



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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# 01 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.<sup>1</sup>

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](mailto:fraudfighters@employers.com).**

## **EMPLOYERS®**

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

# 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.<sup>1</sup>

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](mailto: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 – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER		OSHA LOG NUMBER		REPORT PURPOSE CODE						
		JURISDICTION		JURISDICTION CLAIM NUMBER								
		INSURED REPORT NUMBER										
		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)				LOCATION #						
INDUSTRY CODE		EMPLOYER FEIN						PHONE #				
<b>CARRIER/CLAIMS ADMINISTRATOR</b>												
CARRIER (NAME, ADDRESS, & PHONE #)			POLICY PERIOD		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)							
			TO					CHECK IF APPROPRIATE				
		SELF INSURANCE										
CARRIER FEIN		POLICY/SELF-INSURED NUMBER			ADMINISTRATOR FEIN							
AGENT NAME & CODE NUMBER												
<b>EMPLOYEE/WAGE</b>												
NAME (LAST, FIRST, MIDDLE)			DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED		STATE OF HIRE			
ADDRESS (INCL ZIP)			SEX M MALE F FEMALE U UNKNOWN		MARITAL STATUS U UNMARRIED SINGLE/DIVORCED M MARRIED S SEPARATED K UNKNOWN		OCCUPATION/JOB TITLE					
							EMPLOYMENT STATUS					
PHONE			# OF DEPENDENTS				NCCI CLASS CODE					
RATE PER:		<input type="checkbox"/> DAY	<input type="checkbox"/> WEEK	<input type="checkbox"/> MONTH	<input type="checkbox"/> OTHER:	DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>OCCURRENCE/TREATMENT</b>												
TIME EMPLOYEE BEGAN WORK	<input type="checkbox"/> AM	<input type="checkbox"/> PM	DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED		<input type="checkbox"/> AM	<input type="checkbox"/> PM	LAST WORK DATE		DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER				TYPE OF INJURY/ILLNESS				PART OF BODY AFFECTED				
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO				TYPE OF INJURY/ILLNESS CODE				PART OF BODY AFFECTED CODE				
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED					ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED							
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED					WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED							
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL										CAUSE OF INJURY CODE		
DATE RETURN(ED) TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?				<input type="checkbox"/> YES	<input type="checkbox"/> NO			
				WERE THEY USED?				<input type="checkbox"/> YES	<input type="checkbox"/> NO			
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)				HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)				INITIAL TREATMENT				
								0	NO MEDICAL TREATMENT			
								1	MINOR: BY EMPLOYER			
								2	MINOR CLINIC/HOSP			
								3	EMERGENCY CARE			
								4	HOSPITALIZED > 24 HOURS			
								5	FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED			
<b>OTHER</b>												
WITNESSES (NAME & PHONE #)												
DATE ADMINISTRATOR NOTIFIED		DATE PREPARED		PREPARER'S NAME & TITLE				PHONE NUMBER				

## EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

### DATES:

Enter all dates in MM/DD/YY format.

### INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

### CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

### CLAIMS ADMINISTRATOR:

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

### AGENT NAME & 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.

### OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

### EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

### DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

### CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

### TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

### PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

### DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED: (eg.

Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

## EMPLOYER'S INSTRUCTIONS – cont'd

### ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

### SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

### WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

### HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

### DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

**LOUISIANA WORKERS' COMPENSATION SECOND INJURY BOARD  
POST-HIRE/CONDITIONAL JOB OFFER KNOWLEDGE QUESTIONNAIRE**

**EMPLOYEE:** The intent of this questionnaire is to provide your employer with knowledge about any pre-existing medical condition or disability which may entitle your employer to reimbursement from the Louisiana Workers' Compensation Second Injury Board in the event you suffer an on-the-job injury.<sup>1</sup> This reimbursement in no way affects the benefits owed to you by your employer or its insurance company under the Louisiana Workers' Compensation Act. La. R.S. 23:1021-1361. However, your failure to answer truthfully and/or correctly to any of the question on this questionnaire may result in a forfeiture of your workers' compensation benefits.

In order for your employer to be considered for reimbursement from the Second Injury Board, it has to show that it knowingly hired or retained you with a pre-existing medical condition or disability. To establish its knowledge, your employer is requesting that this questionnaire be completed.

**INSTRUCTIONS:** Please answer ALL questions completely. If a response requires an explanation, please provide a brief description on the Explanation Page. If you have any questions or need help in answering the questions on this form, please ask for assistance from the Employer Representative signing this form.

