



Cap Your Workers' Compensation Claims with
Excess of Loss Insurance!

**Schedule 2 Employers' Group 2009 Conference
Parapet Underwriters Inc. Presentation**



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Section 1: Introduction - Who We Are

Parapet Underwriters is an insurance manager who in 1994 created the Excess of Loss insurance program that we will review and discuss today. The program, which is called XSCOMP®, provides excess workers' compensation indemnity for Schedule 2 Employers only.

The insurer for this program is Safety National Casualty Corporation of St. Louis. Safety National has been in business for over 70 years.

Our presenters today are Fohtemeh Ali, Lyne Provencher and Sabrina Hutchison. Fohtemeh Ali oversees claims at Parapet and provides advice to employers on related issues. Lyne practised law for 7 years prior to joining Parapet over 10 years ago and Sabrina began working in Parapet's Claims and Underwriting departments and recently made the transition to Marketing.

The purpose of our presentation is two fold:

- 1) For those of you who do not know about Excess of Loss insurance, we will explain the coverage. We will also discuss what this insurance means for the individual who handles workers' comp claims on behalf of the employer.
- 2) For those of you who do know us, we hope that you will find our discussion of many true life cases interesting and informative.

Section 2: Why Insurance?

The first item we are going to discuss is why organizations need Excess of Loss insurance. Schedule 2 Employers are allowed to opt out of the regulatory worker's comp scheme established by the province and to become, effectively, self-insured. When an employer moves from being a Schedule 1 employer to Schedule 2, the employer stops paying premiums to the WSIB. The consequence is that, when benefits must be paid to an injured worker, it is the employer and not the WSIB who pays those benefits. The WSIB remains involved in the administration of the claim to determine what must be paid, and for how long. However, it is the employer that is responsible for all of the costs related to worker's comp claims for all of its employees.

Since each Schedule 2 employer is only accountable for its own workers' comp claims and no longer has to pay into the WSIB's premium pool, the savings can be substantial for an employer. However, workplace accidents that generate extremely large costs to the employer do occur. Such catastrophic claims can be detrimental to an employer's budget and balance sheet, which is where Excess of Loss insurance comes into play.

There are different definitions of what catastrophic may mean for different employers. For a small municipality, for example, an accident generating \$400,000 - \$500,000 in losses may be a catastrophe. On the other hand, for a much larger municipality, a catastrophe may be \$1 million in losses.

When one says the word "catastrophe", we tend to think of drastic events such as:

- a transportation accident involving several deaths or injured persons, such as the crash of a bus transporting workers or a plane crash;
- an explosion such as the one on the Piper Alpha oil platform in 1988 which caused 167 deaths;
- a violent and enormous fire like the one in 1980 at the MGM hotel in Las Vegas where 84 died and 679 were injured;
- the release of a toxic agent such as Legionnaires' disease which caused 29 deaths in 1976 in a Philadelphia hotel;
- the structural collapse of a building such as the Hyatt Hotel walkway that killed 114 in 1981;
- the spread of a new disease or pandemic, for example, SARS;
- a natural disaster such as an earthquake, tornado, flood, ice storm (like the one in Quebec in 1998 which caused 24 deaths and many more injuries) or hurricane (such as Katrina that killed 4,000 in 2005);
- an act of terrorism (bombs, anthrax, etc.) with the most catastrophic being that of 9/11, with 2,974 deaths which cost billions of dollars to workers' compensation insurers;
- an act of arson such as those fires (100) in 2006 in Pine Bluff, Arkansas.

Interestingly, however, the US Department of Labor (Occupational Safety and Health Administration) defines a catastrophe on a much smaller scale than these examples. Catastrophe is defined as *the hospitalization of three or more employees resulting from a work-related incident or exposure; in general, from an accident or an illness caused by a workplace hazard.*

We believe that, in Canada, the definition of catastrophe can be taken down a couple of notches on this 'scale of catastrophic events'. Consider the following examples of real cases that, on the surface, seem as far as can be from the definition of a catastrophe. But the costs for the employer arising from these incidents are very catastrophic indeed.

