Dear Meadowbrook Insurance Services Policyholder:

We are pleased to provide you with the information and appropriate claims forms necessary to report a Workers' Compensation injury that may occur to one of your valued employees.

Within this packet of claims information, you are provided the Claim Forms and Rights and Benefits Poster. Also, included in your policy you will find your "CERTIFICATE FOR POSTING", which will contain information regarding your workers' compensation carrier, *Star Insurance Company, Williamsburg National Insurance Company, or ProCentury Insurance Company*. You, as the employer, are required to post the certificate and poster in each of your locations where you have one or more employees.

If you have any questions regarding this Claim Information Packet, please contact Meadowbrook Claims Service at (702) 360-0571 or Toll Free at (800) 781-8062.

Thank you for choosing Meadowbrook Insurance Services to provide your workers' compensation insurance coverage. We value your business and appreciate any comments or suggestions you may have to help us enhance our service.

Sincerely,

Meadowbrook Insurance Services

Phone 800-781-8062 • Fax 702-441-7083 www.meadowbrook.com

TABLE OF CONTENTS

Workers' Compensation Claim Kit

- Supervisor's Injury Reporting Guide (Important Claim Reporting Procedures)

IMPORTANT FORMS

- **C-1** Notice of Injury or Occupational Disease (Incident Report) updated 10/05
- **C-3** Employer's Report of Industrial Injury or Occupational Disease updated 11/05
- **C-4** Employee's Claim for Compensation/Report of Initial Treatment updated 01/03
- **D-2** Brief Description of Rights and Benefits updated 11/05
- **D-8** Employer's Wage Verification Form updated 07/99
- **D-21** Fatality Report updated 07/99
- **122** Utah First Report of Injury or Illness new
- **ICA 04-0101** Arizona Employer's Report of Industrial Injury new

IMPORTANT NOTICE

- State of Nevada – Rights and Benefits
- Fraud Warning
- State of Utah Posting Notice

Star Insurance Company
Williamsburg National Insurance Company
ProCentury Insurance Company

SUPERVISOR'S INJURY REPORTING GUIDE
Claim Reporting Procedures
24 Hours a Day / 7 Days a Week

FOR *IMMEDIATE EMERGENCY* MEDICAL TREATMENT

Step 1: Immediately transport the injured employee to the nearest medical facility.
Step 2: Call the Star Insurance Company/Williamsburg National Insurance Company/ProCentury Insurance Company Tele-Reporting Claims Service at 1-800-825-9489.

- Identify yourself as a Star Insurance Company/Williamsburg National Insurance Company/ProCentury Insurance Company insured.
- Provide requested information to the Claims Representative.
- Complete the "Notice of Injury or Occupational Disease" form (copy included) and fax the completed form to (702) 441-7083.

FOR *NON-EMERGENCY* MEDICAL TREATMENT

Step 1: Call the Star Insurance/Williamsburg National Insurance Company/ProCentury Insurance Company Tele-Reporting Claims Service at 1-800-825-9489 OR complete and SIGN "Employer's Report of Industrial Injury or Occupational Disease" C3 form (copy included) and fax completed form to (702) 441-7083.

- Identify yourself as a Star Insurance Company/Williamsburg National Insurance Company/ProCentury Insurance Company Insured.
- Provide requested Information to the Claims Representative.
- Complete the "Notice of Injury or Occupational Disease" form C1 (copy included) and fax completed form to (702) 441-7083.

Step 2: Send the injured employee to the nearest Concentra Medical Center, Industrial Medical Group, UMC QuickCare Facility, or the nearest medical service provider.

QUESTIONS ??

For questions regarding Claims Administration, please contact:
Meadowbrook Claims Service
1707 Village Center Circle, Suite 100
Las Vegas, NV 89134-6370
Telephone: (702) 360-0571
(800) 781-8062
Fax: (702) 441-7083

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"

(Incident Report)

Pursuant to NRS 616C.015

Name of Employer ______________________________

Name of Employee		Social Security Number		Telephone Number
Date of Accident (if applicable)	Time of Accident (if applicable)	Place where accident occurred (if applicable)		
What is the nature of the injury or occupational disease?			List any body parts involved:	
Briefly describe accident or circumstances of occupational disease: (Note: if you are claiming an occupational disease, indicate the date on which employee first became aware of connection between condition and employment)				
Names of witnesses:				
Did the employee leave work because of the injury or occupational disease? _____ **YES** _____ **NO**	If yes, when (date and time)?	Has the employee returned to work? ____ **YES** ____ **NO**	If yes, when (date and time)?	
Was first aid provided? ____ **YES** ____ **NO**	If yes, by whom?	Name and address of treating physician, if applicable or known		
Did the accident happen in the normal course of work? (if applicable) ____ **YES** ____ **NO**				
Was anyone else involved? ____ **YES** ____ **NO**	Names of others involved			

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

______________________________ ______________________________

Supervisor's Signature Date Signature of Injured or Disabled Employee Date

TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4).

For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://govcha.state.nv.us E-mail cha@govcha.state.nv.us

Employee should sign, date and retain a copy.