**NOTE:** Since this questionnaire contains medical information, you can request that the form be kept CONFIDENTIAL and not made part of your personnel file. Please let your employer know that you want the completed questionnaire placed in a sealed folder for confidentiality purposes.

**EMPLOYEE WARNING**

**FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF YOUR WORKERS' COMPENSATION BENEFITS UNDER La. R.S. 23:1208.1.**

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_ Male:          Female:

Soc. Sec. # (last 4 digits only): \_\_\_\_\_

Home Address: \_\_\_\_\_

Telephone Number: ( \_\_\_\_ ) \_\_\_\_\_

<sup>1</sup> Under La. R.S. 23:1371(A), the purpose of the Second Injury Board is to encourage the employment, re-employment, or retention of employees who have a permanent partial disability.



**Disease and Other Medical Conditions you currently have or have ever had.**

For all conditions that you check yes, write a brief explanation on the Explanation Page.

[Please check the appropriate box next to each. Every illness/injury requires a Yes (Y) or No (N) answer.]

Y N	Y N	Y N	Y N
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Heart Disease/Heart Attack
<input type="checkbox"/> <input type="checkbox"/> Silicosis	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Parkinson's	<input type="checkbox"/> <input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> <input type="checkbox"/> Varicose Veins	<input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> <input type="checkbox"/> Brain Damage	<input type="checkbox"/> <input type="checkbox"/> Vision Loss, one or both eyes
<input type="checkbox"/> <input type="checkbox"/> Asbestosis	<input type="checkbox"/> <input type="checkbox"/> Post Traumatic Stress	<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Disability from Polio
<input type="checkbox"/> <input type="checkbox"/> Hyperinsulinism	<input type="checkbox"/> <input type="checkbox"/> Osteomyelitis	<input type="checkbox"/> <input type="checkbox"/> Dementia	<input type="checkbox"/> <input type="checkbox"/> Psychoneurotic Disability
<input type="checkbox"/> <input type="checkbox"/> Alzheimer's	<input type="checkbox"/> <input type="checkbox"/> Nervous Disorder	<input type="checkbox"/> <input type="checkbox"/> Thrombophlebitis	<input type="checkbox"/> <input type="checkbox"/> Ruptured or Herniated Disc
<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> <input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> <input type="checkbox"/> Ankylosis or Joint Stiffening
<input type="checkbox"/> <input type="checkbox"/> Hearing Loss	<input type="checkbox"/> <input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> <input type="checkbox"/> Hodgkin's	<input type="checkbox"/> <input type="checkbox"/> High/Low Blood Pressure
<input type="checkbox"/> <input type="checkbox"/> COPD	<input type="checkbox"/> <input type="checkbox"/> Mental Retardation	<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Carpal Tunnel Syndrome
<input type="checkbox"/> <input type="checkbox"/> Hypertension	<input type="checkbox"/> <input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> <input type="checkbox"/> Double Vision	<input type="checkbox"/> <input type="checkbox"/> Compressed Air Sequelae
<input type="checkbox"/> <input type="checkbox"/> Head Injury	<input type="checkbox"/> <input type="checkbox"/> Loss of Use of Limb	<input type="checkbox"/> <input type="checkbox"/> Mental Disorders	<input type="checkbox"/> <input type="checkbox"/> Disease of the Lung
<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Coronary Artery Disease
<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> <input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> <input type="checkbox"/> Heavy Metal Poisoning

**Surgical Treatment** [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.] For each Yes (Y) answer, please complete the information corresponding to the surgery on the right. Additional information can be provided on the Explanation Page, if necessary.

**Y N**

- Spinal Disc Surgery                      Year (approximate if unsure) \_\_\_\_\_
- Spinal Fusion Surgery                      Year (approximate if unsure) \_\_\_\_\_
- Amputated Foot                      Left      Right      Year (approx. if unsure) \_\_\_\_\_
- Amputated Leg                      Left      Right      Year (approx. if unsure) \_\_\_\_\_
- Amputated Arm                      Left      Right      Year (approx. if unsure) \_\_\_\_\_
- Amputated Hand                      Left      Right      Year (approx. if unsure) \_\_\_\_\_
- Knee Replacement                      Left      Right      Year (approx. if unsure) \_\_\_\_\_
- Hip Replacement                      Left      Right      Year (approx. if unsure) \_\_\_\_\_
- Other Joint Replacement                      Joint \_\_\_\_\_ Year \_\_\_\_\_
- Other Surgical Procedure                      Procedure \_\_\_\_\_ Year \_\_\_\_\_
- Other Surgical Procedure                      Procedure \_\_\_\_\_ Year \_\_\_\_\_
- Other Surgical Procedure                      Procedure \_\_\_\_\_ Year \_\_\_\_\_
- Other Surgical Procedure                      Procedure \_\_\_\_\_ Year \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Representative: \_\_\_\_\_ Date: \_\_\_\_\_

**EXPLANATION PAGE**

Please use the space below to explain the illnesses and/or conditions that you checked a Yes (Y) or any other medical conditions that may not be listed on this form. Ask your employer for additional copies of this page if needed.

