



Workers Compensation Insurance Claims Kit

Thank you for placing your workers compensation coverage with Society Insurance. It is our privilege to assist you in this vital area of your business.

Our goal is to provide you the very best service in our industry, and to help keep the cost of workers compensation insurance at an affordable level. We have been doing so since 1915.

Help us provide your injured employees with the prompt service they deserve by immediately reporting all claims to your agent or directly to us. For your convenience, we can accept your claim information via telephone. To submit a claim, please call 888-576-2438.

This package contains a workers compensation claims kit folder that includes checklists for both you and your injured employee to complete should you need to file a claim. These checklists will help explain the tools for you to file your claim quickly with close attention to all claims considerations. These checklists will also allow you to assist us in identifying and maximizing any cost-saving opportunities that may exist.

As always, your agent is an excellent resource for any general questions, or questions you may have regarding the information in this package.

Please feel free to contact us if you have any additional questions regarding the claims process.

Sincerely,

James P. Thomas
President and CEO

As a policyholder, you are entitled to use our Risk Control Services to help you control your workers compensation exposures. We see Risk Control as a team effort between Society Insurance and our policyholders. The team concept requires a commitment from both parties. Society Insurance accepts this challenge. We look forward to working with you to help reduce or eliminate potential losses or exposures to loss. This teamwork results in positive risk control results.

In order to succeed in controlling your exposures, we strongly recommend that you consider instituting a safety and health program if you have not done so already. It is our objective to help you install and/or improve your program and to accomplish the proper goals. Our staff offers a range of capabilities to assist in meeting your responsibility to provide a safe, healthy workplace for employees and customers alike. You may contact Society Insurance at any time to arrange an on-site evaluation.

Society's Risk Control Services staff is well-trained and experienced in the broad spectrum of controlling safety and health challenges. The customer's needs will be analyzed and effective, practical solutions will be recommended. When needed, additional resources will be consulted. Specialty services include:

- Physical Plant/Facility Survey – providing OSHA compliance assistance
- Introduction to Ergonomics – explaining human factors engineering principles
- Restaurant Safety
- Construction Safety
- Property Fire Protection
- Product Safety
- Fleet Safety
- Safety education and training for managers, supervisors, and other key staff
- Assistance in the establishment of safety and health incentive programs

We can also provide and recommend training materials such as videos, booklets, and brochures. Ask for a copy of our *Safety and Health Service/Materials Catalog*. We also have the ability to provide information on applicable safety standards and codes. Society can help in recognizing environmental health and occupational health problems, and refer customers to outside help.

If you have any questions or desire assistance in controlling your accident and illness exposures, please call our Risk Control Services department at 888-576-2438, extension 310.

WORKERS COMPENSATION NOTICE TO EMPLOYEES

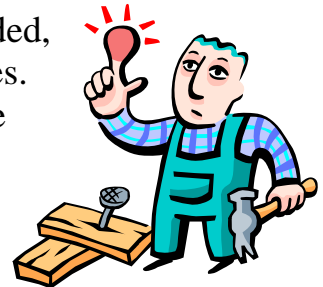
(Employer's Name)

This employer is required to provide for payment of benefits in accordance with the provisions of workers compensation law.

Follow these steps if you are injured at work:



- ✓ **NOTIFY YOUR EMPLOYER.** If you are injured, notify your supervisor, employer, or designated representative immediately. Notify your employer even if you do not intend to seek immediate treatment for your injuries.
- ✓ **SEEK MEDICAL TREATMENT.** If needed, seek immediate medical care for your injuries. It is important to let your employer know the results of that treatment as soon as possible.



- ✓ **IMPORTANT!** The law requires you to give notice of injury and/or illness to your employer. It is beneficial to all parties involved that the notice be provided as soon as possible after the injury occurs.

The workers compensation insurance carrier for this employer is:



Society Insurance
150 Camelot Drive
P.O. Box 1029
Fond du Lac, WI 54936-1029
Toll-free phone: 888-576-2438

Note: By law, Illinois employers must display this notice at a prominent location in each workplace.



WORKERS' COMPENSATION

is a system of benefits provided by law to most workers who have job-related injuries or illnesses. Benefits are paid for injuries that are caused, in whole or in part, by an employee's work. This may include the aggravation of a pre-existing condition, injuries brought on by the repetitive use of a part of the body, heart attacks, or any other physical problem caused by work. Benefits are paid regardless of fault.

