



America's small business insurance specialist®

Basic Accident Report

Date of Report: _____ Report Completed By: _____

Last Name of Injured Person:	First Name:	Job Title:
Date of Accident:	Time of Accident:	Location of Accident:
Supervisor's Name & Job Title:		Name of Witnesses:
Full Description of Injuries:		
Description of accident/incident or employee's account, including sequence of events preceding the accident:		
Basic cause and contributory causes. Explain fully unsafe act, unsafe condition, personal factor, other:		
Recommended Corrective Measures:		Action By:
Names of Inspection Team Participants:		
Management Review By:	Date to be Completed By:	

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Informe Básico de Accidentes

Fecha Del Informe: _____ Informe Completado Por: _____

Apellido De La Persona Lesionada:	Primer Nombre:	Puesto De Trabajo:
Fecha Del Accidente:	Hora Del Accidente:	Lugar Del Accidente:
Nombre Del Supervisor Y Cargo:		Nombre De Los Testigos:
Descripción Completa De Las Lesiones:		
Descripción del accidente / incidente o versión del empleado, incluyendo la secuencia de eventos que preceden al accidente:		
Causas básicas y causas contributivas. Explique el tipo de situación ya sea si fue una situación insegura, condición insegura, factor personal, otros:		
Medidas Correctivas Recomendadas:		Acciones Tomadas Por:
Nombres De Los Participantes Del Equipo De Inspección:		
Revisión Por Parte De La Gerencia:	Fecha Límite De Entrega:	

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One good reason to think twice about workers' compensation fraud



EMPLOYERS® actively investigates suspected workers' compensation fraud and reports such cases to law enforcement authorities.

fraud costs

Workers' compensation fraud costs \$7.2 billion annually.¹

Filing a fraudulent workers' compensation claim could lead to serious civil or criminal consequences, such as fines, incarceration and/or restitution.

If you suspect workers' compensation fraud, please contact EMPLOYERS' Fraud Investigations Department. Call the Fraud Hotline at 1-800-750-3939 or e-mail fraudfighters@employers.com.

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Una buena razón para pensarlo dos veces antes de cometer fraude en una demanda de indemnización laboral



EMPLOYERS® investiga de manera activa casos sospechosos de cometer fraude en una demanda de indemnización laboral y reporta dichos casos a las autoridades policiales.

costos del fraude

Fraude en demandas de indemnización laboral cuesta \$7.2 mil millones al año.¹

Presentar una demanda de indemnización laboral fraudulenta puede acarrear graves consecuencias civiles o penales, tales como multas, cárcel y/o indemnizaciones.

Si sospecha que existe fraude en una demanda de indemnización laboral, póngase en contacto con el Departamento de Investigación de Fraude de EMPLOYERS. Llame a la línea directa de fraude al 1-800-750-3939 o escriba al correo electrónico fraudfighters@employers.com.

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1 Fuente: <http://www.propertycasualty360.com/2015/07/23/3-keys-to-a-successful-workers-compensation-fraud>

WORKERS' COMPENSATION NOTICE

The employees of this business are covered by the Virginia Workers' Compensation Act. In case of injury by accident or notice of an occupational disease:

THE EMPLOYEE SHOULD:

1. Immediately give notice to the employer, in writing, of the injury or occupational disease and the date of accident or notice of the occupational disease.
2. Promptly give to the employer and to the Virginia Workers' Compensation Commission notice of any claim for compensation for the period of disability beyond the seventh day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person in their behalf.
3. In case of failure to reach an agreement with the employer in regard to compensation under the act, file application with the Commission for a hearing within two years of the date of accidental injury or first communication of the diagnosis of an occupational disease.
4. If medical treatment is anticipated for more than two years from the date of the accident and no award has been entered, the employee should file a claim with the Commission within two years from the date of the accident.

NOTE: The employer's report of accident is not the filing of a claim for the employee.

THE EMPLOYER SHOULD:

1. At the time of the accident, give the employee the names of at least three physicians from which the employee may select the treating physician.
2. Report the injury to the Commission through your carrier or directly to the Commission.
3. Accurately determine the employee's average weekly wage, including overtime, meals, uniforms, etc.

Questions may be answered by contacting the Commission. A booklet explaining the Workers' Compensation Act is available without cost from:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION

333 E. Franklin St
Richmond, Virginia 23219

1-877-664-2566
www.workcomp.virginia.gov

Every employer within the operation of the Virginia Workers' Compensation Act **MUST POST THIS NOTICE IN A CONSPICUOUS PLACE** in his place of business.

