

CONNECTICUT WORKERS' COMPENSATION INSURANCE PROGRAM
IMPORTANT NOTICE

POLICY HOLDERS NOTICE OF LOSS CONTROL SERVICES

In compliance with the Connecticut Workers' Compensation Insurance plan, we provide for our policyholders a broad range of Loss Control Services. When requested, our Loss Control Department is prepared to provide, at no additional charge, the following services:

1. Consultative services pertaining to the safety performance of your business and operations.
2. An appraisal of the various mechanical hazards, material handling methods, chemical and ergonomic exposures that may exist at your business.
3. Advice and assistance in the recognition, evaluation and control of occupational safety and health hazards.
4. Advice and assistance in coordinating and implementing employee safety and health programs.
5. Recommendations for corrective actions to address workplace hazards identified in conjunction with other services provided.
6. Assistance in developing a comprehensive safety and health program for your business, including the following elements:
 - Safety Policy
 - Safety Rules
 - Safety Inspections, both Regular and Periodic
 - Preventative Maintenance Programs
 - Safety and Health Training Programs
 - First Aid Programs
 - Accident Investigation Programs
 - Recordkeeping

(Note: Our representatives are ethically and legally required to submit recommendations for discrepancies and deficiencies discovered in the course of their consultations with you. Mandatory compliance may be required.)

Contact Us

If you wish to have the Loss Control Department provide any of these services for your business:


Telephone: (678) 258-8105

Toll-Free: 1-877-882-1305
(please ask for the Loss Control Department)

e-mail: ARlosscontrol@amtrustgroup.com

Or detach the coupon below and mail to:

AmTrust North America
Attn: Gina Forstman
P.O. Box 740042
Atlanta, GA 30374-0042

_____  _____

Yes, we are interested in Loss Control Assistance.

Company Name: _____ **Policy Number:** _____

Address: _____

Telephone Number: _____ **Person to Contact:** _____

Position/Title: _____

Workers' Compensation Quick Reference Guide

Carrier: Technology Insurance Company

Claim Administrator: Amtrust North America
P.O. Box 105074
Atlanta, GA 30348-5074
678-258-8000 Fax - 678-258-8399
Toll Free: 888-239-3909

CONTACTS

Claims Analyst: Joe Maldonado 888-239-3909 x 463016
Policy Svcs/Loss Control: Gina Forstman 678-258-8105
Customer Service: 877-882-1305

YOUR DUTIES UNDER THE WCIP

1. Pay all premiums promptly and timely
2. Advise us or your agent of any material change in your corporate entity, location of business or a change in the nature of your business.
3. All claims must be reported timely.
4. Payroll and overtime records must be available at all times.
5. Allow reasonable access to your workplace for safety inspections during business hours.
6. Loss Control recommendations must be complied within specified time frames.

Lack of cooperation in any of these areas could result in cancellation.

YOUR RESPONSIBILITIES BEFORE & AFTER AN INJURY

1. **Report all injuries immediately on the proper State Board forms.**
2. Emergency Situations:
In case of emergency send the injured employee to the closest emergency facility.
3. Assist injured employees in getting appropriate medical care.

Technology Insurance Company

For Worker's Compensation Claims

24/7 Toll Free Claim Reporting for All States



(888)239-3909



WorkersCompClaimReport@AmTrustgroup.com



www.amtrustfinancial.com

When a work injury is reported to you, simply email the claim report to the email address stated above. The state law **requires the employer to timely and fully complete the State specific First Report of Injury form.** You must have the following information available when you complete the claim form:

Information Required for All Claims Reported



1. Name of employer (name as it appears on the policy is preferred).
2. Policy Number, if known.
3. Injured employees': Name, Address, Phone, Social Security Number, Date of Hire and Date of Birth.
4. Date, Time & Place of Incident
5. Description of accident or incident
6. Nature of Injury
7. Name & phone for initial medical provider, if known.
8. Wage Information



Optum
 PO Box 152539
 Tampa, FL 33684-2539

MAKING IT EASY...

TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:



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. The pharmacist will fill your prescription at low or no cost to you.



If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.




Most pharmacies, including Walgreens, our preferred provider, 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



WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
CARRIER/TPA EMPLOYER

INJURED WORKER 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

	<u>NDC</u>	or	<u>Envoy</u>
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	<u>FF</u>		

NOTE: This First Fill card is only valid for your workers' compensation injury or illness.



