DEPARTMENT OF LABOR AND ECONOMIC OPPORTUNITY

WORKERS' DISABILITY COMPENSATION AGENCY

GENERAL RULES

Filed with the secretary of state on December 10, 2021

These rules take effect immediately upon filing with the secretary of state unless adopted under section 33, 44, or 45a(9) of the administrative procedures act of 1969, 1969 PA 306, MCL 24.233, 24.244, or 24.245a. Rules adopted under these sections become effective 7 days after filing with the secretary of state.

(By authority conferred on the director of the workers' disability compensation agency by section 205 of the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.205, and Executive Reorganization Order Nos. 1996-2, 1999-3, 2002-1, 2003-1, and 2019-3, MCL 445.2001, 418.3, 445.2004, 445.2011, and 125.1998)

R 408.31, R 408.31a, R 408.32, R 408.32a, R 408.33, R 408.34, R 408.35, R 408.36, R 408.38, R 408.39, R 408.40, R 408.40b, R 408.41, R 408.41a, R 408.41b, R 408.41c, R 408.42, R 408.42a, R 408.42b, R 408.43, R 408.43a, R 408.43b, R 408.43c, R 408.43d, R 408.43e, R 408.43f, R 408.43g, R 408.43h, R 408.43i, R 408.43j, R 408.43k, R 408.43m, R 408.43n, R 408.43q, R 408.43r, R 408.43s, R 408.44, R 408.45, R 408.46, R 408.47, and R 408.48 of the Michigan Administrative Code are amended, R 408.31b, R 408.45a, 408.45b, and R 408.49 are added, and R 408.59 is rescinded, as follows:

PART 1. DEFINITIONS

R 408.31 Definitions.

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

(a) "Act" means the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941.

(b) "Appearance" means participation in person, or by telephone, video conference, or other electronic means, at any hearing or conference under this act. This definition should not be interpreted to limit the authority of the director or a magistrate to require a party or a witness to appear in person.

(c) "Approved vocational rehabilitation provider" means any person, firm, partnership, corporation, or other legal entity that has submitted form WC-502, or its electronic equivalent, meets the minimum standards as prescribed by the agency for approval, and has been approved by the agency.

(d) "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.

(e) “Electronic equivalent” means a record created, generated, sent, communicated, or received by electronic means.

(f) “Electronic filing” means the process of submitting a document over the internet to the agency, including State of Michigan File Transfer System (FTS), in accordance with the instructions available on the agency’s website.

(g) “Electronic service” means the serving of any document by e-mail or electronic file transfer.

(h) “Electronic signature” means an electronic sound, symbol, or process, attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record. Both of the following apply regarding an electronic signature:

(i) An electronic signature may be a graphic representation of the signature.

(ii) The following forms are acceptable: “/s/ John Smith,” “/s/ John Smith, Attorney,” or “/s/ John Smith, Authorized Representative.”

(i) “File Transfer Service” (FTS) means an electronic computer-based system that facilitates the transmission of a computer file through a communication channel provided by the State of Michigan from one computer system to another.

(j) “Forensic vocational evaluation” means an independent, individualized assessment and evaluation process involving the application of specialized knowledge and the use of scientific, technical, or other professional knowledge for the resolution or clarification of issues related to a claim, typically in a legal setting. This is not vocational evaluation as used in R 408.45a or section 319 of the act, MCL 418.319.

(k) “IWRP” means an individualized written rehabilitation plan. An IWRP is a document mutually developed by the vocational counselor and the employee that provides a detailed outline of goals, objectives, responsibilities, and services necessary for successful rehabilitation of the employee. The plan is specific to the individual, reviewed on a regular basis, and updated as provided in R 408.45a(3).

(l) “Return-to-work hierarchy” means a sequence of steps designed to assist an employee with returning to any of the following:

(i) Same job, same employer.

(ii) Modified job, same employer.

(iii) Different job, same employer.

(iv) Same job, different employer.

(v) Different job, different employer.

(vi) Self-employment.

Remedial and retraining services can be applied at any level of the hierarchy to facilitate success.

(m) “Vocational evaluation” means a vocational evaluation under section 319 of the act, MCL 418.319. It is a comprehensive process of gathering and analyzing relevant information such as educational, medical, and vocational history, interests, aptitudes, and vocational assessment results in order to develop recommendations and the IWRP. The vocational evaluation should include a face-to-face interview with the employee.

(n) “Week” as used under section 319 of the act, MCL 418.319, means a 7-day period during which the employee actually participates in vocational rehabilitation services that are part of an approved IWRP.

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

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

PART 2. RECORDS

R408.31a Report of injury; claim for compensation, additional reports; weekly rate of compensation.

Rule 1a. (1) An employer shall report immediately, to the agency, on form WC-100, or its electronic equivalent, 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 agency by an employer that fails to meet the requirements of subrule (1) of this rule shall not be maintained as a record of the agency unless filed with a form WC-107, or its electronic equivalent.

(3) An employer shall immediately give a copy of the report of injury form WC-100, or its electronic equivalent, to the injured employee or, in the case of death, to the dependents. The employer or its carrier shall include a written notice to the injured employee or dependents on a form prescribed by the director of the agency, advising of their rights under the act. Any filing required in this section shall indicate compliance with this requirement. In case of death, an employer shall also immediately file an additional report on form WC-106, or its electronic equivalent.

(4) An employee may make a claim for compensation to the agency on form WC-117, or its electronic equivalent. The agency shall provide a copy of form WC-117, or its electronic equivalent, to the employer and carrier. The carrier shall respond to a form WC-117 in the same manner as a form WC-100.

