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
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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.

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filling.

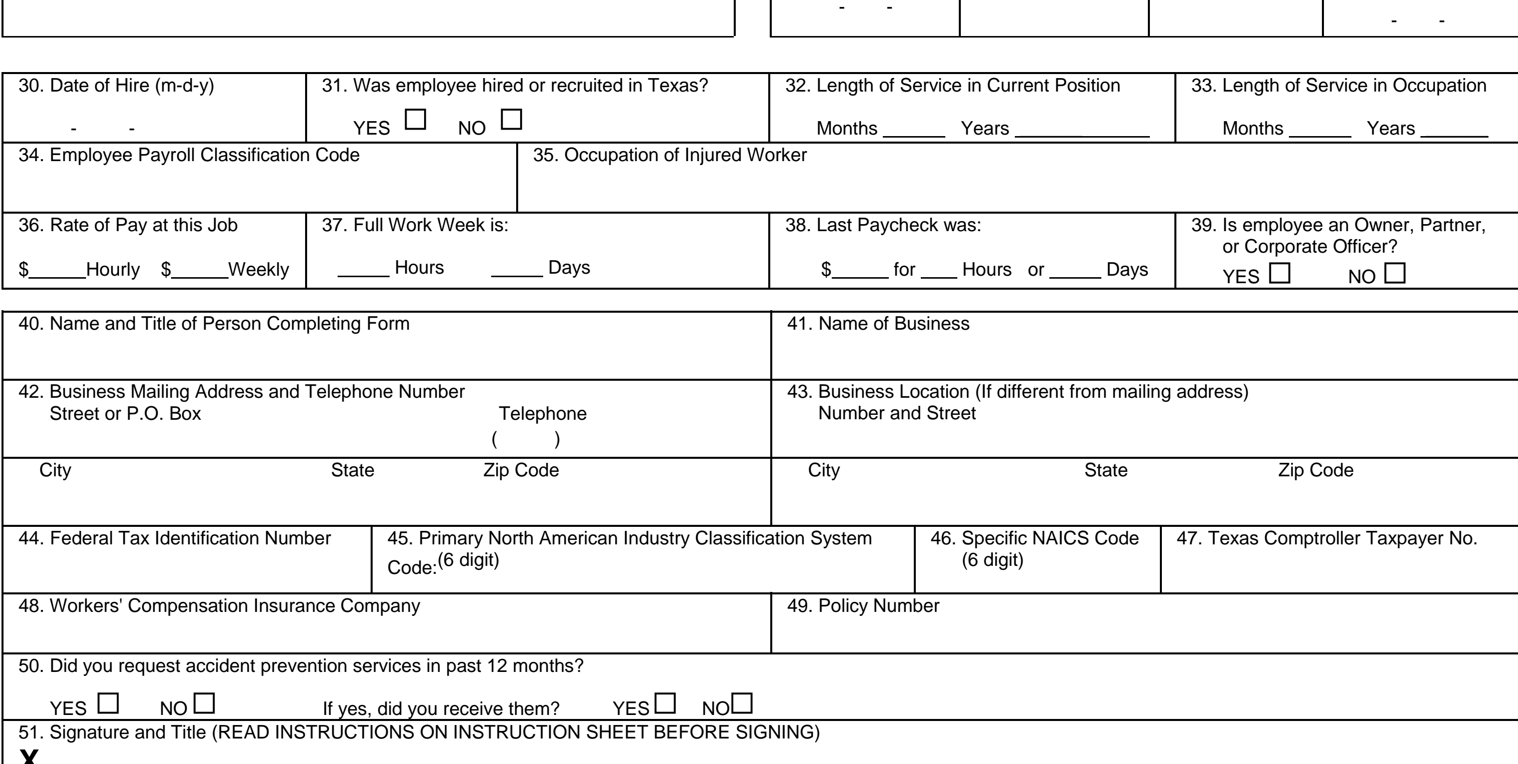
CLAIM # ______________________________

**CARRIER'S CLAIM #** ______________________________

# EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

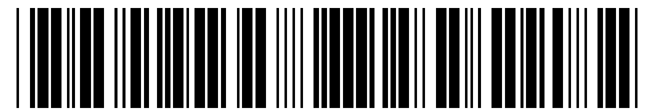
1. Name (Last, First, M.I.)
2. Sex F ☐ M ☐
3. Social Security Number - -
4. Home Phone ( )
5. Date of Birth (m-d-y) - -
6. Does the Employee Speak English? YES ☐ NO ☐ If No, Specify Language
7. Race White ☐ Black ☐ Asian ☐
8. Ethnicity Hispanic ☐ Native American ☐ Other ☐
9. Mailing Address Street or P.O. Box
City State Zip Code County
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐
11. Number of Dependent Children
12. Spouse's Name
13. Doctor's Name
14. Doctor's Mailing Address (Street or P.O.Box)
City State Zip Code

15. Date of Injury (m-d-y) - -
16. Time of Injury : am ☐ pm ☐
17. Date Lost Time Began (m-d-y) - -
18. Nature of Injury*
19. Part of Body Injured or Exposed*
20. How and Why Injury/Illness Occurred*
21. Was employee doing his regular job? YES ☐ NO ☐
22. Worksite Location of Injury (stairs, dock, etc.)*
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site
Street or P.O. Box County
City State Zip Code
24. Cause of Injury(fall, tool, machine, etc.)*
25. List Witnesses
26. Return to work date/or expected (m-d-y) - -
27. Did employee die? YES ☐ NO ☐
28. Supervisor's Name
29. Date Reported (m-d-y) - -



