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,

President and CEO
Society Insurance

MEMO

To: Insureds/Employers in Illinois

From: Society Insurance

Re: Illinois Workers' Compensation Act

Effective 11/27/2018, the Illinois Workers' Compensation Act has changed in the following ways:

- The timeframe to pay medical bills is shorter.
- Medical providers are now allowed to file a legal action to collect the bill cost and interest directly against insured/employer in Circuit Court.

Be aware of medical bills or other legal documents sent directly to your business from a doctor, hospital or other medical provider. There is a limited amount of time – **30 days from the receipt of a bill or legal documents** – to pay, defend or respond. This time will pass quickly. Prompt action is very important and required.

You must notify Society Insurance without delay of any and all medical bills or legal documents that may be related to a possible work-related injury. If the 30-day period expires without a response, there may be costs, fees and interest due from the insured/employer, not Society Insurance.

Best Practices

1. If you receive a medical bill or any type of legal document concerning one of your employees, contact Society Insurance on the same day you receive it.
2. Report work injuries, even disputed injuries, to Society Insurance on the same day as the alleged occurrence or the first day notification is received of the claimed injury.
3. Do not ignore mail if you are unsure what it is. Contact Society Insurance the same day.

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Phone (888) 576-2438 • Fax (920) 922-1071

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.

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Phone (888) 576-2438 • Fax (920) 922-1071

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.

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
INDUSTRY CODE / EMPLOYER FEIN			PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD TO CHECK IF APPROPRIATE ☐ SELF INSURANCE	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
CARRIER FEIN / POLICY/SELF-INSURED NUMBER		ADMINISTRATOR FEIN

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH		DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX ☐ MALE ☐ FEMALE ☐ UNKNOWN	MARITAL STATUS ☐ UNMARRIED SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN	OCCUPATION/JOB TITLE EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE	

RATE PER:	☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	☐ AM ☐ PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED	☐ AM ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS	PART OF BODY AFFECTED
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY/ILLNESS CODE	PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR 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

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT
		☐ NO MEDICAL TREATMENT ☐ MINOR: BY EMPLOYER ☐ MINOR CLINIC/HOSP ☐ EMERGENCY CARE ☐ HOSPITALIZED > 24 HOURS ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals 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 ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR 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:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance 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.

DATE RETURN(ED) TO WORK:

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

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Tampa, FL 33684-2539

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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

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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.*

tmesys®

IMP14-2013-113

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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

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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.*

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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.

Injury 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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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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Witness Statement Form

Injured worker's information

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?

Incident information continued

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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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

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PPO Network Providers

To reduce costs, we use a Preferred Provider Organization (PPO) network for our bill-review process. This document will help you to identify some of the medical providers in your area that have agreed to discount their services for the treatment of your injured worker.

All states allow employers to seek emergency medical assistance for an injured worker on the day of the injury. The choice of medical services varies from state to state. In some states, the employer has the choice to select medical care; in other states, the employee has that choice. In either case, there are specific rules and limitations on the selection of medical services.

Our network look-up system will help you locate members of the PPO network quickly and accurately. Use of these providers may result in lower claim costs for you.

Visit this site to find a network medical provider in your area:

www.talispoint.com/optum/client/society/

**Inclusion on this site is not an endorsement of quality assurance or availability.*

If you require further assistance in identifying a medical provider, please call us at 888-576-2438.

SOCIETY INSURANCE
Small details. Big difference.™
P.O. Box 1029, Fond du Lac, WI 54936-1029
Phone (888) 576-2438 • Fax (920) 922-1071

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.