(5) No later than 28 days following report of an injury, the employer or carrier shall deliver to the employee a form or its electronic equivalent, as prescribed by the director of the agency, describing the employer or carrier's obligation to furnish reasonable and necessary medical care for the work-related injury or disease. 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, MCL 418.315, the employee shall obtain and promptly furnish a report to the employer, insurance company, private employer group self-insurers' security fund (PEGSISF), first responder presumed coverage fund, or self-insurers' security fund. The report must 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) A self-insured employer, insurance company, PEGSISF, first responder presumed coverage fund, or self-insurers' security fund is not required to make payment to the physician until reasonable proof and itemized charges have been furnished to it.

(b) Medical fees may not exceed the maximum allowable payment (MAP) established by the fees considered usual and reasonable for the services performed in accordance with the health care service rules or the provider's usual and customary charge, whichever is less.

(6) For a case that requires the payment of benefits, a carrier, the second injury fund, the PEGSISF, the first responder presumed coverage 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 in the format required by the agency:

(a) Form WC-701, or its electronic equivalent, 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 WC-701, or its electronic equivalent, on the day after the stopping of payment of compensation, showing the amount of compensation paid in every case.

(c) Form WC-701, or its electronic equivalent, within 30 days from the annual anniversary of the date of injury on claims where the starting of weekly compensation benefits has been reported and weekly compensation benefits have not been stopped. The annual report must include a weekly summary of wages earned when partial wage loss benefits pursuant to section 301(9)(c) of the act, MCL 418.301, are being paid or have stopped prior to the anniversary date if not already reported.

(d) Form WC-701, or its electronic equivalent, on the day after due to:

(i) The application of section 301(8), 354, 357, 358, 401(6), or 827 of the act, MCL 418.301, 418.354, 418.357, 418.358, 418.401, and 418.827.

(ii) A change in the number of dependents.

(iii) Recoupment of an overpayment.

(iv) Reimbursement or adjustment resulting from involvement of a fund created under section 501 of the act, MCL 418.501.

(e) If benefits have been reduced to zero for 30 days or longer, a WC-701, or its electronic equivalent, shall be filed in accordance with R 408.31(b).

(f) The form WC-701 shall state the reason for any change and include the calculation applied.

(7) The carrier or fund shall send a copy of any WC-701 to the employee.

R 408.31b Computation of weeks and days.

Rule 1b. 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.

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

Rule 2. (1) A carrier, second injury fund, PEGSISF, or self-insurers' security fund shall claim reimbursement from the compensation supplement fund for payments made in accordance with section 352 of the act, MCL 418.352. A carrier, second injury fund, PEGSISF, or self-insurers' security fund shall make a claim on the form WC-114, or its electronic equivalent, application for reimbursement.

(2) A carrier, second injury fund, PEGSISF, 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, PEGSISF, 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, PEGSISF, or self-insurers' security fund shall submit a separate form WC-114, or its electronic equivalent, 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 agency 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 WC-114, or its electronic equivalent, 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 agency 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, MCL 418.351 and 418.321.

(7) A compensation supplement may 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, MCL 418.335.

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

(e) Partial compensation paid under section 361(1) of the act, MCL 418.361.

(8) In a case involving a lump sum advance payment, supplemental benefits are not part of the advance payment, but must 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 is 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 money 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 is 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, MCL 418.357, may not be applied when the amount of supplemental benefit, as provided for in section 352 of the act, MCL 418.352, 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, MCL 418.352, 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 may not be reduced or increased by changes to the weekly compensation rate that occur after January 1, 1982, except as provided in section 352 of the act, MCL 418.352, and in this rule.

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, MCL 418.862, medical benefits must have been required by the terms of an award and been paid in accordance with section 315 of the act and the rules promulgated under section 315 of the act, MCL 418.315. In providing benefits as required by section 862(2) of the act, MCL 418.862, a carrier shall require that the employee and the provider comply with the requirements of section 315 of the act, MCL 418.315.

(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, MCL 418.847. Claims must be made on forms provided by and submitted to the agency. If other insurance coverage is or was available to cover medical benefits paid under section 862(2) of the act, MCL 418.862, then the agency will not make reimbursement.

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

(4) Reimbursement from the agency must be consistent with benefits awarded in the magistrate’s decision. Reimbursement will only be made for medical benefits that were provided between the agency 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 must 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 must accompany each request for reimbursement. Proof of payment must include certification from the carrier that it has paid the medical bills or, if requested by the agency, must include a receipt from the provider that shows that payment has been made.

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

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

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

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, the carrier, PEGSISF, and self-insurers' security fund shall notify the agency on form WC-107, or its electronic equivalent, if the right of the injured or dependent to compensation is disputed. A copy of the form WC-107, notice of dispute, must be provided to the injured employee.

(2) The following subdivisions govern the administration and enforcement of the penalty provisions under section 801 of the act, MCL 418.801:

(a) Under section 801(1) of the act, MCL 418.801, compensation must 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 that has accrued must 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) A medical bill becomes due and payable when the carrier or employer has received reasonable proof and the itemized 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 30 days after the carrier has received notice of nonpayment by certified mail, 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 by the carrier, 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 receipt of notification of non-payment by certified mail, 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, MCL 418.801. 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, MCL 418.801, and who has not received the payments may apply by notifying the agency in writing. A copy of the request must be forwarded to the carrier. In all cases, the agency 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, MCL 418.801. If a dispute continues beyond a determination by the agency 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, MCL 418.801, 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.

