It is a pleasure to welcome you to Berkley Net Underwriters, LLC! We are committed to providing high quality products and services to our valued customers. Utilizing state-of-the-art risk management, safety and claim management techniques, we strive to help you manage your insurance expenditures and minimize your loss costs.

I'm often asked how employers can lower their workers' compensation costs, and while there's no single answer, here are a few items employers can manage that will prove beneficial in the long-run:

- **Report Claims as Quickly As Possible – ideally within 24 hours of occurrence**
  - www.berkleynet.com
  - BNUClaims@berkleynet.com
  - Fax: 1.866.275.6320 ; call 1.800.435.1127

- **Post All Necessary State Notices for Employees**
  - All forms and posting requirements are included in this packet.

- **Discuss and Promote Safety within your Company**
  - A Safe Attitude begins at the top. Make Safety a Priority.

- **Keep Accurate Records**
  - Your premium is based on employee payroll. Keeping accurate payroll and job records throughout the year will facilitate a smoother final audit.

- **Discuss Potential Changes in Operations with your Insurance Agent**
  - Changes in employee operations can have a direct impact on your premium and coverage. Discuss any potential changes with your agent and avoid costly surprises in the future.

On behalf of our entire team, I thank you for entrusting Berkley Net Underwriters, LLC to service your workers' compensation insurance needs. If you have any questions, please feel free to contact your insurance agent or call us at 1.877.497.2637. You may also visit us online at www.berkleynet.com.

Sincerely

John K. Goldwater
President & CEO

About Berkley Net Underwriters, LLC

Berkley Net Underwriters, LLC is a subsidiary of the W.R. Berkley Corporation, one of the nation's premier property and casualty insurance providers. We are authorized to provide workers' compensation coverage through affiliated W.R. Berkley subsidiaries, including **StarNet Insurance Company**, **Carolina Casualty Insurance Company** and **Midwest Employers Casualty Company**; all are an A rated insurance company. As your workers' compensation carrier, we pride ourselves on having a reputation of unsurpassed quality, service and integrity.

The BerkleyNet Claim Management Difference

BerkleyNet is a world class provider of claim and managed care services; utilizing the best practices in claim management, managed care initiatives and technology to achieve superior outcomes. Our commitment to our clients is: teamwork, responsiveness, mutual respect and technical innovation in delivering industry-leading claims management services.

Important Claims Information Included

In this packet, you will find important risk management information, including claims forms, posting notices and other documents to assist with the administration of your workers' compensation policy. **Please retain this information for future reference**.

- ✓ Claim Reporting Forms
- ✓ Statutory Posting Notices
- ✓ Supervisory Accident Reports
- ✓ Physical Demand Analysis
- ✓ Medical Authorization Form
- ✓ First Health Preferred Provider Network & Panel of Physicians
- ✓ Discount Pharmacy Information
- ✓ Position Physical Demand Analysis Assessment

To Report Claims:

www.berkleynet.com

Email: BNUClaims@berkleynet.com

866.275.6320 Fax

800.435.1127 Phone

Reporting Worker's Compensation Claims

Worker's Compensation claims can be reported in several different ways:

- www.berkleynet.com
- Via email at: **BNUClaims@berkleynet.com**
- Complete and fax the Employer's First Report of Injury to; **1.866.275.6320**
- Call 24 hours/7 days a week at **1.800.435.1127**
- Mail the Employers Report of Injury to:
  Berkley Net Underwriters, LLC
  12701 Marblestone Drive, Ste 250
  Woodbridge VA 22192

Claims Reporting

- **www.berkleynet.com**
- Fax at 1.866.275.6320
- Email Reporting at **BNUClaims@berkleynet.com**
- 24/7 claims reporting facility
- Adjusters begin direct care process immediately
- After Hours toll free number: 1.800.435.1127

Everything you need to know about reporting a claim is included in this packet.

- Employer's First Report of Injury and report your claim
- A step by step telephone reporting guide
- The Employer Rights and Responsibilities
- Information on provider panel and discount pharmacy. Reinforce treating with panel provider and use of the TMESYS pharmacy network with your employee

The After-Hours phone number provides access to the Claims Management staff as well as our most experienced adjusters. Loss details are gathered to determine if an emergency exists and if an immediate field investigation or field contact is indicated.

Employer Rights & Responsibilities in Workers Compensation

Early Reporting. Set an expectation that all injuries be reported promptly; also, have a "same-day" reporting standard for communicating any claims to Berkley Net Underwriters, LLC. Train your managers and supervisors in what to do if an injury occurs. Late reports may impact the rights of an employer. A copy of the Employer's First Report is attached. **To report: www.berkleynet.com; Email: BNUClaims@berkleynet.com; Call toll free to 800.435.1127; Fax 866.275.6320**

Physician List. Make all employees aware of a list of providers. The physician list should be in a prominent location. This list is being prepared specifically for your business. These practioners are members of the First Health network, experienced in the care of injured workers. If you need additional providers to be added, we will direct you on making changes within the panel.