Examples of Real Cases:

1. In a remote municipality, a worker had his life verbally threatened by a patient. This threat was not made directly to the worker but rather was overheard by a colleague who then related it to the worker. Unfortunately, this incident caused the worker great distress and as a consequence he suffers from Post Traumatic Stress Disorder, depression and other psychological problems. The incident occurred twelve years ago and the worker has not returned to work despite great efforts by the employer. The likely lifetime cost of this claim will exceed \$2 million.
2. The next case took place in northern Ontario and it was originally thought that the worker tripped over a tool box and fell backwards landing on his tailbone, which may well have caused a severe injury. However, in a formal statement, the worker stated that he had bent down to retrieve some tools when he hit his tailbone on a plastic bin. Because the worker is unlikely to return to work and given his young age, it is anticipated that the lifetime cost of this claim will exceed \$1 million.
3. Our third case involves a teacher, working in a large urban school, who slipped on a wet floor and struck his head. The accident occurred several years ago and the worker still has not recovered. He remains in the care of a 24/7 personal attendant and has been referred to the WSIB's Acquired Brain Injury Program. The likely lifetime cost of this claim, including health care, will exceed several million dollars if the worker's condition remains as is.
4. In our fourth case, a rural municipal worker had a fake gun pointed at him. He reported his claim to the WSIB in a timely manner. However, rather than receive WSIB benefits, he selected to go on 'sick leave' and received Long Term Disability benefits from his employer's Long Term Disability insurance provider and there was no further contact with the WSIB. Ten years later, when the worker reached age 65, his Long Term Disability payments ceased. At this time, the worker decided to resurrect his WSIB claim and was awarded full Loss of Earnings for the duration of time he was on Long Term Disability, which has increased the estimated cost of this claim to well over \$500,000.
5. The last example involves a teacher based in northern Ontario who injured her back while lifting a heavy backpack onto a desk. She never returned to work for the school but agreed to a Labour Market Re-entry plan. Her benefits were stopped when she failed to complete the training successfully and the file was assumed closed. However, the worker is now appealing for 100% retroactive benefits for a period of 10 years and, since recent medical

evaluations suggest a substantial disability, she will likely be granted these benefits. The lifetime cost of this claim will likely exceed \$500,000.

There are many other 'worse case scenarios' where costs could even exceed those we just mentioned. Think, for example, of a bus accident injuring several workers and perhaps even causing fatalities. Not only would the employer be responsible for the costs related to all of the injured workers, but they would also be liable for survivor benefits to all of the dependants of the deceased workers. We have a few such cases in our files where the costs to the worker's surviving dependants are in excess of \$1 million.

As can be seen from these examples, very significant losses for workers comp claims can also materialize from what at first may appear to be an innocuous incident. In addition, some losses don't appear 'catastrophic' until many years down the line (even 10 years after the accident for some). Large losses triggered by catastrophic events can and do occur and, for that reason alone; it is wise to have some insurance in place.

Insurance for large organizations

Although such catastrophic claims can be detrimental to an organization, some larger employers may well be able to survive a loss of several million dollars in claims costs. What may feel like an earthquake for a small employer may only be a small tremor to a larger organization. However, insurance is also important for large organizations in order to protect their constituencies from a potentially large uninsured loss.

One study in the UK assessed a catastrophic scenario at an organization with 1,000 workers in its head office where 30 workers were assumed to have been killed or disabled in the catastrophe. The assumption is that only 3% of the work force was significantly affected by the catastrophe, which is not an unrealistic scenario given the total number of employees who could have been injured. The study recommended a policy limit of £50 million for an organization of 1,000 employees to cover the costs arising from such a catastrophe. Admittedly, there are significant costs in the study which do not apply to Canada but the message as to the risk faced by employers is a clear and important one.

Another study done in the USA found that the largest corporations do have insurance and, moreover, they buy even higher limits than their smaller counterparts. This means that they protect themselves from more risk, even though their budgets can probably afford to suffer more workers' comp costs than their smaller equivalents.

