



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.

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

TO BE COMPLETED BY EMPLOYER WITH ORIGINAL SENT TO INSURANCE CARRIER AND COPY SENT TO INJURED WORKER

INJURED WORKER INFORMATION:

Name:	Phone:
Address:	City: State: Zip:
Social Security Number:	Date of Birth:
Marital Status:	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/>
Occupation / Job Title:	Date Hired:
Employment Status:	Number of Dependents:
Wage: Wage Period:	Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/>
Full Pay for Day of Injury: Yes <input type="checkbox"/> No <input type="checkbox"/>	Number of Days Worked per Week:

EMPLOYER INFORMATION:

Business Name:	Phone:
Employer Contact:	Phone:
Mailing Address:	City: State: Zip:
Employment Address:	City: State: Zip:
Employer FEIN:	

INSURANCE INFORMATION:

Carrier:	Phone:
Carrier Address:	City: State: Zip:
Policy / Self-Insured Number:	Policy Period:

OCCURRENCE/TREATMENT:

Date of Injury / Disease:	Time of Injury:	Date Employer Notified:
Nature:	Body Part:	Cause:
Last Day Worked:	Date Disability Began:	Date Returned to Work:
Fatality: Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of Death:	Date Administrator Notified:
Address of Occurrence:	City:	State: Zip:
Premises: Employer's <input type="checkbox"/> Other <input type="checkbox"/> Description:		
Accident Description:		
Provider Injured Worker Received Care From:		
Provider Address :	City:	State: Zip:
Treating Physician:	Phone:	
Initial Treatment: No Medical Treatment <input type="checkbox"/> Minor: By Employer <input type="checkbox"/> Minor: Clinic/Hospital <input type="checkbox"/> Emergency Care <input type="checkbox"/>	Hospitalized- 24 Hours <input type="checkbox"/> Future Major Medical/Lost Time Anticipated <input type="checkbox"/>	
Witnesses: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes list their names and phone number:		

For your protection, it is required by Utah Law to give notice that workers' compensation fraud is a crime. See next page for full fraud statement.



INSTRUCTIONS TO THE EMPLOYER**PLEASE NOTE:**

The filing of this form does not admit liability or fault. However, failure to file this report with the insurance carrier and provide a copy to the injured worker can result in a citation and civil penalty for each violation as per §34A-2-407(8), U.C.A.

The insurance carrier is to receive the original of this form. The injured worker shall then receive a copy along with their rights and obligations of the Utah's Workers' Compensation Act (Form 100). The employer should keep a copy for their records. The Labor Commission, Division of Industrial Accidents, will receive an electronic copy from the insurance carrier. The electronic copy of this form is private information and only released to parties of the claim.

In order to dispute the validity of the injured worker's claim, contact the insurance carrier or claim administrator for more information.

All fields on this form are required. Please complete this form entirely and do not leave any blank fields. This form will be returned and additional information will be requested if it is not properly completed. If you, the employer, need assistance to complete the form contact your workers' compensation insurance carrier or claims administrator.

Rule R612-200-1(A)(2) Except for injuries treated only by first aid, an employer shall report each employee work injury within 7 days after receiving initial notice of the injury, as follows:

- a. An employer that has obtained workers' compensation insurance shall report the injury to its insurance carrier.*
- b. An employer that has received Division authorization to self-insure shall report the injury to its claims administrator.*
- c. An employer that has failed to obtain worker's compensation coverage shall report the injury by contacting the Division directly.*

3. An employer has notice of a work injury upon the earliest of:

- a. Observation of the injury;*
- b. Verbal or written notice of the injury from any source; or*
- c. Receipt of any other information sufficient to warrant further inquiry by the employer.*

FRAUD WARNING:

Any person who knowingly presents false or fraudulent underwriting information, files, claim for disability compensation, medical benefits, health care fees, or other professional services are of guilty of a crime and may be subject to fines and confinement in state prison.



