SIF-5 Instructions

Self-insurers must file complete and accurate SIF-5's. Please use the following instructions to complete the form. If you have questions about completing this form for a particular claim, please call L&I at 360-902-6901 to speak with the claim adjudicator assigned to the claim.

1. **Employer:** The employer's name as certified.

2. **UBI:** The self-insured employer's UBI number.

3. **Account ID:** The self-insured employer's account number with L&I.

4. **Claim No.:** The self-insurance claim number.

5. **Service Co.:** If applicable, the name of the service organization hired to manage the claims.

6. **Type of SIF-5**, check all of the applicable blocks:
   - Initial: If you are notifying L&I of an initial time loss payment.
   - Interlocutory Order Request: If you are requesting L&I issue an interlocutory order while further determination is made regarding claim validity.
   - Final: On the date claim is closed by employer: If you have authority to close the claim and have issued a closing order.
   - Final: On the date final determination is requested: If you are requesting L&I close the claim.
   - Supplemental: Upon Department Request: If L&I requested an additional SIF-5.
   - Supplemental: Correction of Previous SIF 5: If you are correcting a previously submitted SIF-5.
   - Wage Order Requested: If you are requesting L&I issue a wage order.
   - Overpayment Order Req.: If you are requesting L&I issue an overpayment order.

7. **For Final SIF-5:** Complete this box if the employer stopped contributing to health care benefits during the period time loss benefits were paid. The time loss rate must be recalculated at the time the contribution to health care benefits stopped.

8. **Claimant:** Injured worker's name.

9. **Address:** Injured worker's current mailing address.

10. **Date of injury:** Injured worker's date of injury.

11. **Last day worked:** Last day worked as a result of the injury. **The final SIF-5 must show all last days worked.** If additional space is needed use the remarks section or use an attachment.

12. **Date of 1st payment:** The date the initial time loss payment was made. This must be the date the payment was actually mailed or given to the worker. If the worker was kept on salary and no time loss check was issued, this field should show "KOS". Under "Compensation Paid", list the days paid from and through and the amount that time loss compensation would have been paid, had the injured worker not been KOS.

13. **Claim arrival date:** The date the injured worker made application for benefits and the date the employer received notice of a claim (description of accident, a diagnosis of a medical condition and treatment or treatment recommendations).

14. **Date returned to work:** The date the injured worker returned to work. Leave blank if the worker has not returned to work. **The final SIF-5 must show all dates returned to work.** If additional space is needed use the remarks section or use an attachment.

15. **Date released for work:** The date the injured worker's physician released them to return to work that resulted in time loss compensation being discontinued. This date must be supported by medical documentation in the claim file. Leave blank if the worker has not been released for work. **The final SIF-5 must show all dates released for work.** If additional space is needed use the remarks section or use an attachment.

    Note: The information in numbers 13 and 14 may not be applicable in all claims. It would be appropriate to leave one or the other blank if there is no return to work or release for work date.

16. **Date first treated:** The date the injured worker was first treated for the injury or disease. It is possible that first time loss is paid before the date first treated is known; it may be appropriate to indicate unknown.

17. **Compensation Paid:** The period of time which time loss/LEP was paid (from first date paid through last date paid), the rate it was paid (@$ dollar amount per day, week, etc.), the number of days in that period, and the total amount paid for that period. If time loss / LEP were paid for more than four periods of time, please attach an additional page for the additional time periods and indicate on this form that you have done so. **The final SIF-5 must reflect all periods of time loss/LEP paid in the claim.**

18. **Time Loss Compensation:** Check if any of the payments made were for time loss.
    - Total number of time loss days paid: The total number of time loss days paid for the claim.
    - Total time loss amount paid: The total dollar amount of time loss paid for the claim.

19. **Loss of Earning Power:** Check if any of the payments made were for LEP.
    - Total number of LEP days paid: The total number of LEP days paid for the claim.
    - Total LEP amount paid: The total dollar amount of LEP paid for the claim.

20. **Is condition medically fixed?:** Yes or No. The answer is based on the medical documentation in the file at the time the SIF-5 is submitted. **This is only completed on a final SIF-5.**

21. **Is there a permanent impairment?:** Yes or No. The answer is based on medical documentation received in the file at the time the SIF-5 is submitted. **This is only completed on a final SIF-5.**

22. **Has claimant returned to same employer?:** Yes or No. Has the worker returned to work for the employer of record at the time of injury?

23. **Has time loss exceeded 90 days?:** Yes or No. Does the total number of days time loss was paid exceed 90 days?

24. **E.A.R. approval date:** The date L&I approved SIVRF. This block can be left blank if no voc has been submitted.

25. **Return to work priority:** Using the list in RCW 51.32.095(2), enter the letter (a, b, c, d, e, f, g, h, or i) of the return to work priority used.

26. **Attending physician, address:** Full name and mailing address for the injured worker's attending physician.

27. **Rehab Outcome Report**:
    - Code #: Enter the code number of the rehabilitation activity:
        i. 1 – Return to work programs.
        ii. 2 – Special services / assignments.
        iii. 3 – Formal programs.
        iv. 4 – Placement services.
        v. 5 – Administrative codes.
    - Type: Describe the type of rehabilitation activity:
        vi. For Code 1, types may include modified / light duty, transitional / graduated return to work, or job modification.
        vii. For Code 2, types may include job analysis / labor marker survey, work evaluation / vocational testing, assessment, work hardening / job station, or motivational workshops.
        viii. For Code 3, types may include plan development / implementation / monitoring, formal retraining / on-the-job training, training expenses / fees, or plan revisions.
        ix. For Code 4, types may include job club / job-seeking skills training.
        x. For Code 5, types may include travel / wait, reports, case management / consultation, coordination of services, or dispute mediation.
    - **Cost:** Enter the cost of the rehabilitation activity. If no cost, enter 0.

28. **Remarks**: Use this space for explanations or to share additional information with L&I. For example, if requesting closure with PPD, enter the category and dollar amount of recommended award.

29. **Complete for Claim Closure Only:** If not requesting/reporting claim closure, you do not need to complete this section. If you are requesting/reporting claim closure check the appropriate boxes.

30. **Date - Authorized Representative:** The date the SIF-5 was completed and filed with L&I, and the name and phone number of the individual completing the SIF-5.