Original to Employer, Copy to Employee

TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF RECEIPT OF THE C-4 FORM

Please Type or Print

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER

Employer's Name	Nature of Business (mfg., etc.)	FEIN	OSHA Log #
Office Mail Address	Location . . . If different from mailing address	Telephone	
City / State / Zip	INSURER	THIRD-PARTY ADMINISTRATOR	

EMPLOYEE

First Name / M.I. / Last Name	Social Security	Birthdate	Age	Primary Language Spoken
Home Address (Number and Street)	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
City / State / Zip	Was the employee paid for the day of injury? (If applicable) ☐ Yes ☐ No	How long has this person been employed by you in Nevada?		
In which state was employee hired?	Employee's occupation (job title) when hired or disabled	Department in which regularly employed:		
Telephone	Is the injured employee a corporate officer? ☐ Yes ☐ No . . . sole proprietor? ☐ Yes ☐ No . . . partner? ☐ Yes ☐ No	Was employee in your employ when injured or disabled by occupational disease (O/D)? ☐ Yes ☐ No		

ACCIDENT OR DISEASE

Date of Injury (if applicable)	Time of injury (Hours; Minute AM/PM) (if applicable)	Date employer notified of injury or O/D	Supervisor to whom injury or O/D reported
Address or location of accident (Also provide city, county, state) (if applicable)			Accident on employer's premises? (if applicable) ☐ Yes ☐ No
What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)			
How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.			

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable)		Witness	Was there more than one person injured in this accident? (if applicable) ☐ Yes ☐ No
Part of body injured or affected	If fatal, give date of death	Witness	
Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.)		Witness	
		Did employee return to next scheduled shift after accident? (if applicable) ☐ Yes ☐ No	Will you have light duty work available if necessary? ☐ Yes ☐ No
If validity of claim is doubted, state reason		Location of Initial Treatment	
Treating physician/chiropractor name		Emergency Room ☐ Yes ☐ No	Hospitalized ☐ Yes ☐ No
IMPORTANT	How many days per week does employee work?	From ☐ am ☐ pm To ☐ am ☐ pm	Last day wages were earned
Scheduled days off S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ Rotating ☐		Are you paying injured or disabled employee's wages during disability? ☐ Yes ☐ No	

IMPORTANT LOST TIME INFO

Date employee was hired	Last day of work after injury or disability	Date of return to work	Number of work days lost
Was the employee hired to work 40 hours per week? ☐ Yes ☐ No	If not, for how many hours a week was the employee hired?	Did the employee receive unemployment compensation any time during the last 12 months? ☐ Yes ☐ No ☐ Do not know	

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more, attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 12 weeks, provide gross earnings from the date of hire to the date of injury or disability.

Pay period ends on: ☐ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☐ FRI	Emloyee is paid: ☐ WEEKLY ☐ MONTHLY ☐ OTHER ☐ BI-WKLY ☐ SEMI-MONTHLY	On the date of injury or disability the employee's wage was: $ per ☐ Hr ☐ Day ☐ Wk ☐ Mo

For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://govcha.state.nv.us E-mail cha@govcha.state.nv.us

★			
I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.		Employer's Signature and Title	Date

Insurer Use Only

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party	Deemed Wage	Account No.	Class Code
Claims Examiner's Signature	Date	Status Clerk	Date

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT
FORM C-4
PLEASE TYPE OR PRINT

EMPLOYEE'S CLAIM – PROVIDE ALL INFORMATION REQUESTED

First Name | M.I. | Last Name | Birthdate | Sex ☐ M ☐ F | Claim Number (Insurer's Use Only)

Home Address | Age | Height | Weight | Social Security Number

City | State | Zip | Telephone

Physical Address | City | State | Zip | Primary Language Spoken

INSURER | **THIRD-PARTY ADMINISTRATOR** | Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred

Employer's Name/Company Name | Telephone

Office Mail Address (Number and Street)

Date of Injury (if applicable) | Hours Injury (if applicable) am pm | Date Employer Notified | Last Day of Work After Injury or Occupational Disease | Supervisor to Whom Injury Reported

Address or Location of Accident (if applicable)

What were you doing at the time of the accident? (if applicable)

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)

If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?

Witnesses to the Accident (if applicable)

Nature of Injury or Occupational Disease | Part(s) of Body Injured or Affected

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 616A TO 616D, INCLUSIVE OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER, OR OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

Date | Place | Employee's Signature

THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT

Place | Name of Facility

Date | Diagnosis and Description of Injury or Occupational Disease | Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident? ☐ No ☐ Yes (if yes, please explain)

Hour

Treatment:

Have you advised the patient to remain off work five days or more?

☐ Yes Indicate dates: from ____________ to __________________

☐ No If no, is the injured employee capable of: ☐ full duty ☐ modified duty

If modified duty, specify any limitations/restrictions: ______________________

X-Ray Findings:

From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? ☐ Yes ☐ No

Is additional medical care by a physician indicated? ☐ Yes ☐ No

Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☐ No (Explain if yes)

Date | Print Doctor's Name | I certify that the employer's copy of this form was mailed to the employer on:

Address | INSURER'S USE ONLY

City | State | Zip | Provider's Tax I.D. Number | Telephone

Doctor's Signature | Degree

BRIEF DESCRIPTION OF RIGHTS AND BENEFITS
(Pursuant to NRS 616C.050)

Notice of Injury or Occupational Disease (Incident Report Form C-1): If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the required forms.

Claim for Compensation (Form C-4): If medical treatment is sought, the form C-4 is available at the place of initial treatment. A completed "Claim for Compensation" (Form C-4) must be filed within 90 days after an accident or OD. The treating physician or chiropractor must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

Medical Treatment: If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractor from a list provided by your workers' compensation insurer, if it has contracted with an Organization for Managed Care (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered into a contract with an MCO or PPO, you may select a physician or chiropractor from the Panel of Physicians and Chiropractors. Any **medical costs** related to your industrial injury or OD will be paid by your insurer.

Temporary Total Disability (TTD): If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

Temporary Partial Disability (TPD): If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

Permanent Partial Disability (PPD): When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractor to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation and your age and wage.