IF YOU SUFFER FROM A WORK-RELATED INJURY OR ILLNESS, YOU SHOULD TAKE THE FOLLOWING STEPS:

- 1. GET MEDICAL ASSISTANCE.** By law, your employer must pay for all necessary medical services required to cure or relieve the effects of the injury or illness. The employee may choose two physicians, surgeons, or hospitals. Where necessary, the employer must also pay for physical, mental, or vocational rehabilitation, within prescribed limits.
- 2. NOTIFY YOUR EMPLOYER.** You must notify your employer of the accidental injury or illness within 45 days, either orally or in writing. To avoid possible delays, it is recommended the notice also include your name, address, telephone number, Social Security number, and a brief description of the injury or illness.
- 3. LEARN YOUR RIGHTS.** Your employer is required by law to report accidents that result in more than three lost work days to the Workers' Compensation Commission. Once the accident is reported, you should receive a handbook that explains the law, benefits, and procedures. If you need a handbook, please call the Commission or go to the Web site.

If you must lose time from work to recover from the injury or illness, you may be entitled to receive weekly payments and necessary medical care until you are able to return to work that is reasonably available to you.

It is against the law for an employer to harass, discharge, refuse to rehire or in any way discriminate against an employee for exercising his or her rights under the Workers' Compensation or Occupational Diseases Acts. If you file a fraudulent claim, you may be penalized under the law.

- 4. KEEP WITHIN THE TIME LIMITS.** Generally, claims must be filed within three years of the injury or disablement from an occupational disease, or within two years of the last workers' compensation payment, whichever is later. Claims for pneumoconiosis, radiological exposure, asbestosis, or similar diseases have special requirements. Injured workers have the right to reopen their case within 30 months after an award is made if the disability increases, but cases that are resolved by a lump-sum settlement contract approved by the Commission cannot be reopened. Only settlements approved by the Commission are binding.

For more information, go to the Illinois Workers' Compensation Commission's Web site or call any office:

Toll-free: 866/352-3033 Chicago: 312/814-6611 Peoria: 309/671-3019 Springfield: 217/785-7087
Web site: www.iwcc.il.gov Collinsville: 618/346-3450 Rockford: 815/987-7292 TDD (Deaf): 312/814-2959

BY LAW, EMPLOYERS MUST DISPLAY THIS NOTICE IN A PROMINENT PLACE IN EACH WORKPLACE AND COMPLETE THE INFORMATION BELOW.			
Party handling workers' compensation claims			
Business address			
Business phone			
Effective date		Termination date	
Policy number		Employer's FEIN	

Employer's Claim Reporting Checklist

<input type="checkbox"/>	1. Address the immediate medical needs of your injured employee.
<input type="checkbox"/>	2. If any injury occurs that may be covered by your policy, let Society Insurance know as soon as possible. Please remember to contact us even when your injured employee will not require immediate medical treatment. Late reporting may result in fines.
<input type="checkbox"/>	3. Provide your injured employee with a copy of the Pharmacy Program Letter of Intent document. This letter is a temporary card that will allow your injured employee to receive an initial supply of medication. A permanent plastic card will be issued to them once the claim is set up.
<input type="checkbox"/>	4. Let us know if your injured employee's treatment will require any of the following: <ul style="list-style-type: none"> • An MRI, CT scan, or other diagnostic testing • Use of durable medical equipment (such as crutches or a knee brace) • Physical or occupational therapy • Chiropractic care
<input type="checkbox"/>	5. Have your injured employee's supervisor complete the Supervisor Incident Report . Be sure to secure the name, address, and phone numbers of any witnesses to the incident.
<input type="checkbox"/>	6. Set aside any materials or machinery that may have contributed to or caused the injury. Secure the name, address, and phone numbers of anyone you feel may be responsible for the injury. We may be able to seek recovery from a responsible party.
<input type="checkbox"/>	7. Provide your injured employee with a copy of the Attending Physician's Return to Work Recommendations Record . Please provide us with a completed copy of this form or any information you receive regarding return to work, or anticipated return-to-work dates. Please let us know if there will be no lost time involved with the claim.
<input type="checkbox"/>	8. Please let us know if you have any type of light-duty work available that you will be able to offer your injured worker when they are capable of returning to work.
<input type="checkbox"/>	9. Phone in your claim to a claim representative at 888-576-2438 . If you know your policy number, please have it available when you call in. Please provide wage information on claims with lost time from work or those that have the potential for lost time. Do not delay your filing if the information is not readily available.
<input type="checkbox"/>	10. You may submit a First Report of Injury , along with any medical documentation that has been received, directly to Society Insurance at the address below. If you chose this method for submitting your claim, please keep a copy for your records. <p style="margin-left: 20px;"> Society Insurance 150 Camelot Drive P.O. Box 1029 Fond du Lac, WI 54936-1029 Phone: 888-576-2438 Fax: 920-922-1071 </p> <p>Note: Always keep a supply of First Report of Injury forms on hand. You can obtain additional forms from our office. Please see the Claims Kit computer screen pull-outs for additional information regarding items contained on this checklist.</p>

