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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

MN Department of Labor and Industry
Workers' Compensation Division
(651) 284-5032 or 1-800-342-5354

First Report of Injury

See Instructions on Reverse Side

Reset

Print in ink or type
Enter dates in MM/DD/YYYY format

FRO 1

DO NOT USE THIS SPACE

1. **EMPLOYEE SOCIAL SECURITY #**	2. OSHA case #	3. Time employee began work on date of injury ☐ am ☐ pm	
4. **DATE OF CLAIMED INJURY**	5. Time of injury ☐ am ☐ pm	6. Date of death	# of dependents (if death is related to injury)
7. **EMPLOYEE** Name (last, suffix, first, middle)		8. Gender ☐ M ☐ F	9. Marital status ☐ Married ☐ Unmarried

10. Home address			11. Home phone #	12. Date of birth	13. Date hired
City	State	Zip Code	14. Occupation	15. Regular department	16. Apprentice ☐ Yes ☐ No

17. Average weekly wage	18. Rate per hour	19. Hours per day	20. Days per week	Normal work schedule Sun - Sat (S M T W T F S) ☐ ☐ ☐ ☐ ☐ ☐ ☐	21. Employment status (check all that apply) ☐ Full time ☐ Part time ☐ Seasonal ☐ Volunteer

22. **Tell us how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was.** *Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."*

23. **What was the injury or illness (include the part(s) of body)?** *Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.*	24. **What tools, equipment, machines, objects, or substances were involved?** *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.*

25. Did injury occur on employer's premises? ☐ Yes ☐ No Name and address of the place of the occurrence	26. Date of first day of any lost time	27. Employer paid for lost time on day of injury (DOI) ☐ Yes ☐ No ☐ No lost time on DOI	
	28. Date employer notified of injury	29. Date employer notified of lost time	
	30. Return to work date	31. RTW same employer ☐ Yes ☐ No	32. RTW with restrictions ☐ Yes ☐ No
33. Treating physician (name)	34. Extent of medical treatment (check all that apply) ☐ None ☐ Minor on-site by employer's medical staff ☐ Minor clinic/hospital ☐ Emergency room ☐ Hospitalization more than 24 hours ☐ Future major medical anticipated		
35. Certified Managed Care Organization (if any)			

36. **EMPLOYER** Legal name			37. EMPLOYER DBA name (if different)	
38. **Mailing** address			39. Employer FEIN	40. Unemployment ID #
City	State	Zip Code	41. Employer's contact name and phone #	
42. **Physical** address (if different)			43. Witness (name and phone) - if more than 1 attach a separate sheet	
City	State	Zip Code	44. NAICS code	45. Date form completed

46. **INSURER** name			51. **CLAIMS ADMIN COMPANY (CA)** name (check one) ☐ Insurer ☐ TPA	
47. Insured legal name and FEIN			52. CA address	
48. Policy # (including effective dates) or self-insured certificate #			City State Zip Code	
49. Insurer FEIN	50. Date insurer received notice		53. CA FEIN	54. CA claim #

55. To be completed by the **CA**:	Claim type code:	Type of loss code:	Late reason code:	Salary paid in lieu of comp?	Death result of injury?

Employer: Send copies to Insurer (or Workers' Compensation Division if no insurer), employee, and employee's union (if applicable)

GENERAL INSTRUCTIONS TO THE EMPLOYER

Employers, not employees, are responsible for completing this form. The information is needed to determine liability and entitlement to benefits. You must file this form with your insurer, and give a copy to the employee and the employee's local union office. You are required to provide the employee with a copy of the Employee Information Sheet, which is available on the Department of Labor and Industry's web site at www.dli.mn.gov.

Filing this form is not an admission of liability. You must report a claim to your insurer whenever anyone believes that a work-related injury or illness that requires medical care or where lost time from work has occurred. If the claimed injury wholly or partially incapacitates the employee for more than **three** calendar days, the claim must be made on this form and reported to your insurer within **ten** days. Your insurer may require you to file it sooner. Failure to file within the **ten** days may result in penalties. It is important to file this form quickly to allow your insurer time to investigate the claim. **Your insurer will report the injury** to the Department of Labor and Industry (Department), when necessary. Self-insured employers have 14 days to report the injury to the Department, when necessary.

If the claim involves death or serious injury (including injuries that later result in death), you must notify the Department and your insurer within 48 hours of the occurrence. The claim can be reported initially to the Department by telephone 651-284-5005, press 3 or 800-342-5354, press 3. The initial notice must be followed by the filing of this form with the Department within **seven** days of the occurrence, at P.O. Box 64221, St. Paul, MN 55164-0221.