Permanent Total Disability (PTD): If you are medically certified by a treating physician or chiropractor as permanently and totally disabled and have been granted a PTD status by your insurer, you are entitled to receive monthly benefits not to exceed 66 2/3% of your average monthly wage. The amount of your PTD payments is subject to reduction if you previously received a PPD award.

Vocational Rehabilitation Services: You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

Transportation and Per Diem Reimbursement: You may be eligible for travel expenses and per diem associated with medical treatment.

Reopening: You may be able to reopen your claim if your condition worsens after claim closure.

Appeal Process: If you disagree with a written determination issued by the insurer or the insurer does not respond to your request, you may appeal to the **Department of Administration, Hearing Officer,** by following the instructions contained in your determination letter. You must appeal the determination within 70 days from the date of the determination letter at 1050 E. William Street, Suite 400, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. If you disagree with the Hearing Officer decision, you may appeal to the **Department of Administration, Appeals Officer**. You must file your appeal within 30 days from the date of the Hearing Officer decision letter at 1050 E. William Street, Suite 450, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. If you disagree with a decision of an Appeals Officer, you may file a **petition for judicial review with the District Court**. You must do so within 30 days of the Appeal Officer's decision. You may be represented by an attorney at your own expense or you may contact the NAIW for possible representation.

Nevada Attorney for Injured Workers (NAIW): If you disagree with a hearing officer decision, you may request that NAIW represent you without charge at an Appeals Officer Hearing. For information regarding denial of benefits, you may contact the NAIW at: 1000 E. William Street, Suite 208, Carson City, NV 89701, (775) 684-7555, or 2200 S. Rancho Drive, Suite 230, Las Vegas, NV 89102, (702) 486-2830

To File a Complaint with the Division: If you wish to file a complaint with the Administrator of the Division of Industrial Relations (DIR), please contact the Workers' Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, telephone (775) 684-7270, or 1301 North Green Valley Parkway, Suite 200, Henderson, Nevada 89074, telephone (702) 486-9080.

For assistance with Workers' Compensation Issues: you may contact the Office of the Governor Consumer Health Assistance, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101, Toll Free 1-888-333-1597, Web site: http://govcha.state.nv.us, E-mail cha@govcha.state.nv.us

EMPLOYER'S WAGE VERIFICATION FORM
(Pursuant to NRS 616C.045(2)(d))

Please provide the following information for the employee named below by completing this form. The information is needed so that the amount of disability compensation to which your employee is entitled may be calculated. Prompt completion and return of this form will ensure the timely payment of any compensation due this injured worker. Please answer all questions and sign the form where indicated.

EMPLOYER: PLEASE PROVIDE THE FOLLOWING INFORMATION ANSWERING ALL QUESTIONS

Date: ______ Injured Employee's Name (Last/First/M.I.): ______ Social Security # ______

Claim No.: ______ D.P.T. No.: ______ Date of Injury: ______ Date of Hire: ______

Was employee hired to work 40 hours per week: [ ] Yes [ ] No If no, # of hours per week: ______ # of days per week: ______

On the date of injury, the employee's wage was: $ ______ per [ ] Hour [ ] Day [ ] Week [ ] Month Date the wage became effective: ______

Was vacation paid during the applicable twelve week period?______ If so, during what pay period? ______

Was sick leave paid during the applicable twelve week period? ______ Was the injured employee paid for any holidays during the applicable twelve week period? ______ Did employee receive payment for overtime during the applicable twelve week period? ______ Did employee receive termination pay during the applicable twelve week period? ______

Provide prior wage if current wage was in effect less than 12 weeks prior to date of injury: $ ______ per [ ] Hour [ ] Day [ ] Week [ ] Month

During this 12-week period did employee change to a job with different (1) duties, (2) hours of employment, (3) rate of pay? [ ] Yes [ ] No

If so, date: ______ Explain: ______

Does the employee receive commissions? [ ] Yes [ ] No Period of commission earned ______ to ______.

Indicate the amount of commission received over the last 6 months, or since date of hire: $ ______

Does the employee receive bonuses/incentive pay? [ ] Yes [ ] No Period of bonuses/incentive pay earned ______ to ______.

Indicate the amount of bonuses received over last 12 months, or since date of hire: $ ______

Are the commission and bonus amounts included in GROSS EARNINGS below? [ ] Yes [ ] No

Does the employee declare tips for the purpose of worker's compensation? [ ] Yes [ ] No **See payroll declaration below. Attach declaration forms.**

Does the employee receive meals or lodging (excluding reimbursement for travel per diem)? [ ] Yes [ ] No **(Do not include in gross earnings)**

How many meals per day? ______ Monetary value of meals $ ______ per [ ] Day [ ] Week [ ] Month

Lodging $ ______ per [ ] Day [ ] Week [ ] Month

TWELVE WEEK VERIFICATION FROM PAYROLL RECORDS. Report GROSS EARNINGS, include overtime payment and any other remuneration (except reimbursement for expenses). (See NAC 616C.423)

Give payroll information from ______ through ______. If employed less than twelve weeks, give gross earnings from date of hire to date of injury.

If absent from work for the following reasons, please specify the date(s) absent and the number code for the reason of absence.
1. Certified illness or disability; 2. Institutionalized in a hospital, or other institution; 3. Enrolled as full-time student, not employed on days of attendance; 4. In military service other than training duty conducted on weekends; 5. Absent because of officially sanctioned strike; 6. Absence because of leave approved pursuant to Family and Medical Leave Act.