Injured Worker's Claim Reporting Checklist

<input type="checkbox"/>	1. If necessary, seek immediate medical attention for your injuries. Notify your employer if you feel your injuries were caused by your job duties, even if you do not plan on seeking immediate medical treatment.	<input type="checkbox"/>	7. Request that your employer submit the First Report of Injury to us as soon as possible. We prefer to receive the information by phone or fax.
<input type="checkbox"/>	2. Request a copy of the Pharmacy Program Letter of Intent from your employer. This letter will allow you to receive an initial supply of any medication that is needed for your injuries. A permanent plastic card will be issued to you once your claim is set up.	<input type="checkbox"/>	8. Your claim representative may contact you to obtain additional information that may be needed to complete the investigation of your claim. You may contact your claim representative at any time with questions regarding your claim: Society Insurance 150 Camelot Drive P.O. Box 1029 Fond du Lac, WI 54936-1029 Phone: 888-576-2438 Fax: 920-922-1071
<input type="checkbox"/>	3. Let your claim representative know if your treatment has included or will likely include any of the following: <ul style="list-style-type: none">• An MRI, CT scan, or other diagnostic testing• Use of durable medical equipment (such as crutches or a knee brace)• Physical or occupational therapy• Chiropractic care	<input type="checkbox"/>	9. Promptly complete and return any forms that you receive from your claim representative. These forms can be returned to us in the postage-paid envelope that you will receive with the forms.
<input type="checkbox"/>	4. Help your employer secure the names of any witnesses to your incident. Help your employer identify any materials or machinery that you feel may have contributed to or caused your injury.	<input type="checkbox"/>	10. Please contact your claim representative immediately following every appointment. This will help us expedite payment of any lost-time benefits that may be owed, as well as provide prompt payment of any medical bills related to your claim.
<input type="checkbox"/>	5. Request a copy of the Attending Physician's Return to Work Recommendations Record from your employer. It is your responsibility to ensure that this document is completed by your physician and given to your employer immediately following every appointment.		
<input type="checkbox"/>	6. Provide your employer with the names and addresses of any medical providers that have provided treatment for your injuries.		



Pharmacy Program Letter of Intent

Injured employee:		Employee Social Security number:	- -
Employee phone:		Employee date of birth:	/ /

Date of injury:	/ /
Description of injury:	

Employer:		Employer representative:	
Employer representative phone:			

Employer: Society Insurance has selected Preferred Medical Network to administer its prescription drug program for your injured employee's workers compensation claim. Please complete the top portion of this letter of intent and present it to your injured employee when you receive first notice of the injury. **Please fax a copy of this letter to Preferred Medical Network at 502-489-5045.**

Employee: Please present this letter of intent to a participating pharmacy. By selecting a participating pharmacy, you provide yourself with an option to bill your out-of-pocket workers compensation pharmacy expenses directly to Society Insurance. More than 64,000 pharmacies, both large and small, participate in this program. Please call Preferred Medical Network on their toll-free line at **888-586-4650** for a list of local participating pharmacies.

This letter of intent is to be used for your initial fill of medication only. In approximately ten business days, you will receive a permanent card from Preferred Medical Network. This letter will provide your pharmacist electronic access to information regarding your eligibility for workers compensation benefits.

Your workers compensation claim provides you the right to select any pharmacy to fill your prescription needs; however, you may be required to make payment for your medications at the time they are dispensed. If this occurs, forward a copy of the itemized receipt to your Claim Representative for payment consideration.

Use of this letter of intent or the card is limited to medications associated with your workers compensation injury. Society Insurance reserves the right to restrict or suspend the use of your benefits associated with this program at any time.

