EMPLOYERS® Claims Kit

America's small business insurance specialist®

Claims Contact Information

Tel: 888-682-6671 | Fax: 877-329-2954 | www.employers.com/claimskit

Your EMPLOYERS® Claims Kit

Thank you for the trust you have placed in EMPLOYERS. As a leading provider of workers' compensation insurance for America's small businesses, EMPLOYERS is focused on making premiums affordable, as well as helping our policyholders reduce the long-term costs associated with workplace injuries and illnesses.

Accessing Claims Kit Information for Your State

EMPLOYERS provides policyholders access to EMPLOYERS specific state-specific claim information on our website: www.employers.com/claimskit. Policyholders can request a printed copy of our claims kit by contacting us by phone at (888) 682-6671 or e-mail at customersupport@employers.com.

How to Report a Workers' Compensation Claim

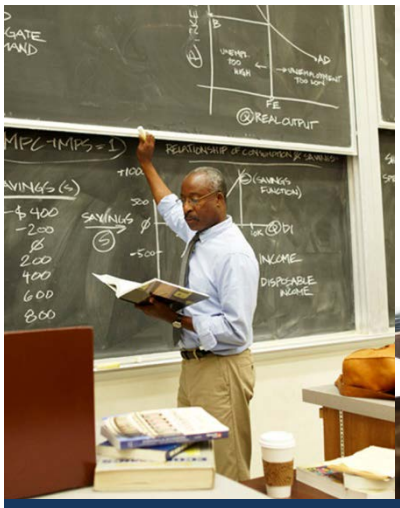
Immediate reporting is a major step in cost and time containment of any claim and is beneficial to all parties involved. Any delays in the reporting of claims can result in delayed access to medical care, which in some instances may lead to further injury, resulting in the need for additional treatment subsequently leading to higher medical costs.

EMPLOYERS® offers two convenient phone numbers that are available 24/7 to report a claim with less paperwork. Both numbers are staffed with individuals fluent in both English and Spanish, with accommodations for other languages.*

1. Injured Employee Hotline – **855-365-6010**
    - Reporting of a new work-related injury or illness when the injured/ill employee has not yet received medical treatment.
        - Access to registered nurses who are specially trained to provide nurse triage and medical guidance.

2. Customer Support – **888-682-6671**
    - Reporting of a new work-related injury or illness when the injured/ill employee has already received medical treatment.
        - Injured employees who have not yet sought medical treatment will be transferred to our Injured Employee Hotline (IEH) and provided the IEH phone number.

*For all injuries or illnesses that require immediate assistance from Emergency Services please call **911**.




What to Do Before an On-The-Job Injury or Illness Occurs

Below are the three critical things you need to do before a work-place injury or illness occurs:

1. **Post all required posters and signage**−each state has its own laws about what employers must post and distribute relating to workers' compensation information in your workplace. Please go to www.employers.com/claim to access a link to the mandatory requirements for your state.
2. **Develop an effective work-place safety program**−employers can help reduce the chances that an on-the-job injury or illness will occur through the development and communication of a work-place safety program.
3. **Create a return-to-work/transitional modified job program**− a transitional modified jobs program can reduce the financial hardship that maybe experienced by the employee as well as the employer as the result of a workplace accident or injury.

What to Do After an On-The-Job Injury or Illness Occurs

Below are several things you can and should do after an on-the-job injury or illness occurs:

- Transport the injured employee to a medical care facility (in the case of an emergency, call 911 immediately).
- Order a post-accident drug test.
- Secure the scene of any serious accident for investigative purposes.
- Secure and save any equipment or materials that were involved in the incident.
- Complete an accident investigation report within 24 hours.
- Report the claim to EMPLOYERS within 24 hours following the injury.

Frequently Asked Questions About Drug-Free Workplaces

Q: What does it mean to be a drug-free workplace?
A: A drug-free workplace is a workplace free of the health, safety and productivity hazards caused by employees' abuse of alcohol or drugs. To achieve a drug-free workplace, many employers develop drug-free workplace programs. A comprehensive drug-free workplace program generally includes five components; a drug-free workplace policy, supervisor training, employee education, employee assistance and drug and alcohol testing. Although employers may choose not to include all five components, it is recommended that all options be explored when developing a drug-free workplace program.