By selecting a high retention or deductible, large employers can reduce the cost of this insurance but, it is still important that they have such coverage in place.

Section 3: The Excess of Loss Policy – Declarations Page

We will now explain how this coverage works and provide a quick guide to the main features of the policy. We understand that you are, for the most part, claim managers so our discussion of the coverage will therefore be done with your needs in mind. The policy has 2 parts:

- i. The Declarations page; and
- ii. The policy wording itself.

The first page of the policy, called the Declarations page, contains the basic information pertaining to the insured, namely the name and address of the organization.

a) Policy period

The Declarations Page also identifies the policy period – the dates on which the policy takes effect and expires. The policy period is generally for one year but it can be arranged to coincide with the other commercial insurance policies of the insured, to make things easier at renewal.

If a workplace injury occurs within the policy period set out on the Declarations Page, the employer will be covered under the policy. Even if problems didn't arise for the worker until later on, you will still be covered as long as the date of the original accident occurred within the policy period. An example is a worker who fell and injured his shoulder in November 2008 but failed to report the incident immediately or, alternatively, reported the incident but did not experience any actual injury from it until three months later, in February 2009. If the WSIB found that the first trigger for the injury was the fall in November 2008 and designated this as the date of loss, there would be coverage for this claim under the 2008 policy.

b) Policy retention & policy limit

The next items on the Declarations Page are the insured's retention and policy limit. The retention, also known as the deductible, refers to the amount the insured retains, or pays, on a claim before the insurer starts reimbursing the insured employer. The policy limit is the maximum amount the insurer will pay under the policy in regards to a particular claim.

For example, let's assume that the retention is \$450,000 and the policy limit is \$15 million. In general, the insurer will reimburse the insured employer for costs exceeding \$450,000 for a maximum of \$15 million.

The policy makes a distinction between an injury caused by an accident and an injury caused by an occupational disease. If there is an accident involving one worker, the retention for that accident is \$450,000. If the same accident had two injured workers, then in calculating the \$450,000 retention, the costs of both workers' claims are added up. The retention is applied to each accident as opposed to each worker which is beneficial for employers as they don't have multiple retentions if two or more workers are injured in a single accident. The same applies for the policy limit: if one worker is injured as a result of an accident, then the maximum the insurer will pay is the amount of the policy limit, in this case \$15

million, in excess of the retention. If two or more workers are injured as a result of the same accident, then the policy limit is again applied to the accident as opposed to the individual worker.

However, things are different when it comes to occupational diseases, or what is referred to under the policy as “injury caused by occupational disease”. There, the retention and the policy limit are both applied to each worker individually.

More generally, the minimum retention is \$350,000. It is available in increments of \$50,000 and can go up to \$1 million. Policy limits range from \$10M to \$25 million in increments of \$5 million. If a higher limit is desired, this is something that can be discussed. Each organization selects its retention and policy limit depending on its size and appetite for risk.

c) **Determining the premium**

We now come to the premium, or the price paid for the policy coverage. When calculating the premium, several factors are taken into consideration:

First, the number of employees: the size of the organization directly affects the potential amount of accidents, so the actual number of employees is an important factor in determining the premium.

Second, and as equally important, is the risk factor for each worker. Namely, the insurer looks at the various occupations of the organization’s employees. For example, an office employee is at a lower risk of being severely injured than a police officer.

Third, the earnings of the employees. Because some WSIB benefits are calculated as a percentage of these earnings, the higher the earnings are for a group of workers, the higher the benefits paid by an employer can be if a claim arises. But, these benefits are capped. Every year the WSIB caps the amount of payable benefits and this is called ‘maximum assessable earnings’. The 2009 figure for this cap is \$74,600 and, therefore, someone who earns more than this amount per year will see his or her benefits calculated as if he or she were earning \$74,600. Any earnings beyond the cap are irrelevant when it comes to assessing the amount of benefits a worker is entitled to. Therefore, the premium is based on the estimated assessable earnings for the policy period.