Payroll Period Beginning	Payroll Period Ending	Gross Salary (Excluding Tips)	Declared Tips	Payroll Period Beginning	Payroll Period Ending	Gross Salary (Excluding Tips)	Declared Tips

Dates of Absence Begin	Dates of Absence End	Reason	Dates of Absence Begin	Dates of Absence End	Reason	Dates of Absence Begin	Dates of Absence End	Reason

Pay period ends on (check one) [ ] Sunday [ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday
Employee is paid: [ ] Weekly [ ] Bi-Weekly [ ] Semi-Monthly [ ] Monthly [ ] Other
Employee scheduled day(s) off: [ ] Sunday [ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday [ ] Other
Explain "other":
Date the employee last worked AFTER injury occurred: ______ Date returned to work: ______

This information is true and correct as taken from the employee's payroll records.

By: ______ Title: ______

Date: ______ Employer: ______

Insurer: ______ Third-Party Administrator: ______

STATE OF NEVADA
DEPARTMENT OF BUSINESS AND INDUSTRY
Division of Industrial Relations

400 West King Street, Suite 400
Carson City, Nevada 89703

1301 N. Green Valley Parkway, Suite 200
Henderson, Nevada 89074

FATALITY REPORT

(Pursuant to NAC 616B.018)

(Note: The insurer must notify the Administrator within 48 hours after receiving notice of fatality)

To: ADMINISTRATOR, D.I.R.

From: ______________________________

Address: ______________________________

Date: ______________________________

Deceased: ____________ D.O.B. ____________ SSN: ____________

Address: ______________________________ City: ____________

County: ______________________________ State: ____________

Date of Accident or onset of Occupational Disease: ____________ Time: ____________ A.M. P.M.

Date of Death: ____________

Marital Status: ________ Name of Spouse: ____________ No. of Dependents: ____________

Name of Dependent: ____________ D.O.B. ____________ Relationship: ____________

Name of Dependent: ____________ D.O.B. ____________ Relationship: ____________

Name of Dependent: ____________ D.O.B. ____________ Relationship: ____________

Employer: ______________________________ Type of Business: ____________

Address: ______________________________

Deceased Employee's Occupation: ______________________________

Exact Location of Accident (if applicable): ______________________________

____

Describe Accident or Occupational Disease: ______________________________

____

____

______

____
Reported By

____
Title

FORM 122

For your protection Utah Law requires notice that worker's compensation fraud is a crime. Please see back of this form for the full fraud statement.

WORKER'S COMPENSATION EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS
STATE OF UTAH - THE LABOR COMMISSION - DIVISION OF INDUSTRIAL ACCIDENTS
160 E 300 S, P.O. BOX 146610
SALT LAKE CITY, UTAH 84114-6610

GENERAL

EMPLOYER (Name & Address Incl. Zip)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
INDUSTRY CODE / EMPLOYER FEIN			PHONE #

CARRIER / CLAIMS ADMIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE#)	POLICY PERIOD ___ TO ___	CLAIMS ADMINISTRATOR (NAME, ADDRESS, & PHONE NO)
	CHECK IF APPROPRIATE ☐ SELF-INSURANCE	

CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN
AGENT NAME AND CODE NUMBER		

EMPLOYEE

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX: M MALE, F FEMALE, U UNKNOWN	MARITAL STATUS: U UNMARRIED SINGLE/DIVORCE, M MARRIED, S SEPARATED, K UNKNOWN	OCCUPATION / JOB TITLE	
			EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE	

WAGE

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER	# OF DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO
		DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ☐ AM ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER	TYPE OF INJURY / ILLNESS	PART OF BODY AFFECTED
DID INJURY / ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY / ILLNESS CODE	PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED / CAUSE OF INJURY CODE

HOW INJURY OR ILLNESS / ABNORMAL HEALTH CONDITION OCCURRED, DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO
		WERE THEY USED? ☐ YES ☐ NO

TREATMENT

PHYSICIAN/HEALTH CARE PROVIDER (NAMES & ADDRESS)	HOSPITAL (NAME & ADDRESS)	INITIAL TREATMENT
		0 NO MEDICAL TREATMENT
		1 MINOR: BY EMPLOYER
		2 MINOR CLINIC/HOSP
		3 EMERGENCY CARE
		4 HOSPITALIZED > 24 HRS
		5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

SEE BACK FOR IMPORTANT INFORMATION

© IAIABC 2002

White: Labor Commission   Yellow: W.C. Insurance Carrier   Pink: Employee   Goldenrod: Employer's File

FRAUD - “Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false of fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison”

INSTRUCTIONS TO EMPLOYER

The Employer’s First Report of Injury or Illness must be submitted to the Labor Commission, Division of Industrial Accidents, per Sections §34A-2-407 and §34A-3-10B, Utah Code Annotated (U.C.A.), 1997. Each employer shall file the report within **seven days** after the occurrence, or the employee’s notification of the same, which results in medical treatment by a physician, loss of consciousness, loss of work, restriction of work, or transfer to another job. Each employer shall file a subsequent report with the commission of any previously reported injury; or occupational disease that later resulted in death. Also, for your information, Section §34A-6-301(3)(b)(ii) states that each employer shall, within 12 hours of occurrence, notify the Division of Occupational Safety and Health, at (801) 530-6901 or (800) 530-5090, of any; work related fatality; disabling, serious, or significant injury; or occupational disease incident. A serious injury includes: amputation, fractures of major bones (both simple and compound), and hospitalization for medical treatment.

* All information requested on this form is of vital importance. Please answer **all** items in detail in order to avoid additional correspondence or the return of this report for completion. **Do not enter data in the shaded areas.**

***** The box titled “OSHA Log Number” must be filled in with the employer assigned Case Number from OSHA’s new 300 Injury Log. The Case Number needs to reflect the year of the injury - for example, your first injury in 2002 should reflect the first injury and the year 00/02 with the next injury being 00202 etc.

* Please provide **WAGE** information. This information is needed by the insurance company for paying the correct amount on a claim.