30. Date of Hire (m-d-y) - -
31. Was employee hired or recruited in Texas? YES ☐ NO ☐
32. Length of Service in Current Position Months ______ Years ______
33. Length of Service in Occupation Months ______ Years ______
34. Employee Payroll Classification Code
35. Occupation of Injured Worker
36. Rate of Pay at this Job $_____Hourly $_____Weekly
37. Full Work Week is: _____ Hours _____ Days
38. Last Paycheck was: $_____ for ___ Hours or _____ Days
39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form
41. Name of Business
42. Business Mailing Address and Telephone Number
Street or P.O. Box Telephone ( )
City State Zip Code
43. Business Location (If different from mailing address)
Number and Street
City State Zip Code
44. Federal Tax Identification Number
45. Primary North American Industry Classification System Code:(6 digit)
46. Specific NAICS Code (6 digit)
47. Texas Comptroller Taxpayer No.
48. Workers' Compensation Insurance Company
49. Policy Number
50. Did you request accident prevention services in past 12 months?
YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
**X** ______________________________ Date ______________



## INSTRUCTIONS FOR EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC FORM-001)

Type (or print in black ink) each item on this form. Failure to complete each item may delay the processing of the injury claim.

Section 409.005, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (DWC FORM-001 Rev. 10/05 to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death. A copy of this report must be sent to the employee or the employee's representative. For purposes of this section, a report is filed when personally delivered, or postmarked. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

If a report has not been received by the carrier, the employer has the burden of proving that the report was filed within the required time frame. The employer has the burden of proving that good cause existed if the employer failed to file the report on time.

An employer who fails to file the report without good cause may be assessed an administrative penalty. An employer who fails to file the report without good cause waives the right to reimbursement of voluntary benefits even if no administrative penalty is assessed.

Once the employer has completed all information pertaining to the injury the employer should maintain the copy of this report to serve as the Employer's Record of Injury required by Section 409.006. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.** The Division’s Health and Safety will use data from this report for the Job Safety Information System established in Section 411.032 of the Texas Workers' Compensation Act.

This report may not be considered admission or evidence against the employer or the insurance carrier in any proceeding before the Division or a court in which facts set out in the report are contradicted by the employer or insurance carrier.

### "SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

Items 2,7,8: Section 402.082, Texas Workers' Compensation Act requires the Division to maintain information as to the race, ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.

Item 4: If no home phone, please provide a phone number where the employee can be reached.

Items 5,15,17, 26,29,30: Enter data in month, day, year format. Example: 08-13-54.

Item 18: List nature of accident or exposure, e.g., fall from scaffold, contact with radiation, etc. If occupational disease, so state.

Item 19: List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.

Item 20: Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.

Item 22: State the exact work-site location of the injury, e.g., construction site, office area, storage area, etc.

Item 24: List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.

Items 32,33: Enter date in month-year format. Example: 02-56.

Item 37: Enter the number of days or hours that make up a full work week for your employees.

Item 45: Enter the 6-digit North American Industry Classification System (NAICS) Code of the employer. The primary code is the code which appears in block 5 of Form C-3, "Employer's Quarterly Report" to the Texas Workforce Commission.

Item 46: For companies with a single NAICS code, the specific code is the same as the primary code. For companies with multiple NAICS codes, enter the code that identifies the specific business, activity, or work-site location the employee was working in at the time of the injury. This may or may not be the same as the primary code.

## DWC FORM-001
## (Employer's First Report of Injury or Illness)

The **employer** is required to file an **Employer's First Report of Injury or Illness** [DWC FORM-001 Rev. 10/05] with the injured worker's insurance carrier, and the injured claimant or the claimant's representative within 8 days after the employee's absence from work or receipt of notice of occupational disease.

The **Employer's First Report of Injury or Illness** provides information on the claimant, employer, insurance carrier and medical practitioner necessary to begin the claims process. Details of the claimant's employment and circumstances surrounding the injury or illness are also requested.

Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

*[Workers' Compensation Rule 120.2]*

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:

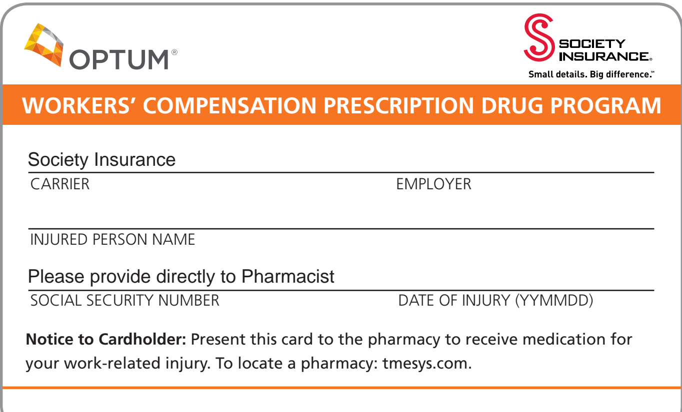
Immediately upon receiving notice of injury, fill in the information below and give this form to the employee.

## 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."

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

150 Camelot Drive
P.O. Box 1029
Fond du Lac, WI 54936-1029
888-576-2438
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<br>☐ Not Work Related<br>☐ 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 | | |

150 Camelot Drive
P.O. Box 1029
Fond du Lac, WI 54936-1029
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 |

150 Camelot Drive
P.O. Box 1029
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: | / / |
| --- | --- | --- | --- |

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

# 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.

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# 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.