Pharmacist: Preferred Medical Network administers this workers compensation prescription drug program through the National Pharmaceutical Services (NPS) network. For immediate online billing information, contact Preferred Medical Network at **888-586-4650**.

Pharmacy processing steps:

1. Call Preferred Medical Network at **888-586-4650** to obtain the unique member ID.
2. Enter bin number **004758**.
3. Enter processor control **NPS**.
4. Enter group number **PMN1152**.
5. Enter the member ID.



Attending Physician's Return to Work Recommendations Record

Physician: Please fill out this form and fax it to 920-922-1071, attention:	
Employee: Completed form must be returned to your employer following each examination.	
Employer: When received, route this form to Society Insurance immediately.	

Employee name:		Claim number:	
Employer name:		Employer address:	
Date of injury/illness:	/ /	Examination/treatment date:	/ /
Brief diagnosis of injury (indicate clinical manifestation of condition to what body part or surface):			

Patient has been advised of the following regarding return to work:

<input type="checkbox"/>	Return to work immediately, with no restrictions.
<input type="checkbox"/>	No return to work until: / /
<input type="checkbox"/>	Return to work with the following temporary restrictions beginning: / / and ending: / /
<input type="checkbox"/>	Sedentary Work. Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as docket, ledgers, and small tools. Although a sedentary job is defined as one that involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.
<input type="checkbox"/>	Light Work. Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.
<input type="checkbox"/>	Light Medium Work. Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.
<input type="checkbox"/>	Medium Work. Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.
<input type="checkbox"/>	Light Heavy Work. Lifting 75 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.
<input type="checkbox"/>	Heavy Work. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.

Number of consecutive hours patient can perform specified activity during an 8-hour work period	6-8	4-5	1-3	0
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Weight-handling frequencies per hour	15 or more	10-14	1-9	0
Lifting/carrying less than 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting/carrying 10-20 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting/carrying 20-50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting/carrying 50-100 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient discharged?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Next scheduled examination/treatment date:	/ /	

Attending physician's signature:	
Print name:	
Address:	



Important: The manager or supervisor should complete this form after the incident.

Supervisor Incident Report

Injured worker's name:		Sex:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Social Security number:	- -	Date of birth:	/ /	
Address:		Phone:		
Date of hire:	/ /	Job title and department:		

Date of injury:	/ /	Time of injury:		
Was medical attention sought?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
(If applicable) Name of facility or physician that provided treatment:				
Was (or will) a drug screen completed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

Last day worked:	/ /	Return-to-work date:	/ /
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Scheduled work week at time of injury							
Hours:		Days per week:		Start time:		End time:	

Injured worker's normal/usual schedule							
Hours:		Days per week:		Start time:		End time:	

Witnesses to the incident:	
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Injured worker's statement regarding the injury (list all circumstances and equipment involved):	
Part(s) of body affected:	
Type of injury or injuries:	

The answers I have provided to the above questions are true to the best of my knowledge.			
Injured worker's signature:		Date:	/ /
Supervisor's signature:		Date:	/ /

Injured worker's name:		Claim number:	
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Your information			
Name:		Address:	
Home phone:		Cell phone:	
Employer:		Job title:	

Incident information			
Date of incident:	/ /	Time of incident:	
What is your relationship to the injured worker?			
Did you see the incident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

What work was being performed when the incident occurred?

Please explain what you saw.

Where were you in relation to the injured employee when the incident occurred? Did you have a clear view of the incident?

Witness signature:		Date:	/ /
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How did the injured employee act after the incident? Did they say anything to you?

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Did the injured employee show you where they were hurt?

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Did you see anyone else who may have seen what happened? If yes, please include names and phone numbers.

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Was anything said to you by anyone other than the injured employee? If yes, who said something? When did they say it? What did they say?

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Did you discuss anything regarding the injury with anyone? If yes, who did you discuss it with? When did you discuss it? What did you discuss?

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Did the injured employee ever mention any prior problems with the injured area to you? If yes, when did they mention it?