* The injury report on file with the Labor Commission, Division of Industrial Accidents, is private information and is only released to parties to the claim.

* Please make sure the **EMPLOYER NAME** is correct, as well as your **FEIN#** (Federal Tax ID Number). The employer’s name should be the same as reported to The Department of Workforce Services and as it appears on your WORKERS’ COMPENSATION insurance policy.

* **The Labor Commission** is to receive the **original** of this report, **Worker’s Compensation Insurance Carrier** gets the **second** copy, the **employee** gets the **third** copy, and the **employer** gets the **fourth** and should maintain a copy of this report.

* Failure to file this report with the Labor Commission or failure to provide the employee with copy of the report, is a Class C misdemeanor and can also result in a citation and a civil penalty for each violation as per §34A-2-407(7), §34-a-3-108(7), §34A-6-302, and §34A-6-307, U.C. A.

* If you dispute the validity of this claim you need to contact your insurance carrier, but you must still file the “Employer’s First Report of Injury or Illness” form with the Labor Commission.

* **Reminder**: Inform your injured employee of his/her rights and obligations (as outlined on the back of the employee’s copy) of Utah’s Workers’ Compensation Act.

For additional information please contact:

State of Utah - Labor Commission
Division of Industrial Accidents
160 East 300 South, 3rd Floor
P.O. Box 146610
Salt Lake City, Utah 84114-6610
(801) 530-6800 (800) 530-5090

FRAUD - "Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison."

EMPLOYEE INFORMATION

- **INJURY/ILLNESS REPORT**: A report of your injury/ occupational illness must be made with your employer. If a report of injury is not filed with your employer or the Labor Commission, Division of Industrial Accidents, within 180 days of the date of your injury/illness, you may lose the right to ever file a claim for workers' compensation benefits for that injury or illness.

- **EMPLOYER'S PHYSICIAN:** If your employer has a company physician or designated clinic for industrial accidents, you MUST see the company physician first, or you may not be eligible for workers' compensation benefits. After you have been seen by your employer's physician, you have the right to choose one treating physician.

- **MEDICAL COOPERATION:** You must cooperate with your employer or the insurance carrier in following prescribed medical treatment in order to return to work as quickly as possible.

- **TRAVEL REIMBURSEMENT:** You may be eligible for travel reimbursement to and from approved medical care. You will need to keep records. Contact your insurance carrier regarding travel expenses.

- **REEMPLOYMENT ASSISTANCE:** You may be eligible for reemployment assistance if you are unable to return to work due to an industrial injury. Contact your insurance carrier or the Labor Commission, Division of Industrial Accidents, for further information.

- **MEDICAL EXPENSES:** You are entitled to have all reasonable medical expenses paid that are a result of the injury or illness.

- **COMPENSATION BENEFITS:** You are entitled to 66-2/3 of your wages up to 100% of the state average weekly wage (as of the date of your injury) after 3 days from the date of your injury, if a physician states you are totally unable to work.

  ☐ If you have sustained a permanent impairment due to the industrial injury or disease, you are entitled to compensation based on the impairment rating as determined by a physician.

  ☐ If you are permanently totally disabled from working due to the industrial injury, you may need to apply at the Labor Commission, Division of Industrial Accidents, for a hearing to determine if benefits are due.

- **ADDITIONAL ASSISTANCE:** If you are unable to work due to an industrial injury and meet the program's requirements, you may be eligible for other assistance. Agencies you may wish to contact:

  ☐ Department of Workforce Services for food stamps, cash assistance, medical assistance, or employment assistance
  ☐ Social Security for total disability benefits

- **UNEMPLOYMENT BENEFITS:** If you are able to work, but have been terminated from your job, you need to apply at the nearest Department of Workforce Services employment office within 90 calendar days after you are released for full-time work by your doctor.

Contact your insurance carrier if problems occur during your injury regarding payment of medical bills or compensation payments. If you need to know who your employer's insurance carrier is, your may ask your employer or contact the Labor Commission, Division of Industrial Accidents.

For further information or assistance contact:
Labor Commission - Division of Industrial Accidents
160 East 300 South 3rd Floor, P.O. Box 146610, Salt Lake City, Utah 84114-6610
(801) 530-6800, 1 (800) 530-5090

THIS IS AN IMPORTANT DOCUMENT TO MAINTAIN FOR YOUR RECORDS

EMPLOYER'S REPORT OF INDUSTRIAL INJURY

COMPLETE AND MAIL THIS REPORT WITHIN 10 DAYS FROM NOTICE OF ACCIDENT. FATALITIES MUST BE REPORTED WITHIN 24 HOURS.

Employer must, on this form, notify his insurance carrier of every injury or disease suffered by an employee, fatal or otherwise, which is claimed to arise our of or in the course of employment. ARIZONA REVISED STATUTES 23-908 & 23-1061

INDUSTRIAL COMMISSION OF ARIZONA
P.O. BOX 19070
PHOENIX, ARIZONA 85005-9070

MAIL TO: (CARRIER NAME & ADDRESS)

FOR CARRIER USE ONLY

FOR OSHA PURPOSES ONLY

OSHA Case #: ______

RECORDABLE INJURY ______

NON-RECORDABLE INJURY ______

EMPLOYEE

1. LAST NAME | FIRST | M.I. | 2. SOCIAL SECURITY NUMBER * | 3. BIRTH DATE
4. HOME ADDRESS (NUMBER & STREET) | CITY | STATE | ZIP CODE | 5. TELEPHONE
6. SEX ☐ MALE ☐ FEMALE | 7. MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