Fourth, the employer’s loss experience for the past 10 years is considered to calculate the premium. It’s important to know the sort of claims the employer has had in the past and also the safety or prevention measures it currently has in place.

And fifth, the policy premium will be higher or lower depending on the retention and policy limit selected. The higher the retention, the lower the premium and the higher the policy limit, the higher the premium will be.

d) **Endorsements**

The last item on the Declarations Page identifies the endorsement(s) attached to the policy, which are an integral part of the policy. An endorsement is used to indicate any change that has been made in the policy.

Section 4: Body of policy

We will now review the body of the policy. The policy wording is short, only 2 pages, and there are five main sections. Section 1 deals with general policy items; Section 2 deals with indemnity and what is covered under the policy; Section 3 deals with claims handling; Section 4 deals with the premium of the policy and finally, Section 5 deals with miscellaneous items, such as the cancellation terms. Each section will now be addressed in slightly more detail.

a) General definitions

The first of the five sections deals with definitions of certain words and phrases. These are simple and self-evident, for example, what is meant by the board (the WSIB), what is meant by losses or loss control, etc.

Section Two of the policy deals with the indemnity, or what the policy will pay to the employer (up to the policy limit) in the case of an insured claim where the retention is reached.

As mentioned, a distinction has to be made between an injury by accident and an injury by occupational disease since that distinction affects the retention and the limit.

For an injury by accident, the insurer will pay the costs that your organization is directed by the WSIB to pay to the worker, such as Non-economic loss awards, Loss of Earnings benefits, medical expenses and pension benefits. Payment by the insurer to the employer takes the form of a reimbursement. Once the benefits have already been paid to the worker, the employer can then be reimbursed.

This reimbursement also covers benefits you have paid directly to the worker, or benefits paid on his or her behalf, as long as they are directed by the WSIB. This could mean Loss of Earnings given directly to the worker or medical treatments which the employer pays for on the worker's behalf. These are called Covered by Advances. This means that the WSIB does not issue compensation cheques to the worker and then invoice the employer as the worker is paid directly by the employer. However, the WSIB still determines exactly what the worker is entitled to and they record all payments as being 'covered by advances'.

An important point to note, in terms of coverage under the policy and Covered by Advances, is that the WSIB decides what amounts are to be paid directly to the worker and this may not necessarily be what the employer has decided to pay the injured worker. For example, the WSIB caps the amount of LOE payable to an injured worker at 85% of the net pre-injury salary. If an employer has been paying its injured worker 100% of his/her salary, the WSIB would not deem the full amount advanced to the worker as WSIB benefits. The policy only covers the benefits designated by the WSIB.

The policy will also reimburse the employer for the WSIB administrative charges. The administrative charge is a fee charged to Schedule 2 employers for the administration of their workers' comp claims. For the year 2009, the WSIB provisional administrative rate is 23.70% (of the benefits paid out in regards to a WSIB claim) while the policy covers an administrative rate of up to 29.19%. The administrative rate covered under the policy has been more than sufficient to cover the WSIB administrative rate each year for the last 7 years.

For an occupational disease, there will be reimbursement for costs paid by the employer only if the last day of last exposure to the conditions causing or aggravating the disease was during the policy period. If this condition is met, then reimbursement of expenses, including the WSIB administrative fee, will take place once the retention is reached and up to the policy limit, in the same manner as if the injury were caused by accident.

b) **Coverage of occupational disease under the policy**

As we discussed earlier, coverage under the policy for an injury caused by an accident is determined by when the accident took place and whether the accident date falls within the policy period. Generally speaking, there is no issue as to when an accident took place.

Things are different when it comes to occupational diseases. The test for whether or not an occupational disease is covered under the policy is whether the worker's last day of last exposure to the conditions that caused or aggravated the disease occurred during the policy period.

Among other things, this means that there must have been during the policy period conditions that caused or aggravated the disease. Otherwise, the policy has no relevancy to the occupational disease. The rationale for this is that the insurer has received no premium for the conditions that caused or aggravated the disease before the policy came into effect.

