paying benefits or the benefit amount is changed, this is reported to the bureau on a Form 701. If benefits stop, this is reported to the bureau on a Form 701. Rehabilitation activities are reported to the bureau on a Form 110. If a dispute arises, the employer may report that to the bureau on a Form 107.

Can a worker or employer get help with these procedures?

The Bureau of Workers' Disability Compensation has many services available to help workers and employers concerning workers' compensation. A list of bureau offices and phone numbers can be found in the back of this booklet. Please feel free to call the office nearest your home.

Some problems concerning workers' compensation require formal litigation, lawyers, and judges. Many others, however, can be solved in a simpler, faster way.

If a worker or an employer has any questions about workers' compensation benefits, he or she can obtain help by simply calling the nearest bureau office. Very often minor disputes concerning workers' compensation can be resolved by the mediators that are available in these offices. Sometimes the problem is solved by simply providing the needed information. Sometimes the mediator will make a phone call to the other party involved in the case and sometimes the mediator will arrange for an informal conference between all the people involved. When problems can be resolved in this way, the need for formal litigation is avoided. Sometimes, however, there is no simple solution and formal litigation will be necessary.

How are formal dispute procedures started?

Most often formal disputes are started when a worker files an "application for mediation or hearing (Form 104)." The law requires that this form include detailed information about the injury. At the time it is filed the worker must also provide the employer with any medical records relevant to the claim that are in his or her possession. When the application is received by the bureau, it is sent to or "served upon" the employer and its insurance carrier. The employer must then file a Carrier's Response Form providing detailed information from its point of view and must send medical records in its possession to the worker or the worker's attorney.

What is mediation?

After an application and the Carrier's Response Form have been exchanged, many cases are set for a mediation hearing. Mediation hearings are scheduled in those cases that involve a claim for a closed period of time where the employee has returned to work, cases involving only a claim for medical benefits, cases in which the worker is not represented by an attorney, and any case in which the bureau determines that the claim might be settled by mediation.

At the mediation hearing the parties sit down with a mediator appointed by the bureau and examine all the aspects of the case. The mediator encourages the

parties to exchange completely all information about the case. The mediator then explores with the parties the various possibilities for an agreeable solution to the problem. The bureau is finding that many workers' compensation disputes can be resolved through a voluntary agreement by the parties arrived at during a mediation.

If the dispute is not resolved at the mediation hearing, the case is assigned a trial date before a workers' compensation magistrate.

What is a pretrial?

In cases in which no mediation is scheduled, the first formal action is a pretrial hearing. At the pretrial hearing, representatives of the parties meet before the workers' compensation magistrate or judge who will try the case. At the pretrial the magistrate reviews the case to be certain that all the proper papers have been filed, checks to see that all appropriate parties have been notified, and determines by whom each party is represented. Any preliminary legal issues can be raised by the attorneys during a pretrial hearing. At the end of the pretrial the case is ordinarily scheduled for a trial date before a magistrate.

In what way are "small claims" treated differently?

If the case involves a claim of less than \$2,000, the case may be heard as a "small claim" rather than having the usual formal trial.

Small claims are heard by the same magistrates or judges as other cases, but the proceedings are much less formal. Written medical reports may be submitted into evidence instead of taking testimony or "depositions" from doctors. The formal rules of evidence are not strictly applied and attorneys are not permitted. (If either side hires an attorney, the case is "removed" to the more formal, usual trial procedures.) At a small claims hearing a party may represent himself or herself or may be represented by another person who is not an attorney.

Ordinarily small claims cases will be scheduled for a mediation hearing as discussed above. After the mediation hearing, if the dispute cannot be resolved, they will then be scheduled for a small claims hearing before a magistrate.

How are trials conducted in workers' compensation cases?

Trials in workers' compensation cases are held before workers' compensation magistrates. These individuals act as judges, they are appointed by the Governor, and hear only cases involving workers' compensation. Trials are held at a variety of locations around the state. There are no juries in workers' compensation cases.

In most workers' compensation cases, both the worker and the employer are represented by attorneys. The law permits individuals to represent themselves at workers' compensation trials but no one other than an attorney may represent someone else at a trial.