PART 3. HEARINGS

R 408.34 Applications for hearing; small disputes.

Rule 4. (1) In cases of dispute coming under the jurisdiction of the agency, any party may apply to the agency for relief. The complaining party shall file an application WC-104a, WC-104b, or WC-104c, or their electronic equivalent, with the agency. The agency shall then serve the adverse party with a copy of the application and, at the same time, notify the parties of the time and place of the initial hearing. The adverse party shall file their answer to the application with the agency within 15 days after service and serve a copy of the answer on the complaining party. A form WC-104b without a corresponding WC-104a or WC-104c does not create an exception under section 230(3) of the act, MCL 418.230.

(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 agency may direct compensation benefits to be paid at the maximum rate, as determined in section 351 of the act, MCL 418.351, 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 must 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, MCL 418.862, applies. 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 agency 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.

(5) Small claims matters submitted under section 841 of the act, MCL 418.841, shall be heard by a magistrate. The parties may stipulate that any decision rendered is applicable only to the issues submitted and not res judicata in any other proceeding between the parties other than for enforcement of the determinations in the decision.

R 408.35 Agency 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 must 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 agency, 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 must 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 agency 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 must, at a minimum, contain sufficient information to warrant investigation or inquiry into a matter. The request for hearing must 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.

R 408.36 Service of papers and other pleadings; manner of service; date of service; statement or proof of service; filings.

Rule 6. (1) Service of all applications, papers, notices, and orders must be in accordance with the following:

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

(b) Service of any subsequent applications or motions filed on a pending contested case that may alter the parties to a case must be by the agency. The agency 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 agency may request the necessary papers, notices, and postage to be provided by the moving party.

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

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

(e) Decisions or orders issued by the agency must be served on all parties, by mail, e-mail to the e-mail address on file, FTS, or personally on the date of hearing. Upon mailing, e-mailing, FTS or personal service, the original order and copies must show a mailed date or acknowledgement of personal service on their face, from which date the appropriate appeal period shall run.

(f) Service of all other papers, unless otherwise directed by law, may be made by mail, e-mail, or FTS 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 agency.

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

(h) Service between the parties may be completed electronically if the parties agree to service by e-mail, or electronic file transfer subject to all of the following:

(i) The agreement for service by e-mail or electronic file transfer must set forth the FTS mailbox or e-mail addresses of the parties or attorneys that agree to electronic service.

(ii) Parties and attorneys who have agreed to service by FTS under this subrule shall immediately notify all other parties if the party's or attorney's FTS mailbox or e-mail address changes.

(iii) Documents served electronically must be in pdf format or other agency-approved format that prevents the alteration of the document contents.

(iv) Documents received by a party electronically on or before 11:59 p.m. Lansing, Michigan time, are considered served on the same business day or, if received on a Saturday, Sunday, or state holiday, are deemed to be received on the next business day.

(v) The parties are not required to file a copy of the electronic service agreement with the agency unless a dispute arises as to service by electronic service.

(vi) The electronic sender shall maintain an archived record of sent items that may not be purged until the conclusion of the contested proceedings, including the disposition of all appeals.

(2) The agency may serve documents on the parties, the parties' attorney, or the parties' authorized representative by mailing a copy, by FTS to the designated mailbox, by e-mail to the e-mail address on file, or by personal service.

(3) At the discretion of the director, the agency may use alternative service methods including any of the following:

(a) Transmitting by facsimile.

(b) Utilizing a commercial delivery service.

(c) Leaving a copy of the document at the residence, principal office, or place of business of the person or agency required to be served.

(4) Documents and pleadings may be filed in a proceeding by mailing, personal delivery, facsimile, FTS, or other agency-approved electronic filing system, if provided.

(5) All document filings must be formatted using a 12-point font on 8½ x 11-inch paper, unless filed electronically using an agency-approved electronic filing system.

(6) Documents and pleadings filed by mail, e-mail, an agency approved electronic filing system, personal delivery, or facsimile and received by the agency on or before 11:59 p.m. Lansing, Michigan time are considered filed on the same business day. If received on a weekend or holiday, they are considered received in the following business day.

(7) A required signature means a written signature, or an electronic signature.

R 408.38 Application for advance payment of compensation.

Rule 8. An applicant shall submit an application for advance payment of compensation on form WC-108, or its electronic equivalent. If the carrier, second injury fund, self-insurers' security fund, PEGSISF, or first responder presumed coverage fund refuses to approve the application, then the matter must be set for hearing to determine whether the application should be approved. A carrier, second injury fund, self- insurers' security fund, PEGSISF, or first responder presumed coverage 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.

R 408.39 Redemptions.

Rule 9. (1) An agreement to redeem the liability of the carrier, second injury fund, self-insurers' security fund, PEGSISF, silicosis and dust disease fund, or first responder presumed coverage fund must be submitted on form WC-556, or its electronic equivalent, agreement to redeem liability. The agreement must be accompanied by a report from a licensed medical provider or examiner.

(2) A request for review of an order of a workers' compensation magistrate entered under section 837(1) of the act, MCL 418.837, must be filed in writing with the director. Filing may be accomplished by hand delivery, mailing, facsimile, or other electronic means as prescribed by the director.

(3) A request for review must be received by the director not later than 15 days after the service date that appears on the face of the redemption order.

(4) The party filing a request for review shall provide copies to all other parties at the time of filing with the director.

(5) The party filing a request for review shall file with the director a copy of the transcript of the redemption hearing within 30 days of filing the request for review. A copy of the transcript must be provided to all parties at the time of filing with the director. The director may grant extensions of time to comply with this requirement for sufficient cause shown.

