EMPLOYEE'S ACKNOWLEDGMENT UNDER SECTION 306 (F.1) (1) (1)

I, _____, recognize and agree that my employer has posted a list of at least six (6) healthcare providers, at least three (3) of which are physicians and no more than four (4) of which are coordinated care organizations (CCO). I further agree that my employer has provided the name, address, telephone number, and area of medical specialty of each designated provider on the list. I also acknowledge that I have been presented with this written notice setting forth my rights and duties under Section 306(f.1)(1)(1) of the Pennsylvania Workers' Compensation Act. My rights and duties include the following:

- I have the duty to obtain treatment for work-related illnesses from one or more of the designated health care providers for ninety (90) days from the date of first visit to a designated provider.
- As long as treatment is obtained from a designated provider during the ninety (90) day period, all reasonable medical supplies and treatment related to the injury will be paid by my employer.
- I have the right to switch from one designated health care provider on the list to another during the ninety (90) day period and my employer must pay for this treatment.
- If I am referred by a designated provider to a non-designated provider, my employer shall provide for the treatment rendered by the referral provider.
- I have the right to seek emergency medical treatment from any provider, but I understand that subsequent non-emergency treatment must be rendered by a designated provider for the remainder of the ninety (90) day period.
- I have the right during the ninety (90) day period to seek medical treatment from a non-designated provider, but I understand my employer is not responsible to pay for these services.
- After the expiration of the ninety (90) day period, I have the right to seek treatment from any health care provider, and my employer must pay for such treatment if it is reasonable and necessary.
- If I treat with a non-designated health care provider after the expiration of the ninety (90) day period, I understand that I must provide my employer notice within five (5) days of my first treatment with the non-designated provider. If I fail to do so, my employer may not be responsible to pay for treatment rendered by the non-designated provider prior to notification.
- If the designated provider recommends invasive surgery, I am entitled to receive an additional opinion from any health care provider of my choice. If the additional opinion differs from that of the designated provider, I am entitled to select which course of treatment to follow. However, if I choose to follow the recommendation of my health care provider (the additional opinion), the procedure shall be performed by one or more of the designated health care providers for a period of ninety (90) days from the date of the visit to my health care provider (date of examination of the additional opinion.

My employer has informed me of my rights and duties, and my signature acknowledges that I have been so informed and understand my rights and duties.

_____ _____

Date Employee's Signature

_____ _____

Date Witness

* To be completed by injured employee following a work related accident.

ACORD™ WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

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

CARRIER/CLAIMS ADMINISTRATOR

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

EMPLOYEE/WAGE

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

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

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ☐ AM ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED		
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE		
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL			CAUSE OF INJURY CODE		
DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO / WERE THEY USED? ☐ YES ☐ NO			
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL (NAME & ADDRESS)	INITIAL TREATMENT: ☐ NO MEDICAL TREATMENT ☐ MINOR: BY EMPLOYER ☐ MINOR CLINIC/HOSP ☐ EMERGENCY CARE ☐ HOSPITALIZED > 24 HRS ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED			
WITNESSES (NAME & PHONE #)					
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER		

ACORD 4 (1/96) **SEE BACK FOR IMPORTANT STATE INFORMATION/SIGNATURE**

Applicable in Alaska

A person who wilfully makes a false or misleading statement or representation for the purpose of obtaining or denying a benefit or payment is guilty of theft by deception.

Applicable in Arkansas

Any person or entity who willfully and knowingly makes any material false statement or representation for the purpose of obtaining any benefit or payment, or for the purpose of defeating or wrongfully decreasing any claim for benefit or payment or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium (or who aids and abets for either said purpose), under this chapter shall be guilty of a Class D. felony.

Applicable in California

Any person who knowingly files a statement of claim containing any materially false or misleading information is subject to criminal and civil penalties.

Applicable in Connecticut

This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Applicable in Delaware and Oklahoma

Any person who knowingly and with intent to injure, defraud, or deceive any Insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. The lack of such a statement shall not constitute a defense against prosecution under this section. *Delaware Statutes Regulations: Del #C Section 913(B)

Applicable in Florida

Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files any statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Applicable in Idaho

Any person who Knowingly and with the intent to injure, Defraud, or Deceive any Insurance Company Files a Statement of Claim Containing any False, Incomplete or Misleading information is Guilty of a Felony.

Applicable in Indiana

A person who knowingly and with intent to defraud an insurer files a state ment of claim containing any false, incomplete, or misleading information commits a felony.