Most workers' compensation cases involve medical questions and accordingly most workers' compensation trials involve testimony by doctors. Often in preparation for a trial the worker will be sent by his or her attorney for an examination by a doctor and will be sent to a different doctor by the employer or its insurance company.

The testimony of doctors is usually taken "by deposition." This means that the lawyers go to the doctor's office with a court reporter. The doctor is then questioned there just as if he or she were in court. A record of what the doctor says is typed up by the court reporter and presented to the magistrate. This procedure makes it much more convenient for the doctor and saves time for both the doctor and the magistrate.

The trial in workers' compensation cases is usually rather formal. All of the usual rules of evidence apply. The witnesses are sworn (exceptions can be made for religious reasons) and everything they say is taken down by a court reporter.

In most cases the injured worker is the primary witness involved. Sometimes the worker will also call as a witness fellow employees or other individuals.

In some cases the employer does not call any witnesses at all. Often, however, a foreman or some other representative from the company might testify. This is most likely to happen where there is a dispute concerning what kind of work the employee was required to perform. Sometimes employers present testimony from private investigators to establish the kinds of things that the worker has been doing during his claimed period of disability.

At the end of the trial the magistrate does not ordinarily issue a decision. Instead he or she "takes the case under advisement," reads all of the records, including the testimony of the doctors, and writes a formal opinion. The opinion is mailed by the bureau to all the people involved, including the attorneys, the worker, and the employer.

What rights do the parties have to appeal the decision of a magistrate?

If the parties disagree with a decision of a magistrate, they may file an appeal to the Workers' Compensation Appellate Commission.

There are two kinds of issues in each workers' compensation case—issues of fact and issues of law. An issue of fact might be a question such as did this injury happen at work or did it happen at home? Is this person's disability serious enough to keep him or her from returning to work? Issues of law might involve questions like the interpretation of a new definition of disability, whether the rules of evidence were properly applied, or whether an injury that happened under specified circumstances was covered by the Workers' Disability Compensation Act.

Concerning issues of fact, the Workers' Compensation Appellate Commission must "affirm" or agree with the magistrate if there is substantial evidence to support his or her findings. On issues of law, the Appellate Commission is free to completely review the matter. In other words the Commission makes a complete review of legal issues but must ordinarily accept the magistrate's determination of factual issues.

If a party disagrees with the decision of the Appellate Commission, it may seek "leave" or permission to appeal to the Court of Appeals or the Supreme Court. The courts are limited by the Constitution to review only issues of law if there is any evidence to support the factual conclusions that were reached by the Appellate Commission and magistrate.

Does the worker receive any benefits during an appeal?

If the magistrate ordered the payment of benefits to the worker, the employer must begin paying current weekly benefits at the rate of 70 percent of the benefits ordered. These benefits are to be paid while the case is being appealed. If the worker eventually wins the case, of course he or she receives the remainder of the benefits. If the worker eventually loses the case, the employer is reimbursed from the Second Injury Fund, but the worker is not required to repay. This applies only to benefits that are payable beginning with the date of the magistrate's decision and continuing until the case is decided by the appeal. It does not apply to benefits that were owing for periods of time before the magistrate's decision. Of course, if the worker wins, those benefits are paid when the case is finally over.

If the worker wins the case before a magistrate, the law also requires the employer to provide medical care required by the terms of the award while the appeal is pending. If it is eventually determined that the medical care should not have been ordered, the employer is reimbursed by the state.

What is arbitration?

A new arbitration procedure was added in Section 864 of the Act in 1985. This provides that instead of using a magistrate or the Appellate Commission, the parties may agree upon an independent arbitrator to hear the case. This provision is strictly voluntary. All the parties must agree to the procedure and to the arbitrator involved. The use of an arbitrator may result in a case being resolved much quicker.

Is interest payable on workers' compensation?

Sections 801(6) and 852(2) deal with the payment of interest. When past due benefits are owed from an employer or carrier to a worker, the worker is entitled to receive interest at the rate of 10 percent per year. Sometimes it happens that the wrong employer or insurance company paid benefits and one carrier is required to reimburse the other. When that happens interest is paid at the rate of 12 percent.