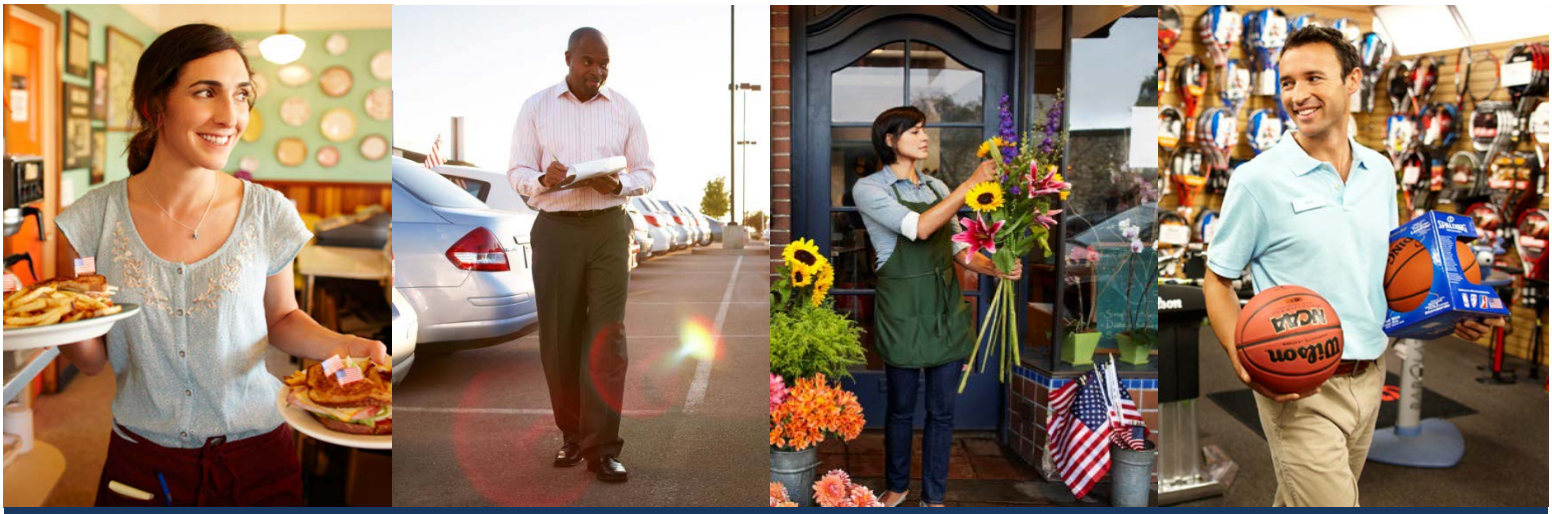
Q: What are the benefits of establishing a drug-free workplace program?
A: Benefits of a drug-free workplace program may include:

- Improvements in morale, quality and productivity.
- Decreases in accidents, absenteeism, downtime, turnover and theft.
- Better employee health status.
- May qualify for incentives, such as decreased costs for workers' compensation and other kinds of insurance.

Q: Do drug-free workplaces receive workers' compensation discounts?
A: Yes. In some states, employers who have a Drug-Free Workplace Program will receive a discount. For more information, contact your insurance agent, visit www.dol.gov/elaws/drugfree.htm or contact your state's workers' compensation department.

Q: I need help developing a drug-free workplace Program. Can you help?
A: Yes. EMPLOYERS can provide you with a written Drug Free Workplace Program template to help you develop a customized drug-free workplace program for your organization.

For more information on how to develop a Drug-Free Workplace Program, please call the EMPLOYERS® Loss Control Department at 800-588-5200 or e-mail them at losscontrol@employers.com.



Ways to Reduce Your Workers' Compensation Costs

Employers have the ability to control or influence many of the factors that contribute to worker's satisfaction levels, return-to-work outcomes, and claim cost. Studies have shown that the following actions can impact the cost and outcome of workers' compensation claims and the overall costs of insurance:

Identify and establish a relationship with a medical provider—setting up relationships with medical providers pre-injury helps facilitate the physician's understanding of employee job duties/transitional job opportunities.

Keep the lines of communication open—employers who maintain compassionate contact with their injured employees during the recovery period have more satisfied workers.

Provide transitional modified jobs (alternate duty)—employers who make transitional modified jobs available to injured workers can reduce the impact of their injured worker's injury or illness.

Develop an effective workplace safety program—the basic elements of an effective work-place safety program include:*

- Management Commitment
- Responsibility and Accountability
- Safety Work Rules and Procedures
- New Employee Orientation
- Ongoing Employee Education
- Employee Involvement
- Training and Safety Committees
- Accident Investigation
- Documentation

*Your EMPLOYERS® Loss Control Consultant can provide your company with more instructional and detailed information regarding how to build an effective work-place safety program. You can reach the EMPLOYERS Loss Control Department by phone at 800-588-5200 or by e-mail at losscontrol@employers.com.

