

MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE
		JURISDICTION	JURISDICTION CLAIM NUMBER	
		INSURED REPORT NUMBER		
SIC CODE	EMPLOYER FEIN	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION # PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)		POLICY PERIOD TO	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
		<input type="checkbox"/> CHECK IF APPROPRIATE SELF INSURANCE	
CARRIER FEIN	POLICY/SELF-INSURED NUMBER		ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)		SEX		MARITAL STATUS	
		<input type="checkbox"/> MALE (M)		<input type="checkbox"/> UNMARRIED/SINGLE/DIVORCED (U)	
		<input type="checkbox"/> FEMALE (F)		<input type="checkbox"/> MARRIED (M)	
PHONE		<input type="checkbox"/> UNKNOWN (U)	<input type="checkbox"/> SEPARATED (S)	OCCUPATION/JOB TITLE	
		# OF DEPENDENTS	<input type="checkbox"/> UNKNOWN (K)	EMPLOYMENT STATUS	
				NCCI CLASS CODE	
RATE	PER: <input type="checkbox"/> DAY <input type="checkbox"/> MONTH	#DAYS WORKED WEEK	FULL PAY FOR DAY OF INJURY?		<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> WEEK <input type="checkbox"/> OTHER:		DID SALARY CONTINUE?		<input type="checkbox"/> YES <input type="checkbox"/> NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	<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		
COUNTY 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 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? WERE THEY USED?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL (NAME & ADDRESS)	INITIAL TREATMENT NO MEDICAL TREATMENT (0) <input type="checkbox"/> MINOR: BY EMPLOYER (1) <input type="checkbox"/> MINOR CLINIC/HOSP (2) <input type="checkbox"/> EMERGENCY CARE (3) <input type="checkbox"/> HOSPITALIZED > 24 HRS (4) <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5) <input type="checkbox"/>
WITNESSES (NAME & PHONE #)			
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER



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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:	

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NOTICE OF PHYSICIAN CHOICE & MEDICAL AUTHORIZATION

Claimant's Name: _____
Claimant's SS #: _____
Employer's Name: _____
Injury Date: _____
MWCC #: _____

I am claiming to have sustained an injury involving my _____

I am I am no claiming that my medical condition is work-related.

If work related:

I understand that by the Mississippi Workers' Compensation Act I have the right to choose one physician to render treatment to me. I can either accept the physician to whom I am sent by my employer or choose someone else on my own.

I also understand that my one chosen physician must make any referral to any other doctor.

I also understand that my employer (or workers' compensation carrier) must approve any physician change, and that if I change doctors without their authorization, I will be responsible for the medical expenses for the unauthorized treatment:

With that understanding, I state as follows:

I accept as my choice of employer's tender of treatment by Dr. _____.

I elect to choose my own physician to render treatment, and that choice is Dr. _____.

I also hereby authorize any doctor, physician, psychologist, hospital, or other provider of medical and related care to release unto and/or discuss with my employer, their agents, employees, workers' compensation insurance carrier, third party administrator, or attorneys, all medical information including reports, psychological test results, opinions, records, x-rays, x-ray reports, laboratory reports, nurses' notes, physicians' orders, and any and all other documents relating to any examination or treatment of myself.

I hereby agree that a copy of this authorization form shall have the same force and effect as the original thereof and further agree that this authorization shall remain valid so long as the claim against my above named employer is pending.

Claimant's Name

Date: _____

Witnessed By:

Original – Employer's File
Copy – Employee
Copy – Carrier/Third Party Administrator

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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.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>

MISSISSIPPI WORKERS' COMPENSATION

NOTICE OF COVERAGE

I. Please take notice that your Employer is in compliance with the requirements of the Mississippi Workers' Compensation Law, and [**select one**] [has been approved by the Mississippi Workers' Compensation Commission to act as a self-insurer], or [maintains workers' compensation insurance coverage with the following:]

(Name of insurance carrier or self-insurance group)

(address & telephone number)

II. Individual workers' compensation claims will be submitted to and processed by:

(Name of third party claims administrator or claims office)

(address & phone number)

III. This workers' compensation coverage is effective for the following period:
_____ to _____.

IV. All job related injuries or illnesses should be reported as soon as possible to your immediate supervisor, or to the person listed below:

(Name of employer contact person)

(Title & Department/Division)

V. Please be advised that any person who willfully makes any false or misleading statement or representation for the purpose of obtaining or wrongfully withholding any benefit or payment under the Mississippi Workers' Compensation Law may be charged with violation of Miss. Code Ann. §71-3-69 (Rev. 2000) and upon conviction be subjected to the penalties therein provided.

