



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.

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.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>

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>

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




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.

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.

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

1. WCB FILE NUMBER (if known):

1a. OSHA 300 CASE NUMBER (if applicable):

REASON FOR REPORT (check all that apply)

- 2a. LOST TIME - ONE OR MORE DAYS 2b. WAS EMPLOYEE PAID FOR IJ DAY OR MORE ON DAY OF INJURY? YES NO
3. LOST EARNINGS BUT NO LOST TIME 4. MEDICAL/HEALTH CARE 5. FATALITY DATE OF DEATH: ____/____/____
MM DD YYYY
- 6a. OCCUPATIONAL DISEASE 6b. DATE OF LAST EXPOSURE: ____/____/____
MM DD YYYY 6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: ____/____/____
MM DD YYYY
- 7a. CORRECT PRIOR REPORT 7b. DATE OF CORRECTION: ____/____/____
MM DD YYYY 7c. DATE CORRECTION SENT TO WCB: ____/____/____
MM DD YYYY

EMPLOYER

8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN):		9. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):		10. EMPLOYER NAME:	
11. STREET/P.O BOX MAILING ADDRESS:		12. CITY:		13. STATE:	
14. ZIP:		15. TELEPHONE NUMBER: ()			
16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED:		17. EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS:		18. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED:	

(check one) INSURER THIRD PARTY ADMINISTRATOR (TPA) SELF-ADMINISTERED EMPLOYER

19. INSURANCE / TPA COMPANY NAME:		20. POLICY NUMBER:		21. INSURER FILE NUMBER:	
22. STREET/P.O. BOX MAILING ADDRESS:		23. CITY:		24. STATE:	
25. ZIP:		26. TELEPHONE NUMBER: ()			

EMPLOYEE

27. LAST NAME:		28. FIRST NAME:		29. MI:		30. TELEPHONE NUMBER: ()		31. SOCIAL SECURITY NUMBER:		32. GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
33. STREET/P.O. BOX MAILING ADDRESS:		34. CITY:		35. STATE:		36. ZIP:		37. DATE OF BIRTH: ____/____/____ MM DD YYYY			
38. OCCUPATION/JOB TITLE:		39. DATE OF HIRE: ____/____/____ MM DD YYYY		40. WEEKLY WAGE AT TIME OF INJURY: \$		41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE NAME AND ADDRESS:					

CLAIM INFORMATION

42. DATE OF INJURY OR ILLNESS: ____/____/____ MM DD YYYY		43. DATE OF INCAPACITY: ____/____/____ MM DD YYYY		44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.):		45. DATE EMPLOYER NOTIFIED INSURER/TPA: ____/____/____ MM DD YYYY					
DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY		DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY		46. TIME OF INJURY (e.g. 1:10 p.m.):		47. HAS EMPLOYEE RETURNED TO WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE DATE: ____/____/____ MM DD YYYY					
48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis):			49. BODY PART(S) AFFECTED (e.g. lower right forearm):			50. ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN THE EVENT OCCURRED (e.g. acetylene torch, metal plate):					

51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring.):					52. HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal.):						
WAS ACTIVITY PART OF NORMAL JOB DUTIES? <input type="checkbox"/> YES <input type="checkbox"/> NO											

53. HOSPITALIZED OVERNIGHT AS INPATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		54. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM? <input type="checkbox"/> YES <input type="checkbox"/> NO:		55. HEALTH CARE PROVIDER NAME:		56. MAILING ADDRESS:		57. TELEPHONE NUMBER: ()			
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PREPARER INFORMATION

58. PREPARER NAME AND TITLE (TYPE OR PRINT):				59. TELEPHONE NUMBER: ()				60. DATE SENT TO WCB: ____/____/____ MM DD YYYY			
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THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY Maine Relay 711.
WCB-1 (eff. 1/1/13)

WAGE STATEMENT
STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:		6. SOCIAL SECURITY NUMBER (LAST 4 DIGITS): XXX -XX-		7. WCB FILE NUMBER:		
2. EMPLOYER NAME:		8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:	
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:		11. ADDRESS-NUMBER AND STREET:				
4. INSURER NAME:		12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:	
5. INSURER MAILING ADDRESS:		16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:			
18. DOES EMPLOYEE WORK CONCURRENTLY FOR ANOTHER EMPLOYER? IF YES, GIVE NAME(S): _____ NOTE: THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FOR EACH ADDITIONAL EMPLOYER.			YES <input type="checkbox"/>	NO <input type="checkbox"/>	19. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS' COMPENSATION? NOTE: THE EMPLOYER SHALL RECALCULATE THE AVERAGE WEEKLY WAGE IF/WHEN FRINGE BENEFITS CEASE (SEE RULE 1.5(2))	
			YES <input type="checkbox"/>	NO <input type="checkbox"/>		

&S" @GH; FCGG95FB-B; G: CF'957< 'K 99?.