Employer:

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

The following entities comprise the Optum Workers Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers Compensation Medical Services, collectively and individually referred as "Optum."



HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL 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 su 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.

Empleado lesionado:



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. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.



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.




La mayoría de farmacias, incluyendo Walgreens, nuestro proveedor preferido, y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

**¿Tiene alguna pregunta?
 ¿Necesita ayuda?**



1-866-599-5426



WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
 PORTADORA EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

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. #
GROUP	FF	

NOTA: Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.



Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

RETURN-TO-WORK; A GREAT IDEA

We at the AmTrust Group, are convinced that an employer who provides light, or restricted work for injured employees, enjoys numerous benefits. This is not just an opinion, it's something we see day in and day out. Consider:

- Unless an injured worker returns to the workplace within 60 days, chances of him/her ever returning drop dramatically. (resulting in a very expensive permanent disability situation.)
- After 6 months away from the workplace, only 50% chance of return.
- After 12 months, only a 10% chance of return.

Some Return-to Work Benefits Include:

- "Test" of malingering potential. Injured employees who refuse light duty are more prone to being malingerers.
- Opportunity for employer to demonstrate true concern for workers' well-being.
- Promotion of rehabilitation and recovery.
- Lower medical and rehabilitation costs.
- Productivity.
- Morale improvement for the injured worker.
- Ability for the employer to monitor the injured employee's recovery progress.
- Decrease of WC claims costs, with resultant downstream WC premium savings.

(Notice we're not just talking about 'feel-good' issues, but also hard dollars !)

Some common misconceptions (and truths) about Return-to-Work / Light Duty:

Misconception: *We've already got too many "programs" around here, and don't need any more paper.*

Truth: While it is true a written, planned program works best, in many cases a Light Duty "program" can be nothing more than a management understanding of the benefits and principles of Return-to-Work, how it works, and the commitment to 'just do it', when light-duty recommendations are made by WC physicians.

Misconception: *It will get me into an Americans With Disabilities (ADA) "situation".*

Truth: Light-duty and ADA "reasonable accommodation" are two entirely separate issues. Generally, light duty is a temporary assignment, for a relatively short period. ADA accommodations are made for serious, permanent disabilities that impair major life activities.

Misconception: *I'll have to devise a whole new job each time an employee needs light duty.*

Truth: The vast majority of light-duty restrictions require accommodating only one or two factors, such as "no lifting over 10 pounds", or the like. In many cases, if you break the jobs down into individual **tasks**, you'll see that only one or two tasks within the employee's normal job are affected, and can be handled in some other way.

Misconception: *Once an employee gets into a "cushy" light-duty job, s/he'll never leave it, and I'll be stuck with it.*

Truth: Light duty is always defined by, and monitored by the attending physician. An employee on light duty is periodically monitored by the physician for improvement, and is released for full-duty as soon as medically indicated.

Misconception: *We're a union company. Our union won't allow us to pay lower rates, or move employees between classifications, or between bargaining groups.*

Truth: Any Local that objects to a Return-to-Work program should be referred to its national body for guidance. Return to Work is universally recognized as a very positive influence on an injured worker (as well as benefiting the employer). Labor unions, whose major purpose for existence is the benefit of the workers they represent, should not only "tolerate" Return-to-Work programs, but enthusiastically promote, and assist in such programs' implementation and operation. It is strongly suggested that management approach labor representatives to solicit their input, and assistance in making Return to Work a positive force in your workplace.

Misconception: *I might be willing to place a worker in a light-duty position, but I can't afford pay them their full pay, for the decreased productivity.*

Truth: Talk to your WC insurer's claims professional. In many cases, states' WC plans provide for "make-up" pay to replace some, or all of the injured employees' decreased earnings. The goal of getting them back to the workplace, and doing some productive work is that important!

YOUR BUSINESS AND UNINSURED SUBCONTRACTORS

Many otherwise knowledgeable business owners utilize uninsured subcontractors for various services; unaware of the risks they are incurring for their businesses. An uninsured subcontractor is typically a business that does not provide workers compensation insurance for its employees. This may be because the business is a “one-man shop”, and believes he wants to personally assume the risk of financial loss in the event of injury; in other cases it may be ignorance of the law; or an effort to avoid the cost of workers’ compensation insurance. Uninsured subcontractors often appear as construction tradespeople, service firms (especially small operators), and others.