Excellent Medical Care. Develop a relationship with the physicians on the physician list. Contact the provider from the outset and advise that your employee is on the way to seek care. Let them know of your interest to provide modified work.

Medical Authorization. Ask the employee to sign the medical authorization form when they've notified you of a claim. This will enable Berkley Net Underwriters, LLC to secure all relevant medical documentation and accelerate the claim handling process. A copy of the form is attached.

Pharmacy Network. Berkley Net Underwriters, LLC has a program through TMESYS which will save cost and allow an employee to fill a prescription without waiting for reimbursement. Any questions by either the employee or pharmacist can be addressed through TMESYS at 800-964-2531.

Posting Required Notices. A notice of insurance placard and workers compensation fraud notice should be posted. Those forms are attached to the correspondence.

Good communication. Take the mystery out of workers comp. Educate employees about their rights and responsibilities in advance. Stay in touch with employees throughout their care and rehabilitation.

Supervisory Investigation. Reinforce that supervisors get all details on injury and accident claims and document in a report format. A recommended copy is attached.

Return to Work. Develop a plan to return the employee to gainful employment from the outset. Look to modify parts of the employee's position to accommodate. Advise employee and attending physician that return to work is expected.

Employee Rights & Responsibilities in Workers Compensation

Notify Supervisor. Let your supervisor know of any injury or accident that happens in the workplace immediately. Failure to notify may impact the rights of the employee.

Medical Authorization. Sign, date and return the medical authorization form to your employer immediately. This will enable the insurer to properly process all related medical costs.

Physician List. Your employer will assist you to a list of physicians that are committed to rehabilitation and the best care. You may consult this list before scheduling any appointment. These are practioners who are familiar with work related injuries.

Pharmacy. A program is available to you through TMESYS with no out of pocket expenses. Make sure that the pharmacy is aware that your employer and insurer are part of the TMESYS program. A first fill sheet is available through your employer or you or the pharmacist may call TMESYS directly at 800-964-2531.

Communicate. Stay in touch with your employer and insurance company after each medical treatment. Keep everyone up to date on your treatment plan and return to work prognosis.

Return to Work. Work with your employer and attending physician to return to work. Share all information regarding your physical capabilities and the potential for making modifications to your job.

NOTICE!

Wisconsin
Workers Compensation

This business operates under Wisconsin Workers' Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, OR AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR OR FOREMAN OF THE EMPLOYER.

Workers Compensation insurance benefits are provided through:

www.berkleynet.com

12701 Marblestone Dr, Ste 250
Woodbridge, Virginia 22192
877-497-2637

Promptly Report all Claims: www.berkleynet.com; Email:BNUClaims@berkleynet.com; Fax 866.275.6320; Call 800.435.1127;

Supervisor's Injury/Accident Investigation

Insured Name _____ Policy Number _____
Location where injury occurred: _____Employer's Premises? _____
Date of accident_____Job site location_____
Who was injured? _____Employee Name _____
Time: _____ Did you or anyone witness? _____ Witness Name _____
When were you notified? _____
Job title of injured employee _____
How long has employee worked at this job? _____
Where did injury or illness occur? _____
Was property or equipment or tools involved with injury? _____
Property/equipment owned by: _____
What was employee doing when injury/illness occurred? _____
What machine or tool was being used? _____
How did injury/illness occur? _____
List all objects and substance involved._____
Part of body affected/injured? _____
Any prior physical conditions? _____If so, what? _____

PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS:

____ Improper instruction ____ Failure to lockout ____ Unsafe arrangement or process
____ Lack of training or skill ____ Unsafe position ____ Poor ventilation
____ Operating without authority ____ Improper dress ____ Improper guarding
____ Horseplay ____ Improper protective equipment
____ Improper maintenance ____ Physical or mental impairment
____ Unsafe equipment ____ Inoperative safety device
____ Failure to secure ____ Poor housekeeping
____ Other _____

What can be done to avoid this in the future?

Was employee trained in the use of Personal Protective Equipment/Proper safety procedures? __Yes ___ No.

Was employee cautioned for failure to use Personal Protective Equipment/Proper safety procedures? __ Yes ___ No

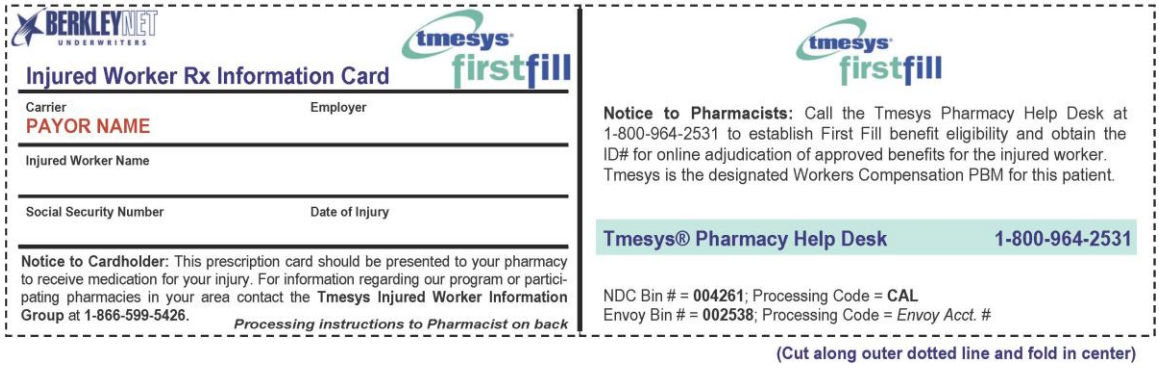
Was the notice of injury prompt? _____

Is there modified duty available? _____ Can the existing job be modified? _____

Supervisor Name_____ Signature _____

Date _____

EMPLOYER – Please give to injured employee before they fill first prescription



Injured Worker Rx Information Card

Carrier: PAYOR NAME
Employer:
Injured Worker Name:
Social Security Number:
Date of Injury:

Notice to Cardholder: This prescription card should be presented to your pharmacy to receive medication for your injury. For information regarding our program or participating pharmacies in your area contact the **Tmesys Injured Worker Information Group** at **1-866-599-5426.**

Processing instructions to Pharmacist on back

Notice to Pharmacists: Call the Tmesys Pharmacy Help Desk at 1-800-964-2531 to establish First Fill benefit eligibility and obtain the ID# for online adjudication of approved benefits for the injured worker. Tmesys is the designated Workers Compensation PBM for this patient.

Tmesys® Pharmacy Help Desk **1-800-964-2531**

NDC Bin # = **004261**; Processing Code = **CAL**
Envoy Bin # = **002538**; Processing Code = *Envoy Acct. #*

(Cut along outer dotted line and fold in center)

Injured Worker Rx Information Card

Carrier: PAYOR NAME
Employer:
Injured Worker Name:
Social Security Number:
Date of Injury:

Notice to Cardholder: This prescription card should be presented to your pharmacy to receive medication for your injury. For information regarding our program or participating pharmacies in your area contact the **Tmesys Injured Worker Information Group** at **1-866-599-5426.**

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Tmesys® Pharmacy Help Desk **1-800-964-2531**

NDC Bin # = **004261**; Processing Code = **CAL**
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(Cut along outer dotted line and fold in center)

Injured Worker Rx Information Card

Carrier: PAYOR NAME
Employer:
Injured Worker Name:
Social Security Number:
Date of Injury:

Notice to Cardholder: This prescription card should be presented to your pharmacy to receive medication for your injury. For information regarding our program or participating pharmacies in your area contact the **Tmesys Injured Worker Information Group** at **1-866-599-5426.**

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NDC Bin # = **004261**; Processing Code = **CAL**
Envoy Bin # = **002538**; Processing Code = *Envoy Acct. #*

(Cut along outer dotted line and fold in center)

Promptly Report all Claims: www.berkleynet.com; Email:BNUClaims@berkleynet.com; Fax 866.275.6320; Call 800.435.1127;

MEDICAL RECORDS RELEASE AUTHORIZATION

In order for your claim to be fully evaluated for purposes of determining your eligibility for the receipt of benefits with respect to this claim, you must sign the following authorization. Please note that the amount and type of medical information sought pursuant to this authorization will depend upon the nature of the claim, but that it will be used solely to facilitate determinations regarding the validity of the claim and the payment of benefits or the administration of the insurance program under which the claim has been made. The authorization is subject to your revocation at any time except to the extent that any party has already acted in reliance upon it. Any revocation must be submitted in writing to Berkley Net Underwriters, LLC. , 12701 Marblestone Dr, Ste 250, Woodbridge, VA 22192, otherwise this authorization will continue to be valid. Your acceptance of benefits shall be considered an acceptance of the terms in this medical authorization, unless you indicate to the contrary in writing.

Authorization to Release Medical Information: I hereby authorize any employer, insurance company, government agency, medical prepayment plan, or service organization, and any physician, surgeon, therapist, pharmacist, or other duly licensed practitioner of the healing arts, and any hospital, including the Veteran's Administration, or medical transportation company, to release to Berkley Net Underwriters and their subsidiaries, affiliates, representatives and agents (collectively, Berkley Net Underwriters), any and all applicable medical records, medical information and benefit payment information with respect to any illness, injury, medical history, consultations, prescriptions, treatment or benefits, and copies of all applicable records thereof, which may be appropriate or necessary to establish the validity of this claim.