First Report of Injury

Virginia Workers' Compensation Commission

workcomp.virginia.gov



Jurisdiction Claim Number (JCN), if assigned

Claim Administrator Number

Employer Information

Employer's Legal Name

Federal Employer Identification Number (FEIN)

Mailing Address

City

State

Zip Code

Name/FEIN of Entity on Policy, if applicable

Nature of Business, if applicable

Name of Insurer or Self-Insurer for this Claim, if applicable

Policy Number, if applicable

Address of Insurer or Self-Insurer for this Claim, if applicable

City

State

Zip Code

Injured Worker Information

Name

Date of Birth

ID Number

Occupation

Address

City

State

Zip Code

Phone Number

Gender

☐

Female

☐

Male

☐

Nonbinary

☐

Transgender

☐

Unknown

Identification Type ☐ Social Security Number ☐ Employment Visa ☐ Green Card ☐ Passport Number ☐ Unknown

Illness or Injury Information

Location of Illness/Injury

Date Illness/Injury Occured

Date Illness/Injury was Reported

Date of Death, if Applicable

Time of Illness/Injury

If Death Occurred, List Number of Dependent Children

If Death Occurred, Select Marital Status

☐

Married

☐

Separated

☐

Unmarried, Widowed, Divorced, or Single

☐

Unknown

Type of Machine, Tool, or Object Which Caused Illness/Injury

Describe Illness or Injury, Including Body Parts Affected

Describe How Illness or Injury Occurred

Signature

SUBMITTER (Required)

PRINT

DATE

PHONE NUMBER

SUBMITTER'S ADDRESS

CITY

STATE

ZIP CODE

Toll-Free: 877-664-2566 | Online: workcomp.virginia.gov | Mail: 333 E. Franklin St., Richmond, Virginia 23219 Form #3 | Rev. 08/26

WC8045n (08-26) Wolters Kluwer | Uniform Forms



Report the Injury or Illness

The Virginia Workers' Compensation Act requires employers to report all workplace injuries and occupational diseases to the Commission under Va. Code § 65.2-900. In accordance with 16VAC30-91-20, all claims reports must be filed electronically with the Commission.

Uninsured employers who do not have a claim administrator or insurance carrier and are unable to file electronically must submit the First Report of Injury form directly to the Virginia Workers' Compensation Commission.



Employer Responsibilities

The employer is responsible for accurately completing all sections of this form when an employee is injured or is diagnosed with an occupational disease. The form should be typed or legibly printed, signed, and dated by the preparer. **Send the original form to the claim administrator for the insurance company who provided insurance coverage on the date of the occurrence, if applicable.** The claim administrator will report this information to the Commission if the employer has coverage. Otherwise, the employer should submit the First Report of Injury directly to the Virginia Workers' Compensation Commission.

Uninsured employers who do not have a claim administrator or insurance carrier and are unable to file electronically must submit the First Report of Injury form directly to the Virginia Workers' Compensation Commission.



Claim Administrator Responsibilities

Claim administrators who are EDI enabled will use the information contained on this form to submit electronic data to the Commission. Claim administrators who are not EDI enabled should contact the Virginia Workers' Compensation's EDI Support team at EDI.Support@workcomp.virginia.gov for support in getting set up with the EDI system.



Uninsured Employers' Responsibilities

Uninsured employers who do not have a claim administrator or insurance carrier and are unable to file electronically must submit the First Report of Injury form directly to the Virginia Workers' Compensation Commission.

Virginia Workers' Compensation Commission (VWC)

VWC Ombudsman Department- If you are an uninsured employer and/ or are not represented by an attorney, you can contact the Ombudsman Department toll-free at 833-448-1681.

Other Questions? For other questions or assistance completing this form, please contact the Commission toll-free at 877-664-2566.



PO Box 152539
Tampa, FL 33684-2539

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MAKING IT EASY TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured person:



If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacy will fill the prescription at no cost to you.



If your workers' compensation claim is accepted, you will receive a permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.



Employer:

Immediately upon receiving notice of injury, fill in the information below and give this form to the employee.



Finding a network pharmacy

Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.



Questions? Need Help?

1-866-599-5426


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WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

CARRIER/TPA

EMPLOYER

INJURED PERSON NAME

Please provide directly to Pharmacist

SOCIAL SECURITY NUMBER

DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	EMPLFF		

NOTE: This First Fill card is only valid for your workers' compensation injury or illness.



