When replying, refer to: Customer Number
Policy Number
Policy Period to

Dear Insured:

SUBJECT: WORKERS' COMPENSATION CLAIM INFORMATION

Thank you for choosing NSI, a division of West Bend Mutual Insurance Company, as your insurance carrier for your Workers Compensation Coverage. The associates of NSI look forward to working with you to control the cost and number of work related incidents.

West Bend is pleased to provide you with …

1. Workers' Compensation reporting tips that are helpful when you must report a work-related injury.
2. Employer's First Report of Injury or Disease form.
3. Supervisor's Incident Report.
4. A description of our cost containment initiatives.

The following forms are also available and are helpful in returning your employee to work …

1. **Job Analysis.** (WB 501) Use this form when working with the treating physician.
2. **Attending Physicians Return to Work Recommendations Record.** (WB 531) Send this with the injured employee to the initial treating doctor's appointment. You may ask the employee to return the form directly to you after initial medical treatment, or ask the doctor to fax it back to you.
3. **Return to Work Log.** (WB 603) Use this log as an efficient method to monitor and document the specific tasks your employees are performing while on light or modified duty.

We hope you find this information useful.

Sincerely,

NSI
Workers' Compensation Claim Department

NS 0212 B 03 07

WORKERS' COMPENSATION REPORTING TIPS

– ATTENTION–
YOU MAY BE FINED IF YOU DO NOT REPORT ON–THE–JOB INJURIES ON TIME

You must complete an Employer's First Report of Injury IMMEDIATELY after an on–the–job injury occurs and forward the report to your claims administrator. **You may be fined if you do not submit the report on time.**

Send, fax, call, or e-mail the initial loss report immediately, even if you do not have all the information about the injury.

- Do not wait for medical bills.
- Do not withhold the loss report because you believe the claim is questionable. Reporting a loss is not an admission of liability.
- Be sure to include the policy number on all correspondence.

Please mail, fax, call, or e-mail the report to:

West Bend Mutual Insurance Company Claims:

All States

Workers' Compensation Claims Department
West Bend Mutual Insurance Company
1900 S. 18th Avenue
West Bend, WI 53095
Phone: 877-922-5246
FAX: 888-926-9299 or 262-334-6378
e-mail: directconnect@wbmi.com

General Questions:
Phone: 800-236-5004 or 334-6430
e-mail: wccentral@wbmi.com

NSI Claims:

Workers' Compensation Claims Department
8401 Greenway Blvd., Ste 1100
Middleton, WI 53562
Phone: 800-760-9250
Fax: 877-434-9585
e-mail: nsiclaims@wbmi.com

Do not withhold the loss report for any reason. Send, fax, call, or e-mail it **IMMEDIATELY** after the injury occurs. **You may be fined** if the claims administrator cannot make the initial lost time payment because you failed to send the Employer's First Report of Injury on time.

If you fax or e-mail the report, please do not send it. If you need to notify your agent, please send your agent a photocopy of the report. Direct reporting saves time.

If you have any questions, please call your claims administrator.

HOW TO WRITE INJURY DESCRIPTIONS

The following instructions will help you avoid some common errors and save time when describing an injury on the First Report of Injury form.

For most accidents, you can describe what happened in one or two sentences. "He strained his lower back lifting a box." "She bruised her left knee when she fell on a wet floor." However, your descriptions must be specific. "Hurt back working" does not provide enough information.

Answer the following questions when describing an injury:

1.What part of the body was injured?

- Lower back
- Upper right leg
- Right forearm
- Third toe on left foot

2. How did the accident happen?

- Did the person fall?
- Did they twist their body as they got out of a chair?
- Were they moving or stationary when the accident happened?

3. Was the injured person carrying anything?

Even if it probably didn't cause the injury, we need to know if the person was carrying anything. For example, "Carrying broom, stepped wrong and twisted left ankle."

4. What specifically appears to have caused the accident?

If someone hurt their back lifting a box, say that. Don't say:

- Lifting a unit of material
- Lifting equipment
- They hurt their back lifting product

Avoid jargon or trade names for equipment. Explain precisely what they were doing.

- Lifting an air conditioner
- Carrying magazines
- