DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

WORKERS' COMPENSATION AGENCY

GENERAL RULES

(By authority conferred on the director of the workers' compensation agency by section 205 of 1969 PA 317, MCL 418.205; section 48 of 1969 PA 306, MCL 24.248; and Executive Reorganization Order Nos. 1996-2, 1999-3, 2002-1, and 2003-1, MCL 445.2001, 418.3, 445.2004, and 445.2011)

PART 1. RECORDS

R 408.31 Report of injury; claim for compensation, additional reports; weekly rate of compensation.

Rule 1. (1) An employer shall report immediately, to the bureau, on form 100, all injuries, including diseases, which arise out of and in the course of the employment, or on which a claim is made, and result in any of the following:

(a) Disability extending beyond 7 consecutive days, not including the date of injury.

(b) Death.

(c) Specific losses.

(2) Any report of injury filed with the bureau by an employer that fails to meet the requirements of subrule (1) of this rule shall not be maintained as a record of the bureau unless filed with a form 107.

(3) An employer shall give a copy of the report of injury (form 100) to the injured employee immediately and in the case of death, to the dependent. Form 100 shall indicate compliance with this requirement. A delay in reporting shall not occur because of this requirement. In case of death, an employer shall also immediately file an additional report on form 106.

(4) An employee shall make a claim for compensation to the bureau on form 117. The bureau shall mail a copy of form 117 to the employer.

(5) After an employee has given an employer the name of the physician with whom he or she intends to seek treatment and has commenced treatment with the physician under section 315 of the act, the employee shall obtain and promptly furnish a report to the employer, insurance company, or self-insurers' security fund. The report shall set forth the history obtained, the diagnosis, the prognosis, and other information reasonably necessary to properly evaluate the injury, the disability, and the necessity for further rehabilitation or treatment. Thereafter, at reasonable intervals of not more than 60 days, an employee shall obtain and furnish a current medical report, paid for by the carrier, containing the same information, together with an itemized statement of charges for services rendered to date.

A self-insured employer, insurance company, or self-insurers' security fund is not required to make payment to the physician until the reports and itemized charges have been furnished to it.

Medical fees shall not exceed fees considered usual and reasonable for the services performed in accordance with the health care service rules.

(6) For a case that requires the payment of compensation, a carrier, the second injury fund, the self-insurers' security fund, and the silicosis, dust disease and logging industry compensation fund, shall file all of the following reports, notices, or statements as required by the bureau:

(a) Form 701 on the day after the first payment of compensation. The carrier or fund shall furnish a copy of form 701 to the employee.

(b) Form 701 on the day after the stopping of payment of compensation showing the amount of compensation paid in every case. Subject to R 408.40, when compensation is stopped on the basis that the employee has recovered from disability or that the employee is able to return to work, but has not done so, the medical report supporting this position shall be attached to form 701, or filed within 30 days thereafter. When a supplemental form 701 is filed, only that amount not previously reported shall be shown. In a case that requires the filing of form 701, the carrier and the funds shall, in writing, advise the injured employee whose benefits have stopped of the reasons for the action taken at the same time by furnishing a copy of the form 701 to the employee.

(c) The director may require a report showing the amount of compensation actually paid in cases where payment of compensation has not been previously stopped as of December 31 by the filing of form 701, for that calendar year, regardless of the length of time the case was open. If during the calendar year a form 701 had been previously filed, then only the payments made during the calendar year after the filing of form 701 shall be reported. The report shall be furnished to the bureau at a time and in a manner as the director may reasonably require.

(d) Immediate notification to the bureau of any change in the rate of compensation. The notice shall state the reason on form 701.The carrier or fund shall send a copy to the employee.

(e) A statement of the attending physician in every specific loss. The statement shall identify the date and extent of the loss.

History: 1979 AC; 1980 AACS; 1984 AACS; 1998-2000 AACS.

R 408.31a Computation of weeks and days.

Rule 1a. In computing periods of disability and of compensation, a week shall be computed as 7 days and a day as 1/7 of a week, without regard to Sundays, holidays, and working days.

History: 1998-2000 AACS.

R 408.32 Compensation supplement fund; "maximum benefit" defined.

Rule 2. (1) A carrier, second injury fund, or self-insurers' security fund shall claim reimbursement from the compensation supplement fund for payments made in accordance with section 352 of the act. A carrier, second injury fund, or self-insurers' security fund, shall make a claim on bureau form 114, application for reimbursement.

(2) A carrier, second injury fund, or self-insurers' security fund shall make an initial application for reimbursement not later than 3 months after the end of the quarter for which the right to reimbursement first accrues.

The right to reimbursement first accrues on the first day of the quarter following any quarter for which supplemental benefits are first paid or ordered to be paid.

(3) A carrier, second injury fund, or self-insurers' security fund may make subsequent application for reimbursement quarterly, but not later than 1 year after the closing date of the quarter for which reimbursement is being requested.

(4) A carrier, second injury fund, or self-insurers' security fund shall submit a separate form 114 for each quarter for which reimbursement is requested. A quarter, as used in this rule, is based on a calendar year as identified by the bureau on an annual basis.

(5) Upon a proper showing of a claim for reimbursement, the compensation supplement fund shall make payment within a reasonable time after the receipt of the claim. The compensation supplement fund shall normally make reimbursement within 3 months after the receipt of form 114, unless a dispute arises.

(6) For the purpose of these rules, "maximum benefit" means the statutory maximum for the year of injury upon which benefits are based; 2/3 of the employee's average weekly wage on the date of injury; the minimum compensation rate in effect on the date of injury; or a maximum compensation rate established by bureau order. If an employee, or his or her dependents, is receiving maximum benefits as defined in this subrule, there will be a presumption that benefits are being paid under section 351 or 321 of the act.

(7) A compensation supplement shall not be paid for any of the following received by an eligible employee or dependent:

(a) Benefits received for any period of disability before January 1, 1982.

(b) Benefits received under an agreement to redeem the liability of the carrier.

(c) A lump sum payment for remarriage under section 335 of the act.

(d) Interest paid on benefits awarded by a magistrate.

(e) Partial compensation paid under section 361(1) of the act.

(8) In a case involving a lump sum advance payment, supplemental benefits shall not be part of the advance payment, but shall continue to be paid weekly.

(9) In a case involving the carrier's right to subrogation in a third-party recovery, the amount of supplemental benefits shall be based on the weekly compensation rate that the employee would have been receiving on January 1, 1982.

(10) If compensation supplement benefits have been paid and if the employee is later found to be entitled to total and permanent disability benefits, then the second injury fund shall reimburse the compensation supplement fund for the appropriate amount of benefits paid by the compensation supplement fund, and the second injury fund shall reimburse the carrier for the balance of benefits that would have otherwise been paid by the compensation supplement fund.

(11) If the second injury fund is paying differential benefits directly to the injured employee and if the amount of differential benefits increases, then the second injury fund either shall reimburse the compensation supplement fund for any overpayment of monies that the compensation supplement fund has already

reimbursed the carrier or shall reimburse the carrier directly in cases where the compensation supplement fund has not yet reimbursed the carrier.

(12) If a case is on appeal over the issue of whether the injured employee is totally and permanently disabled and if the claimant is receiving 70% of the amount of differential benefits that would be owed if total and permanent disability is found to apply, the amount of supplement that is due may be reduced or offset by the 70% amount that is being paid.

(13) If the compensation supplement fund has reimbursed a carrier for the supplemental benefits paid, and if it is later found that the amount reimbursed included an overpayment, then the compensation supplement fund shall be entitled to recoupment of the overpayment from the carrier. The carrier is entitled to recoup the overpayment from the employee.

(14) Section 357 of the act shall not be applied when the amount of supplemental benefit, as provided for in section 352 of the act, is calculated for eligible employees whose date of personal injury is before July 1, 1968.

(15) After the supplemental benefit has been computed in accordance with section 352(1) of the act, based on the weekly compensation rate that the employee or dependent of a deceased employee is receiving or is entitled to receive on January 1, 1982, had the employee been receiving benefits at that time, the supplemental benefit shall not be reduced or increased by changes to the weekly compensation rate that occur after January 1, 1982, except as provided in section 352 and in this rule.

History: 1979 AC; 1980 AACS; 1984 AACS; 1986 AACS; 1998-2000 AACS.

R 408.32a Medical benefits; reimbursement application.

Rule 2a. (1) To be reimbursed for payments made in accordance with the provisions of section 862(2) of the act, medical benefits shall have been required by the terms of an award and shall have been paid in accordance with section 315 of the act and the rules promulgated under section 315.

In providing benefits as required by section 862(2) of the act, a carrier shall require that the employee and the provider comply with the requirements of section 315 of the act and the rules promulgated under section 315.

(2) Reimbursement shall apply only to cases for which an initial application for mediation or hearing is filed after March 31, 1986, under section 847 of the act. Claims shall be made on forms provided by the bureau and sent to the bureau of workers' disability compensation. If other insurance coverage is or was available to cover medical benefits paid under section 862(2) of the act, then the bureau will not make reimbursement.

(3) Applications for reimbursement from the bureau shall be made not less than 30 days after the benefit amount is reduced or rescinded by a final determination. An application for reimbursement shall be made not later than 1 year after a final determination is entered that reduces or rescinds benefits.

(4) Reimbursement from the bureau shall be consistent with benefits awarded in the magistrate's decision. Reimbursement will only be made for medical benefits that were provided between the bureau's mailing date of the magistrate's award and the mailing date of the final determination of the appeal or for a shorter period as specified

in the award. A copy of the magistrate's order and all subsequent appellate decisions shall accompany each request for reimbursement.

(5) A copy of the medical bills, proof of payment, and a medical report with sufficient documentation to demonstrate that the medical services provided fall within the provision of the magistrate's decision shall accompany each request for reimbursement. Proof of payment shall include certification from the carrier that it has paid the medical bills or, if requested by the bureau, shall include a receipt from the provider which shows that payment has been made.

(6) Reimbursement shall not be paid if the claim was redeemed before the final determination or if the carrier has not provided proper documentation.

(7) The bureau shall not pay interest on reimbursable amounts.

(8) If the bureau determines that all or part of the request for reimbursement is not proper, then the bureau shall notify the carrier in writing. If the carrier disputes the determination, then it may file an application for mediation or hearing.

History: 1989 AACS; 1998-2000 AACS.

R 408.33 Disputed claims; late payment penalty.

Rule 3. (1) On or before the fourteenth day after the employer has notice or knowledge of an alleged injury or death, a carrier and the self-insurers' security fund shall notify the bureau, on form 107, if the right of the injured or dependent to compensation is disputed. If compensation thereafter is paid, report it on form 701. A copy of form 107, notice of dispute, shall be mailed or given to the injured employee.