It also means that the last day of last exposure to the conditions causing or aggravating the disease must occur during the policy period. The rationale for this is that the insurer will receive no premium for the conditions that cause or aggravate the disease after the policy has ceased.

The WSIB's practice of designating a date of loss for an occupational disease differs from the Excess of Loss policy: the WSIB uses the date when the worker first sought medical attention with regards to the disease. The policy will cover the cases that meet the test under the policy as just explained. If your organization has occupational disease claims that are not insured, we might be able to nonetheless assist you by exploring a solution with your organization to provide coverage that would apply to those uninsured claims.

c) **When to report a potential claim**

Carrying on with the body of the policy, section 3 sets out when notice of a claim must be given to the insurer which includes 7 specific events or scenarios. These are listed in the policy to describe when claims must be reported but generally speaking, notice must be given:

1. When there is a serious accident. If in doubt as to what constitutes a serious accident, provide notice.
2. Where the total amount covered by advances exceeds \$25,000 or the total amount of worker's compensation costs exceeds \$50,000, including the admin fee.

d) Sharing claim information / cooperation with the insurer

It is extremely important to monitor the development of a WSIB claim from early on. First of all, the insurer must set reserves i.e. it must set aside funds to cover potential losses. Therefore, sufficient information must be available so that the likelihood of the retention being reached can be assessed and the potential costs of the claim can also be assessed, i.e. will the retention be exceeded by \$200,000, \$500,000 or \$1M? Then, the insurer can set an appropriate reserve.

Another reason why the insurer needs to be notified early on regarding the existence of a claim is that we will then be able to provide your organization with assistance in returning the employee to work as early as possible. Statistics indicate, and it is well known, that the longer an employee is off work due to an injury, the higher the chance is that he or she will remain off work indefinitely. So, it is important that one actively intervenes early in all WSIB claims. Where there is a possibility that the employee might be able to return to work, options should be canvassed at an early stage.

Section 3 of the policy also contains some provisions for the sharing of claim information by the employer with the insurer. In practice, the information is shared with Parapet, who acts on behalf of the insurer. Parapet then reports to the insurer regarding the information provided by the employer.

As just discussed, we need to receive notice of a potential claim long before it reaches the policy retention. As with any other type of insurance policy, the insurer requires a full understanding of each potential claim. The interests of the insurer are fully in line with those of the employer; the insurer wants to help, in every way it can, to facilitate a safe and early return to work for the worker and cost containment for the employer. Our experienced claims people are able to provide extensive assistance in the management of the WSIB claim.

Later on, we will discuss in more detail the assistance we provide to employers who are insured under the Excess of Loss policy.

Section 4 of the policy covers the issue of premium, or payment for the policy coverage. Since we touched on this earlier, we will just mention that section 4 sets out how the premium is calculated if the policy is cancelled.

e) Recovery of Losses / subrogation

Section 5 of the policy has several miscellaneous provisions; however, we will only address two of them in this presentation. These are subrogation and cancellation of the policy.

In terms of subrogation, the policy provides that, where applicable, reimbursement for losses may be sought from a third party responsible for the injury.

Although this is a relatively rare occurrence, the employers and the insurer share a common interest and responsibility in using all reasonable measures to minimize claims costs. This includes taking legal action against a third party who may be at fault for the injury of a worker.

As a Schedule 2 employer, you have the right to bring a subrogated claim under **Section 30, subsection (11) of the *Workplace Safety and Insurance Act***, which states the following:

If the worker or survivor elects to claim benefits under the insurance plan and if the worker is employed by a Schedule 2 employer or the deceased worker was so employed, the employer is subrogated to the rights of the worker or survivor in respect of the action. The employer is solely entitled to determine whether or not to commence, continue or abandon the action and whether to settle it and on what terms. 1997, c. 16, Sched. A, s. 30 (11)

A successful subrogated claim by the employer against the party that is at fault would produce the beneficial result of recovering some or all of the WSIB costs (current and future) that the employer would be liable to pay to the injured worker.