(6) If the director requests review of the order of the workers' compensation magistrate, the director is responsible for adherence to these rules.

(7) Service of all filings made under this rule may be made upon a party's attorney of record. A party not represented by an attorney must be served personally or by mail.

(8) Proof of service must be filed with the director with each filing and served upon all parties or their attorney.

(9) Failure to comply with these rules may result in dismissal of the request for review.

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, workers' disability compensation appeals commission, or an appellate court, then compensation may 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(8), 301(9)(c), and 401(6) and 301(9)(c) of the act, MCL 418.301 and 418.401.

(2) At the time of filing an application requesting a stoppage of compensation, the moving party shall provide to the claimant and counsel, if represented, the following:

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

(i) An affidavit stating that the employee has returned to gainful employment paying wages at or greater than his or her average weekly wage at the time of injury and that substantially describes the nature of the employment.

(ii) A signed statement from 1 of the following:

(A) A physician stating that the employee is able to return to unrestricted employment.

(B) A physician stating that the employee is able to return to restricted employment accompanied by an affidavit demonstrating that such reasonable employment has been offered, or is reasonably available, to the employee.

(C) A physician stating that the conditions found to be work-related cease to exist and are no longer a cause of current wage loss.

(D) Proof of any other ground for stopping benefits permitted by law.

(3) Upon receipt of an application requesting a stoppage of compensation, the agency shall schedule a hearing with a magistrate within 60 days.

(4) 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 with the agency an affidavit that the check was returned and a diligent search was made to locate the party. The suspension may not prejudice the reinstatement of suspended payments.

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

(6) Except as provided under section 354 of the act, MCL 418.354, where the carrier, PEGSISF, first responder presumed coverage fund, or self-insurers' security fund has voluntarily paid benefits or paid benefits pursuant to a voluntary pay agreement, no reimbursement of previously paid benefits may be ordered against the employee unless the employer or carrier establishes that the employee concealed post-injury earnings, or establishes that benefits were overpaid as a result of a mathematical, technological, or clerical error. Reimbursement of previously paid benefits shall not be ordered where an employer or carrier unreasonably changes its position regarding whether a condition is work-related or whether a claimant was disabled. If an overpayment occurs as result of a mathematical, technological, or clerical error, the employer or carrier shall not recoup overpayments by reducing ongoing weekly benefits greater than 50% as provided in section 354(9) of the act, MCL 418.354. A magistrate may, in his or her discretion, waive

reimbursement of an overpayment upon an employee's showing of undue harm. The magistrate may take into consideration whether recoupment of an overpayment would not serve the purposes of the act.

R 408.40b Appearances at conferences.

Rule 10b. (1) In a contested case, in a hearing district designated by the director, the parties or their attorneys shall appear before the agency at any hearing or mediation conference at a date and place scheduled by the director in person, by telephone, video conference, or other electronic means. 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 conference or hearing being deemed to have been voluntarily withdrawn under section 205 of the act, MCL 418.205. 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 agency 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 must be specified on the voluntary payment form signed by both parties and the director or designated representative. If the benefits agreed to are not paid within 30 days of the date the agreement is personally served or mailed by the agency, then the carrier shall pay to the employee penalties in accordance with section 801 of the act, MCL 418.801.

R 408.41 Notice of insurance.

Rule 11. (1) Every notice of issuance of a workers' disability compensation insurance policy must be reported to the agency on form WC-400, or its electronic equivalent, insurer's notice of issuance of policy. If the employer is a partnership, the notice must state the names and addresses of all the partners. If the employer is doing business under an assumed name, the notice must state the assumed name and each Michigan location covered. If the employer is a corporation doing business through a number of divisions, the notice must state the names of all the divisions of the corporation. The agency shall be notified when any insurance company receives a change of address of an insured.

(2) A form WC-403, or its electronic equivalent, insurer's notice of name or address change, shall be filed when an employer is updating, adding, or deleting information related to a business name, address, or division. Any changes must be specific to the federal identification number noted on the form. Changes to business entities under different federal identification numbers will require separate forms for each number.

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 must be reported to the agency on form WC-401, or its electronic equivalent, notice of termination of liability. A copy of the notice must be mailed to the employer. If the employer is a partnership, the notice must state the

names and addresses of all the partners. If the employer is doing business under an assumed name, the notice must 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 must state the names of all the divisions of the corporation. If a business changes names notice must 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.

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

Rule 11b. (1) A notice of election to be excluded under section 161(5) of the act, MCL 418.161, must be reported to the agency on form WC-337**,** or its electronic equivalent, notice of exclusion. The employer shall have the notice notarized. If the employer is a partnership or corporation, then the notice must state the names of all the partners or corporate officers. If the employer is doing business under an assumed name, then the notice must state the assumed name and each Michigan location covered.

(2) 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, MCL 418.161. 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 agency. The exclusion shall become effective upon receipt of the notice of exclusion by the agency.

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

Rule 11c. (1) Every notice of election to terminate an exclusion from coverage previously filed under section 161(5) of the act, MCL 418.161, must be reported to the agency on form WC-338, or its electronic equivalent, notice to terminate exclusion. The employer shall have the notice notarized. The notice must state the reason for terminating the exclusion. The notice to terminate exclusion must 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 agency. The employer shall furnish its federal identification number.

(2) The termination of exclusion is effective not later than 20 days after the notice to terminate exclusion is received by the agency. 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 is effective on the date the carrier assumes coverage.