(2) The following subdivisions govern the administration and enforcement of the penalty provisions under section 801 of the act:

(a) Under section 801(1) of the act, compensation shall be paid promptly and directly to the person entitled to compensation. Weekly benefits become due and payable on the fourteenth day after the employer has notice or knowledge of the disability or death. On that date, all compensation which has accrued shall be paid. If benefits are not paid within 30 days of becoming due and payable, then the carrier shall pay to the employee $50.00 per day for each day after 30 days that the benefits remain unpaid, not to exceed $1,500.00.

(b) If a case is in litigation and the defendant agrees to pay benefits on a voluntary basis, then the magistrate shall specify the weekly compensation rate, the period of time for which accrued benefits have become due, and which medical bills shall be paid by the carrier as a result of the injury or disability. If the benefits agreed to are not paid within 30 days of the date the agreement is formalized by the magistrate, then the carrier shall pay to the employee $50.00 per day for each day after 30 days that the benefits remain unpaid, not to exceed $1,500.00.

(c) Medical bills become due and payable on the day the carrier receives the bill. If there is a dispute resulting in a delay in paying the medical bills, then the carrier shall advise the employee and doctor of the reasons for the delay in writing. If there is no dispute and the bill remains unpaid after 30 days, then the carrier shall pay to the employee $50.00 for each day after 30 days that the bill remains unpaid, not to exceed $1,500.00.

(d) The travel allowance for medical examination, treatment, or rehabilitation is provided in R 408.45. The employee shall be notified, in writing, of any dispute resulting in a delay in paying travel allowance payments. If the expenses are not paid within 30 days of the date of the carrier's notification, and if the expenses are not disputed, then the carrier shall pay the employee $50.00 for each day after 30 days that the expenses remain unpaid, not to exceed $1,500.00.

(e) Under section 801(4) of the act, an employer may be liable for all or a portion of the penalty provided in section 801(2) of the act. If there is a dispute between an employer and insurance carrier as to who is liable for the payment of the penalty, the carrier shall be liable for paying the penalties, but may be entitled to reimbursement from the employer.

(f) Any employee who may be entitled to penalty payments under section 801 of the act and who has not received the payments may apply by notifying the bureau in writing. A copy of the request shall be forwarded to the carrier. In all cases, the bureau of workers' disability compensation shall respond within a reasonable period of time and shall act, as it deems appropriate, to resolve any disputes involving the penalty provisions of section 801 of the act. If a dispute continues beyond a determination by the bureau or if the director believes there is a question of compliance with the act, then the dispute may be set for a hearing under R 408.35. A party to a dispute may request a formal hearing before a magistrate.

(g) A carrier shall pay any penalty amounts due an injured employee as a result of the penalty provisions specified in section 801 of the act in a separate check. Penalty amounts are not a part of the basic benefits to which an employee is entitled for the purpose of loss or assessment.

(h) Benefits, allowances, or bills are presumed paid within 30 days if a check is mailed within 27 days of becoming due and payable under these rules.

History: 1979 AC; 1980 AACS; 1998-2000 AACS.

PART 2. HEARINGS

R 408.34 Petitions for hearing; small disputes.

Rule 4. (1) In cases of dispute coming under the jurisdiction of the bureau, any party may petition the bureau for relief. The complaining party shall file his or her petition (form 104A, 104B, or 104C) with the bureau at its Lansing office. The bureau shall then serve the adverse party with a copy of the petition and, at the same time, notify the parties of the time and place of the initial hearing. The adverse party shall file his or her answer to the petition with the bureau within 15 days after service and serve a copy of the answer on the complaining party.

(2) In any case where the compensable disability of an injured employee is undisputed and involves 1 or more disputed injury dates during the course of employment with 1 or more employers, or during the course of employment with 1 employer who is insured by 1 or more insurance carriers, the bureau may direct compensation benefits to be paid at the maximum rate, as determined in section 351 of the act, with no dependents as provided in the schedule of benefits on the earliest or

initial date of injury alleged. The self-insured employer or insurance carrier that has the risk on the earliest or initial date of injury shall make the payments. Payments shall continue through the mailing date of the decision of the magistrate and shall be adjusted in accordance with the decision unless an appeal is taken. If an appeal is taken section 862 of the act shall apply. The magistrate shall order reimbursement where appropriate.

(3) In apportionment cases that are tried involving a date of injury before January 1, 1981, the primary action is between the last employer and the injured employee. All other joined employers may appear, cross-examine witnesses, give evidence, and defend on the issue of liability. In setting trial dates for such cases, only the convenience of the plaintiff and the last employer, or their attorney, shall be considered.

(4) After attempting to resolve the dispute without bureau involvement, either party may request the director to schedule a conference or the director, on his or her own motion, may schedule a conference to resolve small disputes. Parties involved in such disputes shall attend the conference.

History: 1979 AC; 1984 AACS; 1998-2000 AACS.

R 408.35 Bureau compliance hearings.

Rule 5. (1) If the director believes that there has not been compliance with the act, then the director may, on his or her own motion, give notice to the parties and schedule a hearing for the purpose of determining compliance. The notice shall contain a statement of the matter to be considered.

(2) If a matter that is alleged to be grounds for a hearing in accordance with this rule is brought to the attention of the bureau, then the director or his or her authorized representative shall review the evidence of noncompliance with the act that is presented and, after making inquiries or investigations that he or she deems appropriate, determine if a hearing in accordance with this rule is necessary. The parties involved shall be notified within 30 days of a receipt of the request as to the time and date of hearing or the reasons for denial.

(3) The bureau shall schedule a hearing within a reasonable time, subject to the availability and schedules of hearing personnel and the parties involved.

A request for a hearing under this rule shall, at a minimum, contain sufficient information to warrant investigation or inquiry into a matter. The request for hearing shall include, but is not limited to, all of the following information:

(a) Facts and law involved in the alleged failure to comply, including names, dates, amounts, or other pertinent information.

(b) A description of the redress or other specific action requested with specific references to sections of the act allegedly not complied with.

(4) The director shall issue an order on the hearing in which compliance may be ordered.

(5) Any order of the director under this rule may be appealed to the board of magistrates within 15 days after the order is mailed to the parties. If the order is not appealed within 15 days after mailing, then the order of the director is final. The board of

magistrates shall conduct a hearing on the appeal within 60 days of the date of appeal to the board of magistrates.

History: 1979 AC; 1984 AACS; 1998-2000 AACS.

R 408.36 Service of papers.

Rule 6. Service of all petitions, papers, notices, and orders shall be in accordance with the following:

(a) Service of all original petitions for hearing under R 408.34(1) shall be by the bureau on each named party to the case at the time service is made.

(b) Service of any subsequent petitions or motions filed on a pending contested case which may alter the parties to a case shall be by the bureau. The bureau shall serve all new parties but may serve only the attorney for each previously named party. Parties not represented by legal counsel shall be served directly. The bureau may request the necessary papers, notices, and postage to be provided by the moving party.

(c) Service of any subsequent petitions or motions filed on a pending contested case which do not alter the parties to a case may be made by the moving party upon the adverse party. The moving party shall only be required to serve the attorney for each previously named party. Any party not represented by legal counsel shall be served directly. The original petition or motion and proof of service shall be filed with the bureau.

(d) Notices mailed by the bureau after service of the original petition for hearing shall be served upon the attorney for each named party. Any party not represented by legal counsel shall be served directly. If the notice requests or requires the appearance or action of a specific party, that party shall also be served.

(e) Decisions or orders issued by the bureau shall be mailed to all parties or may be served personally on the date of hearing. All mailed decisions shall be served from the Lansing office or from such other bureau offices as designated by the director. Upon mailing or personal service, the original order and copies shall show a mailed date or acknowledgement of personal service on their face, from which date the appropriate appeal period shall run. The mailed or personal service date shall be considered the filed date for the order.

(f) Service of all other papers, unless otherwise directed by law, may be made by mail by the moving party upon the adverse party and proof of such mailing shall be prima facie evidence of such service. Proof of such service shall be filed with the bureau.

(g) Service of all papers under this rule upon employers whose liability under the act is not insured according to the records of the bureau, or who have not been granted the privilege of self-insurance, shall be by certified mail with a return receipt requested. Filing of the return receipt shall be prima facie proof of service.

History: 1979 AC; 1984 AACS.

R 408.37 Rescinded.

History: 1979 AC; 1998-2000 AACS.

R 408.38 Application for advance payment of compensation.

Rule 8. An applicant shall submit an application for advance payment of compensation on form 108. If the carrier, second injury fund, self-insurers' security fund, or silicosis and dust disease fund refuses to approve the application, then the matter shall be set for hearing to determine whether the application should be approved. A carrier, second injury fund, self- insurers' security fund, or silicosis and dust disease fund shall not approve, and a magistrate shall not order an advance payment of compensation to a minor dependent until a legal guardian has been appointed.

History: 1979 AC; 1998-2000 AACS.

R 408.39 Redemptions.

Rule 9. An agreement to redeem the liability of the carrier, second injury fund, self-insurers' security fund, or silicosis and dust disease fund shall be submitted on form 556, agreement to redeem liability. The agreement shall be accompanied by a report, approved by the employee, from a licensed physician stating, in detail, the findings of a recent examination.

History: 1979 AC; 1998-2000 AACS.

R 408.40 Stoppage, reduction, or suspension of compensation.

Rule 10. (1) If compensation is being paid under an order or award of the magistrate or workers' compensation appellate commission, then compensation shall not be discontinued or reduced without a further order or award, except as provided in subrules (3) and (4) of this rule and sections 301(5)(b) and 361(1) of the act. A petition to stop compensation shall include both of the following:

(a) Proof of payment of compensation to within 15 days of the date of the filing of a petition to stop compensation.

(b) An affidavit stating that the employee has returned to gainful employment and substantially describing the nature of the employment, or a signed statement from a physician stating that the employee is able to return to employment.

(2) The bureau shall schedule a hearing within 30 days of receiving a petition to stop compensation, and an order shall be entered under R 408.36.

(3) If a letter that carries a compensation check is returned by the United States post office unopened, and if a diligent search has been made for the party to whom compensation payment is due under the terms of an order or award, then the party liable for payment may suspend payment upon filing an affidavit that the check was returned and a diligent search was made to locate the party. The suspension shall not prejudice the reinstatement of suspended payments.

(4) Upon filing of the report required by R 408.31(6)(d) and notification to an employee, compensation benefits may be reduced in accordance with the act for changes in dependency and age 65 reductions.

History: 1979 AC; 1980 AACS; 1998-2000 AACS.

R 408.40a Rescinded.

History: 1979 AC; 1998-2000 AACS.

Editor's note: Former R 408.40a, pertaining to pre-trial procedure, was rescinded by 1954 ACS 65. For history of the rescinded rule, see 1970-71 AACS.

R 408.40b Appearances at mediation conferences.

