150 Camelot Drive
P.O. Box 1029
Fond du Lac, WI 54936-1029
888-576-2438
societyinsurance.com

Policy Number: [1]   Policy Period: [2]

Workers Compensation Insurance Claims Kit

Our Workers Compensation Claim Kit and Workers Compensation Claims webpage will help you navigate the claims process. There are also mandatory postings required by the various state agencies. To access this information, visit societyinsurance.com, or scan this QR code with your mobile device.

If an injury occurs at work:

- Address the immediate needs of the injured worker. If the injury requires immediate attention, call 911.
- For all non-emergent work injuries, the supervisor and injured worker should call the Society Nurse Triage hotline 24 hours a day, 7 days a week at (877) 501-3050 to speak to a nurse regarding the injuries and need for treatment, or to report a claim.

As always, your agent is an excellent resource should you have questions regarding the information in this package.

Please feel free to contact us at (888) 576-2438 if you have any additional questions regarding the claim process.

Sincerely,

Heather L. Bryan

President and CEO
Society Insurance

150 Camelot Drive
P.O. Box 1029
Fond du Lac, WI 54936-1029
888-576-2438
societyinsurance.com

Employer's Claim Reporting Checklist

Important: This form is for the employer's use.

☐ 1. Address the immediate medical needs of your injured employee.

☐ 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.

☐ 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.

☐ 4. Let us know if your injured employee's treatment will require any of the following:
- 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

☐ 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.

☐ 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.

☐ 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.

☐ 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.

☐ 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.

☐ 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.

Society Insurance
150 Camelot Drive
P.O. Box 1029
Fond du Lac, WI 54936-1029
Phone: 888-576-2438
Fax: 920-922-1071

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.

150 Camelot Drive
P.O. Box 1029
Fond du Lac, WI 54936-1029
888-576-2438
societyinsurance.com

Injured Worker's Claim Reporting Checklist

Important: This form is for the injured worker's use.

- ☐ 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.
- ☐ 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.
- ☐ 3. Let your claim representative know if your treatment has included or will likely include any of the following:
  - 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
- ☐ 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.
- ☐ 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.
- ☐ 6. Provide your employer with the names and addresses of any medical providers that have provided treatment for your injuries.
- ☐ 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.
- ☐ 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
- ☐ 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.
- ☐ 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.

Iowa **Division of** Workers' Compensation – FIRST REPORT OF INJURY OR ILLNESS (**FROI**) Jurisdiction Code______________ Jurisdiction Claim Number______________

CLAIM ADMIN

Claim Administrator Name:

Claim Representative Business Phone Number:

Insurer Name (if different than claim administrator):

Mailing Address, City, State, & Postal Code:

Claim Administrator Claim Number:

Insurer FEIN:

Claim Administrator FEIN:

Claim Type Code:

EMPLOYER

Employer Name:

Employer FEIN:

Insured Report Number:

Employer Type Code:
__ Employer (E)
__ Lessor (L)

Physical Address, City, State, & Postal Code:

Mailing Address, City, State, & Postal Code:

Industry Code:

Insured Location Number:

Employer UI Number:

Nature of Business:

Employer Contact Name and Business Phone Number:

POLICY

Insured Name (parent company if different than employer):

Insured FEIN:

Insured Postal Code:

Policy/Contract Number:

Coverage Effective Date:

Coverage Expiration Date:

Self Insurance License/ Certificate Number:

EMPLOYEE

Employee Name (First, Middle, Last, & Suffix):

Date of Birth:

Gender: __ Male (M) __ Female (F) __ Transgender (T) __ Non-Binary (X) __ Unknown(U)

Tax Filing Status (check one):
____ Single (A)
____ Single/Head of Household (B)
____ Married/Filing Joint (C)
____ Married/Filing Separate(D)

Mailing Address, City, State, & Postal Code:

Date of Hire:

State of Hire:

Educational Level (grade completed): _______ [GED = 12]

Marital Status: (check one)
___ Unmarried/Single/Divorced (U)
___ Married (M)
___ Separated (S)

Email:

Phone Number (include area code):

Occupation Description:

NCCI Classification Code:

Department Where Regularly Worked:

Employment Status (check one):
____ Piece Worker
____ Volunteer
____ Seasonal
____ Apprenticeship/Full-Time
____ Apprenticeship/Part-Time
____ Regular Employee/Full-Time
____ Part-Time
____ Other