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Witness signature:

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Date:

/ /

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Employee name:		Claim number:	
Employer:		Job title:	
Supervisor interviewed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, list supervisor name:

Was the employee hired with any restrictions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, explain the restrictions:		

Typical work hours per week:		Overtime?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breaks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, list frequency:	

Body movements at work

	Rarely	Occasionally (1/3 or less)	Frequently (1/3 to 2/3)	Continuously (2/3 or more)
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vertical reaching at or above shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending/stooping/squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling/kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Close-distance hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Near/far vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Describe the driving involved:				

Body movements at work (continued)

Weights handled (lbs.)	Item	Alone or assisted?	Push/pull/lift?	Times per day	Distance moved
1-10					
11-20					
21-50					
More than 50					

Hand coordination

Movement required	Tool/machine	Left	Right	Both
Fine manipulation		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hand twisting		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Power gripping		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Simple grasping		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Physical surroundings

Work:	<input type="checkbox"/> Inside	Percentage performed inside:	
	<input type="checkbox"/> Outside	Percentage performed outside:	

Work around moving machinery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, describe:		

Check each of the following that the employee comes in contact with:

Strong odor	<input type="checkbox"/>	Fumes	<input type="checkbox"/>	Describe fumes:	
Mist	<input type="checkbox"/>	Steam	<input type="checkbox"/>	Air conditioning	<input type="checkbox"/> Dust <input type="checkbox"/>

Additional comments or observations:	
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Signature:		Date completed:	/ /
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Transitional Return to Work Log

Injured worker's name:		Supervisor:	
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Date	Hours worked		Tasks performed	Comments regarding injured worker's tolerance of modified-duty tasks	Initials	
	In	Out			Injured worker:	Supervisor:
(Sunday) / /					Injured worker:	Supervisor:
(Monday) / /					Injured worker:	Supervisor:
(Tuesday) / /					Injured worker:	Supervisor:
(Wednesday) / /					Injured worker:	Supervisor:
(Thursday) / /					Injured worker:	Supervisor:
(Friday) / /					Injured worker:	Supervisor:
(Saturday) / /					Injured worker:	Supervisor:

I clearly understand, take responsibility for, and acknowledge the limitations my physician has placed on me while participating in this temporary transitional work program.		Physician's name:	
Injured worker's signature:		Date:	/ /



Top PPO Network Providers by State

Another way we are reducing claim costs is through the use of a PPO network for our bill review process. This document lists some of the medical providers who have agreed to discount their billings for the treatment of your injured worker. For a complete listing of PPO providers in your area, please contact us at 888-576-2438.

Wisconsin:

All Saints Medical Centers
Aurora Medical Group
Bay Care Clinics
Clintonville Clinic
Columbia St. Mary's Hospital
Dean Health Centers
Elmbrook Memorial Hospital
Froedtert Memorial Lutheran Hospital
Hales Corners Clinic
Lakeland Medical Clinic
Manitowoc Clinic
Marinette Menominee Clinic
Memorial Hospital of Burlington
Mercy Health System
St. Mary's Hospital – Ozaukee
West Allis Memorial Hospital
Wheaton Franciscan Health Care

Iowa:

21st Century Rehab
Accelerated Health Systems
American Prosthetics
Chladek Orthotic & Prosthetic Associates
Concentra Medical Centers
Des Moines Orthopaedic Surgeons (DMOS)
Eastern Iowa Orthotics & Prosthetics
EMPI
Employment Cost Solutions
Genesis Health System
Mercy Medical Center
M.R. Associates
Nydic
Radiology Consultants of Iowa
Shell Rock Family Health
Surgical Associates of Neenah
University of Iowa

Illinois:

Advanced Occupational Medicine Specialists
Advocate Medical Group
Alexian Brothers Corporate Health Services
Aurora Medical Centers
Concentra Medical Centers
Holy Cross Hospital
Lake Forest Hospital
Michael Reese Hospital
Mount Sinai Hospital
Northwest Community Hospital
Norwegian American Hospital
Occupational Health Centers
OSF St. Anthony Medical Center
Provena Medical Center
Rockford Memorial Hospital
Rush Medical Centers
Sacred Heart Hospital
St. Anthony's Health Center
St. Clare's Hospital
University of Chicago Hospitals
University of Illinois Medical Center – Chicago

Indiana:

Ball Memorial Hospital
Bloomington Hospital
Clarian Medical Centers
Community Hospitals
Jackson County Memorial Hospital
Lake Ridge Clinic
Methodist Hospitals
Orthopaedics Indianapolis
Parkview Hospitals
Porter Memorial Hospital
Riverview Hospital
St. Catherine Hospital
St. Joseph Regional Medical Center
St. Mary Medical Center
Wishard Memorial Hospital
Woodman Clinic