SEND THIS FORM TO YOUR INSURER IMMEDIATELY – DO NOT WAIT FOR THE DOCTOR'S REPORT

SPECIFIC INSTRUCTIONS TO THE EMPLOYER ON COMPLETING THIS FORM

- Item 2: OSHA case #. Fill in the case number from the OSHA 300 log. This form contains all items required by the OSHA form 301.
- Items 17-21: Fill in all the wage information. If the employee does not work a regularly scheduled work week, attach a 26 week wage statement so your insurer can calculate the appropriate average weekly wage. Attach a separate sheet giving the weekly value of any meals, lodging, or 2nd income paid to the employee.
- Item 20: Fill in the average number of days per week that the employee works. Also include their normal work schedule, Sunday - Saturday, by checking the appropriate boxes. If the employee's work schedule fluctuates from week-to-week, leave the boxes blank.
- Items 22-24: Be as specific as possible in describing: the events causing the injury; the nature of the injury (cut, sprain, burn, etc.), and the part(s) of body injured (back, arm, etc.); and the tools, equipment, machines, objects or substances involved.
- Item 26: Fill in the first day the employee lost any time from work (including time lost for medical treatment), even if you paid the employee for the lost time.
- Item 27: Check the appropriate box to indicate if there was lost time on the date of injury and whether you paid for that lost time.
- Item 28: Fill in the date you first became aware of the injury or illness.
- Item 29: Fill in the date you became aware that the lost time indicated in Item 26 was related to the claimed injury.
- Item 30: Leave the box blank if the employee has not returned to work by the time you file this form. If the employee has returned to work, fill in the date and answer the questions in Items 31 and 32. Notify your insurer if the employee misses time due to this injury after that date.
- Item 34: Check all the boxes that apply AT the time you file this form.
- Item 39: Fill in your Federal Employer Identification Number (FEIN). For information, see https://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Lost-or-Misplaced-Your-EIN.
- Items 40 and 44: Fill in your Unemployment ID number and North American Industry Classification System (NAICS) code, which are both assigned by the Minnesota Unemployment Insurance Program (651-296-6141).
- Items 46-54: Your insurer or claims administrator will complete this information if you do not have it available.

INSTRUCTIONS TO THE INSURER/CLAIMS ADMINISTRATOR
(For first reports of injury filed on or after Jan. 1, 2014)

Pursuant to Minnesota Statutes, section 176.231, and Minnesota Rules, part 5220.2530, insurers and self-insured employers must file with the Department's Workers' Compensation Division an electronic first report of injury, according to the requirements set out in sections 2 to 4 of the Minnesota implementation guide, in all cases where a first report of injury is required to be filed under Minnesota Statutes, chapter 176. The Minnesota implementation guide can be found on the Department's website at www.dli.mn.gov/WC/Edi.asp.

A first report of injury submitted by the insurer or self-insured employer in any other manner or format is not considered filed with the division, except for a written first report of injury on a paper form filed by a self-insured employer within seven days of death or serious injury.

If the claim does not involve lost time beyond the waiting period or potential permanent partial disability (PPD), or has not been requested to be filed by the Department, a first report of injury does **not** need to be filed.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354 Voice or TDD (651) 297-4198

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

Department of Labor and Industry
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5032 o 1-800-342-5354
Fax: (651) 284-5731

Derechos de Rehabilitación y Responsabilidades del Trabajador Lesionado

(Rehabilitation Rights and Responsibilities of the Injured Worker – Spanish version)

IW 05

Llenar a máquina o con letra de molde
Escriba las fechas en el formato MM/DD/AAAA.

NO USE ESTE ESPACIO

Número WID o Número de seguro social (SSN)	Fecha de la lesión
Nombre del empleado	

El propósito de la Rehabilitación Vocacional en virtud de los Estatutos § 176.102 de Minnesota es ayudarlo para que pueda regresar a su antiguo puesto de trabajo, a un trabajo relacionado con su empleo anterior o a un trabajo en otro sector. El trabajo debe ser físicamente apropiado y generar una situación económica lo más cercana posible a la que hubiese tenido sin la discapacidad.

El primer paso en este proceso de regreso al trabajo es una Consulta de Rehabilitación, es decir, una reunión con un Consultor de Rehabilitación Calificado (QRC, por sus siglas en inglés) para determinar si califica para los servicios de rehabilitación. Si el QRC determina que usted califica, el próximo paso es desarrollar un plan de rehabilitación. Su QRC le ayudará a desarrollar e implementar este plan y le explicará los servicios de rehabilitación disponibles para usted. Se dará consideración a factores como su empleo anterior, su salario semanal promedio, el mercado laboral actual y sus calificaciones, incluyendo destrezas transferibles, historial de trabajos previos, edad, educación e intereses. No recibirá factura alguna por los servicios de rehabilitación.

Derechos del trabajador lesionado

Bajo la ley de compensación para trabajadores de Minnesota, usted tiene derechos de rehabilitación vocacional.