For example: In one of our files, a worker was assaulted by an individual while performing his regular work duties. The result was serious injuries being sustained by the worker and entitlements were granted by the WSIB. This claim has the potential to reach costs of several hundred thousand dollars. The employer, in this case, had the right to pursue subrogation and it brought a subrogated claim against the individual who committed the assault.

Another example is of a worker who was badly injured while an outside landscaper was working on the premises of his employer. Due to the negligence of the landscaper, the employer brought a subrogated claim against the landscaping company to recover its losses.

The general limitation period to bring a claim in Ontario is two years. This means that, generally speaking, one would have two years from the date of the accident to start a lawsuit against the third party (e.g. the landscaping company). This is another reason why the insurer needs early notice of a WSIB claim as the limitation period to bring a law suit is relatively short.

As stated, the opportunity to subrogate against a third party is a rare occurrence in workers' comp matters. But where there is a valid claim against a third party, it should be pursued as it is in both the insurer's and the employer's interest to recover costs in relation to a claim.

f) **Cancellation of the policy**

A final item to note in Section 5 is that the policy can be cancelled at any time by giving written notice. That concludes our review of some of the main features of the XSCOMP© policy.

Section 5: Reporting Claims to the Insurer

a) **Disclaimer**

We will now look at the process of reporting a claim to the insurer, in this case to Parapet as the insurance manager. To begin, we want to point out that certain sections in the *Workplace Safety and Insurance Act* (WSIA) deal with the issue of confidentiality of the worker's identity. For example, **section 59, subsection (6) of the WSIA states that:**

s. 59 (6) The employer and the employer's representatives shall not disclose any health information obtained from the Board except in a form calculated to prevent the information from being identified with a particular worker or case.

Therefore, it's very important to make sure that information that could potentially identify the injured worker is not shared with Parapet in order to provide confidentiality for the worker. This is why we never ask for the worker's name, address, social insurance number or any other potentially identifiable information.

b) **First Report form**

As discussed, the claims department should report any WSIB claims that fall within the policy period when, generally speaking, the injury is serious and/or covered by advances have exceeded \$25K or the WSIB costs, including administrative fees, have exceeded \$50K.

When notifying us of a claim, we ask you to complete a First Report form. We do not ask you to fill out one of these for all WSIB claims that cross your desk, just the ones that require notification to the insurer.

The First Report form should take you 5 to 10 minutes to complete. When completing this form – please pay special attention to the following 4 items:

1. The form does not ask for the name of the worker for the reason just mentioned concerning keeping the identity of the worker confidential. It also does not ask for the WSIB number for the claim, for the same reason. The First Report form, as you will see, seeks some health information. Therefore, it is vital that the personal information of the worker is kept confidential so the worker cannot be identified.
2. Section 4 of the form, the table halfway down the page, asks for the Total (estimated) Loss (at the bottom of this table). It is especially important that we know the current total for the WSIB costs incurred on the file to date, not including administrative fees. This is what we are looking for in the first column of this table (paid to date).
3. Just below this table, we ask for the 'pre-injury gross weekly earnings' and 'current compensation benefits'. Please input the weekly salary or wage before the injury, ensuring to use the gross amount before deductions, and the amount of the current WSIB benefits. At this particular point of the form, this is in regards to Loss of Earning benefits only, so there is no

need to include any costs for health care, non-economic loss etc. as these are covered in the table above. If the worker is not receiving any Loss of Earning benefits from the WSIB, make of a note of that here.

4. Next, there are a few questions at the bottom of the First Report form that are very important for the insurer to know.

- a. The first one is 'Are there any subrogation possibilities?'

We discussed subrogation earlier and, as we said then, it is not often an issue. But in cases where there is an act of violence or negligence by a non-employee, for example in the event that a tool or some machinery malfunctioned, subrogation may be a possibility. If you are not sure, just give us a quick call so that we can help you resolve the issue.

Sometimes, where a worker is injured in a motor vehicle accident involving a non-employee who is at fault, the worker will elect not to pursue a WSIB claim but rather sue the other driver who is at fault. In such cases, an election form is completed by the worker and, when this happens, we ask for a copy of the signed election form.

