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

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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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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.

MN Department of Labor and Industry
Workers' Compensation Division
(651) 284-5032 or 1-800-342-5354

First Report of Injury

See Instructions on Reverse Side

Print in ink or type
Enter dates in MM/DD/YYYY format

FRO 1

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #	2. OSHA case #	3. Time employee began work on date of injury ☐ am ☐ pm	
4. DATE OF CLAIMED INJURY	5. Time of injury ☐ am ☐ pm	6. Date of death	# of dependents (if death is related to injury)
7. EMPLOYEE Name (last, suffix, first, middle)		8. Gender ☐ M ☐ F	9. Marital status ☐ Married ☐ Unmarried

10. Home address		11. Home phone #	12. Date of birth	13. Date hired
City	State Zip Code	14. Occupation	15. Regular department	16. Apprentice ☐ Yes ☐ No

17. Average weekly wage	18. Rate per hour	19. Hours per day	20. Days per week	Normal work schedule Sun - Sat S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐	21. Employment status (check all that apply) ☐ Full time ☐ Part time ☐ Seasonal ☐ Volunteer

22. **Tell us how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was.** *Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."*

23. **What was the injury or illness (include the part(s) of body)?** *Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.*	24. **What tools, equipment, machines, objects, or substances were involved?** *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.*

25. Did injury occur on employer's premises? ☐ Yes ☐ No Name and address of the place of the occurrence	26. Date of first day of any lost time	27. Employer paid for lost time on day of injury (DOI) ☐ Yes ☐ No ☐ No lost time on DOI	
	28. Date employer notified of injury	29. Date employer notified of lost time	
	30. Return to work date	31. RTW same employer ☐ Yes ☐ No	32. RTW with restrictions ☐ Yes ☐ No
33. Treating physician (name)	34. Extent of medical treatment (check all that apply) ☐ None ☐ Minor on-site by employer's medical staff ☐ Minor clinic/hospital ☐ Emergency room ☐ Hospitalization more than 24 hours ☐ Future major medical anticipated		
35. Certified Managed Care Organization (if any)			

36. **EMPLOYER** Legal name	37. EMPLOYER DBA name (if different)	
38. **Mailing** address	39. Employer FEIN	40. Unemployment ID #
City State Zip Code	41. Employer's contact name and phone #	
42. **Physical** address (if different)	43. Witness (name and phone) - if more than 1 attach a separate sheet	
City State Zip Code	44. NAICS code	45. Date form completed

46. **INSURER** name Society Insurance a mutual company		51. **CLAIMS ADMIN COMPANY (CA)** name (check one) ☐ Insurer ☐ TPA	
47. Insured legal name and FEIN		52. CA address	
48. Policy # (including effective dates) or self-insured certificate #		City State Zip Code	
49. Insurer FEIN	50. Date insurer received notice	53. CA FEIN	54. CA claim #

55. To be completed by the **CA**:	Claim type code:	Type of loss code:	Late reason code:	Salary paid in lieu of comp?	Death result of injury?

Employer: Send copies to Insurer (or Workers' Compensation Division if no insurer), employee, and employee's union (if applicable)

GENERAL INSTRUCTIONS TO THE EMPLOYER

Employers, not employees, are responsible for completing this form. The information is needed to determine liability and entitlement to benefits. You must file this form with your insurer, and give a copy to the employee and the employee's local union office. You are required to provide the employee with a copy of the Employee Information Sheet, which is available on the Department of Labor and Industry's web site at www.dli.mn.gov.

Filing this form is not an admission of liability. You must report a claim to your insurer whenever anyone believes that a work-related injury or illness that requires medical care or where lost time from work has occurred. If the claimed injury wholly or partially incapacitates the employee for more than **three** calendar days, the claim must be made on this form and reported to your insurer within **ten** days. Your insurer may require you to file it sooner. Failure to file within the **ten** days may result in penalties. It is important to file this form quickly to allow your insurer time to investigate the claim. **Your insurer will report the injury** to the Department of Labor and Industry (Department), when necessary. Self-insured employers have 14 days to report the injury to the Department, when necessary.