Benefits of a Return-to-Work/Transitional Modified Job Program

Many injuries - including minor sprains and strains - can result in weeks, even months off the job. But they don't have to - if you take a proactive stance to prevent lost work time and long-term disability. Be prepared to offer a transitional modified job when an injured employee is released to work by his/her doctor, regardless of level of work.

Transitional modified jobs allow workers who are unable to perform their regular job duties because of a work-related injury or illness to return to work in a temporary modified duty capacity. Keep in mind, a transitional modified job (alternative duty) need not be at full hours, full wages and/or job/department of injury. Creativity in developing modified assignments enables the employee to be productive while meeting medical restrictions.

The primary goal of a Return-to-Work Program is to assist employees who sustain a work-related injury or illness in safely returning to work at the earliest medically approved time in a temporary (modified or alternate duty) assignment. The longer an injured worker remains away from work, the more difficult it may be to return to gainful employment. Returning to regular work duties is generally expedited when transitional or modified duty is offered.

Through safety measures and the development of a Return-to-Work program, employers may lower their experience modification rating, thereby reducing premium costs.

Benefits to the Employer:

- Recruitment and hiring costs for new or temporary employees may be eliminated
- The employer is able to better manage the claim, possibly leading to a better outcome
- The employer maintains the resources of an experienced worker on site
- Some employee production is received for wages paid
- The likelihood of malingering or fraud may be reduced
- Communication and relations between employee and management can be enhanced

Benefits to the Employee:

- Wages earned from the transitional modified job may bring the injured worker’s income closer to preinjury
- wages than workers’ compensation benefits alone
- Self-esteem, morale and personal security are maintained or restored through gainful employment and
- a productive lifestyle
- Stress, boredom, and depression are reduced or eliminated
- Skill level is maintained
- A connection with the company (including social contact) is continued

For more information on how to develop a Return-to-Work Program, please call the EMPLOYERS® Loss Control Department at 800-588-5200 or e-mail them at losscontrol@employers.com.

Arizona Required Postings & Forms

Please print and post the following notices, both in English and Spanish, in a conspicuous location frequented by employees such as the break room, lunch room or time clock. If you have multiple business locations, be sure to post the notices at each location.

- √ **Notice to Employees Re: Arizona Workers' Compensation Law**
- √ **Notice to Employees Re: Work Exposure to Bodily Fluids**
- √ **Notice to Employees Re: Work Exposure to methicillin-resistant Staphylococcus Aureus (MRSA), Spinal Meningitis, or Tuberculosis (TB):** This notice must be displayed immediately next to the Notice to Employees Re: Work Exposure to Bodily Fluids

The following forms need to be completed and submitted to EMPLOYERS® when a work-related injury occurs:

- √ **Form ICA-04-0101 Employer's Report of Industrial Injury**
  As soon as you have been notified of a work-related injury, please fill out this form and submit it to EMPLOYERS. This form must be completed within 10 days from notice of an accident. Fatalities must be reported within 24 hours. You must use this form to notify EMPLOYERS of every work-related injury or disease suffered by an employee, regardless of severity.
- √ **Form ICA-41-100 Report of Significant Work Exposure to Bodily Fluids**
  This form is completed by you and must be signed by the employee. You should keep the original and provide a copy to EMPLOYERS. This copy will serve as our notice that your employee experienced a significant work-related exposure to bodily fluids of another individual.
- √ **First Fill Form (English and Spanish)**
  This form provides your employees with basic information about our Pharmacy Benefit Program, including such things as the phone number to call to locate a First Fill participating pharmacy. When your employee becomes injured, please print and complete this form and provide it to your injured employee. Your employee will need to provide this completed form along with the prescription for his/her work-related injury or illness to the pharmacist. Using this form will help enable quick authorization for your employee's initial medication and ensure that the initial prescription is provided at no cost to the injured employee.
- √ **Wage Statement**
  This form enables us to calculate the correct compensation that may be owed to an injured employee. Please complete the form and submit it to EMPLOYERS within five days after your knowledge of any accident that has caused your employee to be disabled for more than seven scheduled work calendar days.