WORKERS' COMPENSATION NOTICE

Employer: _____

has complied with the provisions of the Workers' Compensation Act (§34A-2-101, Utah Code Annotated), the Utah Occupational Disease Act (§34A-3-101, Utah Code Annotated), and the rules of the Labor Commission by insuring the liability to pay the compensation and other benefits provided by said Acts through:

Insurance Company: _____

Policy Number: _____

Address for the above insurance company: _____

Telephone number: _____

Check here if the employer has been authorized by the Division of Industrial Accidents to self-insure and directly pay workers' compensation benefits.

WORKERS' COMPENSATION

Workers' Compensation is insurance which pays medical expenses and helps offset lost wages for employees with work-related injuries or illnesses. If you have an on-the-job injury or occupational disease, it may pay for: hospital and medical bills, time lost from work, permanent loss of body function, prosthetic devices, and burial and dependent benefits in case of death.

HOW TO REPORT AN ACCIDENT

1. Report the injury, no matter how slight, immediately to your supervisor. You may lose your rights if your injury is not reported within 180 days of the injury or work-related illness.
2. Ask your employer where you should go for treatment. If your employer has a first-aid room or company designated doctor, go there promptly for treatment. If not, go to a doctor of your choice.
3. Tell the doctor **HOW, WHEN and WHERE** the accident happened. The doctor will fill out a physician's initial report form. A copy of the report is given to you and copies of the report are sent to the insurance company and the Labor Commission within seven (7) days of your doctor visit.
4. Your employer shall fill out the employer's first report of injury form. A copy of this report is sent to the insurance company within seven (7) days of the accident. The insurance company will report the injury to the Labor Commission.

HOW TO START COMPENSATION

1. Ask your employer which insurance company pays workers' compensation benefits for the company.
2. Ask your employer to report the accident to the insurance company and give you the claim number.
3. Call the insurance company and ask them to start your workers' compensation benefits. The insurance company will require the employer's report, the physician's report, and may ask you to fill out a request for compensation. Cooperate with the adjuster's investigation of the injury.
4. Ask your doctor to send medical reports to the insurance company, including the work status statement.

REHABILITATION

If you cannot return to work, you may be eligible for a rehabilitation program. Contact the insurance company listed above or the Utah State Office of Rehabilitation.

FRAUD STATEMENT: "Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison."



160 East 300 South 3rd Floor P.O. Box 146610 Salt Lake City, Utah 84114-6610
Office: (801)-530-6800 Fax: (801)-530-6804 Toll Free: (800)-530-5090 www.laborcommission.utah.gov

If you want copy of an *Employee's Guide to Workers' Compensation* booklet or have questions, contact the Labor Commission or go to the webpage at www.laborcommission.utah.gov.

Note: This notice must be posted and kept continuously in public and conspicuous places in the office, shop or place of business of the employer as per §34A-2-204 and §34A-2-104.5, Utah Code Annotated.

AVISO DE COMPENSACIÓN PARA LOS TRABAJADORES

La Empresa: _____

Ha cumplido con las disposiciones de la Ley de Compensación para los Trabajadores (§34A-2-101, Código de Utah Anotado), la Ley de Enfermedades Ocupacionales de Utah (§34A-3-101, Código de Utah Anotado), y las reglas de la Comisión Laboral por asegurando la obligación de pagar compensación y otros beneficios previstos por las Leyes y teniendo cobertura con:

Compañía de Seguros: _____

Numero de Póliza: _____

Dirección de la compañía de seguros: _____

Numero de teléfono: _____

- Marque aquí si la División de Accidentes Industriales ha autorizado el empleador a tener el auto-seguro y pagar los beneficios de compensación directamente al trabajador.

COMPENSACIÓN PARA LOS TRABAJADORES

Compensación para los trabajadores es un seguro que paga los gastos médicos y ayuda a compensar los salarios perdidos de los empleados con lesiones o enfermedades relacionadas con el trabajo. Si usted tiene una lesión en el trabajo o una enfermedad ocupacional, puede pagar: facturas hospitalarias y médicas, pérdida de tiempo del trabajo, pérdida permanente de la función corporal, dispositivos protésicos y servicios funerarios y beneficios para dependientes en caso de muerte.