PO Box 152539
Tampa, FL 33684-2539

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HACEMOS MÁS SENCILLO QUE SE LE ABASTEZCA LAS RECETAS DE SU PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Persona lesionada:



Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica sin costo alguno.



Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.



Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información que aparece a continuación y entregue este formulario al empleado.



Cómo encontrar una farmacia de la red

La mayoría de farmacias y todas las grandes cadenas de farmacias forman parte de la red. Para ubicar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.



**¿Tiene alguna pregunta?
¿Necesita ayuda?**

1-866-599-5426


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WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

PORTADORA

EMPLEADOR

NOMBRE DEL PERSONA LESIONADA

Please provide directly to Pharmacist

NUMERO DE SEGURO SOCIAL

FECHA DE LA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	<u>NDC</u>		<u>Envoy</u>
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	EMPLFF		

NOTA: Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.

Wage Chart

Employer's Statement of Wage Earnings

Virginia Workers' Compensation Commission
333 E. Franklin St., Richmond, Virginia 23219

The boxes
to the right
are for the
use of the
insurer.

Reserved

VWC File Number

Insurer Claim Number

	Employee		Address								
Name of Employee				Date of Accident				Date of Hire			
	Employer		Address								
Name of Employer											

PLEASE REFER TO THE FILING INSTRUCTIONS PRINTED ON THE BACK OF THIS FORM

Week No.	Week Ending Date	Days Worked	Gross amount paid, including overtime	Week No.	Week Ending Date	Days Worked	Gross amount paid, including overtime	Week No.	Week Ending Date	Days Worked	Gross amount paid, including overtime
1				19				37			
2				20				38			
3				21				39			
4				22				40			
5				23				41			
6				24				42			
7				25				43			
8				26				44			
9				27				45			
10				28				46			
11				29				47			
12				30				48			
13				31				49			
14				32				50			
15				33				51			
16				34				52			
17				35							
18				36							

Value of perquisites for entire year:

Total gross earning \$ _____

Total weeks worked _____

Bonuses \$ _____ Electricity \$ _____
 Meals/Lodging \$ _____ Water \$ _____
 Meals Only \$ _____ Telephone \$ _____
 Temporary Lodging \$ _____ Uniforms \$ _____
 House Rent \$ _____ Laundry \$ _____
 Tip Income \$ _____

Total value of perquisites \$ _____

Total earnings & perquisites \$ _____

VWC use only:

AWW: _____

CR: _____

INSURER OR EMPLOYER (include name & signature)	Date	Telephone number
--	------	------------------

FILING INSTRUCTIONS

Wage Chart VWC Form No. 7A

How to complete the Wage Chart:

- ☐ Indicate gross weekly earnings for the 52 weekly periods immediately **preceding** the date of accident.
- ☐ Note that these earnings are GROSS earnings and include overtime and tips, before any deductions are made for taxes or Social Security. If there were any perquisites, please list the TOTAL value separately at the bottom of the chart.
- ☐ If an injured employee lost more than seven consecutive calendar days, although not in the same week, these periods should be noted on the Wage Chart (VWC Form No. 7-A) using an asterisk in the Week No. column and are not to be counted in the calculations. Va. Code § 65.2-101.
- ☐ If injured employee has worked less than 12 months, the earnings for the time worked should be used. The earnings for a similar employee may be used if the employee has worked less than 60 days.

How to calculate the Wage Chart:

- If a full year's wage information **has been** provided covering the 52 week period prior to the date of accident:
 - determine the total wages earned, including yearly perquisites;
 - divide the total wages earned for this period by 52;
 - the sum will be the average weekly wage.
- If a full year's wage information **has not been** provided covering the 52 week period prior to the date of accident:
 - determine the total wages earned, including yearly perquisites;
 - divide the total wages earned by the number of weeks wages were earned (Note: if warranted, the weeks can be converted into days and calculated on that basis);
 - the sum will be the average weekly wage.
- If the form is completed on a **bi-weekly basis**:
 - determine the total wages earned, including yearly perquisites;
 - divide the total wages earned by the number of weeks worked (employee paid 26 times a year represents 52 weeks of wages);
 - the sum will be the average weekly wage.
- Samples of properly completed wage chart(s) are available through the Commission's website at workcomp.virginia.gov under the forms menu.
- Have questions about the Virginia Workers' Compensation Commission and no lawyer? Call the Ombuds Department at 833-448-1681, or email at ombuds@workcomp.virginia.gov. We cannot give legal advice, but all conversations will be kept confidential.