



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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America's small business insurance specialist®

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.

WORKERS' COMPENSATION

INSURANCE COVERAGE

EMPLOYEE NOTICE

┌ (Insert business name and address here.)

┐ Date:

Policy Number:

└

┘

The above-named employer's workers' compensation insurance coverage is active and in good standing for the period of _____ to _____, provided the employer meets all premium and reporting requirements.

IF YOU ARE INJURED

You should report any on-the-job injury to your supervisor, employer, or insurer as soon as possible. You must report the accident within 30 days. A sole proprietor, partner, manager of a manager-managed limited liability company, member of a member-managed limited liability company, or corporate officer covered under the Montana Workers' Compensation Act must report an accident to the insurer within 30 days.

Report minor injuries to your employer whether or not you receive medical treatment. After you report the injury, your employer has 6 days to notify their insurer. You must submit a written First Report of Injury within 12 months from the date of the accident or within one (1) year from the knowledge of an occupational disease. You can submit this form to your employer, insurer, or the Department of Labor and Industry.

All employees sustaining a compensable work related injury or occupational disease, other than those who are exempted by statute (Section 39-71-401, MCA), are covered for medical and wage-loss benefits.

Prior to the Insurer's designation or approval of a Treating Physician you may choose your initial Health Care Provider.

You may continue to receive treatment from your initial health care provider unless the insurer designates a treating physician other than your initial health care provider. After providing you with a notice of a designated or approved treating physician, the insurer is no longer liable for treatment provided by other health care providers unless authorization is obtained to continue treatment.

For specific information about this policy, call or write your employer's insurance carrier:

(Insert insurer name, address and phone number here)

**FAILURE TO POST THIS SIGN OR POSTING AN ALTERED SIGN IN THE
WORKPLACE WILL RESULT IN A \$50 FINE AGAINST THE EMPLOYER!**

For general information about workers' compensation, call or write: Montana Department of Labor and Industry, Employment Relations Division, P.O. Box 8011, Helena, MT 59604-8011, Phone (406) 444-6532.

Compensación de Trabajadores

Cobertura De Seguro

AVISO DEL EMPLEADO



(Inserte el nombre y la dirección de negocio aquí.)
(Insert business name and address here.)



Fecha:

Número de la Poliza:



La cobertura de compensación para trabajadores de la antedicha compañía esta vigente por el periodo de al, mientras tanto que la compañía halla reunido todos los requisitos de reportes y la prima.

SI USTED ES HERIDO

Usted debe informar cualquiera lesion que ocurre en el trabajo a su supervisor, el empleador o el asegurador tan pronto posible. Usted tiene que reportar el accidente dentro de 30 días. Un propietario único, el socio, el director de una compañía manejado por el director de obligación limitada, el miembro de una compañía miembro-manejado por obligación limitada, oficial corporativo cubierta bajo el Acto de Compensación de Trabajadores de Montana debe informar un accidente al asegurador dentro de 30 días.

Informe las lesiones secundarias a su empleador aunque usted no reciba tratamiento médico. Después que usted informa la lesión, su empleador tiene 6 días para notificar a su asegurador. Usted tiene que entregar un escrito "Primer Informe de la Lesion" dentro de 12 meses de la fecha del accidente o dentro de un (1) año del conocimiento de una enfermedad profesional. Usted le puede entregar esta forma a su empleador, al asegurador, o al Departamento de Labor y de Industria.

Todos los empleados que sostienen una lesion compensable relacionada al trabajo o la enfermedad profesional, con excepción de las que sean eximidas por el estatuto (la Sección 39-71-401, MCA), son cubierta por médico y por los beneficios de perdida de salario.

Antes de la designación de la Aseguradora o aprobación de un médico tratante puede elegir su proveedor de atención médica inicial.

Usted puede continuar recibiendo tratamiento de su proveedor de atención médica inicial a menos que el asegurador designa un médico tratante que no sea su proveedor de atención médica inicial. Después de proporcionarle con un aviso de un designado o aprobado médico tratante, el asegurador es no más obligado para el tratamiento proporcionado por otros proveedores de asistencia médica a menos que autorización sea obtenida para continuar el tratamiento.

Para información específica sobre esta póliza, llame o escriba al portador del seguro de su empleador:

(Insert insurer name, address and phone number here) (Inserte el nombre y la dirección del portador del seguro aquí.)