Employee ID Number (check one):
ID # ____________________
____ Social Security Number
____ Employment VISA Number
____ Passport Number
____ Green Card
____ Employee ID Assigned by Jurisdiction

Employee's Authorization to Release the Following:
Medical Records __ yes __ no
Social Security Number __ yes __ no

WAGE

Average Wage $ ___________ (check one):
___ hourly ___ daily ___ semi-monthly ___ monthly
___ bi-weekly ___ annual ___ weekly

Number of Days Regularly Worked Per Week: _______

Salary Continued In Lieu of Compensation: ___ yes ___ no

Full Wages Paid for Date of Injury: ___ yes ___ no

Discontinued Fringe Benefits: $____________

Employee Number of Dependents: _________

Employee Number of Exemptions: __________ (check one)
___ Entitled
___ Withholding

ACCIDENT/INJURY

____________________ Date of Injury
____________________ Date Employer Had Knowledge of the Injury
____________________ Date Claim Administrator Had Knowledge of the Injury
____________________ Initial Date Last Day Worked
____________________ Initial Return to Work Date (if applicable)
____________________ Employee Date of Death (if applicable)

____________________ Time of Injury
____________________ Time Employee Began Work

Pre-Existing Disability Code:
___ Yes
___ No
___ Unknown

Accident Premises Code:
___ Employer (E) ___ Other (X)
___ Lessee (L) ___ Employee Residence (R)

Accident Site Organization Name:

Accident Site Street, City, State, & Postal Code:

Accident Location Narrative (if no street address):

Accident Site County/Parish:

Type of Injury / Illness Code:

Describe the nature of the injury. (ex. amputation, burn, cut, fracture):

Part of Body Affected Code:

Part(s) of body directly affected by the injury or illness. (ex. hand, arm, circulatory system):

Describe the events that caused the injury. (ex. fell, operating machinery, chemical exposure):

Name the object or substance that directly injured the employee. (ex. knife, floor, acid, oil):

Specify activity the employee was engaged in when the event occurred. (ex. cutting metal plate for flooring) Indicate if activity was part of normal duties:

Witness Name & Business Phone Number:

MEDICAL

Initial Treatment Code (check one):
___ no medical treatment (0)
___ minor/on-site treatment (1)
___ clinic/hospital visit (2)
___ emergency care (3)
___ hospitalization > 24 hours (4)
___ future medical treatment/lost time anticipated (5)

Initial Medical Provider Name:

Initial Medical Provider Physical Address, City, State, & Postal Code:

Managed Care Organization Name or ID Number:

ICD Primary Diagnostic Code (if known):

Preparer's Name & Title:

Preparer's Company Name:

Phone Number:

Date:

IOWA DIVISION OF WORKERS' COMPENSATION

www.IowaWorkComp.gov

FIRST REPORT OF INJURY OR ILLNESS REQUIREMENT

An employer or the employer's representative must file with the Iowa Division of Workers' Compensation (DWC) a First Report of Injury or Illness (FROI) in case of occupational:

- Fatality,
- Permanent disability, or
- Temporary disability lasting more than three days.

An employer or the employer's representative must file a FROI within four days of the event.

An employer or the employer's representative must file a FROI if the employee claims the disability is caused by work even if the employer or employer's representative disagrees.

For more information on these and other requirements, go to: www.iowaworkcomp.gov

RECORDS AND REPORTS

Every employer must keep a record of all injuries sustained by employees in the course of their employment resulting in incapacity for longer than one day.

All books, records, and payrolls of an employer must be open for inspection by the Iowa Workers' Compensation Commissioner for purposes of administering the Iowa Workers' Compensation Act.

An employer must furnish to an employee upon request one statement of earnings, wages, or salary for the year preceding the injury. An employer may be subject to a civil penalty of $1,000.00 per offense for failure to furnish such wage statement.

CIVIL PENALTY

The Commissioner may require an employer to appear and show why the employer should not be subject to a civil penalty of $1,000.00 per occurrence for failure to comply with the reporting or inspection requirements. Upon hearing, if the facts indicate, the Commissioner may enter an order requiring payment of such penalty. Unless voluntarily paid, the Commissioner may petition the district court for entry of judgment on the order. The employer's insurance carrier shall be responsible in the same manner and to the same extent as the employer when a report of injury has been submitted to the employer's insurance carrier and not filed by it with the agency.

ADDITIONAL IOWA OSHA REPORTING REQUIREMENTS

Additional reporting and recordkeeping requirements may apply to the incident described in the FROI.

