MEADOWBROOK℠
INSURANCE GROUP

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Workers' Compensation Claim Kit

IMPORTANT FORMS

IMPORTANT NOTICE

NAC 616A.460 Informational poster to be displayed by employers. (NRS 616A.400, 616A.490)

1. Each employer governed by the provisions of chapters 616A to 617, inclusive, of NRS shall prominently display at his place of business a poster with the language and in the format specified in Form D-1.

2. The title of the poster must be printed in not less than 20-point bold type. The required statement concerning questions and problems relating to claims must be printed in not less than 12-point bold

type. The text appearing on the remainder of the poster must be printed in not less than 10-point type. The poster must be at least 11 inches by 17 inches in size.

3. Each employer shall:

(a) Display the poster as required by this section; and
(b) Advise his employees of the name, business address and telephone number of his insurer's or third-party administrator's adjuster in this state that is located nearest to the employer's place of business for their claims for workers' compensation.

4. The poster must be displayed in such a manner as to be readily visible by all employees. A poster must not be displayed unless it has been issued or approved by the Workers' Compensation Section.

- Employer Brochure
  http://dirweb.state.nv.us/wcs/Brochures/employer.pdf

MEADOWBROOK INSURANCE GROUP

www.meadowbrook.com

WORKERS' COMPENSATION INJURY REPORTING PROCEDURES

Report all workers' compensation injuries sustained on the job to the Meadowbrook Insurance Group Customer Service Center

Report Online

www.meadowbrook.com/onlineclaimreporting.html

Report your claim electronically using our online *First Report of Injury* form. It's fast, easy and convenient and allows for 24/7 claims reporting. You will receive a confirmation number after submission.

Report by Phone

Call **(800) 825-9489** to report your claim. Please have the following claimant information ready:

1. Policy Number and Name of Insured/Policyholder as Named on the Policy
2. Full Name, Age, Date of Birth, Social Security Number
3. Date/Hours of Employment and Wages
4. Date, Time and Location of Injury
5. Home Address and Phone Number

SMART PHONE USERS

SCAN HERE TO GET CONNECTED

Report by Fax or Email

Complete the *State Workers' Compensation First Report of Injury* form and fax or email it to the customer service center. To download the form, visit **www.meadowbrook.com**.

Fax: **(800) 832-8793**

Email: **newclaim@meadowbrook.com**

STAR INSURANCE COMPANY

AMERITRUST INSURANCE CORPORATION

Williamsburg NATIONAL INSURANCE COMPANY

CENTURY SURETY COMPANY
DIVISION OF MEADOWBROOK INSURANCE GROUP

PRO CENTURY

STATE NATIONAL INSURANCE COMPANY

STAR Insurance Company
Williamsburg National Insurance Company
Pro Century Insurance Company
State National 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 / State National Insurance Company Tele-Reporting Claims Service at 1-800-825-9489.

- Identify yourself as a Star Insurance Company / Williamsburg National Insurance Company / Pro Century Insurance Company / State National Insurance Company insured.
- Provide requested information to the Claims Representative.
- Complete the required state forms (copies included) and fax them to (800) 832-8793.

FOR *NON-EMERGENCY* MEDICAL TREATMENT

Step 1: Call the Star Insurance / Williamsburg National Insurance Company / Pro Century / State National Tele-Reporting Claims Service OR complete and SIGN "Employer's Report of Industrial Injury or Occupational Disease" C3 form (copy included) and fax completed form.

- Identify yourself as a Star Insurance Company / Williamsburg National Insurance Company / Pro Century Insurance Company / State National Insurance Company insured.
- Provide requested Information to the Claims Representative.
- Complete the required state forms (copies included) and fax them to (800) 832-8793.

Step 2: Send the injured employee to the nearest approved medical service provider.

QUESTIONS ?

For questions regarding Claims Administration, please contact:
Meadowbrook Claims Service
Claims Mail (on existing claims)
Email: Claims@meadowbrook.com
Fax 855-858-8187

Medical Authorizations
Email: authorization@meadowbrook.com
Fax number: 855-603-8407

New Claim Reports
Email: newclaim@meadowbrook.com
Fax number: 800-832-8793

Employee's Report of Injury / Illness
Reporte de Herida/Enfermedad

Date of Injury or Illness/*Fecha de Herida o Enfermedad*		**Employee**/*Empleado*	**SS #**	**DOB**/*Fecha de Nacimiento*
Hour/*Hora*	**Time Began Work/***Empiezo de Trabajo*	**Address**/*Direccion*		**Phone Number**/*Numero de Teléfono*
Date Employee Reported Injury or Illness/*Fecha Empleado Reporto Herida o Enfermedad*		**Occupation**/*Occupacion*	**Crew**/*Cuadria*	**Foreman**/*Mayordomo*
Nature of Injury or Illness/*Clase de Herida o Enfermedad*		**Location**/*Lugar*		**County**/*Condado*