This authorization shall specifically include but shall not be limited to medical records, medical information and benefit payment information pertaining or relating to the treatment of AIDS, HIV, mental illness, and drug or alcohol related medical problems. I also authorize the Social Security Administration to release to Berkley Net Underwriters, information concerning entitlement dates and benefit amounts for myself and my dependents.

I further authorize Berkley Net Underwriters to release any such medical information to its reinsurers, attorneys or to medical peer review panels, state insurance or fraud agencies, managed care vendors, industry anti-fraud or law enforcement organizations, research and statistical reporting organizations, or my employer and its excess insurer, to the extent that Berkley Net Underwriters considers doing so to be reasonably appropriate or necessary for purposes of its administration of the claim or the insurance program under which the claim has been made. I understand that authorizing the disclosure of this health information is voluntary. I understand the information released to Berkley Net Underwriters as a result of this authorization may no longer be subject to certain protections provided under the Health Insurance Portability and Accountability Act of 1996.

Unless revoked earlier by me in writing this authorization shall be valid for three years after the claim has been closed by Berkley Net Underwriters. A copy of this authorization is to be considered as valid as the original.

Employee Signature _____ ***Date***_____

Employee Name _____ *Claim No.* _____

Promptly Report all Claims: www.berkleynet.com; Email:BNUClaims@berkleynet.com; Fax 866.275.6320; Call 800.435.1127;

PHYSICAL DEMAND ANALYSIS ASSESSMENT

This Position Physical Demand Analysis Assessment describes the physical requirements of the injured workers job or position. The focus is on strength, flexibility, sensory and environmental requirements or conditions of specific tasks. This form should be completed for the injured employee's present position as well as modified duty positions available, so it may be used by the health care provider to determine if the employee is capable of returning to work at regular or modified duties. Employer _____

Job or Position _____ Date form completed _____

Regular Hours of work per day _____ Completed by _____

Employee _____

During a regular work day, the employee must (circle number of hours and indicate if intermittent **(I)** or constant **(C)** for each activity.

Sit	**0 1 2 3 4 5 6 7 8 hours**	**I / C**
Stand	**0 1 2 3 4 5 6 7 8 hours**	**I / C**
Walk	**0 1 2 3 4 5 6 7 8 hours**	**I / C**
Drive	**0 1 2 3 4 5 6 7 8 hours**	**I / C**
Bend	**0 1 2 3 4 5 6 7 8 hours**	**I / C**

Job Requirements include (**Y/N**): __ Squatting; __ Kneeling; __ Bending; __Twisting; __Reaching; __Crawling; __Ladder Work; __Stair Climbing; __Work above Shoulder; __Work below Shoulder; __Walking on Rough Ground; __Working at Heights; __Exposure to Heat or Cold (circle which or both); __Exposure to Dust, Fumes or Gases; __Exposure to High Humidity; __Exposure to Noise; __Repetitive Movements

Lifting Requirements

	Never	Occasionally	Frequently	Continuous
Up to 10 lbs	☐	☐	☐	☐
11 to 24 lbs	☐	☐	☐	☐
25 to 34 lbs	☐	☐	☐	☐
35 to 50 lbs	☐	☐	☐	☐
51 to 74 lbs	☐	☐	☐	☐
75 to 100 lbs	☐	☐	☐	☐
Above 100 lbs	☐	☐	☐	☐

Carrying Requirements

	Never	Occasionally	Frequently	Continuous
Up to 10 lbs	☐	☐	☐	☐
11 to 24 lbs	☐	☐	☐	☐
25 to 34 lbs	☐	☐	☐	☐
35 to 50 lbs	☐	☐	☐	☐
51 to 74 lbs	☐	☐	☐	☐
75 to 100 lbs	☐	☐	☐	☐
Above 100 lbs	☐	☐	☐	☐

Pushing Requirements

	Never	Occasionally	Frequently	Continuous
Up to 10 lbs	☐	☐	☐	☐
11 to 24 lbs	☐	☐	☐	☐
25 to 34 lbs	☐	☐	☐	☐
35 to 50 lbs	☐	☐	☐	☐
51 to 74 lbs	☐	☐	☐	☐
75 to 100 lbs	☐	☐	☐	☐
Above 100 lbs	☐	☐	☐	☐

To Report Workers' Compensation Claims

www.berkleynet.com

Fax: 866.275.6320

Call Toll-Free 800.435.1127

Email:BNUClaims@berkleynet.com

Promptly Report all Claims: www.berkleynet.com; Email:BNUClaims@berkleynet.com; Fax 866.275.6320; Call 800.435.1127;

In case of Injury or Illness on the job, the following participating providers are available in your area.