Applicable in Kentucky and New York

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. In New York, such person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable in Michigan

Any person who knowingly and with intent to injure or defraud any insurer submits a claim containing any false, incomplete, or misleading information shall, upon conviction, be subject to imprisonment for up to one year for a misdemeanor conviction or up to ten years for a felony conviction and payment of a fine of up to $5,000.00.

Applicable in Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Applicable in Nevada

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

Applicable in New Hampshire

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insur ance fraud, as provided in RSA 638:20.

Applicable in New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Applicable in Ohio

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicable in Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

Applicable in Utah

Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

EMPLOYEE SIGNATURE: _____

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

SIC CODE:

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

CARRIER:

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

CLAIMS ADMINISTRATOR:

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

AGENT NAME & CODE NUMBER:

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

OCCUPATION/JOB TITLE:

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

EMPLOYMENT STATUS:

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

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

DATE DISABILITY BEGAN:

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

CONTACT NAME/PHONE NUMBER:

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

TYPE OF INJURY/ILLNESS:

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

PART OF BODY AFFECTED:

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

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

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

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

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

(eg. Acetylene cutting torch, metal plate)

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

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

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

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

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

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

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

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

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

WORKERS' COMPENSATION
EMPLOYEE NOTIFICATION

Workers' Compensation is designed to provide wage loss benefits and reimbursement for reasonable medical care for one who is injured on the job. Your employer shall provide payment for reasonable surgical and medical services, services rendered by physicians or other health care providers, medicines and supplies, as and when needed.

Your employer, in compliance with the Workers' Compensation Act, has posted a list of at least six (6) medical providers from which you are to select. You are to obtain treatment from one of the providers of your choice for ninety (90) days from the date of your first visit.

If you are faced with an immediate medical emergency, you may secure assistance from the closest hospital, physician or other health care provider of your choice. If follow up treatment is needed, you must then seek treatment from a physician or other health care provider listed on your employer's physician panel list for the first ninety (90) days from the date of your first treatment.

If during the initial 90-day period you wish to change medical providers, you must once again re-visit your employer's panel and select a new physician. If you do not seek treatment from a provider on the panel list for the initial 90 days following your first visit, your employer will not have to pay for the services rendered.

If one of the listed providers recommends invasive surgery, you are entitled to a second opinion from a physician of your choice. Should your physician's opinion differ, and you choose that opinion, the panel physician will abide by same for 90 days.

After the initial 90-day period, if additional or continued treatment is needed, you may now choose to go to another physician or health care provider of your choice. Should you decide to change providers, you must notify your employer within five (5) days of your first visit with your new provider. Failure to notify your employer will relieve your employer of the responsibility for the payment of the services rendered if such services are determined to have been unreasonable or unnecessary.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I hereby acknowledge that I have been informed of and understand my rights and duties under the Workers' Compensation Act.

Employee signature _____ **Date** _____

WORKER'S COMPENSATION
EMPLOYEE NOTIFICATION

Workers' Compensation Information

(1) The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

(2) Benefits are required to be paid by your employer when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.

(3) You should report immediately any injury or work-related illness to your employer.

(4) Your benefits could be delayed or denied if you do not notify your employer immediately.

(5) If your claim is denied by your employer, you have the right to request a hearing before a workers' compensation judge.

(6) The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at: Bureau of Workers' Compensation, 1171 South Cameron Street, Room 103, Harrisburg, Pennsylvania 17104-2501; telephone number within Pennsylvania (800) 482-2383; telephone number outside of this Commonwealth (717) 772-4447; TTY (800) 362-4228 (for hearing and speech impaired only); www.state.pa.us, PA Keyword: workers comp.

Los TRABAJADORES' la NOTIFICACION de EMPLEADO de COMPENSACION

Los trabajadores' la Compensación es diseñada para proporcionar el sueldo los beneficios de la pérdida y el reembolso para el cuidado médico razonable para uno que es herido en el trabajo. Su empleador proporcionará el pago para servicios razonables, quirúrgicos y médicos, los servicios rendidos por médicos u otros proveedores de asistencia médica, las medicinas y los suministros, como y cuando sea necesario.

Su empleador, en conformidad con los Trabajadores' el Acto de la Compensación, ha anunciado una lista de por lo menos seis (6) proveedores médicos de que usted es de escoger. Usted es de obtener el tratamiento de uno de los proveedores de su elección para noventa (90) días de la fecha de su primera visita.

Si usted es encarado con una emergencia médica inmediata, usted puede asegurar ayuda del hospital más cercano, el médico o otro proveedor de asistencia médica de su elección. Si sigue el tratamiento es necesitado, usted entonces debe buscar el tratamiento de un médico o otro proveedor de asistencia médica listó en su lista de entrepaño de médico de empleador para el primer noventa (90) días de la fecha de su primer tratamiento.