Rule 10b. (1) In a contested case, in a hearing district designated by the director, the parties or their attorneys shall appear personally before the bureau at a mediation conference at a date and place scheduled by the director.

Failure of the petitioner or his or her attorney to appear in a timely manner and participate in a mediation conference may result in the application for mediation or hearing being deemed to have been voluntarily withdrawn under section 205 of the act. Failure of the defendant or its attorney to appear in a timely manner and participate in a mediation conference may subject the defendant to being charged immediately under R 408.35 for noncompliance with the act. A party that fails to appear and participate in a scheduled mediation conference shall obtain the dates for any future mediation conferences or hearings scheduled.

(2) The bureau may require any information from the parties that may be necessary to monitor the progress of the case, assist in the voluntary exchange of information between parties, and facilitate the scheduling of cases.

(3) If the parties agree to compromise the dispute by voluntary payment, the terms of such payment shall be specified on the voluntary payment form signed by both parties and the mediator. If the benefits agreed to are not paid within 30 days of the date the agreement is personally served or mailed by the mediator, then the carrier shall pay to the employee penalties in accordance with section 418.801 of the act.

History: 1979 AC; 1984 AACS; 1998-2000 AACS.

R 408.40c Rescinded.

History: 1979 AC; 1998-2000 AACS.

R 408.40d Rescinded.

History: 1979 AC; 1984 AACS; 1998-2000 AACS.

R 408.40e Rescinded.

History: 1979 AC; 1998-2000 AACS.

R 408.40f Rescinded.

History: 1979 AC; 1998-2000 AACS.

R 408.40g Rescinded.

History: 1979 AC; 1984 AACS; 1998-2000 AACS.

R 408.40h Rescinded.

History: 1980 AACS; 1998-2000 AACS.

PART 3. INSURANCE

R 408.41 Notice of insurance.

Rule 11. Every notice of issuance of a workers' disability compensation insurance policy shall be reported to the bureau on form 400, insurer's notice of issuance of policy. If the employer is a partnership, the notice shall state the names and addresses of all the partners. If the employer is doing business under an assumed name, the notice shall state the assumed name and each Michigan location covered. If the employer is a corporation doing business through a number of divisions, the notice shall state the names of all the divisions of the corporation. The bureau shall be notified when any insurance company receives a change of address of an insured.

History: 1979 AC; 1980 AACS.

R 408.41a Termination of insurance.

Rule 11a. A notice of termination of the liability of an insurance company on a policy covering the risk of an employer under the act shall be reported to the bureau on form 401, notice of termination of liability.

A copy of the notice shall be mailed to the employer. If the employer is a partnership, the notice shall state the names and addresses of all the partners. If the employer is doing business under an assumed name, the notice shall state the assumed name and the names of all parties doing business under the assumed name. If the employer is a corporation doing business under a number of divisions, the notice shall state the names of all the divisions of the corporation. If a business changes names notice shall be given stating both the new and former names. Notice of termination of a policy which has expired shall not be reported when the insurance carrier has accepted responsibility under a further or renewal policy, except for an assured's name change.

History: 1980 AACS.

R 408.41b Notice of election to be excluded as employees under act.

Rule 11b. A notice of election to be excluded under section 161(4) of the act shall be reported to the bureau on form 337, notice of exclusion. The employer shall have the notice notarized. If the employer is a partnership or corporation, then the notice shall state the names of all the partners or corporate officers. If the employer is doing business under an assumed name, then the notice shall state the assumed name and each Michigan location covered.

The employer shall certify that the employees signing the exclusion comprise all of the employees of the employer. The employer shall further certify that all employees are eligible to be excluded under section 161(2) or (3) of the act. Each employee shall furnish his or her social security number and certify that the employee voluntarily signed the election to be excluded. The employer shall furnish its federal identification number. The employer shall furnish each employee with a copy of the completed exclusion form before filing the form with the bureau. The exclusion shall become effective upon receipt of the notice of exclusion by the bureau.

History: 1987 AACS; 1998-2000 AACS.

R 408.41c Notice of election to terminate exclusion as employees under act.

Rule 11c. Every notice of election to terminate an exclusion from coverage previously filed under section 161(4) of the act shall be reported to the bureau on form 338, notice to terminate exclusion. The employer shall have the notice notarized. The notice shall state the reason for terminating the exclusion. The notice to terminate exclusion shall certify that all employees and the employer signing the notice to terminate exclusion have received a copy of the completed notice to terminate exclusion before filing the notice with the bureau. The employer shall furnish its federal identification number.

The termination of exclusion shall become effective not later than 20 days after the notice to terminate exclusion is received by the bureau. If a carrier is providing coverage at the time the notice to terminate exclusion is filed, or assumes coverage during the 20-day period, then the notice to terminate exclusion shall become effective on the date the carrier assumes coverage.

History: 1987 AACS; 1998-2000 AACS.

R 408.42 Application for specific risk insurance policy to cover specified construction site.

Rule 12. An applicant may make written application to the bureau of workers' disability compensation for permission to obtain a specific risk insurance policy to cover all employers on a specified construction site where the cost of construction will be more than $65,000,000.00 and the contemplated completion period will be 5 years

or less. The application shall give sufficient detail to specify the location of the proposed construction site, a breakdown of the total cost, and the contemplated completion period for the construction. After considering the application and all supportive data, the bureau shall either grant approval or advise the owner of the requirements to be met before approval is granted. The applicant shall be given 30 days from the receipt of the bureau's notice in which to comply with the requirements of the bureau. The approval for a specific risk policy is not effective until the bureau has received proof that all requirements of the bureau for issuance of a specific risk policy to cover a specified construction site have been met. The applicant, at the discretion of the director, may be granted additional time to meet the requirements for approval of a specific risk policy. A request for an extension of time shall be made in writing within the 30-day compliance period. If the bureau does not receive proof that all requirements for the approval of a specific risk policy for a specified construction site have been met within the time prescribed, then the application shall be considered withdrawn.

History: 1979 AC; 1980 AACS; 1998-2000 AACS.

R 408.42a Notice of insurance; specified construction site insurance policy.

Rule 12a. If an insurance policy is issued to cover a specified construction site where the cost of the construction will be more than $65,000,000.00 and the contemplated completion period will be 5 years or less, then the insurers shall notify the bureau on a form 400a, insurer's notice of issuance of specific risk policy, of the date upon which the employer became subject to the specific insurance policy. If the employer is a partnership, then the notice shall state the names and addresses of all the partners. If the employer is doing business under an assumed name, then the notice shall state the assumed name and the names of the parties doing business under the assumed name. If the employer is a corporation doing business through a number of divisions, then the notice shall state the name of the employer and the divisions that are covered under the specific risk policy. The specific risk carrier shall notify the bureau when the specific risk carrier receives a change of address for the employer.

History: 1980 AACS; 1998-2000 AACS.

R 408.42b Termination of insurance; specified construction site insurance policy.

Rule 12b. A notice of termination for coverage of an employer under an insurance policy covering the specified construction where the cost of construction will be more than $65,000,000.00 and the contemplated completion period will be 5 years or less, shall be reported to the bureau on form 401a, notice of termination of liability for employer under specific risk policy.

The insurer shall mail a copy of the notice to the employer. If the employer is a partnership, then the notice shall state the names and addresses of all the partners. If the employer is doing business under an assumed name, then the notice shall state the assumed name and the names of all parties doing business under the assumed name. If the employer is a corporation doing business under a number of divisions, then the

notice shall state the name of the employer and the divisions of the corporation covered by the termination. If the business changes names, then notice shall be given stating both the new and former names. Notice of termination of a policy which has expired shall not be reported when the specific risk carrier has accepted responsibility under a further or renewal policy, except for an assured's name change. The termination notice shall be filed with the bureau of workers' disability compensation at Lansing, Michigan, not less than 20 days before the effective date of any termination or cancellation of the policy with respect to the employer. The notice shall give the date of termination or cancellation of the contract or policy with respect to the employer. Termination or cancellation of the specific risk policy takes effect, with respect to the employees of the insured employer, 20 days after notice of a proposed termination or cancellation is received by the bureau of workers' disability compensation.

History: 1980 AACS; 1998-2000 AACS.

R 408.43 Employer self-insured application; combinable entities.

Rule 13. (1) An employer who applies for the authority to become an individual self-insurer shall apply to the bureau on form 402.

(2) The initial and annual renewal application shall contain answers to all questions, shall include all requested supporting information, as directed, and shall be sworn to by an authorized representative of the employer whose signature is notarized.

(3) Separate legal entities may be self-insured under a single authority if they are majority-owned by the self-insured entity submitting the application or if the same person or group of persons owns a majority interest in each entity on a single application. "Majority interest" of a corporation means ownership of a majority of the voting stock or authority to appoint a majority of directors, if there is no voting stock. "Majority interest" of a partnership means majority partnership interest by the same person or group of persons. "Majority interest" in a limited liability company means majority member ownership by the same person or group of persons.

History: 1979 AC; 1980 AACS; 1984 AACS; 1998-2000 AACS.

R 408.43a Employer individual self-insurer; surety bond or letter of credit; consideration of employer in business less than 5 years; excess liability Insurance; required guaranties; claims service companies; self-administered claims.

Rule 13a. (1) A nonpublic self-insurer may be required to furnish a surety bond or letter of credit. The bureau will establish the amount of security at the time of initial application. The bureau shall review the adequacy of security periodically. The bureau shall prescribe the format and language of the bond or letter of credit. The bureau shall accept surety bonds only from a surety writer authorized to transact security bond business in Michigan. A surety bond shall provide for 60 days' notice of cancellation to the bureau. Letters of credit are administered under R 408.43q.

(2) An employer that is in business less than 5 years shall not be considered for self-insured authority unless its workers' disability compensation liability will be guarantied by a parent corporation or combinable affiliated entity that has been in

business not less than 5 years and that would qualify for self-insured authority in Michigan.

(3) The bureau shall require specific excess liability insurance, with policy limit and retention acceptable to the bureau, for every self-insured employer, unless the bureau, at its discretion, waives the requirement. The bureau may require aggregate excess liability insurance as a condition of approval for a self-insured employer. Specific and aggregate excess liability insurance policies are accepted under R 408.43k.

(4) Parent corporations shall guaranty all liability incurred by their self- insured subsidiaries under the workers' disability compensation act, unless the bureau, at its discretion, waives the requirement. The bureau shall prescribe the form and substance of the guaranties. The bureau may require employers, combinable under a single self-insured authority, to execute workers' disability compensation payment guaranties as a condition for approval of the self-insured authority. The bureau shall prescribe the form and substance of the guaranties.

(5) A self-insurer approved under section 418.611(1)(a) of the act shall contract with a claims service company approved by the bureau under R 408.43m.The bureau may approve a self-insurer to self-administer claims if the employer has all necessary systems, processes, and reporting capabilities and can demonstrate it has employed competent claims personnel with Michigan workers' compensation adjusting experience.

