INSTRUCTIONS

General Instructions:

1. Please enter information into all of the areas of the First Report form, except the boxes at the top right corner of the form which is for office use only.

2. Enter all dates in MM/DD/YY format.

3. Please return completed form electronically by an approved EDI process.

4. For answers to questions, please call (317) 232-3808.

Definitions:

AGENT NAME AND CODE NUMBER: Enter the name of your insurance agent and his / her code number if known. This information can be found on your insurance policy.

ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR EXPOSURE OCCURRED: List anything the employee was using, applying, handling or operating when the injury or exposure occurred. If the injury involves a fall, indicate any surfaces and / or objects the claimant fell on and where they fell from. Enter "NA" if no equipment, materials or chemicals were being used (*e.g. Acetylene cutting torch, metal plate, etc.*).

AVG WG/WK: Claimant's average weekly wage, calculated by totaling the latest 52 weeks of wages (*including overtime, tips, etc.*) and dividing by 52.

CLAIMS ADMINISTRATOR: Enter the name of the carrier, third-party administrator, state fund, or self-insured responsible for administering the claim.

CONTACT NAME / TELEPHONE NUMBER: Enter the name of the individual at the employer's premises to be contacted for additional information (*i.e. Supervisor, HR Person, Nurse, etc.*)

DATE DISABILITY BEGAN: The first day on which the claimant originally lost time from work due to the occupational injury or disease or as otherwised deigned by statute.

DEPARTMENT OR LOCATION WHERE ACCIDENT OR EXPOSURE OCCURRED: If the accident or exposure did not occur on the employer's premises, enter address or location. Be specific (*e.g. Maintenance, Client's Office, Cafeteria, etc.*).

EMPLOYEE STATUS: Indicate the employee's work status from the following choices: Full-time, Part-time, Apprentice Full-time, Apprentice Part-time, Volunteer, Seasonal Worker, Piece Worker, On-Strike, Disabled, Retired, Not Employed or Unknown (you may also abbreviate the above as: (*FT, PT, AFT, APT, VO, SW, PW, OS, DI, RE, NE, or UK*).

HOW INJURY / ILLNESS OCCURRED: Describe the sequence of events leading to the injury or exposure (*e.g. Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, he brushed against the hot metal; Worker stepped to the edge of the scaffolding, lost balance and fell six feet to the concrete floor. The worker's right wrist was broken in the fall*).

NCCI CLASS CODE: A four-digit code classifying the occupation of the claimant.

OCCUPATION / JOB TITLE: Enter the primary occupation of the claimant at the time of the accident or exposure.

PART OF BODY AFFECTED: Indicate the part of body affected by the injury / illness (*e.g. Right forearm, Low Back, etc.*)

REPORT PURPOSE CODE: 00 = Original First Report of Injury; 02 = Updated or Amended First Report.

RTW DATE (*Return to Work Date)***:** Enter the date following the most recent disability period on which the employee returned to work.

SIC CODE: This is the code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

SPECIFIC ACTIVITY EMPLOYEE ENGAGED IN DURING ACCIDENT / EXPOSURE: Describe the specific activity the employee was engaged in during the accident or exposure (*e.g. Cutting metal plate for flooring, sanding ceiling woodwork in preparation for painting*).

TYPE OF INJURY / ILLNESS: Briefly describe the nature of the injury or illness (*e.g. Contusion, Laceration, Fracture, etc.*)

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN DURING ACCIDENT / EXPOSURE: Enter "NA" if employee was not engaged in a work process, such as if walking down the hallway (*e.g. Building maintenance*).

Reset Form

INDIANA WORKER'S COMPENSATION FIRST REPORT OF EMPLOYEE INJURY, ILLNESS

State Form 34401 (R10 / 1-02)

FOR WORKER'S COMPENSATION BOARD USE ONLY		
Jurisdiction	Jurisdiction claim number	Process date

Please return completed form electronically by an approved EDI process.

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

EMPLOYEE INFORMATION

Social Security number	Date of birth	Sex ☐ Male ☐ Female ☐ Unknown	Occupation / Job title	NCCI class code
Name (*last, first, middle*)		Marital status ☐ Unmarried ☐ Married ☐ Separated ☐ Unknown	Date hired / State of hire	Employee status
Address (*number and street, city, state, ZIP code)*			Hrs / Day / Days / Wk / Avg Wg / Wk	☐ Paid Day of Injury ☐ Salary Continued
Telephone number (include area		Number of dependents	Wage $ Per ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year ☐ Other	

EMPLOYER INFORMATION

Name of employer	Employer ID#	SIC code	Insured report number
Address of employer (*number and street, city, state, ZIP code*)	Location number / Telephone number	Employer's location address (*if different)*	
	Carrier / Administrator claim number	OSHA log number	Report purpose code
Actual location of accident / exposure (*if not on employer's premises*)			

CARRIER / CLAIMS ADMINISTRATOR INFORMATION

Name of claims administrator	Carrier federal ID number	Check if appropriate ☐ Self Insurance
Address of claims administrator (*number and street, city, state, ZIP code*)	☐ Insurance Carrier ☐ Third Party Admin.	Policy / Self-insured number
Telephone number		Policy period From To
Name of agent	Code number	