CLINICS

HOSPITALS

PHYSICIANS

TMESYS Pharmacy Program - To contact your local TMESYS Pharmacy, please call (800) 964-2531

Notify your immediate supervisor of your injury. If you feel that you need medical attention, **you may choose one of the providers listed here or a provider of your own choice**. Please call the provider to confirm First Health participation and to schedule an appointment for faster service. Many clinics are open extended hours for your convenience. For urgent care needs after clinics hours, you may proceed directly to the hospital listed here. Patients will be seen on a medical priority basis. In emergency situations you may immediately seek treatment from the nearest qualified facility or provider. IF YOU NEED AN ALTERNATE TO THE PROVIDERS LISTED HERE, CALL 888-476-2669.

Your Employer and its Insurance Carrier utilizes **First Health contracted providers**. The above list is not a complete list of healthcare providers with First Health. For a complete listing of providers, or to verify whether a particular doctor does participate, please call800-828-2389. **If your situation is a medical emergency requiring immediate attention, dial 911 or proceed to the nearest hospital which provides emergency services.** Use of network does not confirm or verify compensability under the Workers' Compensation Act, which is determined solely by the claims administrator.

Promptly Report all Claims: www.berkleynet.com; Email:BNUClaims@berkleynet.com; Fax 866.275.6320; Call 800.435.1127;

En caso de lesión o enfermedad laboral, los siguientes proveedores participantes están disponibles en su área.

CLINICS

HOSPITALS

PHYSICIANS

TMESYS Pharmacy Program - To contact your local TMESYS Pharmacy, please call (800) 964-2531

Notifique a su supervisor inmediato acerca de su lesión. Si usted siente que necesita atención médica, puede elegir a uno de los proveedores acá listados. Por favor llame el proveedor para confirmar que participa en el programa de First Health y fije una cita para un servicio más rápido. Muchas clínicas están abiertas durante un horario ampliado para su conveniencia. Para situaciones de cuidado médico urgentes después de horas de atención al público, puede proceder directamente al hospital listado acá. Los pacientes serán vistos de acuerdo con la urgencia médica. En situaciones de emergencia usted puede solicitar tratamiento inmediato en la instalación o proveedor calificado más cercano. SI USTED NECESITA UNA ALTERNATIVA A LOS PROVEEDORES INDICADOS ACÁ LLAME 888-476-2669.

Su empleador y la empresa aseguradora utilizan la red **The First Health**® Network. Para un listado completo de proveedores, o verificar si un doctor en particular está en la red, por favor llame al 800-828-2389. **Si su situación es una emergencia médica que requiere atención inmediata, marque el 911 o proceda al hospital más cercano que proporcione un servicio de emergencias.** El uso de la red no confirma o verifica la facultad de ser compensado conforme a la Ley de Compensación de Trabajadores lo cual es determinado exclusivamente por el administrador de reclamaciones.

Promptly Report all Claims: www.berkleynet.com; Email:BNUClaims@berkleynet.com; Fax 866.275.6320; Call 800.435.1127;

EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

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

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 the Imaging Fax Server number on this form.

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].
(**Please read the instructions on page 2 for completing this form**)

EMPLOYEE

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

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?	Nature of Business (Specific Product)
		☐ Yes ☐ No	

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?	Date of Death	Was This a Lost Time or Other Compensable Injury?	Did Injury Occur Because of:		
☐ Yes ☐ No		☐ Yes ☐ No	☐ 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.

WAGE INFORMATION SUPPLEMENT

Insurers, including self-insured employers, must submit this form with the first **WKC-13 report** for each claim where TTD is less than the maximum rate in the year the injury occurred.

Read instructions on reverse carefully before completing.

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.wisconsin/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.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

Employee Name	Employee Social Security Number	Date of Injury

Employer Name

Name of Insurance Company or Self-Insured Employer (do not list adjusting company)

Claims Handling Address (number, city, state, zip code)

Complete Section 4 for part-time employees (include anyone working less than 35 hours per week) before completing Sections 1 and 2.)