Is there any penalty if an employer does not pay the benefits it owes?

Section 801 provides for a penalty of up to \$50 per day (with a maximum of \$1,500) if benefits are not paid within 30 days after the date they are due. The statute also provides, however, that if there is a "dispute" about the payment of benefits, the penalty provision does not apply. The courts have held that any dispute, even a bad faith dispute, is enough for an employer to avoid the penalties. If the payment is for a medical bill, the 30-day penalty period does not start to run unless the employer receives the bill by certified mail.

Accordingly, if an employer is disputing a worker's right to benefits, the penalty provisions do not ordinarily apply. However, if an employer simply fails to pay benefits that it does not dispute, penalties may be charged against the employer.

What if the employer simply refuses to make payments that are ordered?

In nearly all cases benefits that are ordered are paid voluntarily. If, however, there is a final order requiring the payment of benefits and the employer does not pay, the worker may go into circuit court and obtain an order from the court requiring the payment of benefits. This is provided for in Section 863 of the Act.

Rule 5 of the Administrative Rules also gives the director of the Bureau of Workers' Disability Compensation the authority to hold a hearing when he or she believes that the carrier is not complying with the requirements of the Act. These procedures are rarely used but can be helpful where necessary.

When can a worker get a "settlement" of his or her workers' compensation claim?

Workers' compensation benefits are ordinarily paid on a weekly basis. There are a number of circumstances, however, under which workers can receive a payment of benefits in a single lump sum. As discussed in Chapter 9, a worker can receive future payments as a lump sum advance. This alternative is available but rarely used.

When an employer has denied benefits and a case is eventually decided in favor of the worker, the worker is usually entitled to receive a large payment for past due benefits. Under these circumstances the worker receives a large lump sum payment but it is not in any way a "settlement" of the case.

We mentioned above that many disputes can be resolved through mediation. These cases can be "settled" in a variety of ways. Sometimes the employer looks at all the information the worker has presented and decides that it is a valid claim and makes a full payment. Sometimes the worker, after looking more closely at the matter and receiving advice from various parties, decides that he or she should withdraw the claim. In many cases the dispute is resolved by a compromise voluntary payment. The employer pays some but not all of the benefits the worker claimed and the worker agrees to accept these.

Under all of the circumstances described above, the worker keeps his or her right to file a new claim if he or she has additional trouble in the future. In other words, if the worker has more medical bills or another period of disability involving that same injury, the claim can be reopened.

Sometimes cases are settled by a **redemption**. If a case is redeemed, the worker receives a single, lump sum payment from the employer and in return gives up all of his or her future rights to workers' compensation benefits. Redemptions are valid only if they are approved by a magistrate after a formal hearing. At such a hearing papers are prepared that show exactly how much the settlement will be, where the monies will go and how much the worker will receive. The case and the reasons for the settlement are then explained to the magistrate by the parties. The magistrate makes certain that the worker understands his or her rights. Only then will a magistrate approve such a redemption settlement.

If an employer is represented by an insurance company, it must be notified of any proposed redemption at least ten days before the hearing. It has a right to come to the hearing and object to the settlement.

How are attorney fees calculated?

When employers or carriers are represented by attorneys, they ordinarily pay the attorney on a fee-for-service basis. In other words, the attorneys are paid by the hour or by the case regardless of the outcome. Some large employers and insurance carriers have "house counsel." These are attorneys who work full-time for the company and are paid a salary.

Workers are usually represented by attorneys who are paid on the basis of a contingent percentage fee. The worker is not ordinarily required to pay any fee or monies when he or she hires the attorney. Instead the attorney agrees to accept as his or her fee a percentage of the amount the attorney recovers for the worker. If there is no recovery, the attorney does not receive any fee.

Ordinarily the attorney will pay the costs of preparing the case for trial. This often involves a considerable amount of money to pay doctors for reports and examinations and to pay court reporters. If there is a recovery of money for the worker, this amount is deducted first to reimburse the attorney for the monies he or she has paid out. Then the attorney charges a percentage fee on the remaining amount of money that is recovered. The attorney is allowed to base the fee on all the workers' compensation benefits that have been recovered for the worker up to the time the case is concluded. The attorney is not permitted to charge a fee on benefits that are paid in the future.

