



# EMPLOYERS<sup>®</sup> Claims Kit



*America's small business insurance specialist<sup>®</sup>*

## Claims Contact Information

Tel: 888-682-6671 | Fax: 877-329-2954 | [www.employers.com/claimskit](http://www.employers.com/claimskit)

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## 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 state-specific claim information on our website:

[www.employers.com/claimskit](http://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](mailto:customersupport@employers.com).

### How to Report a Workers' Compensation Claim

Immediate reporting is a major step in the cost and time containment of any claim and is beneficial to all parties involved.

*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 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](http://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 job program can reduce the financial hardship that may be 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 incident of injury/ illness to EMPLOYERS immediately.



## 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](http://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](mailto: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](mailto: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](mailto:losscontrol@employers.com).





## Delaware 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 area. If you have multiple office locations, be sure to post the notices at each location.

✓ **Delaware Labor Law Poster**

✓ **Anti-Fraud Notice**

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

✓ **First Report of Injury (FROI)**

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 ten days from notice of a work-related injury. Fatalities must be reported within 24 hours. Please use this form to notify EMPLOYERS of every work-related injury or disease suffered by an employee, regardless of severity.

✓ **Wage Statement**

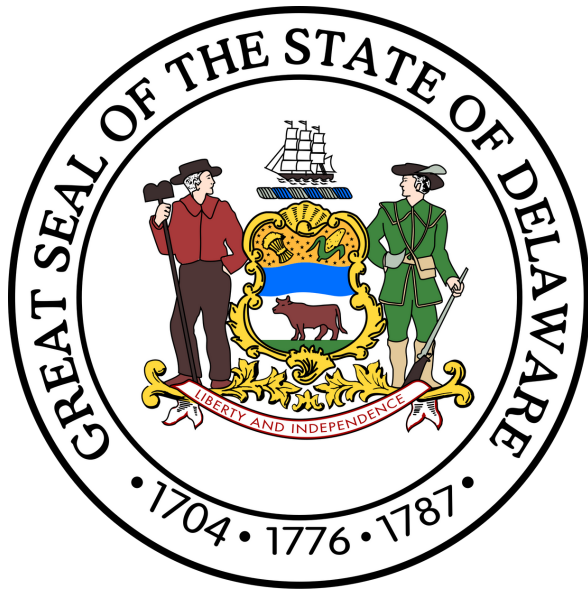
This form enables us to calculate the correct compensation owed to an injured employee. Please complete the form and submit it to EMPLOYERS within five days after your knowledge of any accident that has caused your employee to be disabled for more than three scheduled calendar work days.

✓ **Accident Investigation Report**

This basic accident form should be completed by the employee's supervisor/manager as soon as possible after the accident. Please send the report to the following EMPLOYERS address as soon as it has been completed by the supervisor/manager: EMPLOYERS Claims 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/ClaimKit-Delaware.aspx>

**Fox Valley Offices**  
4425 North Market Street- 3rd Floor  
Wilmington, DE 19802  
(302) 761-8200



**DEPARTMENT OF LABOR  
DIVISION OF INDUSTRIAL AFFAIR**

**Blue Hen Corporate Center**  
655 S Bay Road, Ste. 2H  
Dover, DE 19901  
(302) 422-1134

**Georgetown American Job Center**  
8 Georgetown Plaza, Suite 2  
Georgetown, DE 19947  
(302) 856-5230

**University Office Plaza**  
252 Chapman Road, 2nd Floor  
Newark, DE 19702  
(302) 761-8200

Email: [dol\\_dia\\_workcomp@delaware.gov](mailto:dol_dia_workcomp@delaware.gov) | Email: [dol\\_dia\\_wc\\_compliance@delaware.gov](mailto:dol_dia_wc_compliance@delaware.gov) | Website: [Labor.delaware.gov](http://Labor.delaware.gov)

**WORKERS COMPENSATION**

**IMPORTANT THINGS TO DO IN CASE OF INJURY**

**THE EMPLOYER SHALL:**

**Carry Workers' Compensation Insurance Coverage per Title 19, Chapter 23, 2303. Every employer shall keep of record of all injuries received by employees; and within 10 days, file a First Report of Injury with the Office of Workers Compensation as per Title 19, Chapter 23, 2313. In addition, the employer should notify their Workers' compensation Insurance carrier of said injury. First Report of Injury forms are available on our website listed above**