History: 1980 AACS; 1998-2000 AACS; 2007 AACS.

R 408.43b Employer individual self-insurer; compliance with bureau requirements; notice; additional time; certification; renewal application.

Rule 13b. (1) If the agency approves an initial application of an employer to be an individual self-insurer, then the approval shall be in writing. The approval letter shall contain the excess liability insurance terms, bond, letter of credit, and guaranties required by the agency as a condition of the self-insured authority. The employer has 30 days from the receipt of the agency's notice in which to comply with the requirements of the agency. The self-insured authority shall not become effective until the agency has received proof that all requirements of the agency for self- insured authority have been met.

(2) The employer may, at the discretion of the agency, be granted additional time to meet the requirements for the self-insured authority. An employer shall make a request for an extension of time in writing within the 30-day compliance period. If the agency does not receive proof that all requirements for the self-insured authority have been met within the time prescribed, then the application shall be considered withdrawn.

(3) The agency will issue a letter certifying self-insured authority to the employer when the employer meets the requirements of the agency. The self-insured authority for all approved employers expires on the designated renewal date, which shall not be more than 12 months from the effective date of the authority. A self-insured employer shall submit a renewal application (form 402R) and requested documents, including a current financial statement and loss information, to the agency 30 days before the expiration of the self-insured authority. Upon receipt of a renewal application, the authority shall be extended until denied or approved for an additional 12 months.

History: 1980 AACS; 1998-2000 AACS; 2013 AACS.

R 408.43c Financial, loss experience and liability exposure analysis; notice of denial or termination.

Rule 13c. (1) The bureau may decline to approve an application for, or may terminate the self-insured authority if an employer is unable to demonstrate a position of reasonable solvency and the ability to pay benefits as prescribed in the act. The bureau analysis of each nonpublic employer application shall include a review of the employer's financial position and operating results.

Standard financial ratio analysis and comparison to similar industry statistical data will be considered in the financial position analysis. Other information relevant to the applicant's financial ability, including but not limited to the following, will be considered:

(a) The historical operating results.

(b) Evaluation of financial trends.

(c) Banking relations.

(d) Contingent liabilities.

(e) Pending litigation.

(f) Corporate guaranties.

(g) Management team continuity and experience.

(h) General and specific industry economic conditions.

(i) Legal structure.

The bureau's analysis of the employer's loss experience and liability exposure shall include but is not limited to the following:

(a) Claims for not less than 3 policy years broken down by paid, reserve, and total incurred amounts.

(b) Number of employees.

(c) Payroll code classifications.

(d) Excess liability insurance policy terms will be required and considered in the determination of financial ability.

(2) The bureau shall mail notice of a denial or termination of self-insured authority to the employer. The notice shall include the grounds for denial or termination. The employer may request a hearing in accordance with section 418.611(5) of the act and R 408.43n.

History: 1980 AACS; 1998-2000 AACS.

R 408.43d Group self-insurers; application.

Rule 13d. Application for group coverage, as contemplated in section 611 of the act for the express purpose of establishing a group self-insurers' fund, to be administered under the direction of an elected board of trustees and to provide workers' compensation coverage for a group of private employers in the same industry or for public employers of the same type of unit, shall be made to the bureau. The application shall be made on a form prescribed by the bureau and shall contain answers to all questions. Answers shall be given under oath.

History: 1980 AACS.

R 408.43e Group self-insurers; new and renewal application requirements.

Rule 13e. (1) A new application, as submitted by the initial board of trustees of the self-insurer's fund, shall be accompanied by all of the following:

(a) A copy of the approved bylaws of the proposed group self-insurers' fund.

(b) An original signed individual member application approved by the board of trustees for each member of the group applying for coverage in the fund.

(c) A current financial statement of each member of a private self-insurers' group that, taken collectively, shows both of the following:

(i) The combined net assets of all members applying for coverage on the inception date of the fund, which shall not be less than $1,000,000.00.

(ii) Working capital, which shall be in an amount that establishes the financial strength and liquidity of the business.

(d) A composite listing of the estimated standard premium to be developed by each member of the group individually and in total as a group.

(e) Proof of payment by each member of not less than 25% of the estimated annual standard premium into a designated depository.

(f) An excess insurance policy which is issued by an authorized carrier in an amount acceptable to the bureau and which is in compliance with the requirements set forth in R 408.43k.

(g) A copy of a signed service agreement that designates an approved service company.

(h) A copy of the current contract or agreement between the trustees and the administrator if one is used.

(i) Proof of a fidelity policy in a form and amount acceptable to the bureau.

(j) If required, a surety bond written by an authorized carrier or other security in a form and amount acceptable to the bureau.

(k) In the case of a private employer's group, an indemnity agreement jointly and severally binding the group and each member of the group to comply with the provisions of the act. The indemnity agreement shall conform to an indemnity agreement as approved by the bureau.

(l) A breakdown of all rates by code classification that will be used by the group fund to develop final audited premium, including an exhibit that shows all administrative expenses as a percentage of estimated final audited premium and loss fund developed under the aggregate excess contract as a percentage of final audited premium.

(m) The trustees shall provide proof, satisfactory to the bureau, that the annual gross premiums of the fund will be not less than $500,000.00.

The premium collected from each member shall be based upon applying the appropriate manual rates per payroll code classification as approved by the bureau and the excess carrier. The premium collected from each participant in a group self-insurance program shall be adjusted by an experience modification formula approved by the bureau. The total premium collected from all participants shall be sufficient to fund the loss fund developed under the excess insurance contract and the

total administrative expenses of the group fund. A written excess insurance policy shall confirm that the rate structure proposed by the aggregate excess insurer will be used by the group fund to develop the loss fund under the aggregate excess contract. The loss fund shall be 75% of final audited premium or as approved by the bureau.

(n) Proof, satisfactory to the bureau, shall be provided to prove that the fund has, within its own organization, ample facilities and competent personnel to service its own program with respect to underwriting matters and loss control services or the fund shall contract with an approved service company to provide the services. An approved service company shall be used to handle claims adjusting and reporting of loss data to the bureau.

(2) Each group fund shall submit a renewal application to the bureau 30 days before the expiration of the self-insurance privilege, together with the terms of renewal for the excess insurance contract. Upon receipt of the renewal application, the self-insurance privilege shall be extended until it has been acted upon by the director. The application shall be accompanied by all of the following:

(a) Evidence of the financial ability of the group to meet its obligations under the act.

(b) Confirmation of an excess insurance policy which is issued by an authorized carrier in an amount acceptable to the bureau and which is in compliance with the requirements set forth in R 408.43k. With the approval of the director and after meeting all requirements the director imposes, a group self-insurance fund may use a letter of credit in place of aggregate excess insurance if the fund gives the bureau 6 months' notice of its intent to use a letter of credit.

(c) A copy of a signed service contract which designates an approved service company, which provides for claims administration and reporting of loss data to the bureau, and which may include underwriting and loss control services, unless approval has been granted to self-administer claims.

(d) Proof of a fidelity policy in a form and amount acceptable to the bureau.

(e) A breakdown of all rates by code classification that will be used by the group fund to develop final audited premium. If aggregate excess insurance is required by the bureau, the rates used by the fund to develop final audited premium shall be the rates used by the aggregate excess insurer and shall be included as an exhibit to the aggregate excess insurance policy. In addition, an exhibit that shows all administrative expenses as a dollar amount and a percentage of estimated final premium and the loss fund developed under the aggregate excess contract as a percentage of final audited premium shall be provided.

(f) A copy of the current contract or agreement between the trustees and the fund administrator, if one is used.

(g) Proof provided by the trustees that the premium collected from each member shall be based upon applying the appropriate manual rates per payroll code classification as approved by the bureau and the excess insurance carrier or consulting actuary. Each member's premium shall be experience rated. The experience modification formula shall be approved by the bureau. The total premium collected from all participants shall be sufficient to fund all administrative expenses and the estimated loss fund developed under the excess insurance contract. The loss fund shall be 75% of

final audited premium or as approved by the bureau. If a letter of credit is used in place of aggregate excess insurance, the fund shall collect sufficient premiums to fund the ninetieth percentile confidence level of losses, as calculated by a consulting actuary, and all administrative expenses. If a public employer group fund operates with specific excess insurance only, the fund shall collect sufficient premiums to fund the ninetieth percentile confidence level of losses, as calculated by a consulting actuary, and all administrative expenses of the fund.

(h) If the fund intends to provide underwriting and loss control services, the fund shall provide proof that the fund has ample facilities and competent personnel to service the programs.

(i) If the fund requests approval to self-administer claims, then all of the following:

(i) Proof that the fund has been in operation not less than 5 years.

(ii) Proof that the fund has annual collected premium of more than $10,000,000.00.

(iii) A written document in which the fund agrees to all of the following provisions:

(A) The fund will demonstrate that the estimated cost of self-administration of the claims program will be fully funded by premium collections.

(B) The fund will demonstrate that it has ample facilities and competent staff, including licensed adjusters with workers' compensation qualifications under chapter 12 of Act No. 218 of the Public Acts of 1956, as amending, being S500.1201 et seq. of the Michigan Compiled Laws, who will be handling the workers' compensation claims.

(C) That the claims-handling function will be subject to an annual independent audit of all established cases and operational processes. The independent auditor will meet guidelines established by the bureau.

(D) That annually, the fund administrator will provide a written assertion to the fund's independent certified public accountant that the fund's claim-paying function maintains an effective internal control structure over financial reporting as of the fund's fiscal year end. The fund's independent certified public accountant shall issue a report on the administrator's assertion in accordance with statements on standards for attestation engagements No. 2 (SSAE#2), as amended.

(E) The group fund will furnish loss data in a form acceptable to the bureau and the excess carrier.

(F) That failure to provide accurate and timely payment of claims or failure to meet the requirements of self-administered claims may result in termination of approval to self-administer claims.

(G) That the excess insurer will provide documentation of its approval of the group fund's self-administration of claims.

History: 1980 AACS; 1984 AACS; 1996 AACS; 1997 AACS.

R 408.43f Group self-insurance; same industry requirement; approval; review; certificate.

Rule 13f. (1) After considering an application for group self-insurance and all supportive data, the bureau shall either grant approval or advise the trustees of the self-insurers' group of the requirements to be met before approval is granted. In

determining whether private employers are in the same industry, the bureau may use the standard industrial classification codes assigned to each employer applying for membership in the group. The bureau shall also consider all information available on the nature of the business of each private employer and may require the group fund to present additional evidence, either oral or written, to verify that all employers applying for membership in the group fund meet the statutory requirement of being in the same industry. The group shall be given 30 days from the receipt of the bureau's notice in which to comply with the requirements of the bureau. The self-insured authority shall not become effective until the bureau has received proof that all requirements of the bureau for self-insured approval have been met.

