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 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

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:

Your employer’s workers’ compensation insurer is: Employers Insurance Company of Nevada P.O. Box 539004, Henderson NV 89053-9004 (888) 682-6671 • www.employers.com

Your employer’s Managed Care Company is: Employers Occupational Health, Inc. P.O. Box 539004, Henderson NV 89053-9004
If you are injured on the job

1. Immediately report your injury.
   No matter how major or minor your injury, immediately report it to your supervisor or manager. In the event of an emergency, go to the nearest hospital or urgent care facility or call 911.

2. Your Designated Medical Provider is:
   If you need non-emergency medical care for your on-the-job injury or illness, seek medical attention from the designated medical provider listed here:
   
   (Notice to Policyholder: Before posting, fill in name and contact information of your employees’ designated medical provider.)

   (In some states, employers must identify two providers. A second provider must be listed here for those states.)

3. Obtain additional information:
   PHARMACY BENEFITS INFORMATION: (888) 682-6671
   Continued treatment questions: EMPLOYERS® claims office (888) 682-6671
   For more information, go to www.employers.com and click on Injured Workers link

Prompt Claims Reporting Will Reduce Costs

To Report a Claim
   Telephone: (800) 232-3085
   Fax: (877) 329-2954

To Find a Provider
   Visit: www.employers.com
   Click on Injured Workers link, then Provider Locator
   Nevada: (888) 682-6671
   California: (866) 700-2168
   All other states: (800) 243-2336

Customer Service
   E-mail: customersupport@employers.com
   Telephone: (888) 682-6671

Fraud Hotline
   E-mail: fraudunit@employers.com
   Telephone: (800) 750-3939

Your Claims mailing address is:
   Employers Insurance Company of Nevada
   P.O. Box 539004
   Henderson, NV 89053-9004

Loss Control
   E-mail: losscontrol@employers.com
   Telephone: (800) 588-5200

Your Designated Medical Provider information:

Name
Address
City/state
Tel/e-mail

Policyholder: Provide contact information for designated medical provider.

Name
Address
City/state
Tel/e-mail

In states in which employers must list two providers, a second provider may be listed here.

EMPLOYERS®
America's small business insurance specialist*
How to identify workers’ compensation fraud

Top 10 warning signs

1. Monday morning reports
   The alleged injury occurs first thing on Monday morning, or the injury occurs late on Friday afternoon but is not reported until Monday.

2. Employment change
   The reported accident occurs immediately before or after a strike, job termination, layoff, end of a big project, or at the conclusion of seasonal work.

3. Suspicious providers
   An employee’s medical providers or legal consultants have a history of handling suspicious claims, or the same doctors and lawyers are used by groups of claimants.

4. No witnesses
   There are no witnesses to the accident and the employee’s own description does not logically support the cause of the injury.

5. Conflicting descriptions
   The employee’s description of the accident conflicts with the medical history or First Report of Injury.

6. History of claims
   The claimant has a history of a number of suspicious or litigated claims.

7. Treatment is refused
   The claimant refuses a diagnostic procedure to confirm the nature or extent of an injury.

8. Late reporting
   The employee delays reporting the claim without a reasonable explanation.

9. Claimant is hard to reach
   The allegedly disabled claimant is hard to reach at home.

10. Changes
    The claimant has a history of frequently changing physicians, changing addresses and numerous past employment changes.

Experience shows that when two or more of these factors are present in a workers’ compensation claim, there is a chance the claim may be fraudulent. Remember though, these are simply indicators. Many perfectly legitimate claims are filed on Mondays—and some accidents have no witnesses.

If you suspect workers’ compensation fraud, please contact the EMPLOYERS® Fraud Investigations Department:

(800) 750-3939
fraudunit@employers.com

America’s small business insurance specialist®
Workers’ compensation fraud

EMPLOYERS® wants to hear from you.

Each year, fraudulent workers’ compensation claims steal millions of dollars from employers, deserving employees, and their families. Everyone ends up paying the tab for fraud—in lost jobs and profits, lower wages and benefits, and higher costs for goods and services.

We can fight fraud, but we need your help.