COMO REPORTAR UN ACCIDENTE

1. Informe inmediatamente a su supervisor de la lesión. Usted puede perder sus derechos si no reporte su lesión o enfermedad relacionada con el trabajo dentro de 180 días.
2. Pregunte a su empleador dónde debe ir para recibir tratamiento. Si su empleador tiene un clínico designado, vaya allí de inmediato para recibir tratamiento. Si no tiene un clínico designado, vaya a un médico de su elección.
3. Informe al doctor **CÓMO, CUÁNDO y DÓNDE** ocurrió el accidente. El médico llenará el formulario de informe inicial del médico. Usted debe recibir una copia del informe y copias se envían a la compañía de seguros y a la Comisión Laboral dentro de siete (7) días de su visita al médico.
4. Su empleador llenará el formulario de informe inicial del empleador. Usted debe recibir una copia del informe y una copia se envía a la compañía de seguros dentro de siete (7) días. La compañía de seguros es responsable a reportar a la Comisión Laboral.

COMO EMPEZAR COMPENSACIÓN

1. Pregunte a su empleador qué compañía de seguros pagará los beneficios de compensación para los trabajadores.
2. Pídale a su empleador que reporte el accidente a la compañía de seguros y que le dé el número de reclamo.
3. Llame a la compañía de seguros y pídale que inicien sus beneficios de compensación para trabajadores. La compañía de seguros requerirá el informe del empleador, el informe del médico, y puede pedirle a usted que llene una solicitud de compensación. Cooperar con la investigación del ajustador sobre la lesión.
4. Pídale a su médico que envíe informes médicos a la compañía de seguros, incluyendo la declaración de estado de trabajo.

REHABILITACIÓN

Si no puede regresar al trabajo, puede ser elegible para un programa de rehabilitación. Póngase en contacto con la compañía de seguros mencionada anteriormente o con la Oficina de Rehabilitación del Estado de Utah.

DECLARACIÓN DE FRAUDE: “Cualquier persona que a sabiendas presente información falsa o fraudulenta de suscripción de seguros, archivos o causas para presentar un reclamo falso o fraudulento por compensación de incapacidad o beneficios médicos, o presente un informe o facturación falsa o fraudulenta por gastos médicos u otros servicios profesionales es culpable de un crimen y pueden ser sujetos a multas y confinamiento en una prisión estatal.”



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Teléfono: (801)-530-6800 Fax: (801)-530-6804 Línea gratuita: (800)-530-5090 www.laborcommission.utah.gov

Si desea una copia del folleto de *la Guía Sobre el Seguro de Compensación Para los Trabajadores* o tiene preguntas, comuníquese con la Comisión Laboral o visite la página web en www.laborcommission.utah.gov.

Nota: Este aviso debe ser publicado y mantenido continuamente en lugares públicos y visibles en la oficina, tienda o lugar de negocios del empleador según §34A-2-204 y §34A-2-104.5, Código de Utah Anotado.

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	or	Envoy
RxBIN	004261		002538
RxPCN	CAL		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.



P.O. Box 32036, Lakeland, FL 33802-2036

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. Please complete and return the wage report below, which is required by your state's workers' compensation law.

Please fill in all the wages paid to the employee during the three (3) months 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 basis, explain fully and give the earnings during the 13 weeks preceding the accident.

Employee	Claim Number:
Injury Date:	Wage Rate:
Disability Date:	Date Employed:

Week No.	Date From	Date To	Total Hours	Hourly Rate	Days Worked	Gross Pay Including Overtime
1					\$	\$
2					\$	\$
3					\$	\$
4					\$	\$
5					\$	\$
6					\$	\$
7					\$	\$
8					\$	\$
9					\$	\$
10					\$	\$
11					\$	\$
12					\$	\$
13					\$	\$

Totals				
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P.O. Box 32036, Lakeland, FL 33802-2036

What number of hours was a normal work day? _____

What number of days was a normal 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: _____

Once completed, please fax to EMPLOYERS at 800-371-8204.

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