Arizona Required Postings & Forms (Continued)

The following forms need to be completed and submitted to EMPLOYERS® when a work-related injury occurs (continued):

- √ **Accident Investigation Report**
  This basic accident form should be completed by the employee's supervisor/manager as soon after the accident as possible. Please send the report to the following EMPLOYERS address as soon as it has been completed by the supervisor/manager: EMPLOYERS Claim Department, P.O. Box 32036, Lakeland, FL 33802-2036. You should keep a copy on file for your records.

Additional copies of these postings and forms can be found online at
http://www.employers.com/sup/ClaimKit-Arizona.aspx

TO BE POSTED BY EMPLOYER **POLICY NUMBER** _____

NOTICE TO EMPLOYEES

RE: ARIZONA WORKERS' COMPENSATION LAW

All employees are hereby notified that this employer has complied with the provisions of the Arizona Workers' Compensation Law (Title 23, Chapter 6, Arizona Revised Statutes) as amended, and all the rules and regulations of The Industrial Commission of Arizona made in pursuance thereof, and has secured the payment of compensation to employees by insuring the payment of such compensation with: _____

All employees are hereby further notified that in the event they do not specifically reject the provisions of the said compulsory law, they are deemed by the laws of Arizona to have accepted the provisions of said law and to have elected to accept compensation under the terms thereof; and that under the terms thereof employees have the right to reject the same by written notice thereof prior to any injury sustained, and that the blanks and forms for such notice are available to all employees at the office of this employer.

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PARA SER COLOCADO POR EL PATRON **NUMERO DE POLIZA** _____

AVISO A LOS EMPLEADOS

RE: LEY DE COMPENSACION PARA LOS TRABAJADORES DE ARIZONA

A todos los empleados se les notifica por este medio que este patron ha cumplido con las provisiones de la Ley de Compensacion para los Trabajadores de Arizona (Titulo 23, Capitulo 6, Estatutos Enmendados de Arizona) tal como han sido enmendados, y con todas las regias y ordenanzas de La Comision Industrial de Arizona hechas en cumplimiento de esta, y ha asegurado el pago de compensacion a los empleados garantizando el pago de dicha compensacion por medio de:

_____

Ademas, a todos los empleados se les notifica por este medio que en caso de que especificadamente ellos no rechazen las disposiciones de dicha ley obligatoria, se les considerara bajo las leyes de Arizona de haber aceptado las provisiones de dicha ley y de haber escogido aceptar la compensacion bajo estos terminos; tambien bajo estos terminos los empleados tienen el derecho de rechazar la misma por medio de una notificacion por escrito antes de que sufran alguna lesion, todos los formularios o formas en blanco para tal notificacion por escrito estaran disponibles para todos los empleados en la oficina de este patron.

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KEEP POSTED IN A CONSPICUOUS PLACE.

COLOQUESE EN LUGAR VISIBLE.

WORK EXPOSURE TO BODILY FLUIDS

NOTICE TO EMPLOYEES

Re: Human Immunodeficiency Virus (HIV),
Acquired Immune Deficiency Syndrome (AIDS) & Hepatitis C

Employees are notified that a claim may be made for a condition, infection, disease, or disability involving or related to the Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or Hepatitis C within the provisions of the Arizona Workers' Compensation Law, and the rules of The Industrial Commission of Arizona. Such a claim shall include the occurrence of a significant exposure at work, which generally means contact of an employee's ruptured or broken skin or mucous membrane with a person's blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. **AN EMPLOYEE MUST CONSULT A PHYSICIAN TO SUPPORT A CLAIM.** Claims cannot arise from sexual activity or illegal drug use.

Certain classes of employees may more easily establish a claim related to HIV, AIDS, or Hepatitis C if they meet the following requirements:

1. The employee's regular course of employment involves handling or exposure to blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. Included in this category are health care providers, forensic laboratory workers, fire fighters, law enforcement officers, emergency medical technicians, paramedics and correctional officers.

2. **NO LATER THAN TEN (10) CALENDAR DAYS** after a possible significant exposure which arises out of and in the course of employment, the employee reports in writing to the employer the details of the exposure as provided by Commission rules. Reporting forms are available at the office of this employer or from the Industrial Commission of Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 or 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5181. If an employee chooses not to complete the reporting form, that employee may be at risk of losing a prima facie claim.

3. **NO LATER THAN TEN (10) CALENDAR DAYS** after the possible significant exposure the employee has blood drawn, and **NO LATER THAN THIRTY (30) CALENDAR DAYS** the blood is tested for **HIV OR HEPATITIS C** by antibody testing and the test results are negative.