1. Hourly Wage Multiply — Equals — Add — Equals

a. Hourly rate at time of injury:	x	b. Hours per week: (fill in "usual scheduled hours," check the box you use to set the wages)	=	c. Base weekly rate: (See reverse for computing rates for time and a half employees)	+	d. Additional weekly compensation from Section 3 below: (exclude tips)	=	e. Average weekly earnings: (hourly)
☐ Standard Base $_____ ☐ Piece Rate (if higher than the standard rate) ☐ Standard base rate plus tips Tip Rate only: $_____ Base + Tip $_____		☐ **Normal scheduled hours:** _____ Includes those hours paid at time-and-a-half: **(See Instructions)** _____ ☐ Actually Worked: (use with piece rate, or tips in Section 1a.) _____ ☐ Expand to: (See Section 4) 24 ☐ Expand to Normal Full-time: _____ ☐ Seasonal: (See instructions) 44		$_____		$_____		$_____

2. Gross Wage Divide — Equals — Add — Equals

a. Gross taxable wages in 52-week period prior to date of injury: (Exclude tips)	÷	b. Number of weeks worked in 52-week period prior to injury:	=	c. Base Gross Wage:	d. Additional weekly compensation from Section 3 below:	=	e. Actual average weekly earnings:
$_____		_____		$_____	$_____		$_____

3. Additions to Cash Wage Received by Employee Per Week (Mark any that apply)

☐ Free meals (Number/week) _____ Weekly Amount $_____
☐ Room (Number of days/wk _____ Weekly Amount $_____
☐ Tips Amount/Week $_____ (Add only to Section 2d., not 1d.)
☐ House or Apartment Weekly Amt $_____ ☐ Check if this is continued during disability

☐ Fuel Weekly Amount $_____
☐ Lights Weekly Amount $_____
☐ Other Weekly Amount $_____
Total Weekly Value: $_____

4. Part-Time Employment (Worked less than 35 hrs/wk) Divide — Equals

Part of Class Determination	1. Normal number of hours scheduled per week:	2. Number of other part-time employees doing same work on same schedule:	÷	3. Number of full-time employees doing the same type of work:	=	4. _____ **%** ☐ Yes, part of class (2 divided by 3 is greater than 10%) ☐ No, not part of class (2 divided by 3 is less than 10%)
	_____	_____		_____		

(Choose a, b or c that applies)

a ☐ Employee worked **less** than 24 hrs/wk, **is part of a class and does not restrict** availability for work. Check the box listed as "expand to" in Section 1b above with number of scheduled hours shown as 24.

b ☐ Employee worked less than 35 hours/wk, but **is not part of a class and does not restrict** availability for work. Check the box in Section 1b listed as "Expand to Normal full-time" and enter the number of hours which full-time employees normally work for the employer in this occupation.

c ☐ Employee works less than 27 hrs/wk., and **restricts availability** for work. Check the box in Section 1b listed as "Normal Scheduled Hours" and enter the number of normal scheduled hours. If the employee does not have "normal scheduled hours", leave Section 1b blank and complete all parts of Sections 2 and 5 using the 100% option of the result in Section 2e in Section 5b. **Attach the self-restriction statement**. See instructions on reverse for an **exception to using 100% in Section 5b.**

Important: These options are the only circumstances for which you will use a number other than the "normal hours scheduled" to compute weekly hourly wages. Use normal hours scheduled or actual hours worked (piece rate, time and 1/2 or tip rate) in Section 1b unless 4a, 4b or 4c applies.

5. Weekly Wage and TTD Rate Computation Multiply — Equals

a. Weekly Wage (Greater of #1 or #2 above) $_____	X	**b.** ☐ 66.67% **OR** ☐ 100%(see 4.c)	=	c. Weekly TTD Rate: $_____

Insurance Claim Representative	Telephone Number ( )

(See reverse side for instructions)

Instructions for Completing the Wage Information Supplement, Form WKC-13-A

These instructions will help you complete the WKC-13-A and compute the TTD rate correctly. If more help is needed, please contact a wage specialist at (608) 266-3264 or 261-6532, or send an e-mail to **wcwage@dwd.state.wi.us.** Section DWD 80.02(2)(c) of the Wis. Admin. Code requires insurers, including self-insured employers, to submit this form within 30 days after the injury. It must be submitted for every claim where the TTD rate is less than the maximum rate for the year the injury occurred. For a reference to the maximum rates, see our website at: **http://www.dwd.state.wi.us/wc_train**

Section 1a- Hourly Rate at Time of Injury: Enter the standard base rate at the time of injury. Include in the hourly rate any additional hourly amounts which the employee received at the time of injury, e.g., shift differentials. For employees receiving time-and-a-half, enter the standard base rate, not time and a half rate. If this employee did not have an hourly rate but had a weekly, bi-weekly or monthly salary and has scheduled hours of work, divide the salary by the number of hours worked in the pay period to arrive at the hourly rate. If an employee is paid solely by commission or by mileage or some other method where scheduled hours are not used, the TTD rate will be based only on gross earnings. In such a case, enter "NA" in Section 1 and go on to Section 2. For employees paid on a piece work basis, compute the hourly piece work rate by dividing the earnings from piece work by the number of hours actually worked while on piece rate. Exclude time and a half earnings and hours in this computation. Use the piece rate amount only if the resulting rate is higher than the standard hourly rate. If the employee received tips, compute the additional hourly amount of tips. Enter that amount next to **"tip rate"** and add the hourly tip rate to the standard hourly rate to get the "standard base rate plus tips". Compute the tip rate by dividing total tip earnings (only the earnings received in tips) by total hours actually worked on a tip basis. The total hourly rate must be at least the legal minimum hourly wage.