CONDITION: \_\_\_\_\_ Year Diagnosed (approx): \_\_\_\_\_

Are you still treating for this condition?                      Yes      No

Are you taking medication for this condition?                      Yes      No

Do you have any permanent restrictions for this condition?                      Yes      No

Brief Explanation: \_\_\_\_\_

---

CONDITION: \_\_\_\_\_ Year Diagnosed (approx): \_\_\_\_\_

Are you still treating for this condition?                      Yes      No

Are you taking medication for this condition?                      Yes      No

Do you have any permanent restrictions for this condition?                      Yes      No

Brief Explanation: \_\_\_\_\_

---

CONDITION: \_\_\_\_\_ Year Diagnosed (approx): \_\_\_\_\_

Are you still treating for this condition?                      Yes      No

Are you taking medication for this condition?                      Yes      No

Do you have any permanent restrictions for this condition?                      Yes      No

Brief Explanation: \_\_\_\_\_

---

CONDITION: \_\_\_\_\_ Year Diagnosed (approx): \_\_\_\_\_

Are you still treating for this condition?                      Yes      No

Are you taking medication for this condition?                      Yes      No

Do you have any permanent restrictions for this condition?                      Yes      No

Brief Explanation: \_\_\_\_\_

---

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Please answer the following questions.

1. Has any doctor ever restricted your activities? Yes No

If "Yes," please list the restrictions: \_\_\_\_\_

Were the restrictions: Permanent Temporary

Are your activities currently restricted? Yes No

What is the medical condition for which you have restrictions? \_\_\_\_\_

2. Are you presently treating with a doctor, chiropractor, psychiatrist, psychologist or other health-care provider? Yes No

Please list the medical condition being treated: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

3. If you are currently taking prescription medication other than those listed on the Explanation Page, please complete the requested information below.

Medication: \_\_\_\_\_ Prescribing Doctor: \_\_\_\_\_

Medication: \_\_\_\_\_ Prescribing Doctor: \_\_\_\_\_

4. Have you ever had an on the job accident? Yes No

If you answered "YES," please provide the date for each injury and the nature of the injury:

\_\_\_\_\_

How long were you on compensation? \_\_\_\_\_

Name of Employer: \_\_\_\_\_

5. Has a doctor recommended a surgical procedure, which has not been completed prior to this date, including but not limited to knee, hip or shoulder replacement? Yes No

If you answered YES, please provide:

Recommended surgery: \_\_\_\_\_

Approximate date of recommendation: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Representative: \_\_\_\_\_ Date: \_\_\_\_\_

**EMPLOYEE WARNING**

**FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF ANY AND ALL WORKERS COMPENSATION BENEFITS UNDER La. R.S. 23:1208.1.**

I have completed this form honestly and to the best of my knowledge. I understand that providing false information or omitting pertinent information could result in loss of my workers compensation benefits should I become injured on the job.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employee Printed Name: \_\_\_\_\_

**EMPLOYER WARNING**

**PURSUANT TO La. R.S. 23:1208 OF THE LOUISIANA WORKERS' COMPENSATION ACT, IT SHALL BE UNLAWFUL FOR A PERSON, FOR THE PURPOSE OF OBTAINING OR DEFEATING ANY BENEFIT PAYMENT UNDER THE PROVISIONS OF THIS CHAPTER, EITHER FOR HIMSELF OR FOR ANY OTHER PERSON, TO WILLFULLY MAKE A FALSE STATEMENT OR REPRESENTATION. PENALTIES FOR VIOLATIONS INCLUDE IMPRISONMENT, FINES, AND/OR THE FORFEITURE OF BENEFITS.**

You must certify the following:

1. That I am an authorized representative of the employer designated to obtain and review the information provided by the employee on this questionnaire;
2. That I have provided the employee with as many copies of the Explanation Page as needed and have confirmed the number of and labeled the pages of this questionnaire;
3. That I have provided assistance to the employee (if requested) in responding to the questions on this questionnaire;
4. That the information sought by this authorization is made on an applicant for employment only after a conditional job offer has been made and accepted, or on a current employee; and
5. That the information obtained in the authorization will **NOT** be used to discriminate in any manner against the individual who is the subject of this authorization on any basis, in violation of the Americans with Disabilities Act of 1990, 42 U.S.C. §12101, *et seq.*, or any other state or federal law;
6. That if requested, a photocopy of this fully completed and signed form will be provided to the employee.