4. **NO LATER THAN EIGHTEEN (18) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are HIV positive or the employee has been diagnosed as positive for the presence of HIV, or **NO LATER THAN SEVEN (7) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are positive for the presence of Hepatitis C or the employee has been diagnosed as positive for the presence of Hepatitis C.

KEEP POSTED IN CONSPICUOUS PLACE
NEXT TO WORKERS' COMPENSATION NOTICE TO EMPLOYEES

THIS NOTICE IS APPROVED BY THE INDUSTRIAL
COMMISSION OF ARIZONA FOR CARRIER USE

EXPOSICION A FLUIDOS CORPORALES EN EL TRABAJO

AVISO A LOS EMPLEADOS

Re: El Virus de la Inmunodeficiencia Humana (VIH),
Síndrome de la Inmundeficiencia Adquirida (SIDA) y Hepatitis C

Se les notifica a los empleados que se puede hacer una reclamación por una condición, infección, enfermedad o incapacidad relacionada con o derivada del Virus de Inmunodeficiencia Humana (VIH), Síndrome de Inmunodeficiencia Adquirida (SIDA), o Hepatitis C bajo lo provisto por la Ley de Compensación para los Trabajadores de Arizona y las reglas de La Comisión Industrial de Arizona. Tal reclamación debe incluír el suceso de una exposición importante en el trabajo, la que por lo general significa contacto de alguna ruptura de la piel o mucosa del empleado con la sangre, semen, fluido vaginal, fluido(s) quirúrgico(s) o cualquier otro fluido de una persona que contenga sangre. **EL EMPLEADO DEBE CONSULTAR A UN MEDICO PARA CONFIRMAR SU RECLAMACION.** Las reclamaciones no pueden resultar de actividad sexual o uso ilícito de drogas.

Ciertas clases de empleados pueden establecer más fácilmente una reclamación relacionada con el VIH, SIDA O Hepatitis C si reúnen los requisitos siguientes:

1. El curso regular del empleo del empleado requiere el manejo de o la exposición a sangre, semen, fluido vaginal, fluido(s) quirúrgico(s) o cualquier otro fluido que contenga sangre. Incluídos en esta categoría son los proveedores de cuidados de la salud, trabajadores de laboratorios forenses, bomberos, agentes policiales, técnicos médicos de emergencia, paramédicos y agentes correccionales.

2. **NO MAS DE DIEZ (10) DIAS DE CALENDARIO** después de una possible exposición importante que resulta de y en el curso de su trabajo, el empleado reporta a su patrón por escrito los detalles de la exposición como lo proveen las reglas de la Comisión. Las formas de reporte están disponibles en la oficina de este patrón o de la Comisión Industrial de Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 o 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5181. Si un empleado elige no llenar la forma de reporte, ese empleado corre el riesgo de perder una reclamación de prima facie.

3. **NO MAS DE DIEZ (10) DIAS DE CALENDARIO** después de una posible exposción importante el empleado va a que le saquen sangre, y **NO MAS DE TREINTA (30) DIAS DE CALENDARIO** la sangre es analizada para **VIH O HEPATITIS C** por medio de análisis de anticuerpos y el análisis resulta negativo.

4. **NO MAS DE DIECIOCHO (18) MESES** después de la fecha de la posible exposición importante en el trabajo, el empleado es examinado nuevemente y los resultados del análisis son positivos por VIH o el empleado ha sido diagnosticado como positivo por la presencia de VIH, o **NO MAS DE SIETE (7) MESES** después de la fecha de la posible exposición importante en el trabajo, el empleado es examinado nuevamente y los resultados del análisis son positivos por la presencia de Hepatitis C o el empleado ha sido diagnosticado como positivo por la presencia de Hepatitis C.

MANTENER FIJO EN UN LUGAR SOBRESALIENTE JUNTO AL AVISO A LOS EMPLADOS SOBRE COMPENSACION PARA TRABAJADORES

ESTE AVISO HA SIDO APROBADO POR LA COMISION INDUSTRIAL
DE ARIZONA PARA USO DE LAS ASEGURADORAS

Este documento es una traduccion del texto original escrito en ingles. Esta traduccion no es oficial y no es vinculante para este estado o para una subdivision politica de este estado.

This document is a translation from original text written in English. This translation is unofficial and is not binding on this state or a political subdivision of this state.

WORK EXPOSURE TO METHICILLIN-RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA), SPINAL MENINGITIS, OR TUBERCULOSIS (TB)

Notice to Employees

Employees are notified that a claim may be made for a condition, infection, disease or disability involving or related to MRSA, spinal meningitis, or TB within the provisions of the Arizona Workers' Compensation Law. (A.R.S. § 23-1043.04) Such a claim shall include the occurrence of a significant exposure at work, which is defined to mean an exposure in the course of employment to aerosolized MRSA, spinal meningitis or TB bacteria. Significant exposure also includes exposure in the course of employment to MRSA through bodily fluids or skin.