WK	WEEK ENDING	GROSS EARNINGS	WK	WEEK ENDING	GROSS EARNINGS	WK	WEEK ENDING	GROSS EARNINGS
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			K ? 'C: '		
17			35			-B>I FM		
18			36			&S" HCH5 @		
					95FB-B; G		
						&S"; FCGG5J9F5; 9'		
					'K 99? @MK 5; 9		

23. COMMENTS:

24. PREPARER NAME (TYPE OR PRINT):		25. TELEPHONE NUMBER: ()		26. DATE MAILED:	
E-MAIL ADDRESS:		TOLL-FREE NUMBER: ()		MM / DD / YYYY	

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.
WCB-2 (eff. 1/1/13)



WORKERS' COMPENSATION

WORKERS' COMPENSATION BOARD REGIONAL OFFICES

AUGUSTA

442 Civic Center Drive, Suite 225
156 State House Station
Augusta, ME 04333-0156
207-287-2308
1-800-400-6854

LEWISTON

36 Mollison Way
Lewiston, ME 04240-5811
207-753-7700
1-800-400-6857

BANGOR

106 Hogan Road, Suite 1
Bangor, ME 04401
207-941-4550
1-800-400-6856

PORTLAND

1037 Forest Avenue, Suite 11
Portland, ME 04103
207-822-0840
1-800-400-6858

CARIBOU

43 Hatch Drive, Suite 110
Caribou, ME 04736-2347
207-498-6428
1-800-400-6855

Visit our website at:
www.maine.gov/wcb
Statewide TTY: 711

Notice to Employees:

State law requires your employer to provide workers' compensation insurance for its employees. Workers' compensation insurance provides benefits to employees who are injured at work.

If you are injured at work, NOTIFY YOUR EMPLOYER AT ONCE. You may lose your right to receive benefits unless your employer is notified within 60 days of your injury. Your claim is also subject to a two year statute of limitations. Worker advocates are available at the Workers' Compensation Board to help injured workers.

It is against the law for employers to misclassify employees as independent contractors for the purposes of avoiding workers' compensation insurance, unemployment coverage, or other employer paid taxes and withholdings. For more information on laws pertaining to the hiring of independent contractors, visit the Worker Misclassification Task Force website at www.maine.gov/labor/misclass.

If you have any questions about your rights, please contact one of the regional offices.

A l'intention des Employes:

D'après les lois de l'Etat du Maine, votre employeur est tenu de souscrire à une assurance indemnisant ses employés victimes d'un accident du travail.

Si vous êtes victime d'un accident du travail, PREVEZ VOTRE EMPLOYEUR IMMEDIATEMENT. Passé un délai de 60 jours, vous risquez de perdre vos droits à l'indemnisation. Au-delà de deux ans, votre déclaration n'est plus recevable. Pour aider les victimes d'un accident du travail, le Workers' Compensation Board met des conseillers juridiques à leur disposition.

La loi interdit aux employeurs de classer fallacieusement leurs salariés comme étant des contractants privés aux fins d'échapper à l'assurance compensatrice-employé, aux

indemnités de chômage, ou aux autres charges et retenues dues par employeur. Pour plus de détails sur la législation relative à l'utilisation des services privés, visitez le site internet de Worker Misclassification Task Force (Unité anti-fraude en matière de classification des salariés) : www.maine.gov/labor/misclass.

Si vous n'êtes pas sûr de vos droits, veuillez contacter l'un des bureaux régionaux.

Aviso a los Trabajadores:

La ley del estado de Maine requiere que su empresario proporcione el seguro de compensaciones para el trabajador a todos los trabajadores. El seguro de compensaciones para el trabajador proporciona beneficios a los trabajadores accidentados en el trabajo.

En caso de sufrir accidente o daño laboral, NOTIFIQUELO INMEDIAMENTE A SU EMPRESARIO. Podría perder el derecho a recibir compensación a menos que su empresario sea notificado de este accidente o daño en el plazo de 60 días. Así mismo esta reclamación debe hacer referencia a un accidente o daño que no haya ocurrido hace más de dos años. Los defensores del trabajador están disponibles para proporcionar ayuda a los trabajadores accidentados en el Consejo de Administración de Compensaciones para el Trabajador (Workers' Compensation Board).

