



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:	

EMPLOYERS® y America's small business insurance specialist® son marcas registradas de Employers Insurance Company of Nevada. El seguro se ofrece a través de la Compañía de Seguros de Compensación del Empleador, la Compañía de Seguros del Empleador de Nevada, la Compañía de Seguros Preferida del Empleador y la Compañía de Seguros del Empleador. EIG Services, Inc. (en California, dba EIG Insurance Services) es una agencia afiliada y de peritaje. No todas las aseguradoras realizan actividades comerciales en todas las jurisdicciones.



TO THE EMPLOYER: THIS NOTICE MUST BE POSTED IN A
CONSPICUOUS PLACE UPON YOUR PREMISES.

NOTICE

REGARDING WORKERS' COMPENSATION INSURANCE

ALL WORKERS EMPLOYED BY THE UNDERSIGNED ARE HEREBY NOTIFIED THAT THE EMPLOYER HAS COMPILED WITH THE LAW AS TO SECURING THE PAYMENT OF COMPENSATION TO HIS EMPLOYEES AND THEIR DEPENDENTS, IN ACCORDANCE WITH THE PROVISIONS OF THE WORKER'S COMPENSATION LAW.

Date: _____

Employer: _____

Employer's Authorized Agent: _____

An Employee receiving an injury by accident must immediately notify his/her supervisor, superintendent, or the undersigned, who will provide medical attendance.

Claim for compensation must be made in writing and given to the employer. Forms for giving notice of injury and making claim for compensation will be furnished by the employer; by the surety,

or upon application, by the Industrial Commission in Boise, Idaho.



PARA EL PATRON: ESTE AVISO DEBE SER PUESTO EN UN LUGAR CONSPICUO EN SU SITIO DE NEGOCIO.

AVISO

REPECTO A EL SUGURO DE COMPENSACIÓN PARA TRABAJADORES

TODOS LOS TRABAJADORES EMPLEADOS POR EL SUSCRITO SON. POR LA PRESENTE, NOTIFICADOS QUE EL PATRÓN HA CUMPLIDO CON LA LEY CON RESPECTO A ASEGURAR EL PAGO DE COMPENSACIÓN A LOS EMPLEADOS Y SUS DEPENDIENTES, DE ACUERDO CON LAS PROVISIONES DE LA LET DE COMPENSACIÓN PARA TRABAJADORES.

Fecha: _____

Patrón: _____

Agente Autorizado del Patrón: _____

Un empleado que recibe un daño en un accidente tiene que notificar inmediatamente a su mayordomo mayordoma , superintendente o a la persona suscrita, quien proveera atencioan medica.

Reclamación para compensación tiene que ser hecha por escrito y entregada al patrón. Formas explicando el daño y reclamando compensación serán proveidas por el patrón; por el fiador,

o con solicitud, por La Comisión Industrial en Boise, Idaho.

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

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.

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




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

	NDC		Envoy
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.



P.O. Box 32036, Lakeland, FL 33802-2036

EMPLOYERS® WAGE REPORT

It is necessary for us to determine the average weekly earnings of your employee named below who was injured in an accident while in your employment. Please complete and return the wage report below, which is required by your state's workers' compensation law.

Please fill in all the wages paid to the employee during the three (3) months before the accident, showing the number of days on which any work was done during each week, including part-time days. If the injured worker was not paid on a weekly basis, explain fully and give the earnings during the 13 weeks preceding the accident.

Employee	Claim Number:
Injury Date:	Wage Rate:
Disability Date:	Date Employed:

Week No.	Date From	Date To	Total Hours	Hourly Rate	Days Worked	Gross Pay Including Overtime
1					\$	\$
2					\$	\$
3					\$	\$
4					\$	\$
5					\$	\$
6					\$	\$
7					\$	\$
8					\$	\$
9					\$	\$
10					\$	\$
11					\$	\$
12					\$	\$
13					\$	\$

Totals				
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P.O. Box 32036, Lakeland, FL 33802-2036

What number of hours was a normal work day? _____

What number of days was a normal work week? _____

Did the employee receive any premium, bonus, board or lodging from you in addition to the wages listed above?

If so, please explain, stating amounts of value thereof _____

Did the employee do the same type of work during all of the time while employed by you during the year before the accident?

If not, please explain fully: _____

Once completed, please fax to EMPLOYERS at 800-371-8204.

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