Section 1b- Hours Per Week: Enter the normal number of hours scheduled (regular fixed schedule) at the time of injury). Include the number of hours the employee is paid at the time and a half rate. If the employee does not have regular scheduled hours, enter the number of hours which full-time employees normally work for the employer in this occupation. Include scheduled hours paid at a time-and-a-half rate in the number of "normally scheduled hours". If scheduled hours vary by more than 5 hours from week to week during the 90-day period immediately preceding the injury, use the number of hours that is normal for full time employees for this occupation. Check the box "Actually Worked" in Section 1b and enter the hours actually worked if the hourly rate in Section 1a is piece rate or includes tips. Check the "seasonal" box with **44** hours entered for employees who meet the definition of **"seasonal"** employees in s.102.11(1)(b) Wis. Stats. Seasonal employment cannot exceed 14 weeks. For part time employees, follow the instructions in Section 4.

Section 1c- Base Weekly Rate: Multiply the hourly rate in Section 1a times the hours used in Section 1b. For employees who worked a time and a half schedule at the time of injury and at least 13 consecutive weeks immediately prior to the injury, use the following formula: multiply the standard rate times the normal scheduled hours excluding those hours paid at the time-and-a-half rate; then multiply the time and a half rate times the time and a half hours, and add the two results to get the Base Weekly Rate.

Sections 1d & 1e- Hourly Wages/Additions to Base Average Weekly Wages and Average Weekly Earnings: Enter here and in Section 2d (except for tips) the weekly value of any other type of compensation the employee received, as shown in Section 3.

Section 2a-e Gross Wages and Average Weekly Earnings Enter the gross wages and the number of weeks the employee worked on that job (same type of work) in the 52-week period prior to the date of injury. When counting weeks for Section 2b, do not Include the week of injury in the 52-week period. Count partial weeks as whole weeks. Include tips and additions to wages from Section 3 in section 2e. For employees who worked less than 6 weeks, TTD will be determined solely by the hourly rate in Section 1 or, if the employee does not have an hourly rate, by wages paid in a "same or similar" occupation. Enter "same or similar" wages in Section 2e and skip 2a, 2c and 2d. Complete the computations in Sections 2c, d and e for all others.

Section 3- Additions to Cash Wages: Enter the weekly value of any additional compensation paid to the employee. This value is added to the computations in Sections 1 and 2. The standard value of **"meals"** and **"room"** is set in Wis. Admin. Code DWD 80.29 and DWD 272. The value of all other items is set by common marketplace value to the employee.

Section 4- Part-Time Employment: Complete this Section for all workers at less than the maximum TTD rate if they were scheduled to work less than 35 hours per week at the time of injury.

Part of Class Determination: Complete this part before choosing and checking the applicable Section 4a, 4b or 4c. If the employee's regular work schedule varies by more than 5 hours per week during the 90-day period immediately preceding the injury, always consider the employee as "not part of class". Choose Section 4a, 4b or 4c that applies to the employee before doing the computations in Sections 1 or 2 to set the wage for the employee. If you check Section 4b, you will need to check the box in Section 1b "expand to normal full-time" and enter the number of normal full-time hours there for this occupation. Use the number of hours that are normally considered as full-time for that employer for that occupation to compute the wage.
Self Restriction: An employee "self restricts" employment if he/she limits his/her availability on the labor market to part-time work only and was not employed elsewhere. If you indicate that the worker self-restricts in Section 4c and wages are set at 100%, you must attach a copy of a self-restriction statement signed by the employee, stating the limitation to part-time and that he/she was not working elsewhere at the time of injury. A sample statement can be found in the training website at **http://www.dwd.state.wi.us/wc_train**.

Section 5-- Wage and Rate Computation: Enter the wage used to compute the TTD rate (the higher amount from Section 1e or 2e). The rate in Section 5c is computed by multiplying the wage by either 66.67% or by 100% (see Section 4c).
Exception to using 100% in Sections 4c and 5b: If using 100% in Section 4c exceeds 66.67% of the wages of a full-time employee doing this job, use 66.67% of wages (higher of 1e or 2e) after expanding the hours in Section 1b to full-time.
Exception Note: If this employee's employment situation is unique and you cannot use the computation formulas in Sections 1 and 2, indicate the wage and TTD rate in Section 5, and attach an explanation of how you computed the wage and TTD rate to this request.