OCCURRENCE / TREATMENT INFORMATION

Date of Inj./ Exp.	Time of occurrence ☐ AM ☐ PM ☐ Cannot be determined	Date employer notified	Type of injury / exposure	Type code
Last work date	Time workday began	Date disability began	Part of body	Part code
RTW date	Date of death	Injury / Exposure occurred on employer's premises? ☐ Yes ☐ No	Name of contact	Telephone number
Department or location where accident / exposure occurred			All equipment, materials, or chemicals involved in accident	
Specific activity engaged in during accident / exposure			Work process employee engaged in during accident / exposure	
How injury / exposure occurred. Describe the sequence of events and include any relevant objects or substances.				Cause of injury code
Name of physician / health care provider				
Hospital or offsite treatment (*name and address*)				INITIAL TREATMENT ☐ No Medical Treatment ☐ Minor: By Employer ☐ Minor: Clinic / Hospital ☐ Emergency Care ☐ Hospitalized > 24 Hours ☐ Future Major Medical / Lost Time Anticipated
Name of witness	Telephone number	Date administrator notified		
Date prepared	Name of preparer	Title	Telephone number	

An employer's failure to report an occupational injury or illness may result in a $50 fine (IC 22-3-4-13).

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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:	

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

CM_0077IF_US
REV 09/2015

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

CM_0077IF_US
REV 09/2015

WORKER'S COMPENSATION NOTICE

Your employer is required to provide for payment of benefits under the Worker's Compensation Act of the State of Indiana.

Any employee who is injured while at work should report the injury immediately to their supervisor, employer, or designated representative.

The worker's compensation insurance carrier or the administrator for

_____ is: _____
(name of company) (name of insurance carrier or administrator)

_____
(name of carrier/administrator)

_____
(mailing address)

_____
(city, state, zip)

_____
(telephone number)

_____
(contact person)

For more information about rights or procedures under the Indiana Worker's Compensation system, call or write:

Worker's Compensation Board of Indiana
Ombudsman Division
402 W. Washington St., Rm W196
Indianapolis, IN 46204
(317) 232-3808
1-800-824-2667

NOTICIA DE COMPENSACION PARA TRABAJADORES

A su empleador le es requerido proveer pagos de beneficios bajo el Acta de Compensación para Trabajadores del Estado de Indiana.

Cualquier empleado que sea lesionado mientras esté trabajando debe reportar el accidente laboral inmediatamente a su supervisor, empleador o representante designado.

La compañía de seguro de compensación del trabajador o el administrador de la compañía _____ es:
(nombre de la compañía)

_____
(nombre de la compañía de seguro/administrador)

_____
(dirección)

_____
(ciudad, estado, código postal)

_____
(número de teléfono)

_____
(persona de contacto)

Para más información acerca de sus derechos o los procedimientos bajo el sistema de compensación para trabajadores de Indiana, llame o escriba a:

Worker's Compensation Board of Indiana
Ombudsman Division
402 W. Washington St., Rm W196
Indianapolis, IN 46204
(317) 232-3808
1-800-824-2667

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this information is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

PATIENT NAME: SOCIAL SECURITY:

DATE OF BIRTH: CLAIM NUMBER:

I AUTHORIZE THE RELEASE OF MY INFORMATION TO:

Employers Preferred Insurance Company
Employers Assurance Company
PO Box 32036
Lakeland, FL 33802-2036
PHONE: (888) 682-6671
FAX: (800) 371-8204

REASON FOR DISCLOSURE: WORKERS COMPENSATION CLAIM

The patient or the patient's representative must read the following statements:
I, _____ understand that this authorization will remain effective for two (2) years, unless otherwise indicated here: _____.

I understand that the information to be released may include diagnosis and/or treatment for alcohol and/or drug abuse, HIV test results, AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment, diagnoses and/or treatment related to other communicable diseases, and mental health records (including psychotherapy notes). This authorization also may include release of medical records for past and present, including but not limited to all charts, records, correspondence, physicians' orders, progress notes, nurses' notes, medication records, therapy notes, laboratory reports, x-ray reports, consents, operative notes, pathology reports, anesthesia reports, admission and discharge summaries and any other medical information.

I understand that I may revoke this authorization at any time by notifying EMPLOYERS in writing, but if I do, it will not have any effect on any actions that took place before EMPLOYERS received the revocation.

I acknowledge that I have read and understand the above and agree that this authorization was completed prior to my signature. I further agree that a copy of this authorization, whether a photocopy, facsimile, or otherwise, shall have equal standing as if it were an original.

Signature of Patient: _____Date:_____

If individual is unable to give authorization because of age, physical condition or otherwise, complete the following:
Individual is: _____ a minor, _____years of age, or _____.

State relationship to individual: _____

Signature of Representative/Legal Guardian: _____Date:_____

Printed Name of Representative/Legal Guardian:_____

OPTUM®

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

Employers
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.*

tmesys®

IMP14-2013-84

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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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America's small business insurance specialist®

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Employers
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.*

tmesys®

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 12 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 52 weeks preceding the accident.

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

Week No.	Week From:	Week To:	Days Worked	Total Hours	Gross Pay Including Overtime	Week No.	Week From:	Week To:	Days Worked	Total Hours	Gross Pay Including Overtime
1						1					
2						2					
3						3					
4						4					
5						5					
6						6					
7						7					
8						8					
9						9					
10						10					
11						11					
12						12					
13						13					
14						14					
15						15					
16						16					
17						17					
18						18					
19						19					
20						20					
21						21					
22						22					
23						23					
24						24					
25						25					
26						26					

Totals			

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.