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

Rule 12. An applicant may make written application to the agency 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 must 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 agency 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 agency's notice in which to comply with the requirements of the agency. The approval for a specific risk policy is not effective until the agency has received proof that all requirements of the agency 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 must be made in writing within the 30-day compliance period. If the agency 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 is considered withdrawn.

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 agency on a form WC-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 must state the names and addresses of all the partners. If the employer is doing business under an assumed name, then the notice must 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 must state the name of the employer and the divisions that are covered under the specific risk policy. The specific risk carrier shall notify the agency when the specific risk carrier receives a change of address for the employer.

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

Rule 12b. (1) 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, must be reported to the agency on form WC-401A, notice of termination of liability for employer under specific risk policy.

(2) The insurer shall mail a copy of the notice to the employer. If the employer is a partnership, then the notice must state the names and addresses of all the partners. If the employer is doing business under an assumed name, then the notice must 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 must state the name of the employer and the divisions of the corporation covered by the termination. If the business changes names, then notice must be given stating both the new and former names. Notice of termination of a policy that has expired may 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 must be filed with the agency 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 must 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 agency.

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 agency on form WC-402, or its electronic equivalent.

(2) The initial and annual renewal application must contain answers to all questions, shall include all requested supporting information, as directed, and 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.

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 agency will establish the amount of security at the time of initial application. The agency shall review the adequacy of security periodically. The agency shall prescribe the format and language of the bond or letter of credit. The agency shall accept surety bonds only from a surety writer authorized to transact security bond business in Michigan. A surety bond must provide for 60 days' notice of cancellation to the agency. Letters of credit are administered under R 408.43q.

(2) An employer that is in business less than 5 years may not be considered for self-insured authority unless its worker’s disability compensation liability will be guaranteed 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 agency shall require specific excess liability insurance, with policy limit and retention acceptable to the agency, for every self-insured employer, unless the agency, at its discretion, waives the requirement. The agency 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 act, unless the agency, at its discretion, waives the requirement. The agency shall prescribe the form and substance of the guaranties. The agency 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 agency shall prescribe the form and substance of the guaranties.

(5) A self-insurer approved under section 418.611(1)(a) of the act, MCL 418.611, shall contract with a claims service company approved by the agency under R 408.43m. The agency 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.

R 408.43b Employer individual self-insurer; compliance with agency 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 must be in writing. The approval letter must 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 may 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 is 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 may not be more than 12 months from the effective date of the authority. A self-insured employer shall submit a renewal application (form WC-402R), or its electronic equivalent, 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 is extended until denied or approved for an additional 12 months.

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

Rule 13c. (1) The agency 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 agency 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.

(2) The agency'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.

(3) The agency shall mail notice of a denial or termination of self-insured authority to the employer. The notice must include the grounds for denial or termination. The employer may request a hearing in accordance with section 611(5) of the act, MCL 418.611, and R 408.43n.

R 408.43d Group self-insurers; application.

Rule 13d. Application for group coverage, as contemplated in section 611 of the act, MCL 418.611, 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, must be made to the agency. The application must be made on a form prescribed by the agency and shall contain answers to all questions. Answers must be given under oath.

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, must be accompanied by all of the following:

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

(b) A copy of the original 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 may not be less than $1,000,000.00.

(ii) Working capital, which must 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 that is issued by an authorized carrier in an amount acceptable to the agency and complies 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 agency.

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

(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 must conform to an indemnity agreement as approved by the agency.

(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 agency, that the annual gross premiums of the fund will be not less than $500,000.00.

The premium collected from each member must be based upon applying the appropriate manual rates per payroll code classification as approved by the agency and the excess carrier. The premium collected from each participant in a group self-insurance program must be adjusted by an experience modification formula approved by the agency.

The total premium collected from all participants must 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 must 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 agency.

(n) Proof, satisfactory to the agency, must 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 must be used to handle claims adjusting and reporting of loss data to the agency.

(2) Each group fund shall submit a renewal application to the agency 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 is extended until it has been acted upon by the director. The application must 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 that is issued by an authorized carrier in an amount acceptable to the agency and complies 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 agency 6 months' notice of its intent to use a letter of credit.

(c) A copy of a signed service contract that designates an approved service company, which provides for claims administration and reporting of loss data to the agency, 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 agency.

(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 agency, the rates used by the fund to develop final audited premium must 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 must 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 is based upon applying the appropriate manual rates per payroll code classification as approved by the agency and the excess insurance carrier or consulting actuary. Each member's premium must be experience rated. The experience modification formula must be approved by the agency. The total premium collected from all participants must be sufficient to fund all administrative expenses and the estimated loss fund developed under the excess insurance contract. The loss fund must be 75% of final audited premium or as approved by the agency. 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 must be provided:

(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 the insurance code of 1956, 1956 PA 218, MCL 500.1200 to 500.1247, 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 agency.

(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 agency 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.

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 agency 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 agency may use the standard industrial classification codes assigned to each employer applying for membership in the group. The agency 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 has 30 days from the receipt of the agency's notice to comply with the requirements of the agency. The self-insured authority may not become effective until the agency has received proof that all requirements of the agency 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 must be made in writing by the group within the 30-day compliance period. If the agency does not receive proof that all requirements for the self-insured program have been met within the time prescribed, the application is considered withdrawn.

(3) On new and renewal applications, the agency 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 agency 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 agency 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 agency, the group shall receive a formal certificate approving its status as a self-insurer. The certificate expires 12 months after the effective date of approval.

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 agency. The board of trustees or its designated representative may approve the application for membership pursuant to the bylaws of the group self-insurers' fund. A copy of the original signed application for membership must then be filed with the agency in Lansing. Membership takes effect after approval by the agency.