Voluntary and Informed Consent for Disclosure of Health Care Information

The provision of your social security number is mandatory under Wisconsin Statutes and will be used to identify the claimant. Failure to provide it may result in penalties or delayed payment of benefits. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://dwd.wisconsin.gov/wc/
e-mail: DWDDWC@dwd.wisconsin.gov

By law, all health care providers must provide to any employee, employer, worker's compensation insurer or their representative any information reasonably related to any alleged work injury. However, determining the relationship of prior medical records to a work injury can be difficult and time-consuming. Therefore, to assist in the timely investigation of your claim, this document authorizes the health care provider to release medical information without attempting to determine the extent of its relationship to your alleged work injury.

You are not required to sign this document. You may refuse to sign this document without jeopardizing your right to collect worker's compensation benefits. However, by assisting in the investigation of your claim, you are likely to receive benefits quicker than if you refuse to authorize the release of medical information.

Health Care Provider Name		Street Address	
P. O. Box	City	State	Zip Code
Patient (Employee) Name		Employer Name	
Patient Social Security Number - -	Patient Birth Date	WC Claim No.	

The patient named above hereby authorizes the health care provider named above to disclose all records checked below in its possession relating to the patient's health, treatment and evaluation to:

Name and Address of Party Authorized to Receive Protected Information

or its designated representatives, and to furnish to them a legible, certified duplicate of all records, writings, reports, test results and x-rays in its possession containing such information. This authorization includes *all* records, reports, correspondence, or other materials in the possession of the health care provider authorized, even if those materials were not generated by the health care provider, and the redisclosure of such materials is hereby authorized. This release is for use in the investigation, preparation, evaluation, and/or hearing of the worker's compensation claim described above.

CHECK ONE:

☐ **A.** **Physical Only**. Release all records, correspondence, and any other information from whatever source regarding the patient's physical health, treatment and evaluation including, but not limited to, any made or provided by any physician, nurse, chiropractor, osteopath, dentist, physical therapist, hospital, or any other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited to Wis. Stat. §§ 146.81 and 146.82, and 45 C.F.R. § 164.508.

☐ **B.** **Physical and Other**. Release all records, correspondence, and any other information from whatever source regarding the patient's physical and mental health, drug and alcohol abuse, HIV and AIDS tests, treatment, and evaluation including, but not limited to, any made or provided by any physician, psychiatrist, psychologist, nurse, chiropractor, osteopath, dentist, physical therapist, hospital or any other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited Wis. Stat. §§ 51.30, 146.025, 146.81 and 146.82, 42 C.F.R., Chap. 1, subpart C, § 2.31 and 45 C.F.R. § 164.508.

Patient Signature (or Person Authorized to Sign for Patient) — for Option B

Patient Signature (or Person Authorized to Sign for Patient)	Date

WKC-9488 (R. 03/2009)

In signing this consent form, I acknowledge that I understand that:

- I am authorizing release of the records and information listed above.
- I am waiving any privilege that may otherwise prevent disclosure of the records and information listed above.
- I understand that the health care provider named above, whom I am authorizing to disclose my protected health information, may not condition my treatment, payment, enrollment or eligibility for benefits (if applicable) on whether I sign this authorization, except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.
- I may revoke this authorization at any time by a written request to the party authorized above to receive information, except that the party authorized above to receive such information may rely upon any personal health information received before the revocation of this authorization.
- I may obtain a copy of the disclosed records and information, upon written request to the party authorized above to receive information, at no charge to me.
- My personal health information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by federal law. My personal health information may be released to any of the following: the employer, the worker's compensation insurer, the Department of Workforce Development, other parties to this matter or their attorneys; the Labor and Industry Review Commission; any court on any action or proceeding relating to this matter; experts retained or consulted by any party; and any of their agents, employees, or representatives. I specifically authorize and consent to any such disclosure and redisclosure.
- I am entitled to a copy of this consent form after I sign it.

If you have any questions about this document, you should contact the Worker's Compensation Division at (608) 266-1340. You should not sign this document if the name of the health care provider is blank.

This consent is subject to revocation at any time. If not revoked, this consent is effective for two (2) years from date signed. This authorization expressly waives any requirement that it must be used within a certain number of days after the date of signing, or that it must be dated within any time period before the date it is used. This authorization shall also extend to records of future treatment, after the date of signing of this authorization, as long as such treatment occurs while this authorization is still in effect. A photocopy copy shall be as valid as the original.

Patient Signature (or Person Authorized to Sign for Patient)	Date
If not signed by patient, authority/designation to sign is based on the fact that the patient is ☐ A minor ☐ Incompetent ☐ Disabled ☐ Deceased ☐ Other:	