For example, if a worker has three months of benefits owing at the time he goes to see the attorney, the attorney files a petition, takes medical testimony, attends a mediation or a pretrial, and eventually takes part in a trial, one year might go by between the time the case is filed and the time of trial. At this point there would be 15 months of benefits payable. If the worker is completely successful, the magistrate would order the payment of those 15 months of past due benefits plus benefits indefinitely in the future. The attorney would base his or her fee on the 15 months of past due benefits.

If there was an appeal to the Appellate Commission, this might take another year. During the time of the appeal the worker would receive 70 percent of the benefits ordered by the magistrate. If the worker wins, at the time the case is concluded the attorney is entitled to charge a fee based on all of the benefits owing up to that date. This includes the 70 percent benefits that the worker received while the case was on appeal.

If the worker wins the case as the result of a trial and/or an appeal, or if benefits are paid as the result of a voluntary payment, the attorney is entitled to charge a maximum fee of 30 percent of the benefits received. The maximum attorney fee, however, cannot be based upon a rate of benefits that is higher than two-thirds of the state average weekly wage. This means that if the worker is receiving the maximum benefit which would be 90 percent of the state average weekly wage, the attorney must calculate his or her fee as if the worker was only receiving an amount equal to two-thirds of the state average weekly wage.

If the case is resolved through a redemption settlement, the amount paid in a lump sum is usually higher. This is because a redemption settlement usually involves some payment for the future. Accordingly, lawyers are limited to smaller fees in those cases. If the case is settled before a trial is completed, the fee is limited to 15 percent of the amount of the settlement if it is for less than \$25,000. If the settlement is for more than \$25,000, the maximum fee is 15 percent of the first \$25,000 and 10 percent of the amount over that. If a trial has been held and completed and the case is later settled through a redemption, the attorney is entitled to a fee of 20 percent.

In redemptions, the magistrate will examine a statement of the fees provided by the attorney. In any case, the director of the Bureau of Workers' Disability Compensation has the authority to review any disputes concerning attorney fees.

Are the records of these state agencies open to the public?

In general they are not open to the public. In 1989 the workers' compensation law was changed. It now provides that some records of the bureau (like records of the Social Security Administration or the Employment Security Commission) are now confidential. Records relating to the claim of an individual worker and financial information concerning self-insured employers are now confidential.

There are several exceptions to this confidentiality. Records of **contested cases** are public records. If an application for a formal hearing, either before a magistrate or the director, has been filed, the records relating to that case are open to the public. The bureau also has the authority to provide information concerning confidential records to other governmental agencies and under certain circumstances to research organizations.

13. ORGANIZATIONS INVOLVED IN WORKERS' COMPENSATION

Who is responsible for paying workers' compensation?

There are a number of organizations involved in workers' compensation. It is important to understand who they are and what they do. First of all, workers compensation benefits ordinarily are **not** paid by the State of Michigan. Workers' compensation is the responsibility of an employer. Benefits are paid either directly by an employer or through an insurance company on behalf of an employer.

What state agencies are responsible for workers' compensation?

The **Bureau of Workers' Disability Compensation** is the state agency with the primary responsibility for overseeing the workers' compensation system in Michigan. The bureau is responsible for seeing to it that every employer in the state either has a policy of workers' compensation insurance or is approved as self-insured. The bureau keeps records of all workers' compensation injuries, payments, and disputes. If there is a disagreement concerning benefits, the bureau may try to help out through a phone call, an informal conference, or a formal mediation hearing.

Although the bureau monitors the reports that are sent to it, the bureau does **not** ordinarily **approve** the payment of benefits. Most of the time benefits are paid voluntarily by the employer or its insurance company. In those cases the bureau does keep a record of what was paid.

If there is a dispute that cannot be resolved by a voluntary agreement, it goes to the **Workers' Compensation Board of Magistrates**. This is a group of 30 magistrates who conduct trials in workers' compensation cases. They only hear workers' compensation cases. Workers' compensation cases are not heard in ordinary courts and juries are never involved.