Employer Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Representative Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

## 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<sup>®</sup> 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](http://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](http://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](http://tmesys.com).



### ¿Tiene alguna pregunta? ¿Necesita ayuda?

# 1-866-599-5426




America's small business insurance specialist®

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](http://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.



CLAIM #:

**4 WEEK WAGE STATEMENT**

In order to determine the correct compensation rate for the employee listed below, it is necessary that we obtain his/her weekly earnings for the 4 FULL WEEK period preceding the date of injury.

If there are any questions concerning this information, please do not hesitate to call.

\*\*\*\*\*

EMPLOYER: \_\_\_\_\_

EMPLOYEE: \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_ S.S. #: \_\_\_\_\_

DATE OF HIRE: \_\_\_\_\_

LENGTH OF EMPLOYMENT: \_\_\_\_\_ NO. OF DAYS EMPLOYEE WAS TO WORK PER WEEK: \_\_\_\_\_

NO. OF HOURS EMPLOYEE WAS HIRED TO WORK PER DAY \_\_\_\_\_ FULL TIME \_\_\_\_\_ PART TIME \_\_\_\_\_

EMPLOYEE'S HOURLY RATE OF PAY: \$ \_\_\_\_\_

\_\_\_\_\_  
Employer's Representative

WEEK NO.	WEEK ENDING			DAYS WORKED	AMOUNT PAID INCLUDING ALL OVERTIME
	MO	DAY	YEAR		
1					
2					
3					
4					

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# Workers' Compensation

## Reporting Injury

You should report to your employer any occupational disease or personal injury that is work-related, even if you deem it to be minor.

## Occupational Disease or Death

In case of an occupational disease, all claims are barred unless the employee files a claim with his/her employer within one year of the date that:

- 1 the disease manifests itself.
- 2 the employee is disabled as a result of the disease.
- 3 the employee knows or has reasonable grounds to believe that the disease is occupationally related.

In case of death arising from an occupational disease, all claims are barred unless the dependent(s) file a claim with the deceased employee's employer within one year of:

- 1 the date of death.
- 2 the date the claimant has reasonable grounds to believe that the death resulted from occupational disease.

## Filing Notice

In case of injury or death caused by a work-related accident, an injured employee or any person claiming to be entitled to compensation either as a claimant or as a representative of a person claiming to be entitled to compensation, must give notice to the employer within 30 days of the injury. If notice is not given within 30 days, no payments will be made for such injury or death. In addition, any fraudulent action by the employer, employee, or any other person for the purpose of obtaining or defeating any benefit or payment of workers' compensation shall subject such person to criminal as well as civil liabilities.

The above mentioned notice should be filed with the employer at the address shown to the right.

A notice so given shall not be held invalid because of any inaccuracy in stating the time, place, nature or cause of injury, or otherwise, unless it is shown that the employer was in fact misled to his detriment thereby. Failure to give notice may not harm the employee if the employer knew of the accident or if the employer was not prejudiced by the delay or failure to give notice.

## Physicians

In the event you are injured, you are entitled to select a physician of your choice for treatment. The employer may choose another physician and arrange an examination which you would be required to attend.

## Formal Claim

In order to preserve your right to benefits under the Louisiana Workers' Compensation Law, you must file a formal claim with the Office of Workers' Compensation Administration within one year after the accident if payments have not been made or within one year after the last payment of weekly benefits.

## Information

If you desire any information regarding your rights and entitlement to benefits as prescribed by law, you may call or write to the Office of Workers' Compensation Administration, Post Office Box 94040, Baton Rouge, Louisiana 70804-9040 or telephone (225) 342-7555.

## Name and Address of Insurance Company

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Notice shall be given by delivering it or sending it by certified mail or return receipt requested to:

Employer Representative

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Employer

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R.S. 23:1302 states that this notice should be posted in a convenient and conspicuous place in the employer's place of business.

Revised May 2003



[www.laworks.net](http://www.laworks.net)