**THE EMPLOYEE SHALL:**

**Or someone on the employee's behalf, notify the employer as soon as possible of an accidental injury or occupational disease and request medical services if needed. Failure to give notice or to accept medical services may deprive the employee of the right to compensation. Give promptly to the employer, directly or through a supervisor, notice of any claim for compensation for the period of disability beyond the third day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person on their behalf. In case of failure to reach an agreement with the employer in regard to compensation under the law, file a petition with the Industrial Accident Board for a hearing on the matters at issue within two (2) years of the date of accidental injury. All forms can be obtained from the Office of Workers' Compensation. ( Email: [dol\\_dia\\_workcomp@delaware.gov](mailto:dol_dia_workcomp@delaware.gov) )**

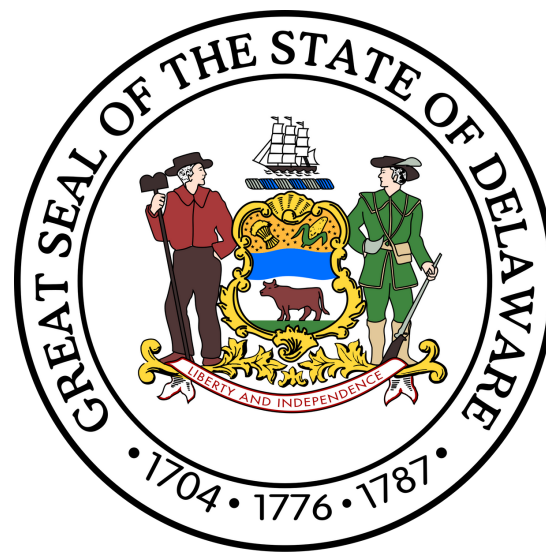
**It is unlawful to retaliate against an employee because (s)he has made a complaint or given information to the Dept of Labor about possible labor law violations.**

**Violations of Delaware Worker's Compensation Labor Laws could result in fines.**





**Fox Valley Offices**  
**4425 North Market Street- 3rd Floor**  
**Wilmington, DE 19802**  
**(302) 761-8200**



**Departamento de Trabajo de Delaware**  
**División de Asuntos Industriales**

**Blue Hen Corporate Center**  
**655 S Bay Road, Ste. 2H**  
**Dover, DE 19901**  
**(302) 422-1134**

**Georgetown American Job Center**  
**8 Georgetown Plaza, Suite 2**  
**Georgetown, DE 19947**  
**(302) 856-5230**

**University Office Plaza**  
**252 Chapman Road, 2nd Floor**  
**Newark, DE 19702**  
**(302) 761-8200**

**Correo electrónico: [wages@delaware.gov](mailto:wages@delaware.gov) | Correo electrónico: [workpermits@delaware.gov](mailto:workpermits@delaware.gov) | Sitio web: [Labor.delaware.gov](http://Labor.delaware.gov)**

## **INDEMNIZACIÓN POR ACCIDENTE LABORAL**

### **MEDIDAS IMPORTANTES QUE LLEVAR A CABO EN CASO DE LESIONES**

#### **EL EMPLEADOR DEBE:**

Tener una cobertura de seguro de indemnización por accidente laboral. Brindar todo tratamiento médico, quirúrgico y hospitalario necesario desde la fecha del accidente. Cada empleador debe llevar un registro de todas las lesiones sufridas por los empleados y presentar un informe dentro de los diez (10) días desde ese momento por escrito a la Oficina de Indemnización por Accidente Laboral. Determinar los salarios semanales promedio del empleado y brindar indemnización de acuerdo con las disposiciones legales por discapacidad después del tercer día luego del accidente. Todos los acuerdos en relación con la indemnización deben presentarse ante la Oficina de Indemnización por Accidente Laboral para su aprobación.