If the parties are dissatisfied with the decision of a magistrate, they can appeal that decision. If the case was started before April 1, 1986, the appeal goes to the **Workers' Compensation Appeal Board**. If it was started on or after that date, it goes to the **Workers' Compensation Appellate Commission**.

The **Funds Administration** is involved in certain special cases. These are discussed in Chapter 8 above. Sometimes the Funds pay benefits directly and sometimes they reimburse employers for certain benefits that they pay. This includes the **Second Injury Fund**, the **Self-Insurers' Security Fund**, and the **Silicosis, Dust Disease, and Logging Industry Compensation Fund**.

The **Health Care Services Division** is responsible for the administration of workers' compensation health care services rules.

The phone numbers and addresses of all of these organizations are listed at the end of this booklet.

Are there any other federal or state laws which provide protections to injured workers?

Yes, both of the following laws apply to some workers:

The Federal **Americans With Disabilities Act of 1990 (ADA)**, which covers some injured workers, makes it unlawful for covered employers to discriminate against a qualified individual with a disability. The part of the ADA which prohibits job discrimination is enforced by the US Equal Employment Opportunity Commission (EEOC) and state and local civil rights enforcement agencies that work with the commission.

The part of the ADA enforced by the EEOC outlaws job discrimination by:

- # all employers, including state and local government employers, with 25 or more employees after July 26, 1992, and
- # all employers, including state and local government employers, with 15 or more employees after July 26, 1994.

Employers covered under the ADA may not discriminate against an individual with a disability in hiring or promotion if the person is otherwise qualified for the job and they are required to provide "reasonable accommodation" to individuals with disabilities. This includes steps such as job restructuring and modification of equipment. Employers do not need to provide accommodations that impose an "undue hardship" on business operations.

The Federal **Family and Medical Leave Act (FMLA)**, signed into law on February 5, 1993 requires employers to give employees 12 weeks of unpaid leave for births, adoptions, and family illness.

The FMLA contains the following key provisions:

- # employers must have 50 or more employees within a 75 mile radius;
- # employees must have been employed for 12 months;
- # employers are required to maintain health care coverage during the leave:
- # on completion of the leave, the employees are entitled to return to the same job or to an equivalent job;
- # the employee must give 30 days' notice when the need for the leave is foreseeable; and
- # employers can exempt the highest paid 10 percent of the work force.

The FMLA will take effect for most employers 6 months after the law's enactment.

Where can additional information be obtained about the Americans With Disabilities Act of 1990 (ADA) and the Family and Medical Leave Act (FMLA) described in the previous question?

For more specific information about the ADA or FMLA requirements affecting employment, please contact:

ADA Assistance	
Great Lakes Disability and Business Technical Assistance Center (M/C 627) University Affiliated Program in Developmental Disabilities 1640 West Roosevelt Road Chicago IL 60608 800-949-4ADA (V/TDD) or (312) 413-7756 (V/TDD) (312) 413-1326 (FAX)	

Family and Medical Leave Act Assistance		
US Department of Labor Employment Standards Administration Wage and Hour Division		
Southeastern Michigan Area	(313) 226-7447	Please phone between 12:30 p.m. and 2:30 p.m. on Fridays
Main Office-Grand Rapids	(616) 456-2183	
Lansing Office	(517) 377-1790	

Information or assistance is also available from the following agencies:

Michigan Department of Civil Rights		
110 W. Michigan, Capitol Tower Bldg. Lansing MI 48913	Voice TDD	(517) 335-3165 (313) 961-1552
State of MI Plaza Bldg., 7th Floor 1200 Sixth Avenue Detroit MI 48226	Voice TDD	(313) 256-2663 (313) 961-1552
For Upper Peninsula and Northern Michigan residents		1-800-482-3604

Family Independence Agency		
Comm. On Disability Concerns Thorhill Bldg. #250 P O Box 30037 Lansing MI 48909	V/TDD	(517) 334-7334

Table 1

Specific Loss Schedule: Return to What are "specific loss" benefits?