In truth, there are no uninsured subcontractors. When an “uninsured subcontractor” employee, (including a one-man business) is injured while working on your behalf, the courts have repeatedly held that it is in the public interest that you, the beneficiary of the sub’s work, provide workers’ compensation coverage for these “uninsured employees.” You cannot opt out of this duty. No one can sign a document of any kind and relieve you of this responsibility. You are carrying these employees on your workers’ compensation policy whether you want to or not, whether you even realize it or not. Because of this “involuntary coverage”, when an insurance company auditor finds payment to uninsured subcontractors, he will treat this payment as your payroll, and you will receive a bill for additional premium. With high-hazard occupations, such as steel erectors, roofers, and others, you may be shocked to find that one or two uninsured subs have more than doubled your workers compensation premium! Some businesses, aware of this problem, use “hold-backs”, “retainages” or “backcharges” of a set percentage of job cost, often 10% or 15% to try and offset the additional premiums they know they’ll have to pay for using uninsured subcontractors. The problem with this is that each of the trades carries different rates, according to the relative hazard of the trade. Rates are expressed in dollars per hundred dollars of payroll, so there’s an easy-to-see correlation in percentages. Rates not only vary by trade, but they can fluctuate from state-

to state, they can vary according to the rate filings of different companies, and they go up and down according to actuarial loss experience. Trying to obtain and keep up with this many rates is a time-consuming and unproductive task, well beyond the capabilities of most businesses.

You’re probably aware that safety pays, and you make certain efforts to be sure your direct employees do not take unnecessary risks, do not work with unnecessarily dangerous or broken tools and equipment, and are protected from toxic materials. But a subcontractor might not take these precautions. And if his carelessness leads to employee injury, your claim history will be damaged.

RECOMMENDATIONS—

- 1.) Avoid using any uninsured subs, but especially high-hazard occupations such as roofing, carpenters, and painters. It is false economy to use uninsured businessmen who seem to offer lower costs. They may be operating outside the law, and in fact, are transferring the costs of their risk, and potential economic devastation, to you.
- 2.) Obtain current certificates of workers compensation (and other applicable coverage) from the sub's insurance agent or insurance carrier. Implement a hard and fast rule—"No insurance certificate—no check on Friday".
- 3.) You can easily keep copies of all certificates in a notebook, and check the expiration dates before giving work to a particular subcontractor. Copies of all certificates should be retained.

YOUR INSURANCE AUDIT –

At the end of your policy period, we will conduct an audit. In addition to tax documents, the auditor will ask for documentation of all wages paid to both employees and subcontractors. The auditor will also ask to see the certificates of insurance for each insured subcontractor. If you have a valid certificate that covers the time period that your sub was paid, this payment will not be charged to your work comp policy.

The auditor will ask for the first and last date that each sub was paid during your policy period. We are looking for the time range that each subcontractor was paid, so that we can ensure that this subcontractor had his own coverage during the time he worked for you.

If you take time throughout the year to request certificates and organize them, you will find it very beneficial at the time of audit.



**State of Connecticut
Workers' Compensation Commission**

Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011

Rev. 7-13-2009

FRI

Date filed in Chairman's Office

Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT IN INK.

(for WCC use only)