Certain classes of employees (as defined below) may more easily establish a claim related to MRSA, spinal meningitis or TB by meeting the following requirements:

1. The employee's regular course of employment involves handling or exposure to MRSA, spinal meningitis or TB. For purposes of establishing a claim under this section, "employee" is limited to firefighters, law enforcement officers, correction officers, probation officers, emergency medical technicians and paramedics who are not employed by a health care institution;

2. No later than thirty (30) calendar days after a possible significant exposure, the employee reports in writing to the employer the details of the exposure;

3. A diagnosis is made within the following time-frames:

    a. For a claim involving MRSA, the employee must be diagnosed with MRSA within fifteen (15) days after the employee reports pursuant to Item No. 2 above;

    b. For a claim involving spinal meningitis, the employee must be diagnosed with spinal meningitis within two (2) to eighteen (18) days of the possible significant exposure; and

    c. For a claim involving TB, the employee is diagnosed with TB within twelve (12) weeks of the possible significant exposure.

Expenses for post-exposure evaluation and follow-up, including reasonably required prophylactic treatment for MRSA, spinal meningitis, and TB is considered a medical benefit under the Arizona Workers' Compensation Act for any significant exposure that arises out of and in the course of employment if the employee files a claim for the significant exposure or the employee reports in writing the details of the exposure. Providing post-exposure evaluation and follow-up, including prophylactic treatment, does not, however, constitute acceptance of a claim for a condition, infection, disease or disability involving or related to a significant exposure.

Employers must post this notice in a conspicuous place next to the Workers' Compensation Notice to Employees.

EMPLOYER'S REPORT OF INDUSTRIAL INJURY

COMPLETE AND SUBMIT THIS REPORT WITHIN 10 DAYS FROM NOTICE OF ACCIDENT. FATALITIES MUST BE REPORTED WITHIN 24 HOURS.

Employer must, on this form, notify his insurance carrier of every injury or disease suffered by an employee, fatal or otherwise, which is claimed to arise out of or in the course of employment.
ARIZONA REVISED STATUTES 23-908 & 23-1061

INDUSTRIAL COMMISSION OF ARIZONA
P.O. BOX 19070
PHOENIX, ARIZONA 85005-9070

FOR CARRIER USE ONLY

FOR OSHA PURPOSES ONLY

OSHA Case #: _____

RECORDABLE INJURY _____

NON-RECORDABLE INJURY _____

EMPLOYEE

1. LAST NAME | FIRST | M.I. | 2. SOCIAL SECURITY NUMBER * | 3. BIRTH DATE

4. HOME ADDRESS (NUMBER & STREET) | CITY | STATE | ZIP CODE | 5. TELEPHONE

6. SEX ◯ MALE ◯ FEMALE | 7. MARITAL STATUS: ◯ SINGLE ◯ MARRIED ◯ DIVORCED ◯ WIDOWED

EMPLOYER

8. EMPLOYER'S NAME | 9. POLICY NUMBER | 10. NATURE OF BUSINESS (MANUFACTURING, ETC.)

11. OFFICE ADDRESS (NUMBER & STREET) | CITY | STATE | ZIP CODE | 12. TELEPHONE

ACCIDENT

13. DATE OF INJURY OR ILLNESS | 14. TIME OF EVENT | 15. TIME EMPLOYEE BEGAN WORK | 16. DATE EMPLOYER NOTIFIED OF INJURY

17. LAST DAY OF WORK AFTER INJURY | 18. DATE OF RETURN TO WORK | 19. EMPLOYEE'S OCCUPATION (JOB TITLE) WHEN INJURED

20. CLASS CODE ON PAYROLL REPORT | 21. EMPLOYEE'S ASSIGNED DEPARTMENT | 22. DEPARTMENT NUMBER | 23. DID INJURY OCCUR ON EMPLOYER PREMISES? ◯ YES ◯ NO

24. ADDRESS OR LOCATION OF ACCIDENT | CITY | COUNTY | STATE | ZIP CODE

25. WHAT WAS THE INJURY OR ILLNESS? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or sore." *Examples:* "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."

