Workers' Compensation Claim Reporting Procedures

Your company's workers' compensation insurance is provided by the Alabama Self Insured Worker's Compensation Fund. Claims service is provided by Employer's Claim Management, Inc. If you have questions concerning your workers' compensation program, please call Employer's Claim Management for assistance.

Any work related injury can have the potential to become a workers' compensation claim. For this reason, all employees should be instructed to report all work related injuries, no matter how minor, to their immediate supervisor as soon as possible. The supervisor is responsible for informing the proper management person as soon as possible. This person is then responsible for reporting the injury to Employer's Claim Management. Inc. using the Employer's First Report of Injury form.

If an injury requires off premises medical treatment:

1. Treatment must be provided by the **Company Authorized Physician or Clinic**.
2. All referrals to specialists must be authorized by Employer's Claim Management, Inc. (800)-392-2551.
3. In the event of an emergency, call 911 or other emergency services as soon as possible.
4. Be sure Post Injury Drug Testing procedures are followed for all employees.

Complete a first report of Injury form for all work related injuries that may have the potential to become a workers' compensation claim. Example: An employee states they have strained their shoulder, but they don't want to go for medical treatment. In this situation, complete the First Report of Injury form and at the top of the form mark it as "For Record Only". Then send the form to Employer's Claim Management, Inc. When received, the claim will be filed and closed. If later the injured employee needs to go for medical treatment, contact Employer's Claim Management, Inc. so that the claim can be opened and properly investigated.

If your company makes the decision to pay minor Medical Only claims out of company funds, send the First Report of Injury form to Employer's Claim Management marked as "For Record Only". If bills exceed what the company has decided to pay or if the injury progresses into a lost time claim, Contact Employer's Claim Management and the claim will be opened and properly investigated.

Be sure the company Drug and/or Alcohol Testing Procedures are enforced as specified by the company's written policy. It is critical that screens for substance abuse be administered when the employees seeks initial medical treatment. Employees must also be informed in advance, in

writing that the refusal to cooperate with a test and/or a positive test result may have an impact on the availability of workers' compensation benefits.

Questionable claims should be reported to Employers' Claim Management Inc. as soon as possible. Any claim that involves severe injury such as amputation, head trauma, death, etc., should be reported to Employer's Claim Management immediately (800) 392-1551.

Claims are filed by social security number and employee name. When calling about a specific claim, provide the receptionist with the social security number and name of the employee and they will connect you with the adjuster assigned to the claim.

If you need assistance with your workers' compensation program, contact:

Employer's Claim Management, Inc.	**Phone:**	**800-392-1551**
PO Box 5614		**334-277-9395**
Montgomery, Alabama 36103	**Fax:**	**334-240-2981**

Claim Reporting

Purpose:

Prompt claim reporting is essential and beneficial to all parties involved (employee, employer, and insurance carrier). State requirements also mandate the prompt reporting of employee injuries. The Employer's First Report of Injury form is used to satisfy this requirement (see back page).

Procedure:

1. Work related injuries will be reported to Employer's Clam Management using the Employer's First Report of Injury form.

   Employer's Claim Management, Inc.
   PO Box 5614
   Montgomery, Alabama 36103

2. The First Report of Injury form should be completed and forwarded to Employer's Claim Management within 48 Hours of being made aware of the injury.
3. For accidents involving death or severe injury such as amputation or head trauma, a telephone report should be made as soon as possible, followed by a completed First Report of Injury.

Company Authorized Physician

Purpose:

A workers' compensation claim can be properly managed through good communication involving the employee, employer, insurance carrier and the treating physician. The employer's right to direct medical treatment is critical to the claims management process and should be aggressively utilized at all times. For this reason the following policy regarding company authorized physicians has been established.

Procedure:

1. If an employee injury is incurred and medical treatment by a physician is necessary, a company authorized physician will be utilized. Instructions for seeking initial medical treatment should be provided by management or other designated persons.
2. At the present time, the company authorized physician is as follows:

   Name:
   Address:
   Phone Number:

3. In the event an injured employee's initial treatment is performed by a hospital, emergency room, clinic or physician not authorized by the company, the employee may be asked to be evaluated by the company authorized physician. This situation might occur if an employee is injured after regular working hours and/or at a job site where the company authorized physician is not readily assessable. If additional medical treatment is necessary, the company authorized physician should be utilized.

4. All referral physicians will be selected by Employer's Claim Management, Inc. 800-392-1551

Post Injury Drug Testing

Purpose:

An injured employee who is intoxicated from the use of alcohol or impaired by illegal drugs may be denied workers' compensation benefits if a causal relationship between the injury and the impairment and/or intoxication can be established. Workers' compensation benefits can also be denied if the injured employee refuses to submit to or cooperate with a blood or urine test after the accident, after being warned in writing. For this reason, the following post injury drug testing policy and procedure have been established.

Procedure:

1. Prior to the start of work activities, all new employees will receive training regarding the company Drug and Alcohol Testing Policy. This will include a review of the established policy, procedure and the signing of required acknowledgments and/or training documentation.

2. Employees will be subject to post injury drug testing as specified by the company Drug and Alcohol Testing policy. For example; after a work related injury requiring off premises medical treatment.

Modified Duty / Return to Work

Purpose:

Availability of modified duty will assist employees in returning to their regular work routine and limiting time off from work. This in turn will allow the employee the opportunity of maintaining productive work habits while recovering from their injury.