	From 10-2-53 to
	Weeks
Thumb	65
1 st Finger	38
2 nd Finger	33
3 rd Finger	22
4 th Finger	16
Great Toe	33
Other Toes	11
Hand	215
Arm	269
Foot	162
Leg	215
Eye	162

Table 2

Average Weekly Wage Rates

Year	SAWW	90% of SAWW (Maximum)	2/3 of SAWW*	50% of SAWW (Minimum Benefit for Death Cases)	25% of SAWW (Minimum Benefit for Specific Loss and T&P)
2001	\$714.46	\$644.00	\$476.31	\$357.23	\$178.62
2000	\$678.23	\$611.00	\$452.15	\$339.12	\$169.56
1999	\$644.06	\$580.00	\$429.37	\$322.03	\$161.02
1998	\$614.10	\$553.00	\$409.40	\$307.05	\$153.53
1997	\$591.18	\$533.00	\$394.12	\$295.59	\$147.80
1996	\$581.39	\$524.00	\$387.59	\$290.70	\$145.35
1995	\$554.22	\$499.00	\$369.48	\$277.11	\$138.56
1994	\$527.29	\$475.00	\$351.53	\$263.65	\$131.82
1993	\$506.80	\$457.00	\$337.87	\$253.40	\$126.70
1992	\$489.01	\$441.00	\$326.01	\$244.51	\$122.25
1991	\$477.40	\$430.00	\$318.27	\$238.70	\$119.35
1990	\$474.22	\$427.00	\$316.15	\$237.11	\$118.56
1989	\$454.15	\$409.00	\$302.77	\$227.08	\$113.54
1988	\$440.77	\$397.00	\$293.85	\$220.39	\$110.19
1987	\$433.91	\$391.00	\$289.27	\$216.96	\$108.48
1986	\$414.70	\$374.00	\$276.47	\$207.35	\$103.68
1985	\$397.48	\$358.00	\$264.99	\$198.74	\$99.37
1984	\$370.65	\$334.00	\$247.10	\$185.33	\$92.66
1983	\$358.89	\$324.00	\$239.26	\$179.45	\$89.72
1982	\$340.45	\$307.00	\$226.97	\$170.23	\$85.11

Bureau of Workers' Disability Compensation

7150 Harris Drive
P O Box 30016
Lansing, Michigan 48909

Insurance Programs Division
Self-Insurance (517) 322-1868
Insurance Coverage (517) 322-1885
Compliance (517) 322-1195

Vocational Rehabilitation Division (517) 322-1866

Claims Processing (517) 322-1438

Appellate Commission
1375 S. Washington Ave.
P O Box 30468
Lansing, Michigan 48909
(517) 334-9719

Board of Magistrates
P O Box 30016
Lansing, Michigan 48909
(517) 241-9380

Health Care Services Div.
P O Box 30016
Lansing, Michigan 48909
(517) 322-5433

Funds Administration
7201 W. Saginaw, Ste. 110
Lansing, Michigan 48917
(517) 241-8999

Second Injury Fund
Self-Insurers' Security Fund
Vocationally Handicapped
Fund
Silicosis, Dust Disease, and
Logging Industry
Compensation Fund

Appendix 2

Offices to obtain information and/or ask questions regarding workers' compensation:

Mediator locations:

Detroit	State of Michigan Plaza Building 1200 Sixth Street 48226 (313) 256-2770
Escanaba	State Office Building 49829 305 Ludington (906) 786-2081
Flint	Bristol West Center G-1388 W. Bristol Road 48507 (810) 234-3401
Grand Rapids	2942 Fuller NE 49505-3488 (616) 447-2670
Kalamazoo	940 N. 10th Street 49009-9178 (616) 544-4440
Lansing	2501 Woodlake Circle Okemos P O Box 30016 48909 (517) 241-9393
Mt. Clemens	10th Floor Old County Building 10 N. Main 48043 (586) 463-6577
Pontiac	28 N. Saginaw, Ste. 1310 48342 (248) 334-2497
Saginaw	State Office Building 411-K E. Genesee 48607 (989) 758-1768