Si durante el período de 90 días inicial que usted desea cambiar proveedores médicos, usted debe volver a visitar una vez más su entrepaño de empleador y escoge a un nuevo médico. Si usted no busca el tratamiento de un proveedor en la lista de entrepaño para los iniciales 90 días que siguen su primera visita, su empleador no tendrá que pagar por los servicios rendidos.

Si uno del listó a proveedores recomiendan la cirugía invasiva, usted tiene derecho a una segunda opinión de un médico de su elección. Debe su opinión de médico difiere, y usted escoge esa opinión, el médico de entrepaño respetará mismo durante 90 días.

Después de que el período de 90 días inicial, si el tratamiento adicional o continuado es necesitado, usted ahora puede escoger ir a otro proveedor del médico o la asistencia médica de su elección. Debele decide cambiar proveedores, usted debe notificar a su empleador dentro de cinco (5) días de su primera visita con su nuevo proveedor. El fracaso para notificar a su empleador aliviará a su empleador de la responsabilidad para el pago de los servicios los servicios rendido si tales son determinados a haber sido desrazonable o innecesario.

Cualquier persona que astutamente y con la intención para defraudar cualquier compañía de seguros u otra persona archiva una aplicación para el seguro o la declaración de contener de reclamo cualquier información sustancialmente falsa o oculta para el propósito de descaminar, la información con respecto a cualquier materia del hecho a eso comete un acto fraudulento del seguro, que es un crimen y sujeta tal a persona al criminal y penas civiles.

Yo por la presente reconozco que he sido informado y entiendo mis derechos y los deberes bajo el Acto de los Trabajadores' de la Compensación.

Firma de empleado _____la fecha _____

La Parte de la NOTIFICACION del EMPLEADO de la COMPENSACION del TRABAJADOR 2

Los trabajadores' Información de Compensación

(1) La ley de la compensación de trabajadores proporciona el sueldo la pérdida y los beneficios médicos a empleados que no pueden trabajar, ni que necesita el cuidado médico, a causa de una herida de trabajo-relacionó.

(2) los Beneficios son requeridos a ser pagados por su empleador cuando ser-aseguró, o por el seguro proporcionado por su empleador. Su empleador es requerido a anunciar el nombre de la compañía responsable de pagar los beneficios de la compensación de trabajadores en su oficina primaria y en sus sitios del empleo en un lugar prominente y fácilmente accesible, incluyendo, sin la limitación, las áreas utilizadas para el tratamiento de empleados heridos o para la administración de primeros auxilios.

(3) Usted debe informar inmediatamente cualquier enfermedad de herida o trabajo-relacionó a su empleador.

(4) Sus beneficios podrían ser demorados o podrían ser negados si usted no notifica a su empleador inmediatamente.

(5) Si su reclamo es negado por su empleador, usted tiene el derecho de solicitar una vista antes de un juez de la compensación de trabajadores.

(6) La Oficina de la Compensación de Trabajadores no puede proporcionar el asesoramiento jurídico. Sin embargo, usted puede contactar la Oficina de la Compensación de Trabajadores para la información general adicional en: La oficina de la Compensación de Trabajadores, 1171 South Cameron, Room 103, Harrisburg, Pennsylvania 17104-2501; el número de teléfono dentro de Pennsylvania (800) 482-2383; el número de teléfono fuera de esta República (717) 772-4447; TTY (800) 362-4228 (para oír y discurso dañó sólo); www.state.pa.us, Palabra clave de PA: comp de trabajadores (workers comp).

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

REMEMBER: IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR INJURY

The name, address and telephone number of your employer's workers' compensation insurance company, third-party administrator (TPA), or person handling workers' compensation claims for your company, are shown below.

Employer Name: _____ **Date Posted:** _____

IF INSURED:
(Complete all applicable spaces)

Name of Insurance Company: _____

Address: _____

Telephone Number: _____

Insurer Code: _____

IF SOMEONE OTHER THAN INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator): _____

Address: _____

Telephone Number: _____

IF SELF-INSURED
(Complete all applicable spaces)

Name of person handling claims at the self-insured: _____

Address: _____

Telephone Number: _____

Insurer Code: _____

IF SOMEONE OTHER THAN SELF-INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator): _____

Address: _____

Telephone Number: _____

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services	**Claims Information Services**	**Hearing Impaired**	**Email**
717.772.3702	toll-free inside PA: 800.482.2383 local & outside PA: 717.772.4447	toll-free inside PA TTY: 800.362.4228 local & outside PA TTY: 717.772.4991	ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program