(2) The group may, at the discretion of the director, be granted additional time to meet the requirements for the self-insured program. A request for an extension of time shall be made in writing by the group within the 30-day compliance period. If the bureau does not receive proof that all requirements for the self-insured program have been met within the time prescribed, the application shall be considered withdrawn.

(3) On new and renewal applications, the bureau may require evidence that the proposed rate for each payroll classification is adequate to cover expected losses for that payroll classification and evidence that the experience rating formula will be actuarially sound. The bureau shall take all of the following factors into account before granting approval for a group self-insurance program:

(a) Past and anticipated losses.

(b) Proper reserves for reported and unreported losses.

(c) Past surplus and expected increase in benefit levels.

(d) Administrative costs.

The bureau may contract with a consulting actuary, at the expense of the group fund, to determine if the proposed group self-insurance program will be actuarially sound.

(4) Upon meeting the requirements of the bureau, the group shall receive a formal certificate approving its status as a self-insurer. The certificate shall expire 12 months after the effective date of approval.

History: 1980 AACS; 1984 AACS; 1996 AACS.

R 408.43g Group self-insurers' admission of new members; termination of individual members; notice; records.

Rule 13g. (1) After the inception date of the fund, prospective new members of the fund shall submit an application for membership to the board of trustees, or its designated representative, on a form approved by the bureau. The board of trustees or its designated representative may approve the application for membership pursuant to the bylaws of the group self-insurers' fund. The original signed application for membership shall then be filed with the bureau in Lansing. Membership shall take effect after approval by the bureau.

(2) After a group fund has completed 1 year of operation, application may be made to the director to authorize the group fund to accept new members without prior bureau approval. The application shall be submitted on forms provided by the

bureau and shall define all businesses that will be accepted in the same industry within the group. The application shall define the financial standards that will be applied by the group in accepting new members.

(3) If approved, the group shall submit confirmation of membership to the bureau on form 650, group self-insurance fund notice of acceptance of membership, together with a copy of the individual membership application and the financial report provided by the member. If the employer is a partnership, the notice shall state the names and addresses of all the partners. If the employer is doing business under an assumed name, the notice shall state the assumed name and each Michigan location covered. If the employer is a corporation doing business through a number of divisions, the notice shall state the names of all the divisions of the corporation. The bureau shall be notified when any group fund receives a change of address of a member.

(4) Individual members may elect to terminate their participation in a group self-insurers' program or be subject to cancellation by the group pursuant to the bylaws of the group fund. However, termination or cancellation shall take place not less than 20 days after the bureau has received notice of the termination or cancellation from the group fund reported to the bureau on form 651, group self-insurance fund notice of termination of membership. If the employer is a partnership, the notice shall state the names and addresses of all the partners. If the employer is doing business under an assumed name, the notice shall state the assumed name and the names of all parties doing business under the assumed name. If the employer is a corporation doing business under a number of divisions, the notice shall state the names of all the divisions of the corporation. If a business changes names, notice shall be given stating both the new and former names.

(5) The chairman of the board of trustees or, at the chairman's designation, the administrator shall be responsible for maintaining all records of the fund. The fund shall maintain all of the following documents with respect to records:

(a) Forms 100, 101, 102, 701, and 107.

(b) Redemption papers.

(c) Excess workers' compensation policies.

(d) Spreadsheets containing premium audit summaries.

(e) Contracts with the group's claims service and administrator.

(f) A complete set of claim loss runs as of the end of each fiscal year.

(g) Certified audit reports.

(h) Minutes of trustee and annual meetings.

(i) Group renewal applications and related documents.

(j) Individual membership applications containing signed indemnity agreements.

The records shall be retained for not less than 30 years and the administrator or board of trustees shall know the location of the records at all times. All records of the fund are the property of the fund. If the records are held by the funds service company, the records shall immediately be surrendered to the fund upon the fund's request.

History: 1980 AACS; 1984 AACS; 1996 AACS.

R 408.43h Group self-insurance; reports and filings.

Rule 13h. (1) The group shall make all reports and filings required of carriers by the act. In addition, the group fund shall comply with all of the following provisions:

(a) The financial position of the group fund shall be reported, by the trustees or their designated representative, on a quarterly basis for each open fund year. The report is due within 30 days after the quarter ends.

The format for the report may be prescribed by the bureau. A fund year shall be considered open as long as there are unsettled claims. The annual financial statements shall be audited by a certified public accountant and filed with the bureau within 180 days after the fund year ends. If a fund ceases to provide coverage on an ongoing basis, annual audited financial statements shall be provided to the bureau within 180 days of the end of the fund's fiscal year.

(b) The fund shall file summary loss data, in a manner prescribed by the bureau, on each fund year within 30 days after the evaluation date.

Losses shall be evaluated on a monthly basis or as required by the bureau.

(c) The fund shall file a copy of the minutes of all trustee meetings with the bureau within 30 days after the meeting.

(d) The fund shall provide reports or filings on payroll audits, investments, experience rating, or any other information concerning the group fund upon specific request of the bureau.

(e) An authorized representative of the fund shall sign All financial reports and minutes submitted.

(2) A fund that fails or refuses to file the reports specified in this rule within the time limits prescribed may be notified that its authority to be self-insured will be terminated. If a fund's authority is terminated, then the fund shall be notified of the grounds for termination.

The fund may request a hearing in accordance with R 408.43n.

History: 1980 AACS; 1984 AACS; 1996 AACS; 1997 AACS.

R 408.43i Group self-insurer's fund; board of trustees' power and duties; investment restrictions.

Rule 13i. To ensure the financial stability of each group self-insurers' fund, a board of trustees of each fund shall be responsible for all operations of the fund. A board of trustees shall be a group of members elected by the membership of the fund for stated terms of office. The majority of the trustees shall be owners or employees of members of the self-insurers' fund, but a trustee shall not be an owner, officer, or employee of a service company. The board of trustees of each fund shall take all necessary precautions to safeguard the assets of the fund, including all of the following:

(a) Designate a trustee as administrator or, in the alternative, hire an employee or designate an individual to act as the group fund administrator. The trustees may delegate to the administrator the duties they determine proper. The duties may include, but are not limited to, advising the board with regard to any of the following:

(i) Contracting with a service company.

(ii) Determining the premium charged.

(iii) Investing surplus monies, subject to the restrictions set forth in this rule.

(iv) Accepting applications for membership. However, the board of trustees remains the responsible party for the operation of the fund. The duties delegated to the administrator and all compensation to be paid to the administrator shall be reduced to writing, and a copy shall be provided to the agency with each annual group renewal application. The group fund administrator shall not be an owner, officer, or employee of a service company. The trustees shall purchase a fidelity policy covering the fund trustees, administrator, employees of the fund, and the service company in an amount sufficient to protect the assets of the fund. A copy of the fidelity policy will be provided to the agency with each annual renewal.

(b) Limit disbursements to payment and expenses of handling claims and administrative expenses necessary for operating the fund. The board of trustees shall also establish necessary accounts and accounting procedures for control and accurate financial reporting. Established accounting procedures shall provide accurate financial information for each open year individually with respect to revenue and expense until the year is closed out. The board of trustees shall maintain, and be responsible for, all records and documents relating to the formation and ongoing operation of the group self-insurance fund. If the board of trustees does not maintain the records in a responsible manner and in accordance with these rules, then the self-insured approval of the fund may be terminated by the director.

(c) Audit the accounts and records of the fund annually or at any time required by the agency. Audits shall be made by certified public accountants or by authorized representatives of the agency. The agency reserves the right to prescribe the type of audits to be made and the uniform accounting system to be used by the self-insurers' fund to enable the agency to determine the solvency of the group self-insurers' fund. Copies of financial audits prepared by certified public accountants shall be filed with the agency in Lansing within 180 days after the close of the fund year. Claim reserve audits used in support of surplus distribution requests shall be performed by auditors who meet the requirements of the agency relating to independence, report content, and timing.

(d) Not extend credit to individual members for payment of premium.

(e) Apply a penalty rate in excess of the normal premium to any risk that has unfavorable loss experience, if the member and the agency are notified in writing before the effective date of the change in rates.

(f) Not utilize any of the monies collected as premiums for any purpose unrelated to workers' compensation. Further, the board of trustees shall not borrow any monies from the fund or in the name of the fund without advising the agency of the nature and purpose of the loan and obtaining agency approval. The board of trustees may, at its discretion, invest any surplus monies not needed for immediate cash needs, but the investments shall be limited to United States government bonds, United States treasury notes, United States government agency issues, United States government-sponsored enterprises, investment share accounts in any savings and loan association and credit unions that have their deposits insured by a federal agency, and certificates of deposit issued by a duly chartered commercial bank. Deposits in savings and loan associations, credit unions, and commercial banks shall be limited to institutions in this state and shall not exceed the federally insured amount in any 1 account, except that the federally insured amount in

any 1 account in a commercial bank may be exceeded if the account amount involved does not exceed either of the following factors:

(i) Five percent of the combination of surplus and undivided profits and reserves as currently reported for each bank in the state in the banking division annual report of the office of financial and insurance regulation.

(ii) Five hundred thousand dollars per institution. A group self-insurance fund shall not invest in mutual funds, except that investments in money market mutual funds of short-term duration which invest only in government agency issues, government-sponsored enterprises, and government bills, bonds, and notes will be allowed for short-term cash investment needs. As used in this paragraph, "short-term duration" means 180 days or less.

(g) The board of trustees of a group self-insurance fund, subject to the limitations set forth in subdivisions (h), (i), and (j) of this subrule, may, in its discretion, and upon contracting with a bank trust department or with a professional investment advisor registered with the securities and exchange commission under the investment advisors act of 1940, 15 U.S.C. '80B-3, invest monies not needed for immediate cash needs in corporate bonds and municipal bonds and common and preferred stock.

(h) Limit the combined holdings of corporate and municipal bonds to not more than 45% of the market value of the available investment portfolio. Corporate and municipal bonds must be (A) rated or better by at least 2 nationally recognized rating services. Holdings in any 1 corporation or municipality shall not be more than 5% of the total amount eligible for investment in corporate and municipal bonds as set forth in this subrule.

(i) Of the 45% of the market value of the investment portfolio available for investment in municipal or corporate bonds, 25% may be invested in common or preferred stocks. Common or preferred stocks shall be limited to publicly owned companies that trade on a United States regulated exchange. Mutual funds or bank pooled funds that invest in common or preferred stocks are permitted and shall be calculated as part of the percentage of market value available for investment in common and preferred stocks.