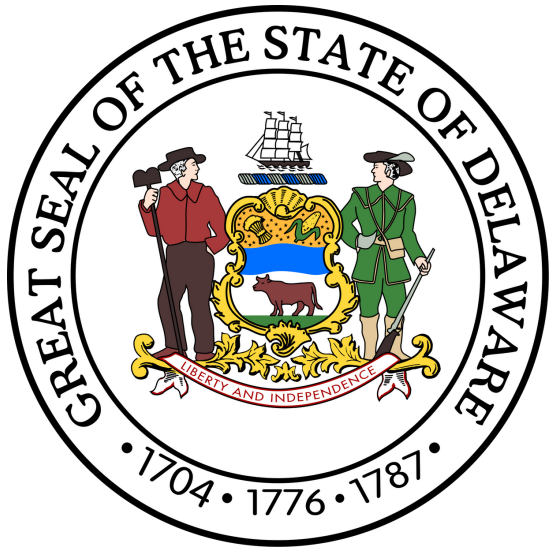
#### **EL EMPLEADO DEBE:**

Notificar de inmediato al empleador por escrito acerca de una lesión por accidente o enfermedad laboral y solicitar servicios médicos. El incumplimiento en la notificación o en la aceptación de servicios médicos pueden privar al empleado del derecho a recibir indemnización. Notificar al empleador de inmediato, de forma directa o a través de un supervisor, sobre cualquier reclamo de indemnización por el período de discapacidad luego del tercer día después del accidente. En caso de lesiones mortales, la notificación debe realizarla uno o más dependientes del fallecido o una persona en su nombre. En caso de no llegar a un acuerdo con el empleador en relación con la indemnización conforme a la ley, presentar una solicitud ante la Junta de Accidentes Industriales para tener una audiencia sobre los temas en cuestión dentro de los dos (2) años de la fecha de la lesión por accidente o de un (1) año del conocimiento de un diagnóstico de enfermedad laboral o una lesión de radiación ionizante. Todos los formularios pueden obtenerse en la Oficina de Indemnización por Accidente Laboral.



**Fox Valley Offices**  
**4425 North Market Street- 3rd Floor**  
**Wilmington, DE 19802**  
**(302) 761-8200**

**Georgetown American Job Center**  
**8 Georgetown Plaza, Suite 2**  
**Georgetown, DE 19947**  
**(302) 856-5230**



**Depatman Travay Delaware**  
**Divizyon Zafè Endistriyèl yo**

**Blue Hen Corporate Center**  
**655 S Bay Road, Ste. 2H**  
**Dover, DE 19901**  
**(302) 422-1134**

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Email: [dol\\_dia\\_workcomp@delaware.gov](mailto:dol_dia_workcomp@delaware.gov) | Email: [dol\\_dia\\_wc\\_compliance@delaware.gov](mailto:dol_dia_wc_compliance@delaware.gov) | Sit Wèb: [Labor.delaware.gov](http://Labor.delaware.gov)

## DEDOMAJMAN TRAVAYÈ

### BAGAY ENPÒTAN POU OU FÈ NAN KA BLESİ

#### PATWON AN DWE:

Peye kouvèti asirans Konpansasyon Anplwaye a dapre Atik 19, Chapit 23, 2303. Chak patwon dwe kenbe yon dosye sou tout blesi anplwaye yo resevwa, epi nan lespas 10 jou, soumèt yon Premye Rapò sou Blesi nan Biwo Konpansasyon Travayè yo dapre Atik 19, Chapit 23, 2313. Anplis de sa, patwon an ta dwe avize responsab Asirans konpansasyon Travayè yo a de blesi sa yo. Fòm Premye Rapò sou Blesi yo disponib sou sit wèb nou an ki parèt anlè a