Procedure:

Prior to an employee injury:

1. The company authorized physician should be made aware that the company has a Modified Duty/Return to Work Program.

After an employee injury has been incurred:

1. Every effort will be made to provide modified duty to any and all injured employee released to modified duty by the treating physician.

2. Management should remind both the treating physician and the insurance claim adjuster that modified duty will be made available.

3. If the injured employee has difficulty completing modified duty work assignments, the employer should contact the insurance company adjuster as soon as possible and the employee referred back to the treating physician so that work restrictions can be modified.

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE ALABAMA WORKMEN'S COMPENSATION LAW

WCC Form 2
Rev. 4/2006

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY
OR OCCUPATIONAL DISEASE

Ombudsman 1-800-528-5166

Check here for ***Record Only*** ☐

CLAIM REFERENCE

1. Insured Report Number 23	2. Filing Office Claim Number	3. OSHA Log Case Number 26

EMPLOYER

4. Employer Business Name **ABC Inc.**	ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS
5. Physical Address 1 **123 Main Street**	10. Mailing Address 1 **P.O. Box 987**
6. Physical Address 2	11. Mailing Address 2
7. City **Ourtown** 8. State **Alabama** 9. Zip **12345**	12. City **Ourtown** 13. State **Alabama** 14. Zip **12345**

15. Federal ID Number **987654321**	16. U.C. Account Number **00123567800**	17. NAICS **56471**

INSURER / FILING OFFICE

18. Insurer Name **ALABAMA SELF-INSURED WC FUND**	21. Filing Office Name **Employer's Claim Management, Inc.**
19. Insurer Federal ID Number **63-0773197**	22. Mailing Address 1 **P.O. Box 5614**
	23. Mailing Address 2 or Telephone Number (**334)277-9395**
	24. City **Montgomery** 25. State **AL** 26. Zip **36103-5614**
20. Type Insurer Ins Co ☐ Self-Insurer ☐ Group Fund ☒	27. Filing Office Federal ID Number **63-1034984**

EMPLOYEE / WAGES

28. First Name **John**	32. Employee ID Number 234-91-7865
29. Middle Name **David**	33. Type Employee ID Number
30. Last Name **Smith**	SSN ☒ Passport Number ☐ Green Card ☐
31 Last Name Suffix (ie. Jr., Sr., III) **Jr.**	Employment Visa ☐ Assigned by Jurisdiction ☐

34. Mailing Address 1 98 Dogwood Street	40. Gender Male ☒ Female ☐	41. Date of Birth 12/10/64
35. Mailing Address 2		
36. City Ourtown 37. State Alabama 38. Zip 12345 39. Phone 334-234-3456		42.Nbr of Dependents 0

43. Marital Status Unmarried (Single or Divorced or Widowed) ☐ Married ☒ Separated ☐ Unknown ☐	44. Date Hired
45. Occupation Description Machine Operator	46. Number of Days Worked Per Week 5
47. Wages $ 400	49. Received Full Pay For Day of Injury? Yes ☒ No ☐
48. Hourly ☐ Daily ☐ Weekly ☒ Bi-weekly ☐ Monthly ☐	50. Did Salary Continue? Yes ☐ No ☒

INJURY / TREATMENT

51. Date of Injury	52. Time of Injury	53. Time Employee Began Work	54. Date Disability Began	55. Date of Death
6/1/06	10:00 a.m. ☒ p.m. ☐ unk ☐	8:00 a.m. ☒ p.m. ☐	6/2/06	

PLACE OF ACCIDENT, INJURY, OR EXPOSURE	61. Injury Occurred on Employer's Premises? Yes ☒ No ☐
56. Site Address 123 Main Street	
57. City Ourtown 58. State Alabama 59. Zip 12345	62. Date Employer Notified 6/1/06
60. County Johnson	

63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT, HOW THE INJURY OCCURRED, AND THE SPECIFIC INJURY. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet., injuring right ankle.)

Employee was clearing a jam from his equipment. When the jam was cleared, the equipment started unexpectedly, pulling John's left hand past the cutting blade. This resulted in a severe cut to John's left hand.

PROVIDE DESCRIPTION CODES to identify **Nature of Injury**, **Part of Body** that was affected, and **Cause of Injury**.
(FOR COMPLETE LIST OF CODES, GO TO HTTP:// DIR.ALABAMA.GOV/WC

64. Nature of Injury Code 40 - Laceration 65. Part of Body Code 35 - Hand 66. Cause of Injury Code 10 - Machine

67. Initial Treatment	No Medical Treatment ☐	68. Name of Treatment Facility Med Care Inc.
First Aid By Employer ☐	Minor Clinic / Hospital ☐	69. Address 567 Medical Park Drive
Emergency Room ☐	Hospitalized > 24 Hours ☐	70. City Ourtown 71. State Alabama 72. Zip 12345
Major medical/Lost time ☒	Hospitalized Overnight ☐	

73. Name of Physician or Other Health Care Professional	74. Has Injured Returned to Work	If so, 75. Date
Dr. Ronald Evans	Yes ☐ No ☒	76. Time a.m. ☐ p.m. ☐

OTHER

77. Date Prepared	78. Preparer's First Name	79. Last Name	80. Title	81. Preparer's Telephone Number
6/2/06	Robert	Turner	HR Manager	334-987-6543