Part of Body Affected/*Parte de Cuerpo Affectado*

Explain How Injury or Illness Occurred, Describe Sequence of Events in Detail, and Specify Object or Substance which Directly Produced the Injury or Illness/*Explique Como la Herida o Enfermedad Occurió, Describe la Sequencia de Eventos en Detalle, y Especifique el Objeto o Substancia que Producio Directamente la Herida o la Enfermedad*

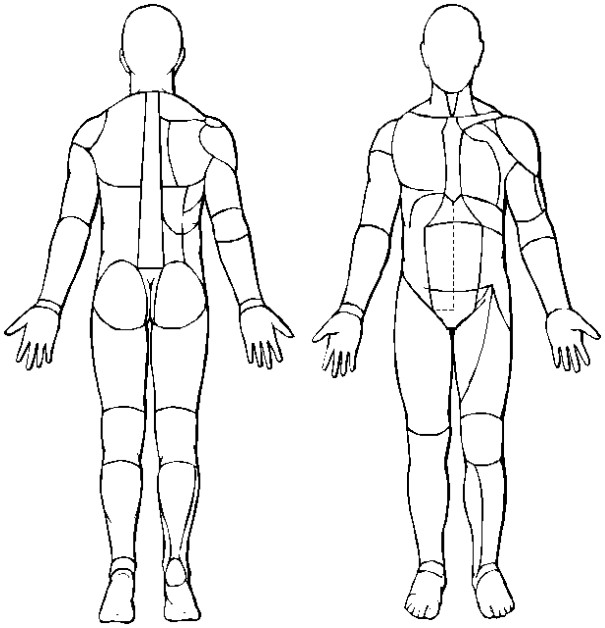
List All Witnesses / *Enumere Todo los Testigos*

List Steps Taken to Eliminate Hazard / *Enumere Pasos Inmediatos Tomados para Eliminar Peligro*

Suggestion to Prevent Recurrence / *Sugerencia Para Prevenir Reaparición*

All work-related injuries/illnesses <u>MUST</u> be immediately reported to your immediate Supervisor, HR Department & Workers' Compensation Carrier. *Todas heridas/enfermedades relacionado con el trabajo <u>DEBEN</u> ser reportardos inmediatamente a su Supervisor, Departamento de Recursos Humanos y la Aseguranza de Compensación para Trabajadores.*

Employee must mark an "X" where injured
<u>Empleado necesita marcar un "X" donde lesionado</u>



Injured employee must complete the following:
<u>Lesionado empleado necesita completar lo siguiente:</u>

I, _____, have sustained a work-related injury/illness while employed with the company. I have identified where I have been injured with an "X" on the diagram above. I understand that any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

_____ **I would like medical attention for my injury/illness.**

_____ **My injury/illness does not require medical attention.**

Yo, _____, ha sostenido una herida/enfermedad relacionado con mi trabajo mientras empleado con la compania. He identificado donde he sido herido con un "X" en el esquema abriba. Yo entiendo que toda aquella persona que a proposito haga o cause que se produzca cualquier declaracion o representacion material falsa o fradulenta con el fin de obtener o negar beneficios o pagos de compensacion a trabajadores lesionados es culpable de un crimen mayor "felonia."

_____ *Yo quiero atención médica para mi lesion/enfermedad.*

_____ *Mi herida/enfermedad no requiere la atención médica.*

_____/_____
Employee's Signature/*Firma de Empleado* **Date**/*Fecha*

_____/_____
Supervisor's Signature/*Firma de Supervisor* **Date**/*Fecha*

Meadowbrook Workers' Compensation Prescription Information

Employer: Please fill out employee information below and provide employee with this document to take to any pharmacy.

Employee Name (Nombre/apellido)	
Member ID/SSN: (número de identidad/seguro social)	
Date of Injury: (fecha de la lesión)	
Group#	10602650
Processor	myMatrixx
BIN#	014211
Day supply is limited to 30 days for a new injury (Abastecimiento diario esta limitado a 30 días para una lesión nueva)	
myMatrixx Help Desk: (877) 804-4900	

Employer Signature:	Phone:	Date:

Employee:

Meadowbrook has partnered with ***myMatrixx*** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 60,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

TRABAJADOR LESIONADO:

Meadowbrook se ha unido con myMatrixx para llenar las recetas médicas por lesions bajo compensación del trabajador más fácil .

Este documento le sirve como tarjeta provisional para su primera receta. Una tarjeta permanente y especificamente para su lesión le será enviada por correo dentro de los próximos 3 a 5 dias laborales.

Por favor lleve este documento y su receta a la farmacia. myMatrixx tiene un red de más de 60,000 farmacias dentro del país. Si quiere saber si una farmacia en particular esta dentro de nuestra red favor de llamar al (877) 804-4900.