Our number one objective is to lower your insurance costs. At EMPLOYERS, we believe remaining alert to the warning signs of workers’ compensation fraud should be a key component of your regular claims review program. Working with you and your independent insurance agent or broker to aggressively fight fraud is one of the ways EMPLOYERS is working to reduce your ultimate net insurance costs. If you suspect a fraudulent claim has been filed, we want to hear from you. Call or write to the EMPLOYERS Fraud Investigations Department:

Educational materials are provided free to inform your employees.

Posted on-line at www.employers.com is a complete package of materials explaining the criminal consequences of filing a fraudulent workers’ compensation claim. These include sample posters which can be reproduced and posted in employee work and break areas, and an informational postcard designed to accompany payroll distribution.

For further details, please contact your independent agent or broker or visit www.employers.com

EMPLOYERS®
Fraud Investigations Department
500 North Brand Boulevard, Suite 800
Glendale, CA 91203-4707

(800) 750-3939
fraudunit@employers.com

Copyright © 2009 EMPLOYERS. All rights reserved. Insurance offered through Employers Compensation Insurance Company, Employers Insurance Company of Nevada, Employers Preferred Insurance Company (also known as AmCOMP Preferred Insurance Company) and Employers Assurance Company (also known as AmCOMP Assurance Corporation). Coverage not available in all jurisdictions.

EIGFR00001FL. Rev.05/09
**EMPLOYER**

**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**

**First Name**

**M.I.**

**Last Name**

**Social Security**

**Birthday**

**Age**

**Primary Language Spoken**

**Sex**

**Male**

**Female**

**Marital Status**

**Single**

**Married**

**Divorced**

**Widowed**

**Home Address (Number and Street)**

**City**

**State**

**Zip**

**Was the employee paid for the day of injury?**

**Yes**

**No**

**Department in which regularly employed:**

**In which state was employee hired?**

**Employee's occupation (job title) when hired or disabled**

**Was employee in your employ when injured or disabled by occupational disease (O/D)?**

**Yes**

**No**

**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.**

**Specify machine, tool, substance, or object most closely connected with the accident**

**Part of body injured or affected**

**If fatal, give date of death**

**Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.)**

**If validity of claim is doubted, state reason**

**Location of Initial Treatment**

**Treating physician/chiropractor name**

**On the date of injury or disability the employee's wage was:**

**$**

**per Hr**

**Day**

**Wk**

**Mo**

**Did employee return to next scheduled shift after accident? (if applicable)**

**Yes**

**No**

**Will you have light duty work available if necessary?**

**Yes**

**No**

**Was employee in your employ when injured or disabled by occupational disease (O/D)?**

**Yes**

**No**

**Date employee was hired**

**Last day of work after injury or disability**

**Date of return to work**

**Number of work days lost**

**If not, for how many hours a week was the employee hired?**

**Was the employee hired to work 40 hours per week?**

**Yes**

**No**

**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**

**SUN**

**TUE**

**THUR**

**SAT**

**ENDS ON:**

**MON**

**WED**

**FRI**

**Employee 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**

**Are you paying injured or disabled employee’s wages during disability?**

**Yes**

**No**

**IMPORTANT**

**How many days per week does employee work?**

**From**

**am**

**pm**

**To**

**am**

**pm**

**Last day wages were earned**

**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**

**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**

**Claim is:**

**Accepted**

**Denied**

**Deferred**

**3rd 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**
"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"
(Incident Report)
Pursuant to NRS 616C.015

Name of Employer ________________________________

<table>
<thead>
<tr>
<th>Name of Employee</th>
<th>Social Security Number</th>
<th>Telephone Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Accident (if applicable)</th>
<th>Time of Accident (if applicable)</th>
<th>Place where accident occurred (if applicable)</th>
</tr>
</thead>
</table>

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? ______ NO ______ YES

If yes, when (date and time)? ________________________________

Has the employee returned to work? ______ NO ______ YES

If yes, when (date and time)? ________________________________

Was first aid provided? ______ NO ______ YES

If yes, by whom? ________________________________

Name and address of treating physician, if applicable or known ________________________________

Did the accident happen in the normal course of work? ______ NO ______ YES

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
Employers Insurance Company of Nevada’s (EMPLOYERS®) experience shows that companies with Early Return To Work (ERTW) programs are able to get their employees back to their regular duties as much as 50% faster than employers without such plans. An effective ERTW program depends heavily on your involvement. It requires a close working relationship with you, EMPLOYERS and the medical provider.