#### ANPLWAYE A DWE:

Oswa yon moun nan plas anplwaye a, avize patwon an dèke posib de yon blesi nan aksidan oswa yon maladi pwofesyonèl epi mande sèvis medikal si sa nesesè. Si anplwaye a pa reyisi bay avètisman oswa aksepte sèvis medikal yo, sa ka anpeche anplwaye a jwi dwa pou l resevwa yon konpansasyon. Bay patwon an san pèdi tan, dirèkteman oswa atravè yon sipèvizè, avi sou nenpòt reklamasyon pou konpansasyon pou peryòd andikap apre twazyèm jou apre aksidan an. Nan ka blesi mòtèl yo, youn oswa plizyè moun ki depann de moun ki mouri a dwe bay yon avi oswa avi a dwe bay sou non yo atravè yon moun. Nan ka ou pa rive jwenn yon akò ak patwon an konsènan konpansasyon dapre lalwa a, soumèt yon pètisyon bay Komisyon Konsèy Aksidan Endistriyèl la pou yon odyans sou zafè ki konsène yo nan lespas de (2) lane dat blesi nan aksidan an. Ou ka jwenn tout fòm yo nan men Biwo Konpansasyon Travayè a. (Email: [dol\\_dia\\_workcomp@delaware.gov](mailto:dol_dia_workcomp@delaware.gov))



Li ilegal pou fè vanjans kont yon anplwaye paske li te pote yon plent oswa li te bay Depatman Travay la enfòmasyon sou yon posib vyolasyon lalwa travay la.

LA LWA OBLIJE PATWON YO POU YO MONTRE AFICH OFISYÈL SA A NAN YON KOTE ANPLWAYE YO KA WÈ EPI KOTE YO PASE REGILYÈMAN.

Vyolasyon Lwa Travay Delaware yo kapab lakòz amann ki rive jiska \$20,000 pou chak vyolasyon.



# 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.<sup>1</sup>

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](mailto:fraudfighters@employers.com).**

## **EMPLOYERS**®

*America's small business insurance specialist®*

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# *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.<sup>1</sup>

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](mailto:fraudfighters@employers.com).**

## **EMPLOYERS**®

*America's small business insurance specialist*®

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1 Fuente: <http://www.propertycasualty360.com/2015/07/23/3-keys-to-a-successful-workers-compensation-fraud>



**ALL COPIES OF THIS FIRST REPORT MUST BE TYPED OR PRINTED**

Department of Labor  
Office of Workers' Compensation (OWC)  
4425 N. Market Street  
Wilmington, DE 19802  
Telephone 302-761-8200