SI LE NIEGAN EL MEDICAMENTO EN LA FARMACIA FAVOR DE LLAMAR AL (877) 804-4900

Pharmacist:

Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only. Document only valid if signed and dated by employer above.

Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

HELPDESK (877) 804-4900

Farmaceútico:

Por favor obtenga la información de arriba del paciente si el pátron no la lleno, para procesar recetas médicas relacionadas a lesiones bajo la compensación del trabajador solamente. El document es válido si esta firmado y fechado en la parte superior por el patron. :

Por favor no envíe al paciente a la casa ni le haga pagar por medicamentos sin antes comunicarse con myMatrixx.

AVISO: Ciertos medicamentos han sido pre-aprobados para este paciente; estos medicamentos son procesados sin autorización. Todos los demás precisan autorización previa.

HELPDESK (877) 804-4900

"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 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 of which the employee first became aware of the connection between the condition and employment)

Name 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? ☐ Yes ☐ No

Was anyone else involved? ☐ Yes ☐ No

Names of other involved:

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGES 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 _____

For assistance with Workers' Compensation Issues, you may contact the Office of the Governor's 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 of this form.
Original to Employer, Copy to Employee

C-1 (Rev. 10/05)

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

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER

Employer's Name | Nature of Business (mfg, etc.) | FEIN | OSHA Log Number

Office Mail | Location . . if different from mailing address | Telephone Number

City, State, Zip Code | 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? ☐ 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? . . . sole proprietor? . . . partner? ☐ Corporate Officer ☐ Sole Proprietor ☐ Partner | 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 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

If validity of claim is doubted, state reason . | Did employee return to work next scheduled shift after accident? (if applicable) ☐ Yes ☐ No | Will you have light duty work available if necessary? ☐ Yes ☐ No

Treating physician/chiropractor name | Location of Initial Treatment | Emergency Room? ☐ Yes ☐ No | Hospitalized? ☐ Yes ☐ No

IMPORTANT LOST TIME INFO

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

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 no, 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

For the purpose of calculation of the average monthly wage, indicate the employee's gross earning 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 renumeration, 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 hireto the date of injury or disability.

Pay Period ends on: ☐ S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S | Employee is paid: ☐ Weekly ☐ Monthly ☐ Other ☐ BiWeekly ☐ Bi-Monthly | On the date of injury or disability the employee's wage was: _____ per ☐ Hour ☐ Week ☐ Day ☐ Month

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 ☐ Third-Party | Deemed Wage | Account No. | Class Code

Claims Examiner's Signature | Date | Status Clerk | Date

Form C-3 (rev.11/05) **ORIGINAL - EMPLOYER** **PAGE 2 - INSURER/TPA** **PAGE 3 - EMPLOYEE**

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.: _____ 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.

Print Name: _____ Signature: _____

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

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

A T T E N T I O N

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: _____ Contact Person: _____

Address: _____ Telephone Number: _____
City State Zip

MCO/Health Care Provider: _____ Contact Person: _____

Address: _____ Telephone Number: _____
City State Zip

Where can I obtain additional information on workers' compensation?

Web site: www.dirweb.state.nv.us/WCSwcs.htm
E-mail: WCSHelp@business.nv.gov

For information concerning claims administration or failure to obtain or maintain workers' compensation insurance:

Department of Business and Industry
Division of Industrial Relations
Workers' Compensation Section

400 West King Street, Suite 400
Carson City, Nevada 89703
(775) 684-7270

1301 N Green Valley Pkwy, Ste 200
Henderson, Nevada 89074
(702) 486-9080

For information regarding occupational safety and health program development and implementation:

SAFETY CONSULTATION & TRAINING SECTION
Website: www.4safenv.state.nv.us
Toll Free: 877-4SAFENV
OSHA 10 & 30 Hr Construction Class must register on-line: www.nv1030.org

The material contained in this publication is derived from chapters 616A to 617, inclusive, of the Nevada Revised Statutes (NRS) & Nevada Administrative Code (NAC), and is provided for informational purposes only. For more detailed information, please refer to the specific statute or code. The NRS and NAC relating to Workers' Compensation can be accessed via the Internet at:
www.dirweb.state.nv.us/WCS/wcs.htm

What will happen to an employer who fails to obtain or maintain workers' compensation insurance?

The Division of Industrial Relations, Workers' Compensation Section (WCS) is responsible for ensuring all employers are in compliance with the law. Employers who do not provide workers' compensation will be charged with an administrative fine up to $15,000; appropriate premium penalties; may be ordered to close business until insurance has been obtained; and will be held financially responsible for all costs arising from a work-related injury. In addition, the uninsured employer may be subject to a criminal penalty for claims resulting in substantial bodily harm or death. **(NRS 616D.200 & NAC 616D.345)**

Who can provide workers' compensation coverage in Nevada?