(j) Ensure that the professional investment advisor completes a compliance review of the investment portfolio on a quarterly basis. A copy of the investment review shall be provided to the fund and the agency within 30 days of the close of each quarter. The annual financial statements shall be audited by a certified public accountant and shall include a certification as to whether the fund has been in compliance with the requirements for investments. Failure to report on investments as required by this rule may result in withdrawal of the authority to invest in corporate and municipal bonds and/or common and preferred stocks.

(k) Any group fund found to have investments in vehicles other than as provided by this rule shall be given 30 days or a time period approved by the director to divest themselves of the investments. Failure to meet the divestiture requirement may subject the fund to further sanction by the director.

History: 1980 AACS; 1984 AACS; 1996 AACS; 1997 AACS; 2003 AACS; 2007 AACS; 2013 AACS.

R 408.43j Group self-insurers' funds; advance premium discounts; surplus monies; surplus investment income and premiums; unfunded claims.

Rule 13j. (1) The trustees of any group self-insurers' fund shall not authorize advance premium discounts to any member in excess of those authorized by the excess insurance underwriter and approved by the bureau.

If discounts are approved by the excess carrier and the bureau, the excess carrier shall agree to base the loss fund on the premium collected after discount.

(2) Any surplus monies for a fund year in excess of the amount necessary to fulfill all obligations under the act for that fund year, including a provision for claims incurred but not reported, may be declared to be refundable by the trustees at any time, and the amount of the declaration shall be a fixed liability of the fund at the time of the declaration. The date of payment shall be as agreed to by the trustees and the bureau, except that monies not needed to satisfy the loss fund requirements, as established by the aggregate excess contract, may be refunded immediately after the end of the fund year with the approval of the bureau. The intent of this rule is to ensure that sufficient monies are retained so that total assets are greater than total liabilities for each fund year.

(3) If premiums collected and earned investment income associated with any fund year are insufficient to completely fund all reported claims and expenses for that year, unfunded amounts, by fund year, shall be reported immediately to the bureau with the proposed plan to achieve 100% funding.

The plan to achieve 100% funding for all claims is subject to bureau approval. A plan may include, but is not limited to, all of the following:

(a) Use of premiums collected in other fund years, but not necessary for payment of claims or expenses in the year collected.

(b) Use of investment earnings associated with other fund years, but not necessary for payment of claims or expenses in the year in which associated.

(c) Assessment of members by order of the bureau.

(4) The bureau may allow investment income earned by a group self-insurance fund during a calendar year to be returned to the fund membership without prior bureau approval if the fund trustees provide all of the following documentation:

(a) Certification, to the bureau, in the form of a letter from a certified public accountant, attesting to the amount of investment income earned during the calendar year.

(b) Certification to the bureau, by the board of trustees, of the amount of the investment income and of the employers to whom the investment income is to be distributed.

(c) Certification by the board of trustees and the group's certified public accountant that, after the distribution of investment income, the aggregate retention in the current fund year, as determined by the group's excess insurance carrier, and all administrative expenses will be fully funded.

(d) If the fund operates with specific excess insurance only or a letter of credit in place of aggregate excess insurance, the board of trustees and the group's certified public accountant shall certify that, after the distribution of investment income, ultimate loss, as calculated by a certified actuary at a 90% confidence level, and all administrative expenses will be fully funded.

(e) Certification by the board of trustees and the fund's certified public accountant that the fund's financial statements are not discounted and do not consider the time value of money.

The information specified in subdivisions (a) to (e) of this rule shall be received by the bureau not earlier than December 1, and not later than December 31, of the calendar year in which the investment income is earned and is to be distributed. If the information specified in this rule is not received by the bureau in a timely manner, then the bureau may withdraw the fund's privilege of returning investment income to fund members without prior bureau approval.

History: 1980 AACS; 1984 AACS; 1996 AACS.

R 408.43k Aggregate excess liability insurance; specific excess liability insurance; individual self-insurer; group self-insurer.

Rule 13k. The bureau shall not recognize a policy of aggregate or specific excess liability insurance in considering the ability of a self-insurer to fulfill its financial obligations under the act, unless the policy is issued by a casualty insurance company authorized, as defined in section 108 of PA 218, MCL 500. to transact such business in this state. The policy shall comply with all of the following provisions unless specifically waived by the bureau. Policies issued that do not comply with all provisions of this rule may be considered grounds for termination of the employer's self-insured authority.

(a) The policy shall not be cancelable or nonrenewable unless written notice, sent by courier, registered mail or certified mail, is given to the other party to the policy and to the bureau not less than 60 days before termination by the party desiring to cancel or not renew the policy.

(b) The policy shall contain no endorsements, provisions, or terms that increase the named insured or insureds retentions or increase the amount that must be paid by the named insured or insureds beyond the retentions reported on the declarations page of the policy and the Michigan certificate of specific/aggregate excess liability insurance. This provision does not apply to customary policy language that may call for increased payments by the insured or insureds for failure to act or abide by a policy provision.

(c) A policy that has any type of commutation clause shall provide that any commutation effected under the policy shall not relieve the casualty insurance company of further liability with respect to claims and expenses unknown at the time of the commutation or in regard to any claim apparently closed at the time of initial commutation that is subsequently reopened by or through a competent authority. If the casualty insurance company proposes to settle its liability for future payments payable as compensation for accidents occurring during the term of the policy by the payment of a lump sum to the employer, to be fixed as provided in the commutation clause of the policy, then the casualty insurance company or the company's agent shall give the bureau not less then 30 days' prior notice of the commutation. Notice shall be by courier, registered mail or certified mail. If any commutation is affected, then the bureau has the right to direct that the sum be placed in trust for the benefit of the injured employee or employees entitled to future payments of compensation.

(d) The policy shall state that if a private self-insured employer becomes insolvent and is unable to make compensation payments and the self-insurers' security fund may have responsibility for making payment under section 537 of the act, then the excess insurance carrier shall make, directly to the claimants or their authorized representatives, payments as would have been made by the excess insurance carrier to the employer after it has been determined that the retention level has been reached on the excess liability insurance policy.

(e) The policy shall state that 100% of the following payments shall be applied toward reaching the retention level in the specific and aggregate excess liability policy:

(i) Benefit payments made by the employer as required in the act.

(ii) Benefit payments, as required in the act that are due and owing to claimants of the employer.

(iii) Benefit payments made on behalf of the employer, as required in the act, by a surety under a bond or through the use of other security required by the director.

(iv) Payments made by the self-insurers' security fund.

(v) Usual and customary claims allocated loss adjustment expenses.

(vi) Payments made, as specified in paragraphs (i), (iii), (iv) and (v) of this subdivision, that are reimbursable by the specific excess liability policy shall not be considered in reaching the aggregate excess liability retention.

(f) The policy shall provide for 100% reimbursement of the following payments that exceed the retention levels as defined in the specific or aggregate excess liability policy: (i) Benefit payments made by the employer as required in the act.

(ii) Benefit payments made on behalf of the employer as required in the act by a surety under a bond or through the use of other security required by the bureau.

(iii) Payments made by the self-insurers' security fund.

(iv) Usual and customary claims allocated loss adjustment expenses.

(g) Reimbursement shall be pro rata if multiple excess insurers insure the same self-insured for the same period. A request to waive a provision of this rule shall be in writing and approved by the bureau before a policy is issued. The carrier shall confirm issuance of an aggregate or specific excess liability policy on a form prescribed by the bureau.

History: 1980 AACS; 1984 AACS; 1989 AACS; 1996 AACS; 1998-2000 AACS; 2007 AACS.

Editor's Note: An obvious error in R 408.43k was corrected at the request of the promulgating agency, pursuant to Section 56 of 1969 PA 306, as amended by 2000 PA 262, MCL 24.256. The rule containing the error was published in Michigan Register, 2007 MR 4. The memorandum requesting the correction was published in Michigan Register, 2007 MR 10.

R 408.43m Servicing self-insured employers or groups; application; requirements; noncompliance.

Rule 13m. (1) An individual, partnership, limited liability company, or corporation that desires to engage in the business of providing 1 or more services for an individual self-insurer or a self-insurers' group shall apply to the bureau before entering into a contract with the individual or group self-insurer and shall satisfy the bureau that it has adequate facilities and competent staff with Michigan workers'

compensation adjusting experience within the state to service a self-insured program in a manner that fulfills the employers' obligations under the act and the rules of the bureau. Workers' compensation claims of Michigan individual or group self-insured employers shall be handled within the state of Michigan by its staff, except that the director, at his or her discretion, may permit an approved service company to handle the claims of a Michigan individual self-insurer outside of this state upon specific written request by the individual self-insurer and the service company. The request for permission shall set forth documentation sufficient to the agency that claims will be handled pursuant to Michigan law, administrative rules, and agency policy. The director will respond to the request in writing, giving the reasons for denial, or if approved, the conditions of approval. The approval may be withdrawn by the director at any time based upon the failure of the service company and/or employer to comply with the conditions of the approval. Service may include claims adjusting, loss control services, underwriting, and the capacity to provide required reporting. Any individual, partnership, limited liability company, or corporation that provides claims adjusting or loss control services to an approved self-insured employer, where the self-insured employer has designated within its own organization an individual to be responsible to the bureau for its claims program or loss control services, or both, shall not be considered a service company for purposes of this rule.

(2) An applicant shall apply to the bureau for approval to act as a servicing company for self-insured employers or group funds on a form prescribed by the bureau. The application shall contain answers to all questions. An applicant shall give the answers under oath. The bureau shall approve the application prior to the service company entering into a contract with an approved self- insurer. Approval to act as a service company for self-insurers is granted for a period of 1 year and is subject to renewal annually.

(3) If a service company seeks approval to service claims for self-insurers, then it shall submit proof that it has, within its organization at least 1 person who has the knowledge and Michigan workers' compensation adjusting experience necessary to handle claims involving the act. The service company shall attach a resume covering the principal person's background to the application of the service company. The principal individuals adjusting workers' compensation claims shall hold a current workers' disability compensation adjuster's license under chapter 12 of 1956 PA 218, MCL §500.1201.

(4) If a service company seeks approval to provide underwriting service to self-insurers, then it shall submit proof that it has, within its organization or under contract on a full-time basis, at least 1 person who has the knowledge and experience necessary to provide underwriting services for workers' compensation excess liability insurance coverage. The service company shall attach a resume detailing the principal person's background to the application of the service company.

(5) If a service company seeks approval to furnish loss control services to self-insurers, then it shall submit proof that it has, within its organization or under contract on a full-time basis, at least 1 person who has the knowledge and background necessary to adequately provide loss control and health services.

(6) A service company shall maintain adequate staff in the state. The service company shall authorize staff to act for the service company on all matters covered by the act and the rules of the bureau.

