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

SOCIETY INSURANCE
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P.O. Box 1029, Fond du Lac, WI 54936-1029
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.

EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

Fatal Injuries: Employers subject to ch.102, Wis. Stats., must report injuries resulting in death to the Department and to their insurance carrier, if insured, within one day after the death of the employee.
Non-Fatal Injuries: If the injury or occupational illness results in disability beyond the three-day waiting period, the employer, if insured, must notify its insurance carrier within 7 days after the injury or beginning of disability. Medical-only claims are to be reported to the insurance carrier only, not the Department.
Electronic Reporting Requirement: All work-related injuries and illnesses resulting in compensable lost time, with the exception of fatalities, must be reported electronically to the Department via EDI or Internet by the insurance carrier or self-insured employer within 14 days of the date of injury or beginning of disability. Employer may fax claims for fatal injuries to (608) 267-0394.

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
https://dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.

The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats. The purpose of this form is to assist with the procurement of information related to or required by Chapter 102. Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102. DWD may use the personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

(**Please read the instructions on page 2 for completing this form**)

EMPLOYEE

Employee Name (First, Middle, Last)	Social Security Number*	Sex ☐ M ☐ F	Employee Home Telephone No. ( ) -

Employee Street Address	City	State	Zip Code	Occupation

Birthdate	Date of Hire	County and State Where Accident or Exposure Occurred?

EMPLOYER

Employer Name	WI Unemployment Ins. Acct No.	Self-Insured? ☐ Yes ☐ No	Nature of Business (Specific Product)

Employer Mailing Address	City	State	Zip Code	Employer FEIN

Name of Worker's Compensation Insurance Co. or Self-Insured Employer	Insurer FEIN

Name and Address of Third Party Administrator (TPA) Used by the Insurance Company or Self-Insured Employer	TPA FEIN

WAGE INFORMATION

Wage at Time of Injury	Specify per hr., wk., mo., yr., etc.	In Addition to Wages, Check Box(es) if Employee Received:		
$	Per:	☐ Meals ☐ Room ☐ Tips	No. of Meals/wk. No. of Days/wk Avg. Weekly Amt. $	

Is Worker Paid for Overtime? ☐ Yes ☐ No If Yes, After How Many Hours of Work Per Week?

For the 52 Week Period Prior to the Week the Injury Occurred, Report Below the Number of Weeks Worked in the Same Kind of Work, and the Total Wages, Salary, Commission and Bonus or Premium Earned for Such Weeks.

No. of Weeks:	Gross Amount Excluding Tips: $	If Piece-Work, No. of Hrs. Excluding Overtime:

	Start Time	Hours Per Day	Hours Per Week	Days Per Week
Employee's Usual Work Schedule When Injured:	: ☐ AM ☐ PM			
Employer's Usual Full-Time Schedule for This Type of Work at Time of Employee's Injury:				

Part-Time Employment Information:	Are there Other Part-Time Workers Doing the Same Work With the Same Schedule? ☐ Yes ☐ No If Yes, how many?	Number of **Full-Time** Employees Doing The Same Type Of Work:

INJURY INFORMATION

Injury Date	Time of Injury : ☐ AM ☐ PM	Last Day Worked	Date Employer Notified	☐ Date Returned to Work ☐ Estimated Date of Return

Did Injury Cause Death? ☐ Yes ☐ No	Date of Death	Was This a Lost Time or Other Compensable Injury? ☐ Yes ☐ No	Did Injury Occur Because of: ☐ Substance Abuse ☐ Failure to Use Safety Devices ☐ Failure to Obey Rules

Was Employee Treated in an Emergency Room? ☐ Yes ☐ No Was Employee Hospitalized Overnight as an In-Patient? ☐ Yes ☐ No

Name and Address of Treating Practitioner and Hospital:

Case Number from the OSHA Log:

Injury Description - Describe Activities of Employee When Injury or Illness Occurred and What Tools, Machinery, Objects, Chemicals, Etc. Were Involved.

What Happened to Cause This Injury or Illness? (Describe How The Injury Occurred)

What Was The Injury or Illness? (State the Part of Body Affected and How It Was Affected)

Report Prepared By	Work Phone Number	Position	Date Signed

SEND REPORT IMMEDIATELY - DO NOT WAIT FOR MEDICAL REPORT

EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS

The employer must complete all relevant sections on this form and submit it to the employer's worker's compensation insurance carrier or third party claim administrator within seven (7) days after the date of a work-related injury which causes permanent or temporary disability resulting in compensation for lost time. The employer's insurance carrier or the third-party claim's administrator may request that this form also be used to immediately report any injury requiring medical treatment, even though it does not involve lost work time.

For any work injury resulting in a **fatality**, the employer must also submit this form directly to the Department of Workforce Development **within 24 hours of the fatality**.

An employer exempt from the duty to insure under s. 102.28, Wis. Stats., and an insurance carrier administering claims for an insured employer are required to submit this form to the Department of Workforce Development within 14 days of the date of work injury.

MANDATORY INFORMATION

In order to accurately administer claims, each of the following sections of this form must be completed. The First Report of Injury will be returned to the sender if the mandatory information is not provided.

Employee Section: Provide all requested information to identify the injured employee. If an employee has multiple dates of employment, the "Date of Hire" is the date the employee was hired for the job on which he or she was injured.

Employer Section: Provide all requested information to identify the injured worker's employer at the time of injury. Provide the name and Federal Employer Identification Number (FEIN) for the insurance carrier or self-insured employer responsible for the worker's compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

Wage Information Section: Provide the information requested regarding the injured employee's wage and hours worked for the job being performed at the time of injury.

Injury Information Section: Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the body injured, the specific nature of the injury (i.e., fracture, strain, concussion, burn, etc.) and the use of any objects or tools (i.e., saw, ladder, vehicle, etc.) that may have caused the injury. Provide the name of the person preparing this report and the telephone number at which they may be reached, if additional information is needed. This form was designed to include information required by OSHA on form 301. If this section is completed and retained, the employer will not have to complete the OSHA 301 form.

OPTUM®

PO Box 152539
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.*

tmesys®

IMP14-2013-113

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

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.

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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.