EMPLOYER

8. EMPLOYER'S NAME | 9. POLICY NUMBER | 10. NATURE OF BUSINESS (MANUFACTURING, ETC.)
11. OFFICE ADDRESS (NUMBER & STREET) | CITY | STATE | ZIP CODE | 12. TELEPHONE

ACCIDENT

13. DATE OF INJURY OR ILLNESS | 14. TIME OF EVENT ☐ A.M. ☐ P.M. | 15. TIME EMPLOYEE BEGANWORK ☐ A.M. ☐ P.M. | 16. DATE EMPLOYER NOTIFIED OF INJURY
17. LAST DAY OF WORK AFTER INJURY | 18. DATE OF RETURN TO WORK | 19. EMPLOYEE'S OCCUPATION (JOB TITLE) WHEN INJURED
20. CLASS CODE ON PAYROLL REPORT | 21. EMPLOYEE'S ASSIGNED DEPARTMENT | 22. DEPARTMENT NUMBER | 23. DID INJURY OCCUR ON EMPLOYER PREMISES? ☐ YES ☐ NO
24. ADDRESS OR LOCATION OF ACCIDENT | CITY | COUNTY | STATE | ZIP CODE
25. WHAT WAS THE INJURY OR ILLNESS? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or sore." *Examples:* "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
26. PART OF BODY INJURED | 27. FATAL ☐ YES ☐ NO | 28. IF THE EMPLOYEE DIED, WHEN DID THE DEATH OCCUR? DATE OF DEATH
29. WAS EMPLOYEE TREATED IN AN EMPERGENCY ROOM? ☐ YES ☐ NO | NAME OF PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL | ADDRESS (STREET, CITY, STATE & ZIP CODE)
30. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? ☐ YES ☐ NO | IF HOSPITALIZED, HOSPITAL NAME | ADDRESS (STREET, CITY, STATE & ZIP CODE)
31. IF VALIDITY OF CLAIM IS DOUBTED, STATE REASON

CAUSE OF ACCIDENT

32. **WHAT HAPPENED?** Tell us how the injury occurred. *Examples:* "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
33. **WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE?** *Examples:* "concrete floor"; "chlorine"; "radial arm saw." *If this question does not apply to the incident, leave it blank.*
34. **WHAT WAS EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."
35. IF ANOTHER PERSON NOT IN COMPANY EMPLOY CAUSED ACCIDENT, GIVE NAME AND ADDRESS

EMPLOYEE'S WAGE DATA

36. WAS WORKER IN YOUR EMPLOY WHEN INJURED? ☐ YES ☐ NO | 37. HOURS PER DAY EMPLOYEE WORKED FROM A.M. P.M. THRU A.M. P.M. | 38. WAS EMPLOYEE ON OVERTIME WHEN INJURED? ☐ YES ☐ NO | 39. NUMBER OF DAYS PER WEEK USUALLY WORKED EMPLOYEE COMPANY

IMPORTANT IF WORK LOSS IS EXPECTED TO EXCEED SEVEN CALENDAR DAYS, COMPLETE ITEMS 40 THRU 47

40. DATE OF LAST HIRE | 41. WAS WORKER PAID FOR DAY OF INJURY? ☐ YES ☐ NO IF YES, $ | 42. WAS EMPLOYEE HIRED FOR PERMANENT EMPLOYMENT? ☐ YES ☐ NO
43. NUMBER OF MONTHS EMPLOYMENT AVAILABLE DURING THE YEAR | 44. GIVE EMPLOYEE'S WAGE STATUS AS APPLICABLE $ PER ☐ HOUR ☐ DAY ☐ WEEK ☐ MONTH | 45. IS EMPLOYEE FURNISHED ☐ LODGING ☐ BOARD ☐ BOTH VALUE $
46. ACTUAL GROSS EARNINGS OF EMPLOYEE FOR THE 30 CALENDAR DAYS PRECEEDING INJURY (EXAMPLE: IF INJURED APRIL 8, GIVE EARNINGS FROM MARCH 9 THRU APRIL 7) | 47. DOES EMPLOYEE CLAIM DEPENDENTS? ☐ YES ☐ NO

IMPORTANT IF EMPLOYEE IS PAID OTHER THAN FIXED WEEKLY OR MONTHLY SALARY, COMPLETE ITEMS 48 THRU 55

48. IF EMPLOYEE EARNS EXTRA PAY FOR OVERTIME, WHAT IS BASIS OF PAYMENT? PER HOUR | 49. NUMBER OF HOURS OVERTIME CONSIDERED NORMAL PER WEEK
50. GROSS WAGES OF EMPLOYEE DURING 12 MONTHS PRECEEDING INJURY FROM THRU $ | 51. IF EMPLOYEE WORKED LESS THAN 12 MONTHS, SHOW GROSS WAGES FROM DATE OF HIRE THROUGH DAY PRIOR TO INJURY FROM THRU $
52. DATE OF LAST WAGE INCREASE IF WITHIN 12 MONTHS PRIOR TO INJURY | 53. WAGE BEFORE INCREASE $ | 54. WAGE AFTER INCREASE $ | 55. GROSS EARNINGS FROM DATE OF INCREASE THRU DAY PRIOR TO INJURY $

AUTHORIZED SIGNATURE

DATE | AUTHORIZED SIGNATURE | TITLE

NOTE TO EMPLOYER:

1. Mail one copy to the Industrial Commission within 10 days.
2. Mail one copy to your insurance carrier within 10 days.
3. Keep one copy, for not less than five (5) years, as your supplementary record of injuries required by the Federal Occupational Safety and Health Act of 1970.