**STATE OF DELAWARE  
FIRST REPORT  
OF OCCUPATIONAL INJURY OR DISEASE**

\_\_\_\_\_  
**OWC Case File No.**

**ALL INFORMATION IS REQUIRED, unless not applicable where "if applicable" is noted.**

|   |               |  |  |  |  |
|---|---------------|--|--|--|--|
| <b>1. EMPLOYEE:</b><br>FIRST MIDDLE LAST  |               |  | <b>2. EMPLOYEE SOCIAL SECURITY NO.</b>   |  |  |
| <b>3. ADDRESS – INCLUDE COUNTY AND ZIP CODE</b>   |               |  | <b>4.</b><br>MALE <input type="checkbox"/><br>FEMALE <input type="checkbox"/>    | <b>5. EMPLOYEE PHONE NUMBER</b><br>(INCLUDING AREA CODE)                                   |  |
| <b>6. DATE OF BIRTH</b><br>/ /  | <b>7. AGE</b> | <b>8. WAGE</b>   | <b>9. WEEKLY HOURS WORKED</b>  |  |  |
| <b>10. OCCUPATION (REGULAR)</b>   |               | <b>11. DEPARTMENT OR DIVISION REGULARLY EMPLOYED</b>                                 |  | <b>12. HOW LONG EMPLOYED</b>   |  |
| <b>13. EMPLOYER:</b>  |               |  | <b>14. PERSON MAKING OUT THIS REPORT</b>   |  |  |
| <b>15. ADDRESS – INCLUDE COUNTY AND ZIP CODE</b>  |               |  | <b>16. EMPLOYER PHONE # (INCLUDE AREA CODE)</b>                                  |  |  |
| <b>17. MAILING ADDRESS – IF DIFFERENT THAN ABOVE</b>  |               |  | <b>18. NATURE OF BUSINESS – TYPE OF MFG., TRADE, CONSTRUCTION, SERVICE, ETC.</b> |  |  |
| <b>19. WORKERS' COMPENSATION INSURANCE CARRIER</b>  |               |  | <b>20. WORKERS' COMP. INS. CARRIER PHONE #, (INCLUDING AREA CODE)</b>            |  |  |
| <b>21. WORKERS' COMP. INSURANCE CARRIER ADDRESS</b>   |               |  | <b>22. POLICY NUMBER / CARRIER CASE NUMBER:</b><br>/                             |  |  |
| <b>23. THIRD PARTY ADMINISTRATOR (TPA), IF APPLICABLE</b>   |               | <b>24. TPA ADDRESS – INCLUDE CITY STATE AND ZIPCODE</b>                              |  |  |  |
| <b>DATES:</b><br><b>25. DATE OF REPORT</b><br>/ /   |               | <b>26. DATE OF INJURY</b><br>/ /   |  | <b>27. NORMAL STARTING TIME</b><br><input type="checkbox"/> AM <input type="checkbox"/> PM |  |
| <b>28. IF EMPLOYEE BACK TO WORK GIVE DATE</b><br>/ /  |               | <b>29. AT SAME WAGE?</b><br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| <b>30. IF FATAL INJURY, GIVE DATE OF DEATH</b><br>/ /   |               | <b>31. DATE EMPLOYER KNEW OF INJURY</b><br>/ /                                       |  | <b>32. DATE DISABILITY BEGAN</b><br>/ /  |  |
| <b>33. LAST FULL DAY PAID-DATE</b><br>/ /   |               |  |  |  |  |
| <b>INJURY OR DISEASE:</b><br><b>34. DESCRIBE THE INJURY/ILLNESS AND PART OF BODY AFFECTED.</b>  |               |  |  |  |  |
| <b>35. SPECIFY THE DEPARTMENT WHERE INCIDENT OCCURRED AND THE WORK PROCESS INVOLVED.</b>  |               |  |  |  |  |
| <b>OCCURRENCE:</b><br><b>36. LIST THE EQUIPMENT, MATERIALS, AND CHEMICALS EMPLOYEE USED WHEN THE INCIDENT OCCURRED, E.G. ACETYLENE.</b> |               |  |  |  |  |
| <b>37. DESCRIBE THE EMPLOYEE'S ACTIVITY AT THE TIME OF INJURY OR ILLNESS, E.G. LIFTING A PATIENT.</b>                                   |               |  |  |  |  |
| <b>38. DESCRIBE HOW THE INJURY/ILLNESS OCCURRED.</b>  |               |  |  |  |  |
| <b>39. NAME OF PHYSICIAN (IF APPLICABLE)</b>  |               |  | <b>40. PHYSICIAN'S ADDRESS</b>   |  |  |
| <b>41. HOSPITAL (IF APPLICABLE)</b>   |               |  | <b>42. HOSPITAL ADDRESS</b>  |  |  |

**DISTRIBUTION OF THIS REPORT (1 original and 3 copies)**

- 1. ORIGINAL MUST BE SENT IMMEDIATELY TO THE WORKERS' COMPENSATION INSURANCE CARRIER.**
- 2. COPY TO THE OFFICE OF WORKERS' COMPENSATION (use the address at the top left of this form)**
- 3. EMPLOYER'S COPY – RETAIN AS RECORD**
- 4. EMPLOYEE'S COPY**

# **WORKERS' COMPENSATION**

## **IMPORTANT THINGS TO DO IN CASE OF INJURY**

### ***THE EMPLOYER SHOULD:***

1. Provide all necessary medical, surgical and hospital treatment from the date of accident.
2. Every employer shall keep a record of all injuries received by employees and make a report within 10 days thereof in writing to the Office of Workers' Compensation
3. Ascertain the average weekly wages of the employee and provide compensation in accordance with the provisions of the law, for disability *beyond the third day* after the accident. All agreements as to compensation must be submitted to the Office of Workers' Compensation for approval.

### ***THE EMPLOYEE SHOULD:***

1. Immediately notify the employer in writing of accidental injury or occupational disease and request medical services. Failure to give notice or to accept medical services may deprive the employee of the right to compensation.
2. Give promptly to the employer, directly or through a supervisor, notice of any claim for compensation for the period of disability beyond the third day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person on their behalf.
3. In case of failure to reach an agreement with the employer in regard to compensation under the law, file application with the Industrial Accident Board for a hearing on the matters at issue within two years of the date of accidental injury or one year of knowledge of the diagnosis of an occupational disease or an ionizing radiation injury. All forms can be obtained from the Office of Workers' Compensation.