Employer:				Address:			
Phone number:			Fax number:			E-mail address:	
Location code of employer:				Doing business as (if different):			
Type of business:					FEIN:		
Unemployment insurance number:					SIC code:		

Workers' Compensation carrier:				FEIN:				
Address:				Policy number:			Unit number:	

Employee name (first, middle, last):					Date of birth:	/ /		
Address:				Phone:			Cell phone:	
Social Security number:	- -		Occupation/job title:					
Marital status:	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	Sex:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Date hired:	/ /		State of hire:			Number of dependents:		
Employment status (full time, part time, seasonal, piece work, other):								

Employee wages	Pay rate:			Per (hour, day, week, month, etc.):			
Employee's usual start time:				Employee's usual hours per day:			
Employee's usual hours per week:				Employee's usual days per week:			
In the 52-week period prior to the incident, how many weeks did the employee do the same kind of work?							
In the 52-week period prior to the incident, what was the gross amount of total wages, salary, overtime, tips, commission, and bonus premium earned for the same kind of work?							
If piece work was involved, how many hours (excluding overtime) did the employee perform the same kind of work in the 52-week period prior to the incident?							
Number of full-time employees doing the same type of work:							
Are any part-time workers doing same work/same schedule?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how many?	

Incident description	Did the incident occur on the employer's premises?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Time employee began work (include a.m. or p.m.):			Date of injury/illness:	/ /
Time of incident (include a.m. or p.m.):			Was salary continued?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Last work date:	/ /		Date employer notified:	/ /
Injury reported to:			Phone number:	
Date returned to work:	/ /		Estimated date of return to work:	/ /
Type of injury/illness:			Part of body affected:	

Incident description (continued)	
Department or location where the incident occurred (include county and state):	
List all equipment, materials, or chemicals the employee was using when the incident occurred:	
Specific activity the employee was engaged in when the incident occurred:	

Explain how the injury/illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill:

If fatal, indicate date of death:	/ /				
Were safeguards or safety equipment provided?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Used?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did the incident involve alcohol or substance abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Do you have mandatory drug testing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Was drug testing performed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Medical treatment	
Physician or healthcare provider name:	
Physician or healthcare provider address:	
Hospital or off-site treatment name:	
Hospital or off-site treatment address:	

Initial treatment:	<input type="checkbox"/> No medical treatment	<input type="checkbox"/> Minor by employer	<input type="checkbox"/> Minor by clinic/hospital
	<input type="checkbox"/> Emergency care	<input type="checkbox"/> Hospitalized > 24 hours	<input type="checkbox"/> Future major medical/lost time anticipated

Witness information			
Witness name:		Phone:	
Witness name:		Phone:	

Date administrator notified:	/ /	Date prepared:	/ /
Preparer name/title:		Preparer phone:	

Employer's instructions

We don't recommend completing the First Report of Injury for lost-time claims, claims with the potential for lost time, claims with complex medical issues, claims with debatable facts, or claims with potential third-party involvement.

If your claim involves any of the above issues, please telephone your claim information to us directly at 888-576-2438.

GENERAL INSTRUCTIONS FOR COMPLETING THE FIRST REPORT OF INJURY

Completion of fields:

Complete as much of the requested information as possible. Do not leave fields blank. If the requested information does not apply to the incident, please indicate N/A.

Shaded fields:

Do not enter information in shaded fields.

Dates:

Enter all dates in the "MM/DD/YY" format (for example, 10/15/07).

EMPLOYER SECTION

Location code of employer:

If the employer has multiple locations, enter the code for the location where the incident occurred.

Type of business:

The type of business that you, the employer, are engaged in.

FEIN:

Your Federal Employee Identification Number. If necessary, please reference your tax records for this information.

Unemployment insurance number (required for all Iowa claims):

Please refer to the packet of information that you received from your state agency that addresses unemployment benefits for your employees.

SIC code (required for all Illinois claims):

Your Standard Industrial Class Code. This is the code that represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

EMPLOYEE NAME (FIRST, MIDDLE, LAST) SECTION

Occupation/job title:

This is the primary occupation of the claimant at the time of the incident.

Employer's instructions (continued)

EMPLOYEE WAGES SECTION

52 week wage information:

Indicate the both the number of weeks worked and the amount of gross wages (including overtime, tips, etc.) earned in the 52 weeks just prior to the incident. It is helpful to us if the wage information is broken out on a week-by-week basis on a separate sheet of paper and forwarded to us with the First Report of Injury.