- Usted puede obtener una lista de QRC registrados (consultores de rehabilitación calificados) en su área visitando el sitio web del departamento en www.dli.mn.gov/WC/QrcData.asp. Para una consulta de rehabilitación, el asegurador puede referirlo a un QRC o usted puede elegir el de su preferencia. Si usted no eligió un QRC para su consulta, tiene hasta 60 días después de la presentación del plan de rehabilitación para solicitar un QRC diferente. Usted también tiene derecho a cambiar de QRC en otras ocasiones; llame a la unidad de Resolución Alternativa de Disputas (ADR) al (651) 284-5032 o al 1-800-342-5354 si desea más información.
- Cuando en primera instancia un QRC le escribe o se contacta con usted, él o ella está obligado a revelarle por escrito cualquier afiliación o participación entre el QRC (o la firma del QRC) y su empleador, cualquier compañía de seguros de compensación para trabajadores o compañía ajustadora de seguros. El QRC también está obligado a revelarle a usted y a todas las partes en un caso, cualquier afiliación o acuerdo de negocio por referencia, documentado o no, entre el QRC (o la firma de QRC) y cualesquiera otras partes en el caso, incluidos abogados y médicos.
- Un plan de rehabilitación vocacional puede incluir capacitación y/o educación formal.
- Usted puede solicitar un cambio en su plan de rehabilitación.
- Su QRC necesita de su permiso para: asistir, programar o cancelar citas médicas; hablar sobre sus cuidados y tratamientos médicos con su médico o proveedores de servicios de salud, o bien obtener registros médicos por parte de su médico o proveedores de servicios de salud.
- Usted puede retirar su permiso para que su QRC: asista, programe o cancele citas médicas; hable sobre sus cuidados y tratamientos médicos con su médico o proveedores de servicios de salud, o bien obtener registros médicos por parte de su médico o proveedores de servicios de salud.
- El QRC deberá proveerle copias de su plan de rehabilitación, informes de rehabilitación requeridos y registros de progreso, incluyendo la correspondencia preparada o recibida por el QRC, dirigida a usted y a las demás partes y abogados. Una excepción es que los registros de progreso deben ser enviados al empleador solo a petición del mismo.

(al dorso)

Número WID o Número de seguro social (SSN)	Fecha de la lesión	Nombre del empleado	IW 0 5

- Usted tiene el derecho de pedir ayuda con respecto a servicios de rehabilitación y otros asuntos de reclamos al Departamento de Trabajo e Industria. Si usted tiene preguntas sobre los servicios de rehabilitación vocacional, llame a la unidad de ADR al (651) 284-5032 o al 1-800-342-5354. Si hay una disputa acerca de su elegibilidad para los servicios de rehabilitación legales o el plan de rehabilitación, puede presentar un formulario de Solicitud de Rehabilitación y el Departamento puede programar una conferencia administrativa para resolver la disputa

Responsabilidades del trabajador lesionado

Bajo la ley de compensación para trabajadores de Minnesota, usted tiene responsabilidades de rehabilitación vocacional.

- Usted debe hacer un esfuerzo de buena fe para participar en su plan de rehabilitación. El no hacerlo puede resultar en la suspensión o terminación de los beneficios de compensación para trabajadores.
- Usted debe notificar a su Consultor de Rehabilitación Calificado (QRC) y a la compañía de seguros sobre su sueldo, horas, empleador y cargo cuando regrese al trabajo con cualquier empleador y cuando sus horas o su sueldo cambien. Esto es necesario para calcular con precisión sus beneficios por pérdida de sueldo y asegurar que se provean los servicios de rehabilitación apropiados. No reportar correctamente el sueldo ganado mientras recibe beneficios de compensación para trabajadores puede resultar en consecuencias civiles o penales.
- Usted debe cooperar con las evaluaciones y los exámenes médicos y de rehabilitación razonables según lo ordenado por el comisionado o juez de compensación. El no hacerlo puede resultar en la suspensión o terminación de los beneficios de compensación para trabajadores.

Divulgación

Las siguientes declaraciones son para verificar si ha recibido los documentos que se indican y que se le ha explicado la información en este formulario. Usted no está obligado a proporcionar la información solicitada a continuación ni a firmar este formulario. Sus beneficios de compensación para trabajadores no se verán afectados si usted elige no proporcionar la información ni firmar este formulario. Este formulario será presentado ante el Departamento de Trabajo e Industria de Minnesota y también puede ser proporcionado a la Oficina de Audiencias Administrativas y a los organismos encargados de hacer cumplir la ley.

Empleado, marque todo lo que corresponda:

☐ Se me ha explicado la información anterior y se me ha proporcionado una copia de este formulario.