COMPENSACIÓN AL TRABAJADOR DE MISSISSIPPI

NOTIFICACIÓN DE COBERTURA

I. Por favor tome nota que su Empleador está en cumplimiento con los requisitos de la Ley de Compensación al Trabajador de Mississippi, y [**seleccione uno**] [ha sido aprobado por la Comisión de Compensación al Trabajador de Mississippi para actuar como asegurador de sí mismo], o [mantiene seguro de compensación al trabajador con el siguiente:]

(Nombre del asegurador o grupo de seguro propio)

(dirección y número de teléfono)

II. Los reclamos individuales de compensación al trabajador serán entregados y procesados por:

(Nombre del administrador de reclamos de terceros u oficina de reclamos)

(dirección y número de teléfono)

III. Esta cobertura de compensación al trabajador está en vigencia durante el siguiente periodo:

_____ hasta _____.

IV. Todas las lesiones o enfermedades laborales deben ser reportadas tan pronto como sea factible a su supervisor inmediato, o a la siguiente persona:

(Nombre de la persona de contacto del empleador)

(Título y departamento o división)

V. Por favor tenga presente que cualquier persona que intencionalmente hace cualquier declaración o representación falsa o engañosa con el propósito de obtener o retener erróneamente cualquier beneficio o pago bajo la Ley de Compensación al Trabajador de Mississippi puede ser acusado de infracción de Miss. Code Ann. §71-3-69 (Rev. 2000) y al ser condenado será sujeto a las penas provistas en ella.

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

	 <small>America's small business insurance specialist[®]</small>
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	or	Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	EMPLFF		

NOTE: This First Fill card is only valid for your workers' compensation injury or illness.

HACEMOS MÁS SENCILLO QUE SE LE ABASTEZCA LAS RECETAS DE SU PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Persona lesionada:



Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica sin costo alguno.



Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.



Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información que aparece a continuación y entregue este formulario al empleado.



Cómo encontrar una farmacia de la red

La mayoría de farmacias y todas las grandes cadenas de farmacias forman parte de la red. Para ubicar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.



¿Tiene alguna pregunta? ¿Necesita ayuda?

1-866-599-5426




WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

PORTADORA _____ EMPLEADOR _____

NOMBRE DEL PERSONA LESIONADA _____

Please provide directly to Pharmacist

NUMERO DE SEGURO SOCIAL _____ FECHA DE LA LESION (AAMMDD) _____

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	EMPLFF		

NOTA: Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.

WORKER'S COMPENSATION

STATE _____

CLAIM NO. _____

Report of Employee's Wages for period of _____ Weeks _____ Days

Please state employee's past wages for the 52-week period prior to the date of injury.

Please give fully and carefully all information requested.

This is IMPORTANT for Employer, Employee and Insurer.

Employer _____ Employee _____ SSN# _____

Date Employee ceased to work _____ How long employed? _____

hours

Number of days employee worked per week _____ Regular wages or piece work? _____

Did employee pay part of earnings to helpers? _____ If so, how much and to whom? _____

Is employee paid by hour, day, week or month? _____ At what rate? _____

WEEK	NO. DAYS	WEEK ENDING	GROSS WAGES	WEEK	NO. DAYS	WEEK ENDING	GROSS WAGES
1				27			
2				28			
3				29			
4				30			
5				31			
6				32			
7				33			
8				34			
9				35			
10				36			
11				37			
12				38			
13				39			
14				40			
15				41			
16				42			
17				43			
18				44			
19				45			
20				46			
21				47			
22				48			
23				49			
24				50			
25				51			
26				52			

This is a correct statement of Employee's earnings as actually taken from our Payroll Records.

Employer By _____

DO NOT FILL IN

Number of weeks which statement covers _____ Number of Days lost _____

Number of weeks actually worked _____ Total amount paid _____

Average Weekly Wage _____