(7) A service company shall attach to the application a copy of its standard service agreement that it will enter into with self-insured employers or group funds. The service company shall certify, in writing, that the service agreement is in compliance with the act and these rules. The service company shall certify, and include a provision in its standard service contract which states, that the contract provides for the handling of all claims with dates of injury or disease within the contract until conclusion of the claims, unless the service company is relieved by the bureau, in writing, of the responsibility for handling claims. If the service contract calls for additional fees for any reason, then the service company shall clearly define the additional fees in the contract. For a service company to be relieved of the responsibility of handling claims to conclusion, the client, the previous service company, and the new service company shall sign a claims transfer agreement. The claims transfer agreement shall be completed on a form prescribed by the bureau and shall include a written request made by the previous service company to be relieved of its claims handling responsibilities to the bureau. A requesting company is relieved of its claims handling responsibility only after receiving a written response from the bureau approving a request. The service company shall certify that it will report to the specific excess insurance carrier or aggregate excess insurance carrier, or both, and put the specific excess insurance carrier or aggregate excess insurance carrier, or both, on notice of all claims as required by the self-insurers' or group self-insurers' insurance policies. The standard service contract filed with the bureau for approval and renewal of the service company authority shall include language specifically stating that the service company is responsible for reporting to the excess insurance carrier. The bureau may waive the reporting requirement upon written request to the bureau. Any dispute involving late reporting of excess liability insurance claims and potential penalties shall be reported to the bureau immediately.

(8) A service company shall certify, and provide for in all service contracts, that all documents generated or prepared by the service company for the group or the individual self-insurer or any materials relating to an individual or group self-insurer held by a service company are the property of the individual or group self-insurer and shall be surrendered to the individual or group self-insurer within 10 days of termination of the service contract, subject to written request by the individual or group self-insurer.

(9) Failure to comply with the provisions of the act constitutes good cause for withdrawal of the approval to act as a service company for self-insurers. The bureau shall give 30 days' notice of withdrawal. The bureau shall give the notice by certified or registered mail, upon all interested parties.

History: 1980 AACS; 1984 AACS; 1996 AACS; 1998-2000 AACS; 2007 AACS.

R 408.43n Hearing before director; self-insured status, individual and group fund; group fund rates, membership applications, security requirements, and surplus refunds.

Rule 13n. (1) Upon receiving a notice of intent to deny or terminate self- insured status under section 611 of the act, a party may request a hearing before the director within 15 days of the mailing of the notice by the bureau.

Upon receiving a notice denying a request by a group fund for deviation from manual rates, denial of an individual membership application or security requirement, or a denial of a request for a refund of surplus, the group fund may request a hearing before the director within 15 days of the mailing of the notice by the bureau.

(2) The director shall, by certified or registered mail, notify the appealing party of the date, time, place, and reasons for holding the hearing. The director shall mail the notice not less than 15 days before the hearing. If the intent to terminate self-insured status is based on the self-insurer's failure to maintain existing security requirements, then the notice shall advise the self-insurer that proof of reinstatement of the security shall accompany the request for hearing or the director may make a final decision on the termination without further hearing.

(3) If an appearance is made at a hearing, then it shall be made in person by a duly authorized representative or by counsel.

(4) A person who has been served with a notice of hearing may, at his or her option, file a written statement before the date set for hearing or may appear at the hearing and present an oral statement and other evidence on the issues contained in the notice of hearing. When written briefs or arguments are presented, a copy shall be served upon the director and other interested parties not less than 5 days before the date set for the hearing.

(5) If the person or persons who have requested a hearing fail to appear at a noticed hearing, the director may consider the request for a hearing as having been abandoned or, in his or her discretion, may proceed with a hearing of the case and may, on the evidence presented, make a decision.

(6) A hearing shall not be adjourned or continued, except upon an order of the director.

History: 1980 AACS; 1996 AACS; 1998-2000 AACS.

R 408.43o Rescinded.

History: 1980 AACS; 1988 AACS; 1996 AACS.

R 408.43p Enforcement by director of order of denial or termination of self-insured status; circuit court relief.

Rule 13p. If the director has probable cause to believe that an order denying or terminating self-insured status is being violated, or that an employer who is approved or has been previously approved as a self-insured is liquidating or may be about to liquidate and distribute its assets to its stockholders or to its members without providing for its obligation as a self-insured employer to pay or arrange for the payment of compensation and benefits as directed by chapter 6 of the act, the director may, through the attorney general of the state, cause a petition to be filed in

the circuit court of Ingham County or the county in which such person does business to enjoin and restrain such person from engaging in such method, act, or practice.

History: 1980 AACS.

R 408.43q Irrevocable letter of credit; acceptance; requirements; payment of surety bond or letter of credit.

Rule 13q. (1) An irrevocable letter of credit may be accepted by the bureau as other security for a self-insured program as provided by section 611(1)(a) of the act. The bureau will retain discretion in each particular case to determine if the letter of credit is acceptable and if its language and format are satisfactory.

(2) Irrevocable letters of credit shall be issued by a state-chartered bank, a federally chartered bank or foreign bank. Funds shall be immediately payable on demand. The director may require confirmation of acceptable letters of credit from any state, federally or foreign chartered bank without state operations or branch services within this state. If a confirmation is required, it shall be by a State of Michigan chartered bank or federally chartered bank with Michigan branch operations and state that the confirming bank is primarily obligated on the letter of credit.

(3) An employer who elects an irrevocable letter of credit as other security for a self-insured program shall furnish a memorandum of understanding with the letter of credit, on a form provided by the bureau, which affirms the employer's acceptance of all of the following requirements:

(a) A letter of credit is furnished to the bureau instead of a surety bond as one of the requirements for approval of a self-insured program.

(b) The employer understands that the letter of credit shall be deemed automatically extended without amendment for 1 year from the expiry date or any future expiry date unless, 60 days before any expiry date, the bureau is notified, by courier, certified or registered mail, that the letter of credit shall not be renewed for any additional period.

(c) A policy of insurance or a surety bond of equal amount may be furnished at a later date as a substitute for the letter of credit if the policy of insurance or surety bond covers all claims that would have been covered by the letter of credit. All policies of insurance and surety bonds furnished as substitutes for letters of credit are subject to prior bureau approval.

(d) The employer shall affirm that the irrevocable letter of credit in the amount requested by the bureau is being offered with the understanding that if the bureau receives notice that the letter of credit will not be renewed, then the bureau, in its discretion, may, after 30 days from the date of receipt of the notice, call the proceeds of the letter of credit and deposit the proceeds in the state treasury. And further, if, in the judgment of the bureau, the letter of credit is needed to cover any worker's disability compensation claims, then the proceeds of the letter of credit shall be called immediately and deposited in the state treasury for such purpose.

(e) If legal proceedings are initiated by any party with respect to payment of any letter of credit, then the proceedings shall be subject to Michigan courts and law.

(4) The bureau shall not grant an effective date for a self-insured program until a completed letter of credit and the memorandum of understanding have been reviewed and accepted by the bureau.

(5) If it is necessary for the director, under statute and bureau rules, to call the bond or other security, then a trust shall be established with the funds, unless the provider of the bond or other security elects to handle the claims directly and the bureau approves. If a trust is established, the funds shall be deposited in the state treasury and the state treasurer, as provided by section 551(7) of the act, shall be the custodian of the trust. The trustees of the trust shall be the trustees of the funds denominated in chapter 5 of the act and also those who are appointed as trustees under section 511 of the act. The service company of the self-insured employer, if any, shall continue to perform in accordance with the terms of the employer's contract with the service company.

History: 1988 AACS; 1998-2000 AACS; 2007 AACS.

R 408.43r Public employer group funds; waiver of requirement for excess insurance.

Rule 13r. A public employer group fund may request a waiver of the requirement for excess insurance. The director shall waive the requirement for excess insurance for a public employer group fund if the fund demonstrates that it has sufficient financial strength and liquidity to assure that all obligations under the act shall be promptly met without the protection of an excess insurance policy.

History: 1987 AACS.

R 408.43s Group funds; insufficient funding; creation of trust; appointment of trustees.

Rule 13s (1) If the plan to achieve full funding for payment of all claims and expenses of the self-insurers group pursuant to rule 408.43j is not approved by the bureau, then the bureau may order the board of trustees of the self-insurers group to immediately assess the employer members of the group for the full amount of the deficiency and/or order that any surplus funds distributed to group members during the previous 12 calendar months from the date of discovery of the funding deficiency by the group fund be immediately returned.

(2) If the bureau determines that the self-insurers group ceases to provide ongoing and active coverage to its members and/or the requirements of this rule are not sufficient to secure all future liability established

by the workers disability compensation act of 1969, then the bureau may

require additional assessment of the employer members of the group and request the director to create and establish the terms of a trust, at the expense of the self-insurers group, for the deposit and administration of any assessment received and/or all assets of the self-insurers group. The trustees of the funds appointed under section 511 of the workers' disability compensation act shall be appointed trustees of the self-insurers group trust fund established under this rule.

History: 2003 AACS.

R 408.43t Group self-insurance; employee leasing.

Rule 43t. On or after the effective date of this rule, an employee leasing company approved for membership in a group self-insurance fund pursuant to MCL 418.611(2) of the workers' compensation act shall qualify as being in the same industry of the group fund if the employee leasing company meets all of the following conditions:

(a) The individual or individuals or entity or entities owning the entity or entities where the employees are or will be placed shall have a combined majority ownership interest of at least 51% in the prospective member leasing company.

(b) The leasing company shall only lease employees to entities that qualify for and participate in the group to which the leasing company seeks admission.

(c) The application submitted for membership by the employee leasing company shall clearly state on the first page of the application that the entity is an employee leasing company and shall name all the owners of the leasing company and the percentage of ownership of each owner. Any change in the percentage of ownership shall be reported to the group fund and the agency within 10 days of the ownership change. If the leasing company no longer meets the requirements of subdivision (a) or (b) of this rule after the change in ownership, then the leasing company shall be subject to termination pursuant to R 408.43g(4).

(d) The application shall identify and name the entity or entities with which employees are placed or to be placed, the name of each individual or entity that owns the entity with which employees are or will be placed, and the percentage or ownership interest for each.

(e) If the leasing company leases employees to any entity which is not a member of the group fund of which the leasing company is a member, or the leasing company fails to report any changes in ownership to the group fund and the agency within 10 days of the change in ownership, then the leasing company shall be terminated from participation in the group fund, pursuant to R 408.43g(4).

History: 2006 AACS.

PART 4. MISCELLANEOUS

R 408.44 Attorney fees.

Rule 14. (1) The limitation in this rule as to fees applies to plaintiff's attorneys, including combined charges of attorneys who combine their efforts toward the enforcement or collection of any compensation claim.

(2) In a case tried to completion with proofs closed or compensation voluntarily paid, an attorney, before computing the fee, shall deduct from the accrued compensation the reasonable expenses incurred on plaintiff's behalf.

The fee that the magistrate may approve shall not be more than 30% of the balance.