El hecho de no clasificar a los empleados como contratistas independientes, con el propósito de evitar el seguro por compensación al trabajador, cobertura para desempleados, u otros impuestos pagados y retenidos por el empleador; está en contra de la ley del empleador. Para mayor información acerca de las leyes pertenecientes a la contratación de contratistas independientes, visite el Worker Misclassification Task Force en la página web de www.maine.gov/labor/misclass.

En caso de tener cualquier pregunta sobre sus derechos, favor de dirigirse a una de las oficinas regionales de compensaciones para el trabajador.

ENGLISH

Interpreters Available

When calling for assistance, please say the name of your language in English and an interpreter will be called for you. Please stay on the line.

SPANISH

Tenemos intérpretes a su disposición

Si necesita que le atiendan en español por favor diga "Spanish" y le conectaremos con un intérprete. Por favor manténgase en la línea.

PORTUGUESE

Temos intérpretes à sua disposição

Se precisar de atendimento em Português, por favor diga "Portuguese" e um intérprete será prontamente chamado. Por favor, aguarde na linha.

ITALIAN

Abbiamo interpreti disponibili

Se avete bisogno di assistenza in Italiano, Vi preghiamo di dire "Italian" e un interprete sarà messo a Vostra disposizione. Vi preghiamo di rimanere in linea.

FRENCH

Des interprètes sont à votre disposition

Lorsque vous appelez pour demander de l'aide, prononcez le mot "French" et nous mettrons un interprète à votre disposition. Prière de rester en ligne.

POLISH

Tłumacze dostępni na życzenie.

Aby uzyskać pomoc tłumacze, proszę powiedzieć po angielsku "Polish" i czekać na linię.

RUSSIAN

"К вашим услугам имеются переводчики"

"Когда Вы обращаетесь за помощью по телефону, пожалуйста скажите, что Вы говорите по-русски (произнесите "РАШН"), и мы обеспечим Вас переводчиком. После этого, пожалуйста, оставайтесь на линии."

CHINESE

提供口譯服務

打電話請求幫助時，請用英語說“換音呢斯”(CHINESE)——我們將為您提供口譯人員。請不要掛斷電話。

JAPANESE

通訳サービスをご利用いただけます

通訳を必要とされる場合は「ジャパニーズ」とおっしゃり、通訳ができるまでそのままお待ちください。

KOREAN

한국어 통역을 이용하실 수 있습니다.

도움이 필요하여 전화를 거실 때 영어로 코리언 (KOREAN)이라고 말씀하시면 통역자를 연결해 드릴 것입니다. 전화를 끊지 마시고 기다리십시오.

VIETNAMESE

"Cố Thông Dịch Viên"

"Khi gọi điện thoại để được giúp đỡ, xin quý vị hãy nói "VIETNAMESE" để chúng tôi cho thông dịch viên giúp quý vị. Xin quý vị chờ trên đường dây."

ARABIC

مترجمون شهيون متيسرون لخدمتكم

عند إتصالكم للمساعدة أو لطلب خدمة معينة نرجو منكم أن تذكروا (أ-ز-ب-ك) ونحن سنقدم لكم مترجماً شهيياً . ابقوا على الخط من فضلكم.

PERSIAN

افراد مترجم در دسترس مي باشند.

را که بدان صحبت مي کنيد به انگليسي ذکر کنيد تا راجع به امري به ما تلفن مي کنيد، لطفاً نام زباني قطع نکنيد. هنگامیکه براي درخواست کمک يا شما تماس گرفته شود، لطفاً روي خط منتظر بمانيد. با يك مترجم براي

SOMALI

Turjunaanno waa la helayaa

Marka aad caawinaad inoogu soo yeeraneysid, fadhlan luqaddaada af Ingiriisi inoogu sheeg turjubaan ayaa lguugu yeeri doonaaye. Talefoonkana ha dhigin.

To the employer: This notice must be posted in a conspicuous place upon your premises accessible to employees. 39-A MRSA §406. The State of Maine does not discriminate on the basis of disability in admission to, access to, or operation of its programs, services or activities.

This poster is available in alternative format. For further assistance, contact the Maine Workers' Compensation Board, ADA Coordinator, telephone: (888) 801-9087 or TTY: 711.