Employer (Name, Address & Zip)		Phone #	Carrier / Administrator Claim #		OSHA Log Case #	Report Purpose Code
SIC Code		FEIN		Jurisdiction	Jurisdiction Claim #	
				Employer's Location Address (if different)		Phone #
Carrier (Name, Address & Zip)			Phone # 888-239-3909		Claims Administrator (Name, Address & Zip)	
TECHNOLOGY INSURANCE COMPANY P.O. BOX 105010 ATLANTA, GA 30348-5010					Phone #	
Policy / Self-Insured #			<input type="checkbox"/> Check, if Self-Insured	Policy Period (MM/DD/YY)		
				FROM: TO:		
Employee: Last Name		First Name	Middle Name	Gender	Date Hired (MM/DD/YY)	State of Hire
D.O.B. (required)		Phone #		<input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation / Job Title	
Address (incl. Zip)					Rate of Pay \$ _____ per	NCCI Class Code
				<input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Other		
Date of Injury / Illness (MM/DD/YY)		Town of Injury / Illness		Physician / Health Care Provider (Name, Address & Zip)		
Time Employee Began Work		Did Injury / Illness occur on Employer's Premises?		Hospital (Name, Address & Zip)		
<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		<input type="checkbox"/> Yes <input type="checkbox"/> No				
Time of Occurrence		Type of Injury / Illness				
<input type="checkbox"/> cannot be determined		Part of Body Affected				
<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Type of Injury / Illness Code				
Date Employer Notified (MM/DD/YY)		Part of Body Affected Code				
Date Disability Began (MM/DD/YY)		Were Safeguards or Safety Equipment provided?				
Date Last Worked (MM/DD/YY)		<input type="checkbox"/> Yes <input type="checkbox"/> No				
Date Return(ed) to Work (MM/DD/YY)		If provided, were they used?				
<input type="checkbox"/> Yes <input type="checkbox"/> No		How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:				
If Fatal, Date of Death (MM/DD/YY)				Initial Treatment		
All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:				<input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Emergency Care		
				<input type="checkbox"/> Minor — by Employer <input type="checkbox"/> Hospitalized More Than 24 Hours		
				<input type="checkbox"/> Minor — by Clinic / Hospital <input type="checkbox"/> Future Major Medical — Lost Time Anticipated		
Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:				Date Administrator Notified (MM/DD/YY)		Date Prepared (MM/DD/YY)
				Preparer's Name & Title		Phone #
Contact Name						
Phone #		Cause of Injury Code				



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Workers' Compensation Commission**

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Employer (Name, Address & Zip)		Phone #	Carrier / Administrator Claim #		OSHA Log Case #	Report Purpose Code
SIC Code		FEIN		Jurisdiction	Jurisdiction Claim #	
				Employer's Location Address (if different)		Phone #
Carrier (Name, Address & Zip)			Phone # 888-239-3909		Claims Administrator (Name, Address & Zip)	
TECHNOLOGY INSURANCE COMPANY P.O. BOX 105010 ATLANTA, GA 30348-5010					Phone #	
Policy / Self-Insured #			<input type="checkbox"/> Check, if Self-Insured	Policy Period (MM/DD/YY)		
				FROM: TO:		
Employee: Last Name		First Name	Middle Name	Gender	Date Hired (MM/DD/YY)	
D.O.B. (required)		Phone #		<input type="checkbox"/> Male <input type="checkbox"/> Female	State of Hire	
Address (incl. Zip)					Occupation / Job Title	NCCI Class Code
Rate of Pay \$ _____ . _____ per				<input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Other		
Date of Injury / Illness (MM/DD/YY)		Town of Injury / Illness		Physician / Health Care Provider (Name, Address & Zip)		
Time Employee Began Work		Did Injury / Illness occur on Employer's Premises?		Hospital (Name, Address & Zip)		
<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		<input type="checkbox"/> Yes <input type="checkbox"/> No				
Time of Occurrence		Type of Injury / Illness				
<input type="checkbox"/> cannot be determined		Part of Body Affected				
Date Employer Notified (MM/DD/YY)		Type of Injury / Illness Code				
Date Disability Began (MM/DD/YY)		Part of Body Affected Code				
Date Last Worked (MM/DD/YY)		Were Safeguards or Safety Equipment provided?				
Date Return(ed) to Work (MM/DD/YY)		<input type="checkbox"/> Yes <input type="checkbox"/> No				
If Fatal, Date of Death (MM/DD/YY)		If provided, were they used?				
<input type="checkbox"/> Yes <input type="checkbox"/> No		How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:				
All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:				Initial Treatment		
Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:				<input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Emergency Care		
Contact Name				<input type="checkbox"/> Minor — by Employer <input type="checkbox"/> Hospitalized More Than 24 Hours		
Phone #		Cause of Injury Code		<input type="checkbox"/> Minor — by Clinic / Hospital <input type="checkbox"/> Future Major Medical — Lost Time Anticipated		
				Date Administrator Notified (MM/DD/YY)		Date Prepared (MM/DD/YY)
				Preparer's Name & Title		Phone #