(3) In a case involving a redemption of liability, the attorney, before computing the fee, shall deduct the reasonable expenses incurred on plaintiff's behalf from the total settlement. The fee that the magistrate may approve is as follows:

(a) Of the first $25,000.00, a fee of not more than 15%.

(b) Of any amount more than $25,000.00, a fee of not more than 10%.

(4) In a case tried to completion with proofs closed but before a final order, after which there is a redemption of liability, the attorney, before computing the fee, shall deduct the reasonable expenses incurred on plaintiff's behalf from the total settlement. The total settlement in such redemptions shall be deemed to include the gross amounts of any partial payments made under section 862 of the act, if the redemption specifically includes a waiver of the right of reimbursement of such amounts from either the plaintiff or the second injury fund. The fee that the magistrate may approve shall not be more than 20% of the balance.

(5) Reasonable expenses, as used in this rule, include all of the following:

(a) Medical examination fee and witness fee.

(b) Any other medical witness fee, including the cost of a subpoena.

(c) The cost of a court reporter service.

(d) Appeal costs.

(6) Subrules (2) to (4) of this rule apply to a case with an injury date on or after September 1, 1965. The rule as to attorney fees in effect before September 1, 1965, applies to a case with an injury date before September 1, 1965.

(7) In a case dismissed for lack of progress or prosecution or in which the petition for hearing is withdrawn for reasons other than voluntary payment or other meritorious reasons and further action is taken by the same attorney or law firm, the fee that the magistrate may approve in cases specified in subrule (2) of this rule shall be not more than 25% of the balance; in subrule (3) of this rule, of the first $25,000.00, not more than 12-1/2%, and of any amount more than $25,000.00, 10%; in subrule (4) of this rule, the fee shall be not more than 15% of the balance.

(8) A group disability or hospitalization insurance company that enforces an assignment given to it as provided in the act shall pay a part of the fee of the attorney who secured the compensation recovery in the same proportion that the group insurance company payments bear to the total compensation recovery upon which the attorney's fee is based.

(9) In the computation of attorney fees in a case decided by the workers' compensation appellate commission, the fee shall be assessed on not more than 104 weeks of the period the matter was pending before the commission. All other weekly benefits due and owing for the period of appeal shall be fully paid to the plaintiff. The limitation of fee applies only to weekly compensation.

(10) In a case where benefits are being voluntarily paid at time of redemption, and no application for mediation or hearing is pending, not more than 10% attorney fee will be allowed.

History: 1979 AC; 1980 AACS; 1998-2000 AACS.

R 408.45 Medical examination and rehabilitation.

Rule 15. (1) A carrier and the self-insurers' security fund shall report to the bureau, on form 110, report on rehabilitation, 3 months after the date of injury and after each subsequent 4 months, what evaluation and what provision has been made for rehabilitation on all cases for which a final form 701, notice of compensation payments, has not been filed. All reports shall be accompanied by a current medical report. In case of a specific loss where the injured employee has returned to work without rehabilitation before expiration of the specific loss period, a notation of the return to work shall be made on form 110, report on rehabilitation, and thereafter further reports shall not be necessary. Where rehabilitation has been undertaken in the form of favored work or on-the-job training by the employer, the rehabilitation shall be so identified in all reports.

(2) When an employee consents or is ordered by the bureau to submit to a medical examination or rehabilitation or undergoes any medical treatment related to the disability, the carrier shall pay the traveling expenses incidental to such examination, medical treatment, or rehabilitation. The employee shall notify the carrier, in writing, of the mileage involved and other expenses. When an employee is examined at the request of the carrier under the provisions of section 385 of the act, MCL 418.385, the expenses incidental to such examination shall be paid in advance. The traveling expenses shall be those authorized in the state standardized travel regulations, except that when special transportation is medically required, payments shall be made at actual cost. The allowance for other expenses, if any, shall be those allowed by this state. The provisions of this rule do not apply to the first examination requested by the employer or insurer if all of the following conditions exist:

(a) An application for hearing is filed upon which no payment of compensation or medical expense has been made for 1 year before the date of filing.

(b) The employee's home at the time of filing the application for hearing is outside of this state.

(c) The citation to appear for examination is at a time reasonably close to the date of hearing so as to obviate the necessity of an additional trip on the part of the employee to attend the hearing.

(3) Under section 319 of the act, MCL 418.319, the director may, on his or her own motion or upon receipt of an application from the employee or employer, refer the employee for an evaluation of the need for a rehabilitation program and the kind of rehabilitation program necessary to return the employee to work. If a hearing is requested, then all of the following provisions apply:

(a) When a request for rehabilitation service is made by the employee or employer, then the director or his authorized representative may schedule a hearing.

(b) If the director, on his or her own motion, orders a rehabilitation program, then he or she shall notify both parties and, if requested by either party within 15 days, shall schedule a hearing.

(c) A hearing shall be scheduled within a reasonable time, subject to the availability of the director or his or her representative and the parties involved. A request for a hearing shall, at a minimum, contain all of the following:

(i) A brief statement of the question concerning rehabilitation.

(ii) If requested by the employer, a citation of the specific instances of the employee's failure to cooperate in the rehabilitation program.

(iii) If requested by the employee, the type of program requested and the reason for it.

(d) Unless a request for review by the Michigan compensation appellate commission is filed by a party within 15 days after the order of the director is mailed, the order shall stand as the order of the bureau.

History: 1979 AC; 1980 AACS; 1998-2000 AACS; 2014 MR 15, Eff. August 19, 2014.

R 408.46 Application for silicosis, dust disease, and logging industry compensation fund and second injury fund benefits.

Rule 16. (1) An application for reimbursement of benefits from the silicosis, dust disease and logging industry compensation fund and second injury fund shall be made on form 112 and sent to the principal office of the funds administrator.

(2) A carrier believing that reimbursement may be due from the second injury fund under section 372 of the act shall immediately notify the fund of the potential claim. The fund may then conduct an investigation of the personal injury and shall have reasonable time to schedule medical examinations.

If a petition is filed with the bureau, then the carrier shall add the second injury fund and the fund shall have the same rights as any other party defendant.

The magistrate shall enter an order determining the liability of the carrier and the fund.

(3) If an employee petitions for a hearing under section 356(1) of the act, then the second injury fund shall be deemed a party in interest and shall be named on the petition filed by the employee or added by the carrier when it has knowledge that a claim is being filed under section 356(1) of the act. The fund shall have the same rights as a carrier in the proceedings.

(4) Any stipulated order presented for entry which may affect the amount or duration of benefits or which involves a potential liability on any state fund created under chapter 5 of the act shall be presented to the magistrate for entry only after a party provides 10 days' notice of the date of hearing to all parties affected or potentially affected. A party shall file proof of service on the other parties before the hearing date. The magistrate may, at his or her discretion, require the presentment of proofs in support of the stipulation.

(5) Reimbursement shall be made on a quarterly basis for the second injury fund's portion of the benefits due the employee.

History: 1979 AC; 1984 AACS; 1998-2000 AACS.

R 408.47 Extensions of time granted by the director.

Rule 17. The director or his authorized representative may grant extensions of time in which to comply with any rule as the director deems reasonable.

History: 1979 AC.

R 408.48 Compensation payments; calculation; payment.

Rule 18. (1) Pursuant to section 313(1) of the act, the calculation of federal income tax, federal insurance contribution act tax, and state income tax shall be based on the federal income tax schedule, federal insurance contribution act tax, and state income tax rate in effect on the applicable July 1 for which the after-tax weekly wage is determined. The state law in effect on the applicable July 1 shall be conclusive in the determination of the after-tax weekly wage for that calendar year.

(2) Weekly payments shall be made payable by check and mailed or electronically transferred directly to the injured employee or the injured employee's dependent, pursuant to subrule (3) of this rule. When the claimant is represented by counsel, the accrued compensation shall be made payable by check to the person or persons entitled to compensation and mailed to the attorney representing the person or persons.

(3) Weekly compensation payments may be made by an electronic transfer when both of the following have occurred:

(a) The claimant consents to and authorizes in writing the use of electronic transfer payments. This authorization shall include acknowledgement by the claimant that any amount received through electronic transfer into the claimant's account or the account of the claimant's dependent at a financial institution may be subject to attachment or garnishment.

(b) The electronic transfer is made by 1 of the following methods:

(i) Direct deposit or electronic transfer to the claimant's account or the account of the claimant's dependent at a financial institution.

(ii) Issuance of a debit card to the claimant or the claimant's dependent provided that the financial institution complies with all of the following:

Allows the claimant to receive immediate payment in full at no charge.

Allows at least 1 additional free transaction per pay period for any amount up to the balance accessible through the card.

(C) Fully and prominently discloses any fees and charges.

(D) Prohibits changes in fees or terms of services, as specified in subrule(3)(b)(ii)(F) of this rule to subrule (3)(b)(ii)(G) of this rule. Any other changes to the fees or terms of service may occur when the claimant has received a written notice of these fees at least 21 days prior to the change and the claimant has consented in writing to the change.

(E) Provides a method for the claimant to make an unlimited number of balance inquiries electronically or by telephone and without charge.

(F) Prohibits a link to any form of credit, including a loan against future payments or a cash advance on future payments.

(G) Ensures that the debit card is negotiable at locations easily and readily accessible to the claimant.

(iii) Any other form of payments approved in advance by the director.

(4) A claimant, at any time, may make a request in writing to the employer to change the method of receiving weekly compensation payments established under this rule. The employer shall take no longer than 1 pay period to implement the change after he or she receives the request and any information necessary to implement the request.

History: 1979 AC; 1985 AACS; 2013 MR 5, Eff. March 4, 2013.

PART 5. REVIEW AND APPEAL

R 408.49 Rescinded.

History: 1979 AC; 1998-2000 AACS.

R 408.50 Rescinded.

History: 1979 AC; 1998-2000 AACS.

R 408.51 Rescinded.

History: 1979 AC; 1998-2000 AACS.

R 408.52 Rescinded.

History: 1979 AC; 1998-2000 AACS.

PART 6. DEFINITIONS

R 408.59 Definitions and use of terms.

Rule 29. (1) As used in these rules:

(a) "Act" means 1969 PA 317, MCL 418.101 to 418.941.

(b) “Debit card” means a stored value card issued by a federally insured financial institution that provides a claimant or the dependent of a claimant immediate access for withdrawal or transfer of the claimant’s weekly compensation payments through a network of automatic teller machines. “Debit card” includes a card commonly known as a payroll debit card, payroll card, or paycard.

(2) Unless the context of the rule indicates otherwise, the terms “agency” and “director” shall have equivalent meaning.

(3) Terms defined in the act have the same meanings when used in these rules.

History: 1980 AACS; 1984 AACS; 2013 MR 5, Eff. March 4, 2013.