- b. Second, 'Is there any part of the claim that is questionable?'

In the event that the answer to this is yes, and again, this is not a frequent occurrence, then we ask for an explanation, and, if there has been correspondence with the WSIB on this point, we will want to see that correspondence. Also, any additional information regarding this issue would also need to be sent to Parapet. For example, if an investigation has been conducted by the employer, we will want to review a copy of such a report. If such an issue has been resolved at the time of completing the First Report form, we will still want to know what made the injury questionable in the first place and how the issue was resolved.

- c. Third and fourth, 'Did the worker suffer from any relevant pre-existing conditions? And were there any relevant previous accidents / injuries?'

These two questions may be redundant if the relevant pre-existing conditions are caused by previous workplace injuries or accidents. But, in many cases, the pre-existing conditions are due to degenerative diseases or other types of diseases that are not work-related. Similarly, the prior accidents or injuries may or may not be work-related. If they are work-related, then please simply submit the WSIB Form 7s for any prior accidents.

- d. Fifth, 'Are there any appeals involved in this WSIB claim?'

What we are looking to find out here is whether the employer or the worker, or both, has disagreed with a WSIB ruling. If the answer to the question is yes, we will want to know about what issues are in dispute, the reasons for the dispute and when the appeal may be heard. A quick way to provide an answer to this question is to provide a copy of the decision letter from the adjudicator. Such a document would usually set out the position of the employer and the employee and the disputes at hand.

- e. Last, 'Is there a rehabilitation or Labour Market Re-entry plan in place, or are they being considered?'

If you check yes to this question, please tell us what is being considered, or if the rehabilitation program or Labour Market Re-entry is being implemented at the time you are notifying us of the claim and what the status is (i.e. the extent of completion reached). An easy way to answer this question is to provide us with a copy of the Labour Market Re-entry or rehabilitation plan or the initial assessment.

c) **WIB Form 7**

Along with the completed First Report form, please send us a copy of the original Form 7 filed with the WSIB in connection with the reported injury.

If there have been other Form 7s filed in connection with the injured worker (for past accidents), we will also want to have a copy of these Form 7s. This request reverts back to the questions we discussed on the First Report form about pre-existing conditions and prior accidents.

We will acknowledge receipt of the information sent to us within 48 hours. We will review the information and then contact you if we have further questions or for further updates.

d) **Claims Management advice / responsibilities**

In order to make the entire process of managing a WSIB claim as smooth and as easy as possible, it is imperative that you keep in constant communication with the adjudicators handling your claims at the WSIB. This means contacting them often so you are kept abreast of all occurrences and decisions made in the file.

Unfortunately, we have seen examples of decisions not being understood fully and such an error can drastically affect the employer's rights, the outcome of the claim and the ultimate cost of the file. To avoid this, ensure that you review every decision immediately and carefully, and seek clarification if it is not clear. Also, reserve your right to appeal within the timeframe for an appeal. This is 6 months from the date of a decision except in decisions regarding return to work or LMRs, in which cases the time limit is reduced to 30 days. You can always retract an appeal at a later date but exceptions are rarely made for missing this timeframe.

As an employer, you have the responsibility of informing the WSIB of any personal matters, such as a motor vehicle accident or a personal pre-existing condition, which may affect the worker's medical condition. This is important because personal accidents and illnesses are non-compensable and the WSIB needs to be fully aware of any while adjudicating the claim.

Section 6: Miscellaneous Claims Management Issues

At this point, we want to mention a few issues that often arise in our day-to-day claims management and our regular communication with employers.

a) Considering Independent Medical Evaluations

As an employer, you should consider Independent Medical Evaluations for some of your injured workers. They can provide valuable insight into a worker's injury and it is the employer's right to request an Independent Medical Evaluation when there is doubt about the compatibility of the medical information received and the disability of the worker. A paper Independent Medical Evaluation can also be conducted as long as all documents are completely void of any information which may identify the worker. If such expertise is required on any files, please contact Parapet for further information and suggestions.