Employers may purchase insurance from a private carrier licensed in Nevada or be certified by the Division of Insurance (DOI) as a self-insured employer or a member of an association of self-insured public or private employers.

Private carriers currently utilize competitive premium rates which allows them to deviate on the expense portion of the premiums. This rate must be filed with the DOI 15 days before if is effective and can be disapproved. Contact DOI for further information at the following:

Carson City (775) 687-4270

Las Vegas (702) 486-4009

EMPLOYER GUIDE

WORKERS' COMPENSATION

E-mail Notification
Stay connected to what's new in Nevada's workers' compensation by registering to receive e-mail notifications.
http://.dirweb.state.nv.us/WCS/wcs.htm

UPDATE!

PUBLISHED BY:
STATE OF NEVADA
DEPARTMENT OF BUSINESS AND INDUSTRY
WORKERS' COMPENSATION SECTION

This pamphlet is provided to inform stakeholders of some significant points concerning workers' compensation insurance in Nevada.

What is workers' compensation?

Workers' compensation is a no-fault insurance program in the State of Nevada, which provides benefits to employees who are injured on the job and protection to employers who have provided coverage at the time of injury.

What protection is provided for the employer?

Because Nevada has "exclusive remedy," the injured workers' benefits are set forth in the statutes. Employers who provide coverage for their employees at the time of injury are protected from any additional damages claimed by their employees as a result of an injury on the job. This protection is established when the injured employee opts to receive workers' compensation benefits.

What type of benefits are employees entitled to?

Nevada's Workers' Compensation Program provides a variety of benefits which are designed to assist the injured employee. These benefits may include (among others):

- Medical treatment;
- Lost time compensation (TTD/TPD);
- Permanent Partial Disability (PPD);
- Permanent Total Disability (PTD);
- Vocational Rehabilitation;
- Dependent's benefits in the event of death; and
- Other claims-related benefits or expenses (i.e., mileage)

How do the Subsequent Injury Accounts benefit employers?

The Subsequent Injury Accounts encourage employers to hire workers with a permanent physical impairment. The costs of any qualified subsequent injury are paid from the appropriate subsequent injury account. **(NRS 616B.557 – 590)** Contact Jacque Everhart at (702) 486-9089 or everhart@business.nv.gov for more information.

Which employers are required to provide workers' compensation insurance?

Unless excluded by statute, it is mandatory for an employer who has one or more employees to provide workers' compensation insurance coverage. Some employees are excluded by **NRS 616A.110** due to unique criteria.

Employment exempt from workers' compensation insurance coverage requirements includes:

- Employment related to those interstate commerce entities that are not subject to the legislative power of the state of Nevada.
- Employment covered by private disability and death benefit plans which comprehend compensation payments of equal or greater amounts than those provided in **NRS 616** and which have been in effect for one year prior to July 1, 1947;
- Employees who are brought into Nevada on a temporary basis and who are insured in another state if extraterritorial coverage provisions are in effect with the other state.

Exception: the construction trades.

- Casual employment (employment lasting not more than 20 days and having a total labor cost of less than $500) is exempt **if employment is not in the course of trade, business, profession or occupation of the employer.**

CONSTRUCTION TRADES ARE REQUIRED TO HAVE WORKERS' COMPENSATION INSURANCE.

Workers' Compensation Employer Compliance Checklist

☑Provide requisite workers' compensation insurance coverage and furnish a place of employment free from recognized hazards that may cause death or serious physical harm to employees.

☑Prominently display in your place of business the required workers' compensation information:

(1) Informational poster to be displayed by employers. **(NAC 616A.460**, Form D-1)

(2) Poster to be displayed by employers with employees who receive tips. **(NAC 616A.470**, Form D-22)

☑Have available at all times and at all locations for inspection by agent of the Division of Industrial Relations or Attorney General:

- The policy including the declaration page issued by private carrier; or
- Certificate issued by the Commissioner if self-insured; or,
- Certificate issued by the Commissioner and a certificate or letter issued by an association of self-insured public or private employers if a member of an association.

Note: Temporary worksites (less than 1 year) must produce the above information within 24 hours. **(NRS 616A.495)**

☑Provide forms for employee use and complete injury or occupational disease reporting requirements and forward the required documents in the allowable timeframe: *(1) C-1, Notice of Injury or Occupational Disease (Incident Report) and (2) C-3, Employers' Report of Industrial Injury or Occupational Disease* **(NRS 616C.015 & 616C.045)**

☑Provide immediate first aid to an injured employee **(NRS 616C.085)**

☑Complete the workers' compensation claim form (C-3) within 6 working days of receipt of the C-4 form from the medical provider and file it with insurer. **(NRS 616C.045)**