26. PART OF BODY INJURED | 27. FATAL ◯ YES ◯ NO | 28. IF THE EMPLOYEE DIED, WHEN DID THE DEATH OCCUR? DATE OF DEATH

29. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? ◯ YES ◯ NO | NAME OF PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL | ADDRESS | CITY | STATE | ZIP CODE

30. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? ◯ YES ◯ NO | IF HOSPITALIZED, HOSPITAL NAME | ADDRESS | CITY | STATE | ZIP CODE

31. IS VALIDITY OF CLAIM DOUBTED ◯ YES ◯ NO | 31.a IF YES, STATE REASON

CAUSE OF ACCIDENT

32. **WHAT HAPPENED?** Tell us how the injury occurred. *Examples:* "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."

33. **WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE?** *Examples:* "concrete floor"; "chlorine"; "radial arm saw." *If this question does not apply to the incident, leave it blank.*

34. **WHAT WAS EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."

35. IF ANOTHER PERSON NOT IN COMPANY EMPLOY CAUSED ACCIDENT, GIVE NAME AND ADDRESS

EMPLOYEE'S WAGE DATA

36. WAS WORKER IN YOUR EMPLOY WHEN INJURED? ◯ YES ◯ NO | 37. HOURS PER DAY EMPLOYEE WORKED FROM THRU | 38. WAS EMPLOYEE ON OVERTIME WHEN INJURED? ◯ YES ◯ NO | 39. NUMBER OF DAYS PER WEEK USUALLY WORKED EMPLOYEE COMPANY

IMPORTANT

IF WORK LOSS IS EXPECTED TO EXCEED SEVEN CALENDAR DAYS, COMPLETE ITEMS 40 THRU 47

40. DATE OF LAST HIRE | 41. WAS WORKER PAID FOR DAY OF INJURY? ◯ YES ◯ NO IF YES, $ | 42. WAS EMPLOYEE HIRED FOR PERMANENT EMPLOYMENT? ◯ YES ◯ NO

43. NUMBER OF MONTHS EMPLOYMENT AVAILABLE DURING THE YEAR | 44. GIVE EMPLOYEE'S WAGE STATUS AS APPLICABLE $ PER HOUR ◯ DAY ◯ WEEK ◯ MONTH ◯ | 45. IS EMPLOYEE FURNISHED ◯ LODGING ◯ BOARD ◯ BOTH VALUE $

46. ACTUAL GROSS EARNINGS OF EMPLOYEE FOR THE 30 CALENDAR DAYS PRECEEDING INJURY (EXAMPLE: IF INJURED APRIL 8, GIVE EARNINGS FROM MARCH 9 THRU APRIL 7)

47. DOES EMPLOYEE CLAIM DEPENDENTS? ◯ YES ◯ NO

IMPORTANT

IF EMPLOYEE IS PAID OTHER THAN FIXED WEEKLY OR MONTHLY SALARY, COMPLETE ITEMS 48 THRU 55

48. IF EMPLOYEE EARNS EXTRA PAY FOR OVERTIME, WHAT IS BASIS OF PAYMENT? PER HOUR | 49. NUMBER OF HOURS OVERTIME CONSIDERED NORMAL PER WEEK

50. GROSS WAGES OF EMPLOYEE DURING 12 MONTHS PRECEEDING INJURY FROM THRU $

51. IF EMPLOYEE WORKED LESS THAN 12 MONTHS, SHOW GROSS WAGES FROM DATE OF HIRE THROUGH DAY PRIOR TO INJURY FROM THRU $

52. DATE OF LAST WAGE INCREASE IF WITHIN 12 MONTHS PRIOR TO INJURY | 53. WAGE BEFORE INCREASE $ | 54. WAGE AFTER INCREASE $ | 55. GROSS EARNINGS FROM DATE OF INCREASE THRU DAY PRIOR TO INJURY $

AUTHORIZED SIGNATURE

DATE | AUTHORIZED SIGNATURE | TITLE

SUBMITTER EMAIL ADDRESS

NOTE TO EMPLOYER:

1. Submit one copy to the Industrial Commission within 10 days.
2. Submit one copy to your insurance carrier within 10 days.
3. Keep one copy, for not less than five (5) years, as your supplementary record of injuries required by the Federal Occupational Safety and Health Act of 1970.

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

REPORT OF SIGNIFICANT WORK EXPOSURE TO BODILY FLUIDS OR OTHER INFECTIOUS MATERIAL

(This form is not a claim form, but a report of exposure. Forms to report a claim to the Industrial Commission are available at: www.azica.gov .)