Para información general acerca la compensación de los trabajadores, llame o escriba:

¡EL FRACASO DE ANUNCIAR ESTE LETRERO O ANUNCIAR UN LETRERO MODIFICADO EN EL LUGAR DE TRABAJO RESULTA EN UNA MULTA DE \$50 CONTRA EL EMPLEADOR!

Worker

Last Name		First Name		M.I.	Date of Birth	Social Security Number	
Mailing Address				City	State	Postal Code	
Phone Number	Education	<input type="checkbox"/> Less Than High School <input type="checkbox"/> GED or High School Diploma <input type="checkbox"/> Beyond High School	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Marital Status	<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed, Divorced, Single, Unmarried <input type="checkbox"/> Unknown	Number of Dependents

Wages

Date Hired	Gross earnings for <u>four</u> pay periods preceding the injury						
	Date/Amount	/	Date/Amount	/	Date/Amount	/	Date/Amount
Employment Status	Number of Days worked per week		Wage	Wage Period			
<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Piece Worker <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer <input type="checkbox"/> Other				<input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Bi-Weekly			
In addition to gross earnings cited above worker received				Estimated value if any		Time Employee began work	
<input type="checkbox"/> Room & Board <input type="checkbox"/> Overtime <input type="checkbox"/> Bonus <input type="checkbox"/> Commissions <input type="checkbox"/> Other:							
Worked next scheduled shift	Off work more than 4 work days	Date Last Worked	Date of Return to Work	Full wages paid for date of injury	Salary Continued		
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Accident Description

Job Title	Description of Accident						
Cause of Injury	Cause Code	Part of Body	Part Code	Nature of Injury	Nature Code	Date of Injury	Time of Injury
Date Disability Began	Date of Death	Names of Witnesses					
		1)	2)	3)			
Accident on Employer's Premises	Accident Address or Location						
<input type="checkbox"/> Yes <input type="checkbox"/> No	City	State	Postal code				
Date Employer Notified	Accident Reported to			Safety Equipment Provided	Safety Equipment Used		
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Medical

Attending Physician's Name	Address	State	Postal Code	Phone Number
Hospital Name	Address	State	Postal Code	Phone Number
Type of initial medical treatment received <input type="checkbox"/> No Treatment <input type="checkbox"/> Emergency Room/Urgent Care <input type="checkbox"/> Treatment on-site by Employer or Medical Staff <input type="checkbox"/> Clinic/Dr. Office				
<input type="checkbox"/> Hospital > 24 hours				

Signature

"This is my claim for workers' compensation benefits due to the on-the-job injury, occupational disease, or death of the above named worker. I understand that signing this claim for compensation authorizes the release to the workers' compensation insurer (and its agents) and to the Montana Uninsured Employers' Fund of: Social Security records; rehabilitation records; and all health care information (medical records, pursuant to HIPAA, Public Law 104-191, 42 USC section 1301, et. seq., and section 39-71-604, MCA), that are directly relevant to the claimed injury, disease, or death. I also understand that if I obtain or exert unauthorized control over workers' compensation benefits to which I am not entitled, I may be prosecuted for theft."

Signature of Injured Worker or Beneficiary _____ Date: _____

Employer

Employer Name	Doing Business as	Federal Employer Identification Number (Tax I.D.)		
Mailing Address	City	State	Postal Code	Phone Number
Location of operation, if different from mailing address		Nature of Business SIC/NAICS Code	Self-Insured <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer is a <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company	Injured worker is a <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> A member of the employer's (sole proprietor) family living in the employer's household.			
Do you have any reason to question this accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain fully. Use separate sheet if you need additional space			Was worker injured while in your employ <input type="checkbox"/> Yes <input type="checkbox"/> No	
Prepared By	Official Title	Phone Number	Date	
Payroll Classification Code under which you report Employee's wages	Authorized Employer's Signature _____ Date _____			

Insurer

Claim Administrator Claim Number	Date Reported to Claim Administrator:	The above information is correct with the following exceptions <input type="checkbox"/> (Attach extra sheets if box at right is checked)
Claim Administrator Name	Claim Administrator Address	Claim Administrator FEIN
Insurer Name	Insurer FEIN	
Policy Number	Policy Effective Date	Policy Expiration Date

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




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.