The expenses related to obtaining Independent Medical Evaluations on potential claim files can be included as part of the retention under the policy and you will be reimbursed for the expense if and when the retention is reached.

b) Labour Market Re-entry plans

Labor Market Reentry plans are usually an extremely costly process and are not necessarily the only option, or even the best one, if you cannot offer modified work immediately. It is a good idea to do a cost-benefit analysis to review all of the employer's options before agreeing to a Labour Market Re-entry plan. Your organization may want to consider in house training or offering a modified position on a permanent basis to avoid the extreme cost of such a plan, which is usually approximately \$200,000. An example of this is presented by a real case in our files:

A few years ago, a worker reported that he noticed a sore back and a pain in his knee. A year and a half after the original injury, the worker was referred to Labour Market Re-entry. The employer was in touch with the plan assessor and a meeting between all parties took place. An agreement was reached that the worker would receive training and upgrades while still continuing to work for the original employer part-time. After his training, the worker was offered a full-time position with the employer and is no longer receiving any Loss of Earning benefits. The total cost for this file to date is under \$40,000. This is a huge success considering it would have likely been over a quarter of a million dollars had the employer not participated so fully in the process and if they had gone the route of a traditional Labour Market Re-entry plan.

c) Communication with injured worker and board

Communication with the injured worker and the workers' compensation board is key! It is very important to keep in constant communication with the WSIB, and also the injured worker. The more open the lines of communication are, the more likely the chances are for a swift and successful return to work as many return to work issues are simply communication issues. A good example of this is to document ALL communications with the injured worker, and make sure that the WSIB is provided with such information. So any letters, phone calls or meetings your organization has had with the injured

worker should be properly noted and given to the WSIB so they can always have a full understanding of the file. This is especially important with any return-to-work offers. As soon as one is made to the worker, and this should always be done in writing, the WSIB should be given a copy of the return-to-work offer and how the worker responded. As a side note, every return-to-work offer should state when the worker would begin work, what he or she would be doing, the hours he or she would work, how he or she is expected to progress and etc. so the WSIB can see that the employer is respecting the worker's restrictions.

Section 7: Support to Insureds

a) General support

The last item we wish to cover is the support Parapet provides to insureds. We offer both general group support, and much more personalized individual support.

In terms of general support, Parapet creates and distributes a quarterly newsletter entitled *The XSCOMP® Communiqué*, which we hope some of you receive. Each issue has a theme selected to provide employers with useful information and assistance in matters regarding workers' compensation. We publish articles, tips or interesting facts that we hope are helpful and appealing. Please let us know if you would like to be added to our distribution list; we would be more than happy to do so.

In addition to the *Communiqué*, we have developed Question & Answer documents based on the common concerns of employers. We have also put together a package on 'How to Report a Potential Claim' which is distributed to all insureds. We also distribute 'Monthly Tip' emails designed to help employers manage their workers' compensation claims.

b) Individual support

When it comes to individual support, Parapet offers assistance in a couple of ways. First of all, we are more than happy to answer questions employers may have. Whether it is by phone or email, our claims people are available during regular business hours and are prepared to answer your questions and concerns. If we need a little more time to find the answer to your question, we may consult other professionals and get back to you, but you will receive a response in one form or another.

Parapet also offers individualized support to insureds. This takes the form of one-on-one meetings where we invite your claims people to come to our office and meet with our claims people. We will address your questions and concerns in regards to the policy, your organization's potential claims, or general claims management techniques. If the travel is too far, we will organize a conference call with your organization, and have found this quite successful in the past.

Parapet uses the services of very experienced and knowledgeable professionals in the workers' comp field and we can put you in touch with such experts or give you our recommendation on the best type of consultant for your needs. The point is, you do not have to manage the files all by yourself if you feel you require assistance.

XSCOMP 2009/Parapet Underwrites Inc. Presentation – Schedule 2 Employers' Group conference 2009

Important Note: The actual XSCOMP® policy wording, and not the text of this presentation, prevails and must be adhered to.