☐ He recibido la notificación por escrito del QRC revelando lo siguiente: 1) cualquier afiliación, participación o acuerdo de negocio por referencia, documentado o no, que el QRC o la firma del QRC pueda tener con el empleador, la compañía de seguros de compensación para trabajadores, la compañía ajustadora de seguros o encargada del caso; 2) cualquier afiliación, acuerdo de negocio por referencia u otro tipo de acuerdo con alguna de las partes, abogado o proveedor de servicios médicos en mi caso.

☐ El QRC me ha informado que él/ella y la firma del QRC no tienen ninguna afiliación, participación, acuerdo de negocio por referencia u otros acuerdos con ninguna de las partes mencionadas anteriormente.

Firma del empleado				Fecha
Firma del QRC	No. del QRC	Fecha	Firma del supervisor interino del QRC	Fecha

El QRC debe firmar y fechar este formulario en la primera reunión en persona o por teléfono con el empleado. Se debe proporcionar una copia del formulario al empleado y a la compañía de seguros. El Departamento de Trabajo e Industria también debe recibir una copia del formulario en un plazo de 14 días después de la primera reunión en persona o por teléfono.

Cualquier persona que, con la intención de engañar, recibe beneficios de compensación para trabajadores a los que no tiene derecho y que a sabiendas tergiversa, falsifica o no revela ningún hecho esencial, es culpable de robo y será sancionado de conformidad con el Estatuto § 609.52 de Minnesota, inciso 3.

Este material puede estar disponible en diferentes formatos, tales como letra grande, braille o audio. Para solicitarlo, llame al (651) 284-5032 o al 1-800-342-5354.

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

OPTUM®

EMPLOYERS®
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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

OPTUM®

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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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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®

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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 even though there may have been no loss of time from work. Please complete and return the wage report below, which is required by the workers' compensation law.

Please fill in all wages paid to the employee during the 26 weeks 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 or regular basis, expain fully by responding to the questions below.

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
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					
26.					

Totals			

What number of hours was a normal full work day? _____

What number of days was a normal full 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: _____

_____

_____

_____

_____

Completed by: _____

Return to EMPLOYERS via email to claimsmail@employers.com or via fax to 866.461.2934.

America's small business insurance specialist®

Workers' compensation

If you are injured

- Report any injury to your supervisor as soon as possible, no matter how minor it may appear. You may lose the right to workers' compensation benefits if you do not make a timely report of the injury to your employer. The time limit may be as short as 14 days.
- Provide your employer with as much information as possible about your injury.
- Get any necessary medical treatment as soon as possible. If you are not covered by a certified managed care organization (CMCO), you may treat with a doctor of your choice. Your employer must notify you in writing if you are covered by a CMCO.
- Cooperate with all requests for information concerning your claim.

  The law allows the workers' compensation insurer to obtain medical information related to your work injury without your authorization, but they must send you written notification when they request the information.

  The insurer cannot obtain other medical records unless you sign a written authorization.
- Get written confirmation from your doctor about any authorization to be off work. The note should be as specific as possible.

Workers' compensation pays for

- Medical care for your work injury, as long as it is reasonable and necessary.
- Wage-loss benefits for part of your lost income.
- Compensation for permanent damage to or loss of function of a body part.
- Vocational rehabilitation services if you cannot return to your pre-injury job or to your pre-injury employer due to your work injury.
- Benefits to your spouse and/or dependents if you die as a result of a work injury.

What the insurer must do

- The insurer must investigate your claim promptly. If you have been disabled for more than three calendar-days, the insurer must begin payment of benefits or send you a denial of liability within 14 days after your employer knew you were off work or had lost wages because of your claimed injury.
- **If the insurer accepts your claim for wage-loss benefits and you have been disabled for more than three calendar-days:** The insurer will notify you and must start paying wage-loss benefits within the 14 days noted above. The insurer must pay benefits on time. Wage-loss benefits are paid at the same intervals as your work paychecks.
- **If the insurer denies your claim for wage-loss benefits and you have been disabled for more than three calendar-days:** The insurer will send notice to you within 14 days. The notice must clearly explain the facts and reasons why they believe your injury or illness did not result from your work or why the claimed wage-loss benefits are not related to your injury.

  If you disagree with the denial, talk with the insurance claims adjuster who is handling your claim. If you are not satisfied and still disagree with the denial, **call the Minnesota Department of Labor and Industry's Workers' Compensation Hotline at 1-800-342-5354.**

Fraud

Collecting workers' compensation benefits you are not entitled to is theft. Call 1-888-372-8366 to report workers' compensation fraud.

Insurer name and contact information

DEPARTMENT OF LABOR AND INDUSTRY

(651) 284-5032 • 1-800-342-5354 • dli.workcomp@state.mn.us • www.dli.mn.gov

Posting required by law in a location where employees can easily see this notice.

August 2017