An employer must:

- Report a workplace fatality to Iowa OSHA within eight hours by calling 877-242-6742 or visiting www.iowaosha.gov for a form and instructions.
- Report a hospitalization, loss of an eye, or amputation within twenty-four hours by calling 877-242-6742 or visiting www.iowaosha.gov for a form and instructions.
- Complete an OSHA Form 301, or equivalent for recordable, work-related incidents within seven days and retain the completed form on site. The FROI is equivalent to the OSHA Form 301 if the case number from the OSHA 300 log is added. For more information, go to: www.osha.gov/recordkeeping
- Make an entry in your Log of Work-Related Injuries and Illnesses, OSHA Form 300, for recordable cases within seven days and retain the completed form on site. Some industries are exempt from this requirement. For more information, go to: www.osha.gov/recordkeeping

For more information on these and other OSHA requirements, go to: www.iowaosha.gov

PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured person:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. In most cases, the pharmacy will fill the prescription at no cost to you.

If your workers' compensation claim is accepted, you will receive a permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions. If the claim is accepted, future prescriptions after this first fill may be subject to prior authorization.

Employer:

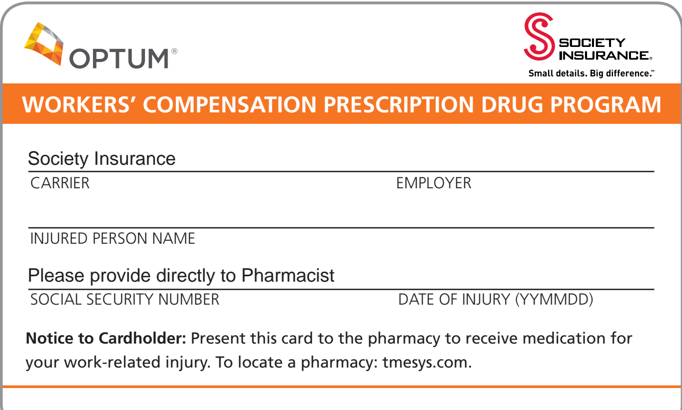
Immediately upon receiving notice of injury, fill in the information below and give this form to the employee.

Finding a network pharmacy

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

Questions? Need Help?

1-866-599-5426



OPTUM

SOCIETY INSURANCE
Small details. Big difference.

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Society Insurance
CARRIER EMPLOYER

INJURED PERSON NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

The following entities comprise the Optum Workers' Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers' Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers' Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers' Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers' Compensation Medical Services, collectively and individually referred as "Optum."

IMP14-2013-113

PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO QUE SE LE ABASTEZCA LAS RECETAS DE SU PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Persona lesionada:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. En la mayoría de los casos, la farmacia abastecerá la receta sin costo para usted.

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. Si el reclamo es aceptado, futuro recetas despues de este primer vez llenando puede estar sujeto a autorizacion previa.

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información que aparece a continuación y entregue este formulario al empleado.

Cómo encontrar una farmacia de la red

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

¿Tiene alguna pregunta? ¿Necesita ayuda?

1-866-599-5426

OPTUM®
SOCIETY INSURANCE. Small details. Big difference.℠

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Society Insurance
PORTADORA — EMPLEADOR

NOMBRE DEL PERSONA LESIONADA

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL — FECHA DE LA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

The following entities comprise the Optum Workers' Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers' Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers' Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers' Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers' Compensation Medical Services, collectively and individually referred as "Optum."

IMP14-2013-113

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societyinsurance.com

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.

Inj ry information

Employee name	Claim number	Date of birth	Date of injury/illness
Employer name	Employer address		Examination/treatment date
Brief diagnosis of injury (indicate clinical manifestation of condition to what body part or surface)			
Please check one: ☐ Work Related ☐ Not Work Related ☐ Undeterminable			

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

☐ Return to work immediately, with no restrictions.

☐ No return to work until: ____________

☐ Return to work with the following temporary restrictions beginning: ____________ and ending: ____________

☐ **Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, 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.

☐ **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.

☐ **Light Medium Work.** Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.

☐ **Medium Work.** Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.

☐ **Light Heavy Work.** Lifting 75 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.