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

Form ICA 04-0101 (Rev. 7/01)

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

WORKERS' COMPENSATION FRAUD WARNINGS

APPLICABLE IN ARKANSAS

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. 23-66-503

APPLICABLE IN CALIFORNIA

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. 1871.2
False representations made on the signed claim form by the insured arising from the theft of an insured vehicle will subject the insured to a penalty of perjury. 1871.3
Any person who makes or causes to be made any knowingly false or fraudulent material statement or material misrepresentation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony. 5401.7

APPLICABLE IN FLORIDA

Amy person who, knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. 817.234(1)(b)
Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree. 440.37(2)(a)

APPLICABLE IN MINNESOTA

A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime. 60A.955

APPLICABLE IN NEW YORK

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. 403
Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of a theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the Department of Motor Vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation. 403

APPLICABLE IN TENNESSEE

It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits. 56-__-112(b)

APPLICABLE IN UTAH

For your protection, Utah law requires the following to appear of this form:
Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE
THAT

Employer: ____

has complied with the provisions of the Workers' Compensation Act, Title §34A-2-101, Utah Code Annotated, 1997 (as amended), and the rules of the Labor Commission, and has insured the liability to pay the compensation and other benefits provided by said Act by insuring with Insurance Carrier: ____

Policy Number: ____

Address for the above insurance carrier is ____

Telephone number is __________________________

WORKERS' COMPENSATION

IS INSURANCE WHICH PROTECTS YOU DURING WORK. IF YOU HAVE AN ON-THE-JOB INJURY OR OCCUPATIONAL DISEASE, IT WILL PAY FOR: HOSPITAL AND MEDICAL BILLS * TIME LOST FROM WORK * PERMANENT LOSS OF BODY FUNCTION * PROSTHETIC DEVICES * BURIAL BENEFITS IN DEATH CASES.

HOW TO REPORT AN ACCIDENT

1. Report the injury - no matter how slight - to your boss immediately. (You may lose your rights if your injury is not reported promptly.)

2. Ask your employer to fill out the employer's first report of injury form. A copy of this report is to be given to you and copies are to be sent to the insurance company within seven (7) days of the accident.

3. If your employer has a first-aid room or company designated doctor, go there promptly for treatment. If not, go to a doctor of your choice.

4. Tell the doctor HOW, WHEN and WHERE the accident happened. The doctor will fill out a medical report form. Copies of the report are to be sent within seven (7) days of your visit to (1) the insurance company, (2) the Labor Commission and (3) you, the employee.

HOW TO START COMPENSATION

1. Ask your employer which insurance company pays workers' compensation for your company.

2. Ask your doctor to send a medical report to that insurance company.

3. Ask your employer to send a report of the accident to that insurance company.

4. Call the insurance company and ask them to start your workers' compensation benefits. The insurance company will require the doctor's report, employer's report, and may ask you to fill out a request for compensation

REHABILITATION

IF YOU CANNOT RETURN TO WORK, YOU MAY BE ELIGIBLE FOR A REHABILITATION PROGRAM – CALL YOUR INSURANCE CARRIER AS LISTED ABOVE.

FRAUD

"For your protection, Utah Law requires the following to appear on this form, any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison."

STATE OF UTAH

LABOR COMMISSION

160 EAST 300 SOUTH, PO BOX 146610, SALT LAKE CITY, UT 84114-6610

(801)530-6800 – (800)530-5090 – (801)530-7685 TDD

If you want an Employee's Guide to Workers' Compensation or have questions, call the Labor Commission at the above listed numbers.

NOTE: This notice must be posted and kept continuously in a public and conspicuous place in the office, shop or place of business of the employer as per §34A-2-204, Utah Code Annotated, 1997.

NOTE QUE

La empresa:______________________________

Ha cumplido con las provisiones del Acta de Compensación al Trabajador, Título §34A-2-101, en el libro de Código de Utah anotado en 1997, y las reglas de la Comisión de Labor (Labor Commission), y ha asegurado tener la responsabilidad de pagar compensación y otros beneficios preve idos por el Acta ya mencionada al tener cobertura con.

Compañía de Seguros:____________________ **No. de Póliza:**____________________

Dirección de la compañía de seguros:______________________________

Número de teléfono:______________________________

COMPENSACION AL TRABAJADOR

ES EL SEGURO EL CUAL LE PROTEGE DURANTE EL TRABAJO. SI TIENE UN ACCIDENTE EN EL TRABAJO O UNA ENFERMEDAD GENERADA A CAUSA DE SU TRABAJO, SU SEGURO PAGARA POR: HOSPITAL Y GASTOS MEDICOS • INCAPACIDAD • PERDIDA PERMANENTE DE UNA FUNCION DE SU CUERPO • PROTESIS • GASTOS DEL FUNERAL EN CASO DE MUERTE.

COMO REPORTAR UN ACCIDENTE

1. Reporte la herida - no importa que tan leve sea - a su supervisor inmediatamente. (Pierde sus derechos si no reporte su accidente entre 180 días después del incidente.)
2. Pida a su supervisor que llene la forma del primer reporte de accidente. Una copia de este reporte es para usted y las demás copias deben ser enviadas a La Comisión de Labor y a la compañía de seguro dentro de los primeros siete (7) días del accidente.
3. Si en su trabajo hay un cuarto de primeros auxilios o un doctor de la compañía, vaya allá inmediatamente para obtener tratamiento, Si no, vaya al doctor de su preferencia.
4. Dígale al doctor **CÓMO, CUÁNDO Y DÓNDE** ocurrió el accidente. El doctor llenará una forma de reporte médico. Copias de ese reporte deben se enviadas dentro de siete (7) días de su visita a (1) la compañía de seguros, (2) La Comisión de Labor y (3) usted, el empleado.