If the claim involves death or serious injury (including injuries that later result in death), you must notify the Department and your insurer within 48 hours of the occurrence. The claim can be reported initially to the Department by telephone (651-284-5041), fax (651-284-5731), or personal notice. The initial notice must be followed by the filing of this form with the Department within **seven** days of the occurrence, at P.O. Box 64221, St. Paul, MN 55164-0221.

SEND THIS FORM TO YOUR INSURER IMMEDIATELY – DO NOT WAIT FOR THE DOCTOR'S REPORT

SPECIFIC INSTRUCTIONS TO THE EMPLOYER ON COMPLETING THIS FORM

- Item 2: OSHA case #. Fill in the case number from the OSHA 300 log. This form contains all items required by the OSHA form 301.
- Items 17-21: Fill in all the wage information. If the employee does not work a regularly scheduled work week, attach a 26 week wage statement so your insurer can calculate the appropriate average weekly wage. Attach a separate sheet giving the weekly value of any meals, lodging, or 2nd income paid to the employee.
- Item 20: Fill in the average number of days per week that the employee works. Also include their normal work schedule, Sunday - Saturday, by checking the appropriate boxes. If the employee's work schedule fluctuates from week-to-week, leave the boxes blank.
- Items 22-24: Be as specific as possible in describing: the events causing the injury; the nature of the injury (cut, sprain, burn, etc.), and the part(s) of body injured (back, arm, etc.); and the tools, equipment, machines, objects or substances involved.
- Item 26: Fill in the first day the employee lost any time from work (including time lost for medical treatment), even if you paid the employee for the lost time.
- Item 27: Check the appropriate box to indicate if there was lost time on the date of injury and whether you paid for that lost time.
- Item 28: Fill in the date you first became aware of the injury or illness.
- Item 29: Fill in the date you became aware that the lost time indicated in Item 26 was related to the claimed injury.
- Item 30: Leave the box blank if the employee has not returned to work by the time you file this form. If the employee has returned to work, fill in the date and answer the questions in Items 31 and 32. Notify your insurer if the employee misses time due to this injury after that date.
- Item 34: Check all the boxes that apply AT the time you file this form.
- Item 39: Fill in your Federal Employer Identification Number (FEIN). For information, see https://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Lost-or-Misplaced-Your-EIN.
- Items 40 and 44: Fill in your Unemployment ID number and North American Industry Classification System (NAICS) code, which are both assigned by the Minnesota Unemployment Insurance Program (651-296-6141).
- Items 46-54: Your insurer or claims administrator will complete this information if you do not have it available.

INSTRUCTIONS TO THE INSURER/CLAIMS ADMINISTRATOR
(For first reports of injury filed on or after Jan. 1, 2014)

Pursuant to Minnesota Statutes, section 176.231, and Minnesota Rules, part 5220.2530, insurers and self-insured employers must file with the Department's Workers' Compensation Division an electronic first report of injury, according to the requirements set out in sections 2 to 4 of the Minnesota implementation guide, in all cases where a first report of injury is required to be filed under Minnesota Statutes, chapter 176. The Minnesota implementation guide can be found on the Department's website at www.dli.mn.gov/WC/Edi.asp.

A first report of injury submitted by the insurer or self-insured employer in any other manner or format is not considered filed with the division, except for a written first report of injury on a paper form filed by a self-insured employer within seven days of death or serious injury.

If the claim does not involve lost time beyond the waiting period or potential permanent partial disability (PPD), or has not been requested to be filed by the Department, a first report of injury does **not** need to be filed.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354 Voice or TDD (651) 297-4198

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

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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 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 ☐ Mist ☐ Steam	Describe fumes _____ ☐ 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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Phone (888) 576-2438 • Fax (920) 922-1071

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.™

150 Camelot Drive
P.O. Box 1029
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 tohelp 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.