(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 agency approval. The application must be submitted on forms provided by the agency and shall define all businesses that will be accepted in the same industry within the group. The application must 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 agency on form WC-650, or its electronic equivalent, 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 must state the names and addresses of all the partners. If the employer is doing business under an assumed name, the notice must state the assumed name and each Michigan location covered. If the employer is a corporation doing business through a number of divisions, the notice must state the names of all the divisions of the corporation. The agency must 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 may occur not less than 20 days after the agency has received notice of the termination or cancellation from the group fund reported to the agency on form WC-651, or its electronic equivalent, group self-insurance fund notice of termination of membership. If the employer is a partnership, the notice must state the names and addresses of all the partners. If the employer is doing business under an assumed name, the notice must 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 must state the names of all the divisions of the corporation. If a business changes names, notice must 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, or their electronic equivalents, with respect to records:

(a) Forms WC-100, 101, 102, WC-701, and WC-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 must 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 must immediately be surrendered to the fund upon the fund's request.

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 agency. A fund year is considered open as long as there are unsettled claims. The annual financial statements must be audited by a certified public accountant and filed with the agency within 180 days after the fund year ends.

If a fund ceases to provide coverage on an ongoing basis, annual audited financial statements must be provided to the agency 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 agency, on each fund year within 30 days after the evaluation date. Losses must be evaluated on a monthly basis or as required by the agency.

(c) The fund shall file a copy of the minutes of all trustee meetings with the agency 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 agency.

(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 must be notified of the grounds for termination. The fund may request a hearing in accordance with R 408.43n.

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 is responsible for all operations of the fund. A board of trustees is a group of members elected by the membership of the fund for stated terms of office. The majority of the trustees must be owners or employees of members of the self-insurers' fund, but a trustee may 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 money, 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 must be reduced to writing, and a copy provided to the agency with each annual group renewal application. The group fund administrator may 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 must 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 must 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 must 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 must 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 money collected as premiums for any purpose unrelated to workers' compensation. Further, the board of trustees shall not borrow any money 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 money 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 must be limited to institutions in this state and may 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 are 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 money 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 may 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, 45% may be invested in common or preferred stocks. Common or preferred stocks must 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 must 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 must be audited by a certified public accountant and shall include a certification as to whether the fund has complied 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 or common and preferred stocks, or both.

(k) Any group fund found to have investments in vehicles other than as provided by this rule has 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.

R 408.43j Group self-insurers' funds; advance premium discounts; surplus money; 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 agency. If discounts are approved by the excess

carrier and the agency, the excess carrier shall agree to base the loss fund on the premium collected after discount.

(2) Any surplus money 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 is a fixed liability of the fund at the time of the declaration. The date of payment is as agreed to by the trustees and the agency, except that money 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 agency. The intent of this rule is to ensure that sufficient money is 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, must be reported immediately to the agency with the proposed plan to achieve 100% funding. The plan to achieve 100% funding for all claims is subject to agency 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 agency.

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

(a) Certification, to the agency, 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 agency, 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 subrule must be received by the agency 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 agency in a timely manner, then the agency

may withdraw the fund's privilege of returning investment income to fund members without prior agency approval.

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

Rule 13k. The agency 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 the insurance code of 1956, 1956 PA 218, MCL 500.108, to transact such business in this state. The policy must comply with all of the following provisions unless specifically waived by the agency. 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 may 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 agency not less than 60 days before termination by the party desiring to cancel or not renew the policy.

(b) The policy may not contain 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 must provide that any commutation effected under the policy may 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 agency not less than 30 days' prior notice of the commutation. Notice must be by courier, registered mail, or certified mail. If any commutation is affected, then the agency 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 must 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, MCL 418.537, 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 must state that 100% of the following payments must 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 may not be considered in reaching the aggregate excess liability retention.

(f) The policy must 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 agency.

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

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

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

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 agency before entering into a contract with the individual or group self-insurer and shall satisfy the agency 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 agency. 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 must 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 or employer, or both, 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 agency 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 agency for approval to act as a servicing company for self-insured employers or group funds on a form prescribed by the agency. The application must contain answers to all questions. An applicant shall give the answers under oath. The agency 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 the insurance code of 1956, 1956 PA 218, MCL 500.1200 to 500.1247.

(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 agency.

(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 complies 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 agency, 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 agency and shall include a written request made by the previous service company to be relieved of its claims handling responsibilities to the agency. A requesting company is relieved of its claims handling responsibility only after receiving a written response from the agency 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 agency for approval and renewal of the service company authority must include language specifically stating that the service company is responsible for reporting to the excess insurance carrier. The agency may waive the reporting requirement upon written request to the agency. Any dispute involving late reporting of excess liability insurance claims and potential penalties must be reported to the agency 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 must 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 agency shall give 30 days' notice of withdrawal. The agency shall give the notice by certified or registered mail, served upon all interested parties.

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, MCL 418.611, a party may request a hearing before the director within 15 days of the mailing of the notice by the agency.

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 agency.

(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 must advise the self-insurer that proof of reinstatement of the security must 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 must 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 must 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 may not be adjourned or continued, except upon an order of the director.

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 agency as other security for a self-insured program as provided by section 611(1)(a) of the act, MCL 418.611. The agency 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 must be issued by a state-chartered bank, a federally chartered bank or foreign bank. Funds must 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 agency, which affirms the employer's acceptance of all of the following requirements:

(a) A letter of credit is furnished to the agency 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 is 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 agency is notified, by courier, or 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 agency approval.