Our staff of experienced ERTW experts will work closely with your company to create and maintain a program custom-tailored to meet your needs. EMPLOYERS experts assess the specific situation of your business, such as the nature of light-duty assignments, and help to design the ERTW partnership. EMPLOYERS coordinates the efforts of the business owner, injured employee and healthcare provider to return the employee to the job as soon as medically possible.

**HERE’S HOW ERTW WORKS FOR YOU:**

**Before an injury:**
- Obtain commitment from all levels of management and designate a manager to coordinate and review off-work claims.
- Select a medical provider and establish clear lines of communication. Using our extensive provider network, EMPLOYERS will help you choose an industrial medicine physician who understands your needs.
- Set up guidelines for prompt reporting of, and continuing communication about, an injury to EMPLOYERS, the doctor and the employee.
- Survey the workplace. Can you design a modified job through in-sourcing, production or other accommodation? EMPLOYERS experts will help you design realistic transitional job descriptions.

**After an injury:**
- Provide on-site aid, arrange emergency transportation and provide medical referral information.
- Report the injury to EMPLOYERS immediately. Within hours, our workers’ comp claims and medical management specialists will have begun the ERTW process.
- EMPLOYERS will talk to the medical provider to determine the extent of the injury and then maintain contact with the doctor to determine the employee’s restrictions and explore modified opportunities you can provide.
- When possible, prepare a description of any available transitional jobs.
- Get in touch with the injured employee regularly until a return to work date and productive job assignment is identified.
- Upon the injured employee’s return, welcome the individual and go over the job assignment. Inform the employee’s supervisor and co-workers about the company’s expectations for support and performance. Periodically check back with them and ask how they are doing. Continuing communication is the key to a successful ERTW program.

For assistance in any of these areas, or for any other occupational safety or health-related questions, please email us at losscontrol@employers.com or call Employers Insurance Company of Nevada Loss Control Hotline at (800) 588-5200.
AFTER AN INJURY OCCURS:

Medical Treatment
Immediately after you receive knowledge of an injury, refer the injured employee to your designated industrial medical provider.

FastReport™ 24-Hour Claim Reporting
Immediate claim reporting is vital to the control of workers' compensation claim costs. A claim reported over 10 days late can increase costs by more than 20%. Even if you feel the claim is not valid, do not delay in reporting the claim. *Filing a claim form is not an admission of liability.*

How to Report A Workers' Compensation Claim:
To report a claim, simply call our FastReport™ claims reporting service toll free at 1-800-232-3085. FastReport™ representatives are available 24 hours a day, 7 days a week. Enclosed is a sample State "First Report of Injury" form that you can use as a guide when reporting a claim telephonically. Before calling, please review the form to ensure that you will be able to answer as many of the questions as possible. Remember, it is important to report the claim as soon as possible, even if you do not have all the information on the form.

OR

Fax the completed "First Report of Injury" form to 1-877-329-2954.

You will receive, by fax, a coversheet and a completed copy of the report of injury on the appropriate state form. Please review the report for accuracy. The coversheet will indicate if you must take additional steps to file the claim.
Employers Insurance Company of Nevada continues to expand our selection of products and services. Yesterday’s solutions will not solve today’s problems. That is why we continually re-evaluate our customers’ needs and strive to ensure that we can offer state-of-the-art workers’ compensation coverage.

Employers Insurance Company of Nevada is making it easy for you to obtain information online. From our web site you can:

- View and Print a C-3 (Nevada Only)
- Submit a Re-order Form
- Access Account Information and Loss Runs (Nevada Only)
- Locate a Provider Facility
- Re-order Forms and Publications
- Review All Company Products and Services
- Find Office Locations and Phone Numbers
- View Questions and Answers
- Read About the Latest Industry News
- Find External Links

If you are unable to access the internet, please use this form to re-order materials.