1. Exposed Employee _____ (Last Name) _____ (First) _____ (M.I.) Birth Date _____ Job Title _____

2. Address _____ Phone No. _____

3. Employer's Full Name _____

4. Employer's Address _____

5. Date of Exposure _____ Time of Exposure _____

6. Address or Location of Exposure _____

7. Describe the circumstances surrounding the exposure, including (if applicable) personal protective equipment worn and the names of any witnesses to the exposure (be specific)

8. What were you exposed to? (Directly or indirectly via bandages, personal items, etc.) Check all that apply.

☐ Blood ☐ Vaginal fluid ☐ Broken skin ☐ Urine ☐ Any other fluid(s) containing blood or infectious material (Describe) _____

☐ Semen ☐ Surgical fluid(s) ☐ Mucous membrane ☐ Feces ☐ Airborne/Respiratory/Oral Secretions Other (specify): _____

☐ Saliva ☐ Vomitus ☐ Skin infection (e.g. abscesses, boils, or pus-filled/red/swollen/painful skin lesions)

9. Source person(s) information ○ Unknown ○ Known

Name _____ DOB _____ Phone No. _____

Address _____ City _____ State _____ Zip _____

10. What part(s) of your body was exposed to bodily fluids/infectious material? Did exposure take place through your skin or mucous membrane (be specific)?

11. Did you have any open cuts, sores, rashes, or other breaks/ruptures in your skin or mucous membrane that were exposed to bodily fluids/infectious material (please describe)?

I HAVE GIVEN THIS FORM TO MY EMPLOYER AND HAVE RECEIVED A COPY OF THIS COMPLETE FORM.

EMPLOYEE SIGNATURE _____ DATE _____

Other Required Steps to Establish Prima Facie Claim for HIV, AIDS or Hepatitis C (A.R.S. §§ 23-1043.02, -03; A.A.C. R20-5-164)

1. **You must file this report with your employer no later than ten (10) days after your exposure.**
2. **You must have blood drawn no later than ten (10) calendar days after exposure.**
3. **You must have blood tested for HIV or Hepatitis C by Antibody Testing no later than thirty (30) calendar days after exposure and test results must be negative.**
4. **You must be tested or diagnosed as HIV positive no later than eighteen (18) months after the exposure, or tested and diagnosed as positive for the presence of Hepatitis C within seven (7) months after the exposure.**
5. **You must file a workers' compensation claim with the Industrial Commission of Arizona no later than one (1) year from the date of diagnosis or positive blood test if you wish to receive benefits under the workers' compensation system.**

Other Required Steps to Establish Prima Facie Claim for MRSA (A.R.S. § 23-1043.04; A.A.C. R20-5-164)

1. **You must file this report with your employer no later than thirty (30) days after your exposure.**
2. **For a claim involving MRSA, you must be diagnosed with MRSA within fifteen (15) days after you report in writing to your employer the details of the exposure.**
3. **You must file a workers' compensation claim with the Industrial Commission of Arizona no later than one (1) year from the date of diagnosis if you wish to receive benefits under the workers' compensation system.**

Other Required Steps to Establish Prima Facie Claim for Spinal Meningitis or TB (A.R.S. § 23-1043.04; A.A.C. R20-5-164)

1. **You must file this report with your employer no later than ten (10) days after your exposure.**
2. **For a claim involving spinal meningitis, you must be diagnosed within two (2) to eighteen (18) days of the possible significant exposure and for a claim involving tuberculosis, you must be diagnosed within twelve (12) weeks of the possible significant exposure.**
3. **You must file a workers' compensation claim with the Industrial Commission of Arizona no later than one (1) year from the date of diagnosis if you wish to receive benefits under the workers' compensation system.**

EMPLOYERS®

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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EMPLOYERS®

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.

America's small business insurance specialist®

OPTUM®

PO Box 152539
Tampa, FL 33684-2539

EMPLOYERS®
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MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits by 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 Employee:

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 pharmacist will fill your prescription at no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit www.tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM® EMPLOYERS® America's small business insurance specialist®

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

CARRIER/TPA _____ EMPLOYER _____

INJURED WORKER 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.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®

IMP14-18201-EMPLFF

PO Box 152539
Tampa, FL 33684-2539

America's small business insurance specialist®

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales por su empleador o su 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.

Empleado lesionado:

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.

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

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM® EMPLOYERS® America's small business insurance specialist®

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

PORTADORA EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist

NUMERO DE SEGURO SOCIAL FECHA DE ALA 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.*

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-18201-EMPLFF

EMPLOYERS®

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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:	