☐ **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	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Pushing	☐	☐	☐	☐
Pulling	☐	☐	☐	☐
Climbing	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Reaching	☐	☐	☐	☐
Grasping	☐	☐	☐	☐

Weight-handling frequencies per hour

	15 or more	10-14	1-9	0
Lifting/carrying less than 10 pounds	☐	☐	☐	☐
Lifting/carrying 10-20 pounds	☐	☐	☐	☐
Lifting/carrying 20-50 pounds	☐	☐	☐	☐
Lifting/carrying 50-100 pounds	☐	☐	☐	☐

Attending physician

Patient discharged? ☐ Yes ☐ No	Next scheduled examination/treatment date		
Comments and Notes			
Attending physician's signature	Date	Phone	Fax
Print Name	Address		

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888-576-2438
societyinsurance.com

Supervisor Incident Report

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

Claim Number			
Injured worker's name	Sex ☐ Male ☐ 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? ☐ Yes ☐ No	(If applicable) Name of facility or physician that provided treatment			Was (or will) a drug screen completed? ☐ Yes ☐ No
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
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

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Fond du Lac, WI 54936-1029
888-576-2438
societyinsurance.com

Witness Statement Form

Injured worker's name:		Claim number:	

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?	☐ Yes	☐ 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:	/ /

How did the injured employee act after the incident? Did they say anything to you?

Did the injured employee show you where they were hurt?

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

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?

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?

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

Witness signature:		Date:	/ /

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Job Analysis

Employment Information

Employee name	Claim number	Employer name

Job title	Supervisor interviewed? ☐ Yes ☐ No	If yes, list supervisor name

Was the employee hired with any restrictions? ☐ Yes ☐ No	If yes, explain the restrictions

Typical work hours per week	Overtime? ☐ Yes ☐ No	Break? ☐ Yes ☐ 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	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Vertical reaching at or above shoulder height	☐	☐	☐	☐
Bending/stooping/squatting	☐	☐	☐	☐
Crawling/kneeling	☐	☐	☐	☐
Close-distance hearing	☐	☐	☐	☐
Near/far vision	☐	☐	☐	☐
Driving	☐	☐	☐	☐

Describe the driving involved

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

Is the injured worker right or left handed? ☐ Right ☐ Left

Movement required	Tool/machine	Left	Right	Both
Fine manipulation		☐	☐	☐
Hand twisting		☐	☐	☐
Power gripping		☐	☐	☐
Simple grasping		☐	☐	☐

Physical surroundings

☐ Work inside	Percentage performed inside:	☐ Work outside	Percentage performed outside:

Work around moving machinery? ☐ Yes ☐ No

If yes, describe

Check each of the following that the employee comes in contact with: ☐ Strong odor ☐ Fumes Describe fumes ________________ ☐ Mist ☐ Steam ☐ Air conditioning ☐ Dust

Additional comments or observations

Signature	Date completed

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888-576-2438
societyinsurance.com

Transitional Return to Work Log

Transitional return to work log

Claim Number	Injured worker's name	Supervisor

Date	Hours Worked		Tasks performed	Comments regarding injured worker's tolerance of modified-duty tasks	Initials
	In	Out			
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

150 Camelot Drive
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Fond du Lac, WI 54936-1029
888-576-2438
societyinsurance.com

Risk Control Services

Our customers call Risk Control when they have something pressing on their minds, whether it relates to employee safety or evaluating trends in their insurance claims. They look for honest, objective, experienced, and thoughtful advice to address their concerns. As a policyholder, you are entitled to use Risk Control Services to help you control your workers compensation exposures.

We help our customers identify and evaluate hazards that might cause insurance losses or otherwise disrupt their business. We use our broad experience in risk control to recommend business solutions to our customers and assist them in avoiding or mitigating these potential losses.

These are our fundamental principles:

Use a collaborative and consultative approach
By working with our customers, we develop a fact-based view of the hazards affecting their business and provide consultative advice to successfully eliminate the hazards.

Use our broad expertise to provide superior value
We rely upon the technical diversity of our people - not a single consultant - to provide our customers with superior service.

Build sustainable improvements for our customers
We provide educational materials and value-added services that build knowledge and support for the customer to sustain their risk control program over the long term.

Build a trusting relationship
We want to earn the trust of our customers and agency partners. We do this by consistently providing professional service with absolute integrity.

Below is a brief overview of the many value-added services available through Risk Control.

- OSHA 10-hour and 30-hour training
- Forklift training
- Safety video library
- Hazard identification
- Safety program development
- Ergonomic assistance
- Review of machine guarding procedures
- Onsite visits
- Customized training
- Safety handouts
- Safety recommendations
- Claims analysis

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. Many of our resources are immediately available for your review in the Risk Control section of societyinsurance.com.