(d) The employer shall affirm that the irrevocable letter of credit in the amount requested by the agency is being offered with the understanding that if the agency receives notice that the letter of credit will not be renewed, then the agency, 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 agency, 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 agency 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 agency.

(5) If it is necessary for the director, under statute and agency rules, to call the bond or other security, then a trust must be established with the funds, unless the provider of the bond or other security elects to handle the claims directly and the agency approves. If a trust is established, the funds must be deposited in the state treasury and the state treasurer, as provided by section 551(8) of the act, MCL 418.551, is the custodian of the trust. The

trustees of the trust are the trustees of the funds denominated in chapter 5 of the act, MCL 418.501 to 418561, and also those who are appointed as trustees under section 511 of the act, MCL 418.511. 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.

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 may 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 ensure that all obligations under the act shall be promptly met without the protection of an excess insurance policy.

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 R 408.43j is not approved by the agency, then the agency 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 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, or both.

(2) If the agency determines that the self-insurers group ceases to provide ongoing and active coverage to its members or the requirements of this rule are not sufficient to secure all future liability established by the act, or both, then the agency 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 or all assets of the self-insurers group, or both. The trustees of the funds appointed under section 511 of the act, MCL 418.511, must be appointed trustees of the self-insurers group trust fund established under this rule.

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

(a) Fees for reports and depositions of doctors, vocational experts, and other experts incurred in the prosecution of the claim.

(b) Medical examination fees and witness fees.

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

(d) Costs of subpoenas, and costs to obtain and copy medical and other records.

(e) The costs of court reporter services, transcripts, subpoena enforcement fees, and certified copies.

(f) Costs of travel to depose medical and vocational witnesses.

(g) Appeal costs.

(h) Other costs or expenses, or both, determined by a magistrate to be reasonable for the prosecution of the claim.

(3) In computing the fee, the total settlement includes all sums paid, or to be paid, to satisfy lienholders, purchase annuities, and fund medical care set-aside accounts.

(4) In a case where benefits are being voluntarily paid at time of redemption, and no application for mediation or hearing (WC-104a) is pending, the magistrate may approve an attorney fee of 15%, or less if requested by the attorney, of the balance recovered for, or for the benefit of, the plaintiff as provided in section 858(2) of the act, MCL 418.858.

(5) In a case tried to completion with proofs closed or compensation voluntarily paid after an application for mediation or hearing is filed, an attorney, before computing the fee, shall deduct from the accrued compensation the reasonable expenses incurred on plaintiff's behalf as defined in subrule (2) of this rule. The magistrate may approve an attorney fee of 30%, or less if requested by the attorney, of the balance recovered for, or for the benefit of, the plaintiff as provided in section 858(2) of the act, MCL 418.858.

(6) In a case involving a redemption of liability, where a form (WC-104a) is pending, 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, or less if requested by the attorney:

(a) Cases alleging dates of injury before September 1, 1965, are subject to the rule as to attorney fees in effect before September 1, 1965**.**

(b) Cases alleging dates of injury between September 1, 1965, and the effective date of this amendment are subject to the rule in effect on the date of injury.

(c) Cases alleging dates of injury after the effective date of this amendment may be subject to attorney fees of all of the following:

(i) Twenty percent of the first $100,000.

(ii) Fifteen percent of any amount more than $100,000.

(7) 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 as defined in subrule (2) of this rule from the total settlement. The total settlement in such redemptions includes the gross amounts of any partial payments made under section 862 of the act, MCL 418.862, 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 magistrate may approve an attorney fee of 20% of the balance, or less if requested by the attorney.

(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 must 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 must be fully paid to the plaintiff. The limitation of fee applies only to weekly compensation.

(10) Nothing in this rule precludes an award of attorney fees under section 315 of the act, MCL 418.315.

(11) If agreed upon by the plaintiff, survivor, party in interest or dependents in writing, the fees specified in this rule may apply to cases with earlier dates of injury.

R 408.45 Medical examination rehabilitation, and forensic vocational evaluation.

Rule 15. (1) Under circumstances prescribed by the director, a carrier, PEGSISF, first responder presumed coverage fund, or self-insurers' security fund shall report to the agency what provision has been made for rehabilitation on all cases for which a final WC-701, notice of compensation payments, has not been filed.

(2) When an employee consents to a request by the carrier, first responder presumed coverage fund, or a fund created in section 501 of the act, MCL 418.501; or is ordered by the agency to submit to a medical examination, forensic vocational evaluation, or rehabilitation; or undergoes any medical treatment related to the disability, the carrier, first responder presumed coverage fund, or a fund created in section 501 of the act shall pay the traveling expenses incidental to such examination, medical treatment, evaluation, or rehabilitation. The employee shall notify the carrier, first responder presumed coverage fund, or a fund created in section 501, in writing, of the mileage involved and other expenses. When an employee is examined at the request of the carrier, first responder presumed coverage fund, or a fund created in section 501 under the provisions of section 385 of the act, MCL 418.385, the expenses incidental to such examination or evaluation shall be paid in advance. The traveling expenses are those authorized in the state standardized travel regulations, except that when special transportation is medically required, payments must be made at actual cost. Reasonable transportation services may include those provided by an entity licensed under the limousine, taxicab, and transportation network company act, 2016 PA 345, MCL 257.2101 to 257.2153. The allowance for other expenses, if any, are 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.

R 408.45a Vocational rehabilitation.