INCIDENT DESCRIPTION SECTION

Injury reported to/phone number:

Enter the name of the individual at the employer's premises to be contacted for additional information if the incident was reported to someone other than the preparer of the First Report of Injury.

Date returned to work:

Enter the date following the most recent disability period that the employee returned to work.

Estimated date of return to work:

Enter the estimated date that the employee will return to work based the information received from the employee or the medical providers.

Type of injury/illness:

Briefly describe the nature of the injury or illness (for example, lacerations to the forearm).

Part of body affected:

Indicate the part of body affected by the injury/illness (for example, right forearm or lower back).

Department or location where the incident occurred:

If the incident did not occur on the employer's premises, enter address or location. Please include the county and state where the incident occurred. For example: Maintenance Department on employer's premises or client's office at 150 Camelot Dr., Fond du Lac, WI 54935 (Fond du Lac County).

List all equipment, materials, or chemicals the employee was using when the incident occurred:

List all of the equipment, materials, or chemicals the employee was using, applying, handling, or operating when the incident occurred. Be specific. For example: scaffolding, electric sander, floor cleaner, box cutters, paintbrush, paint, etc. Enter "N/A" for not applicable if no equipment or materials were being used. **Note:** The items listed do not have to be directly involved in the employee's injury or illness.

Specific activity the employee was engaged in when the incident occurred:

Describe the specific activity the employee was engaged in when the incident occurred, such as sanding ceiling woodwork in preparation for painting or cutting carpeting to be installed.

Explain how the injury/illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill:

Describe how the injury, illness, or abnormal health condition occurred. Include the sequence of events and name any objects or substances that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance, and fell six feet to the floor. The worker's right wrist was broken in the fall.



Workers Compensation Phone and E-mail List

Company address:	P.O. Box 1029 Fond du Lac, WI 54936-1029	Company phone:	888-576-2438
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Name (title)	E-mail address	Phone extension
John Barouski (Vice President)	jbarouski@societyinsurance.com	334
Mike Zajicek (Claims Manager)	mzajicek@societyinsurance.com	452
James Putzer (Supervisor, Unit 1)	jputzer@societyinsurance.com	330
Tonya Buss (Claims Representative)	tbuss@societyinsurance.com	376
Deb Postuma (Claims Representative)	dpostuma@societyinsurance.com	371
Gwen Schwantes (Claims Representative)	gschwantes@societyinsurance.com	405
Suzanne Trepanier (Medical Only Specialist)	strepanier@societyinsurance.com	288
Tracy Schneider (Supervisor, Unit 2)	tschneider@societyinsurance.com	308
Kirsten Pankau (Senior Claims Representative)	kpankau@societyinsurance.com	383
Laurie Grimes (Claims Representative)	lgrimes@societyinsurance.com	361
Pam Gross (Claims Representative)	pgross@societyinsurance.com	357
Cari Julka (Medical Only Specialist)	cjulka@societyinsurance.com	438
Shawn Kelderman (Supervisor, Unit 3)	skelderman@societyinsurance.com	317
Kathy Mentink (Senior Claims Representative)	kmentink@societyinsurance.com	367
Angie Bonlander (Claims Representative)	abonlander@societyinsurance.com	370
Melissa Jakubowski (Claims Representative)	mjakubowski@societyinsurance.com	397
Shelly Wilcox (Medical Only Specialist)	swilcox@societyinsurance.com	329
Doug Miller (Supervisor, Unit 4)	dmiller@societyinsurance.com	353
Yvette Braun (Senior Claims Representative)	ybraun@societyinsurance.com	351
Laurie Buhrow (Claims Representative)	lbuhrow@societyinsurance.com	368
Sue Hoepfner (Claims Representative)	shoepfner@societyinsurance.com	318
Kelly Roberts (Claims Representative)	kroberts@societyinsurance.com	363
Jeanelle Hsieh (Medical Only Specialist)	jhsieh@societyinsurance.com	322
Mike Zajicek (Supervisor, Unit 5)	mzajicek@societyinsurance.com	452
Randy Hermann (Senior Claims Representative)	rhermann@societyinsurance.com	366
Rebecca Beck (Claims Representative)	rbeck@societyinsurance.com	323
Lynne Gibbons (Claims Representative)	lgibbons@societyinsurance.com	380
Nicole Kluck (Claims Representative)	nkluck@societyinsurance.com	352