Please use this form for ordering additional workers’ compensation materials. Print or type your address information and indicate the desired quantities. Please mail your request to Employers Insurance Company of Nevada, P.O. Box 539003 Henderson, NV 89053-9003.

Name/Title

Company

Street

City/State/Zip

Telephone

Policy number(s)

Please indicate the requested quantity next to the description:

- Rights & Benefits Poster
- C-1 Notice of Injury
- C-3 Employer’s Report of Injury
- Early Return to Work
- Fraud Flyer Warning Signs
- Injured on the Job Poster

For additional information, please contact your agent or broker.
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

Employers Insurance Company of Nevada
P.O. Box 539004
Henderson, NV 89053-9004
1-888-682-6671
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? [ ] Yes  [ ] No  If so, during what pay period? ________________________

Was sick leave paid during the applicable twelve week period? [ ] Yes  [ ] No  Did employee receive payment for overtime during the applicable twelve week period? [ ] Yes  [ ] No

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

Was the injured employee paid for any holidays during the applicable twelve week period? [ ] Yes  [ ] No  Did employee receive termination pay during the applicable twelve week period? [ ] Yes  [ ] No

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.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dates of Absence Begin</th>
<th>Reason</th>
<th>Dates of Absence Begin</th>
<th>Reason</th>
<th>Dates of Absence Begin</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: ________________________
Temporary light duty offer form

Employers Insurance Company of Nevada

Injured Employee: ___________________________

Claim #: ___________________________ Employer: ___________________________

In compliance with NRS 616C.475(8), the employer, ___________________________, will provide ___________________________ a temporary light duty position that complies with all restrictions and physical limitations as outlined by an occupational physician from the approved panel. Attached is a copy of the stated restrictions or physical limitations.

The Job Position Will Be: ___________________________

The Job Duties Will Be: ___________________________

__________________________________________________________________________

Job Location Will Be: ___________________________

__________________________________________________________________________

The Hours of Work Will Be: ___________________________ (Similar to previous work hours)

____ I accept the temporary light duty position offered to me.

____ I decline the temporary light duty position offered to me. I understand that by declining an appropriate temporary light duty position offered by my employer I am not entitled to temporary total disability benefits pursuant to NRS 616C.475 (5).

Print Injured Employee Name ___________________________ Print Employer Representative Name & Title ___________________________

Injured Employee Date ___________________________ Employer Representative Date ___________________________

NRS 616C.475 Amount and duration of compensation; limitations; requirements for certification of disability; offer of light-duty employment.

5. Payments for a temporary total disability must cease when:
   (a) A physician or chiropractor determines that the employee is physically capable of any gainful employment for which the employee is suited, after giving consideration to the employee’s education, training and experience;
   (b) The employer offers the employee light-duty employment or employment that is modified according to the limitations or restrictions imposed by a physician or chiropractor pursuant to subsection 7; or
   (c) Except as otherwise provided in NRS 616B.028 and 616B.029, the employee is incarcerated.

8. If the certification of disability specifies that the physical limitations or restrictions are temporary, the employer of the employee at the time of his accident may offer temporary, light-duty employment to the employee. If the employer makes such an offer, the employer shall confirm the offer in writing within 10 days after making the offer. The making, acceptance or rejection of an offer of temporary, light-duty employment pursuant to this subsection does not affect the eligibility of the employee to receive vocational rehabilitation services, including compensation, and does not exempt the employer from complying with NRS 616C.545 to 616C.575, inclusive, and 616C.590 or the regulations adopted by the Division governing vocational rehabilitation services. Any offer of temporary, light-duty employment made by the employer must specify a position that:
   (a) Is substantially similar to the employee’s position at the time of his injury in relation to the location of the employment and the hours he is required to work;
   (b) Provides a gross wage that is:
      (1) If the position is in the same classification of employment, equal to the gross wage the employee was earning at the time of his injury; or
      (2) If the position is not in the same classification of employment, substantially similar to the gross wage the employee was earning at the time of his injury; and
   (c) Has the same employment benefits as the position of the employee at the time of his injury.