Rule 15a. (1) The agency shall issue vocational rehabilitation provider approval for a period of 3 years. To maintain approved status at the expiration of the provider approval period, a provider shall re-apply by submitting a new form WC-502, or its electronic equivalent, within 90 days before the expiration date of the approval.

(2) Agency-approved vocational rehabilitation providers shall deliver services in a manner that is consistent with agency standards and guidelines, and that are within their professional scope of practice, certification, and licensure. Failure to maintain these standards is grounds for denial or revocation of approval.

(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 to an agency-approved vocational rehabilitation provider for an evaluation of the need for a vocational rehabilitation program and the kind of vocational rehabilitation program necessary to return the employee to a remunerative occupation commensurate with their prior wage earning capacity, which is the primary objective of vocational rehabilitation services. Vocational rehabilitation may include, but is not limited to, evaluation and assessment, counseling, development of the IWRP, job search, job development and placement, education, and retraining. Any expenses incurred under this rule are the responsibility of the carrier, PEGSISF, first responder presumed coverage fund, or self-insurers' security fund. If a party objects to the referral for a vocational evaluation within 28 days of mailing of the scheduling notice of the referral, the director or his or her deputy shall conduct a hearing on the matter.

(4) The director may extend the time of the vocational evaluation when there is medical documentation contraindicating the timing of the evaluation, an impending offer of reasonable employment, or other good cause shown by any party on an agency-approved form. A vocational evaluation or other components of the vocational rehabilitation process may be delayed or suspended upon the written stipulation of the employee and employer or carrier for any reason. The employer or carrier may delay or suspend if the case is in dispute and there has been no finding by a magistrate or the commission that the employee has a work-related disability under section 301(4)(a) or section 401(1) of the act, MCL 418.301 and 418.401.

(5) Upon completion of the vocational evaluation, the vocational counselor shall submit an initial evaluation report to the parties within 14 calendar days. If the evaluation recommends initiation of vocational rehabilitation services, including job search activities, training, or both, the following actions must take place:

(a) An IWRP must be provided to all parties for review within 28 days of completion of the vocational evaluation. All plans must comply with the agency's return-to-work hierarchy.

(b) In the absence of a dispute, the IWRP must be implemented by the vocational counselor within 28 days after submission to the parties for review.

(c) The IWRP must be reviewed and updated by the vocational counselor in concert with the injured worker every 91 days to determine completion status of short- and long-term objectives.

(6) The vocational counselor shall not implement IWRP recommendations beyond the initial evaluation without first securing funding for these services.

(7) When an employee consents to or is ordered by the agency to submit to a vocational rehabilitation evaluation, the carrier, PEGSISF, first responder presumed coverage fund, or self-insurers' security fund shall pay the traveling expenses incidental to such evaluation pursuant to R 408.45(2). Subsequent expenses related to vocational rehabilitation services provided to meet the objectives of the IWRP are also the responsibility of the carrier, PEGSISF, first responder presumed coverage fund, or self-insurers' security fund.

R 408.45b Vocational rehabilitation rules disputes.

Rule 15b. Any party may request a vocational rehabilitation hearing before the director or his or her representative, on form WC-104a or form WC-104c, application for mediation or hearing, or an electronic equivalent, and all the following provisions shall apply:

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

(b) A hearing must 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 must, 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 or other objections related to a proposed or ordered IWRP.

(iii) If requested by the employee, the type of program requested and the reason for it or other objections related to a proposed or ordered IWRP.

(c) The director or his or her representative, after providing an opportunity to be heard, may issue orders regarding vocational rehabilitation consistent with the act and these rules including R 408.45a(4).

(d) Unless a request for review by the workers' disability compensation appeals 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 agency until further order of the director.

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 must be made on form WC-112, or its electronic equivalent, 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, MCL 418.372, shall immediately notify the fund of the potential claim. The fund may then conduct an investigation of the personal injury and must have reasonable time to schedule medical examinations. If an application is filed with the agency, 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 files an application for a hearing under section 356(1) of the act, MCL 418.356, then the second injury fund is deemed a party in interest and must be named on the application 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, MCL 418.356. The fund shall have the same rights as a carrier in the proceedings.

(4) Reimbursement pursuant to the second injury fund, dual employment provision must be made on a quarterly basis. Reimbursement payments from all other funds must be made periodically every 6 months.

R 408.47 Extensions of time granted by the director.

Rule 17. The director or his or her authorized representative may grant extensions of

time in which to comply with any rule as the director deems reasonable.

R 408.48 Compensation payments; calculation; payment.

Rule 18. (1) Pursuant to section 313(1) of the act, MCL 418.313, the calculation of federal income tax, federal insurance contribution act tax, and state income tax is 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 is 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 must 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 is on a claim-by-claim basis, and must 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:

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

(B) 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.

R 408.49 Determination of an employee.

Rule 19. If a business entity requests a determination by the director whether 1 or more individuals performing service for the entity in this state are in covered employment, under section 161(n) of the act, MCL 418.161, and Executive Reorganization Order 2019-3(7)(l)(5), MCL 125.1998, unless the issue is already pending before the board of magistrates, the director shall issue a determination of coverage of service performed by those individuals and any other individuals performing similar services under similar circumstances. The request must include the names and addresses of all those known to be impacted by the determination. The agency shall provide written notice to all identified individuals and provide an opportunity to be heard prior to making a determination. The business entity seeking the determination shall notify any carrier that might be impacted, and prominently post, at the business site, notice of any hearing on the request. Any decision rendered pursuant to this rule is not binding on an individual who did not receive notice or was not performing services for the business entity at the time of the closing of proofs.

R 408.59 Rescinded.