## DELAWARE - STATEMENT OF WAGES

**EMPLOYEE:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

SSN: \_\_\_\_\_

DOB: \_\_\_\_\_

**EMPLOYER:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

Contact Person: \_\_\_\_\_

**INSURER/THIRD PARTY ADMINISTRATOR:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

**CLAIM INFORMATION:**

Claim No.: \_\_\_\_\_

Accident Date: \_\_\_\_\_

**Section 1- to be completed if the employee sustains an injury after completing that employee's first 13 weeks of work.**

If the claimant was employed for at least 13 weeks, Delaware law calculates average weekly wage by using a weekly average. If the above employee was employed for at least 13 weeks, please provide a week-by-week statement of the claimant's **gross wages** for as many of the 26 weeks period of time **prior to the accident date** that such employee worked.

**Gross Wages:**

Week 1 \_\_\_\_\_

Week 2 \_\_\_\_\_

Week 3 \_\_\_\_\_

Week 4 \_\_\_\_\_

Week 5 \_\_\_\_\_

Week 6 \_\_\_\_\_

Week 7 \_\_\_\_\_

Week 8 \_\_\_\_\_

Week 9 \_\_\_\_\_

Week 10 \_\_\_\_\_

Week 11 \_\_\_\_\_

Week 12 \_\_\_\_\_

Week 13 \_\_\_\_\_

Week 14 \_\_\_\_\_

Week 15 \_\_\_\_\_

Week 16 \_\_\_\_\_

Week 17 \_\_\_\_\_

Week 18 \_\_\_\_\_

Week 19 \_\_\_\_\_

Week 20 \_\_\_\_\_

Week 21 \_\_\_\_\_

Week 22 \_\_\_\_\_

Week 23 \_\_\_\_\_

Week 24 \_\_\_\_\_

Week 25 \_\_\_\_\_

Week 26 \_\_\_\_\_

**Section 2 – To be completed if the employee sustains an injury before completing that employee’s first 13 weeks of work. Please check the appropriate statement below:**

- \_\_\_\_\_ (a) If the contract of hire was based on hours worked, provide the employee’s hourly rate of pay \$ \_\_\_\_\_ and the number of hours contracted for each week: \_\_\_\_\_  
(If the contract of hire was based on hours worked, average weekly wage is calculated by multiplying these two values).
- \_\_\_\_\_ (b) If the contract was based on weekly wage, please provide the weekly salary contracted for: \$ \_\_\_\_\_.
- \_\_\_\_\_ (c) If the contract was based upon a monthly salary, please provide the monthly salary \$ \_\_\_\_\_, then multiply by 12 \_\_\_\_\_ and divide by 52 \_\_\_\_\_.  
(If the contract was based on monthly salary, average weekly wage is calculated by multiplying the monthly salary by 12 and dividing that figure by 52).
- \_\_\_\_\_ (d) If the hourly rate of earnings of the employee cannot be ascertained or if the pay has not been designated for the work required, average weekly wage shall be taken to be the average weekly wage for similar services performed by other employees in like employment for the past 26 weeks. If you believe section (d) applies, please indicate the reason therefore and what you believe to be the average weekly wage for similar services performed by other employees in like employment for the past 26 weeks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section 3 – Additional Compensation**

1. Under Delaware’s statute, average weekly wage includes the reasonable value of board, rent, housing or lodging received from the employer. If the claimant received any such benefit from the employer, please so advise and provide the details regarding same:  
\_\_\_\_\_  
\_\_\_\_\_
2. If the claimant receives federal reported gratuities, please so advise and provide the amount of weekly federal reported gratuities for the 26 weeks period of time prior to the accident date: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section 4 - Note to insurer or third-party administrator regarding calculation of compensation rate:**

Pursuant to Section 2324, compensation for total disability is 66⅔% of wages not to exceed the State maximum nor less than the State minimum as announced by the Secretary of the Department of Labor on an annual basis. Note that if the claimant’s average weekly wage as calculated in Section 1 or Section 2 is less than the minimum compensation rate as announced by the Secretary of the Department of Labor, the employee’s compensation rate is the full amount of such wages, not the minimum compensation rate.



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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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