COMO EMPEZAR LA COMPENSACION

1. Pregunte a su supervisor cual es la compañía de seguros que paga Compensación al Trabajador de su trabajo.
2. Pida a su doctor que mande un reporte médico a esa compañía de seguros.
3. Pida a su supervisor que mande un reporte del accidente a esa compañía de seguros.
4. Llame a la compañía de seguros y pídales que empiecen sus beneficios de compensación al trabajador. La compañía de seguros requerirá el reporte del doctor, el reporte de su trabajo, y le pedirá que llene una forma para obtener compensación.

REHABILITACION

SI NO PUEDE REGRESAR A SU TRABAJO, USTED PUEDE CALIFICAR PARA UN PROGRAMA DE REHABILITACION - LLAME A LA COMPAÑÍA DE SEGUROS MENCIONADA ARRIBA.

FRAUDE

"Para su protección, la ley de Utah requiere lo siguiente que aparezca en esta forma, cualquier persona que intensionalment presente información falsa o fraudulenta, que abra o cause que sea abierto un caso fraudulento de disabilidad o beneficios médicos, o que entregue un reporte fraudulento de facturas de gastos médicos u otros servicios profesionales es culpable de crimen y puede ser sujeto a multas y encerrado en la prisión del Estado."

ESTADO DE UTAH

COMISION DE LABOR

160 EAST 300 SOUTH • P.O. BOX 146610 • SALT LAKE CITY, UT 84114-6610
(801) 530-6800 • (800) 530-5090 • (801) 530-7685 TDD (aparato telefónico para personas con problemas de sordera y mudez)

Si desea una Guía del Empleado para Compensación al Trabajador o si tiene preguntas, llame a la Comisión de Labor a los números mencionados arriba.

NOTA: Esta información debe ser publicada y permanecer continuamente colocada en un lugar público ya sea en la oficina, taller, o lugar de negocio de la empresa de acuerdo con el Artículo §34A-2-204, en el libro de Código de Utah anotado en 1997.

State of Nevada
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INDUSTRIAL RELATIONS
Workers' Compensation Section

ATTENTION

Brief Description of Your Rights and Benefits If You Are Injured on the Job or have an Occupational Disease

Notice of Injury or Occupational Disease (Incident Report Form C-1) If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the forms.

Claim for Compensation (Form C-4): If medical treatment is sought, the form C-4 is available at the place of initial treatment. A completed "Claim for Compensation" (Form C-4) must be filed within 90 days after an accident or OD. The treating physician or chiropractor must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

Medical Treatment: If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractor from a list provided by your workers' compensation insurer, if it has contracted with an Organization for Managed Care (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered into a contract with an MCO or PPO, you may select a physician or chiropractor from the Panel of Physicians and Chiropractors. Any **medical costs** related to your industrial injury or OD will be paid by your insurer.

Temporary Total Disability (TTD): If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

Temporary Partial Disability (TPD): If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

Permanent Partial Disability (PPD): When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractor to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation and your age and wage.

Permanent Total Disability (PTD): If you are medically certified by a treating physician or chiropractor as permanently and totally disabled and have been granted a PTD status by your insurer, you are entitled to receive monthly benefits not to exceed 66 2/3% of your average monthly wage. The amount of your PTD payments is subject to reduction if you previously received a PPD award.

Vocational Rehabilitation Services: You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

Transportation and Per Diem Reimbursement: You may be eligible for travel expenses and per diem associated with medical treatment.

Reopening: You may be able to reopen your claim if your condition worsens after claim closure.

Appeal Process: If you disagree with a written determination issued by the insurer or the insurer does not respond to your request, you may appeal to the **Department of Administration, Hearing Officer,** by following the instructions contained in your determination letter. You must appeal the determination within 70 days from the date of the determination letter at 1050 E. William Street, Suite 400, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. If you disagree with the Hearing Officer decision, you may appeal to the **Department of Administration, Appeals Officer**. You must file your appeal within 30 days from the date of the Hearing Officer decision letter at 1050 E. William Street, Suite 450, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. If you disagree with a decision of an Appeals Officer, you may file a **petition for judicial review with the District Court**. You must do so within 30 days of the Appeal Officer's decision. You may be represented by an attorney at your own expense or you may contact the NAIW for possible representation.

Nevada Attorney for Injured Workers (NAIW): If you disagree with a hearing officer decision, you may request that NAIW represent you without charge at an Appeals Officer hearing. NAIW is an independent state agency and is not affiliated with any insurer. For information regarding denial of benefits, you may contact the NAIW at: 1000 E. William Street, Suite 208, Carson City, NV 89701, (775) 684-7555, or 2200 S. Rancho Drive, Suite 230, Las Vegas, NV 89102, (702) 486-2830.

To File a Complaint with the Division: If you wish to file a complaint with the Administrator of the Division of Industrial Relations (DIR), please contact Workers' Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, telephone (775)684-7270, or 1301 North Green Valley Parkway, Suite 200, Henderson, Nevada 89074, telephone (702) 486-9080.

For Assistance with Workers' Compensation Issues: You may contact the Office of the Governor Consumer Health Assistance, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101, Toll Free 1-888-333-1597, Web site: http:/govcha.state.nv.us, E-mail cha@govcha.state.nv.us

The information in this publication is derived from Chapters 616A and 617 of the Nevada Revised Statutes and is provided for informational purposes only. If you have any questions, regarding your injury or workers' compensation claim, please call the following:

Insurer/Administrator: Meadowbrook Claims Service   Contact Person: Julie Frisch

Address: 1707 Village Center Circle, Suite 100, Las Vegas, NV 89134   Telephone Number: (702) 360-0571
City State Zip

MCO/Health Care Provider: ____________   Contact Person: ____________

Address: ____________   Telephone Number: ____________
City State Zip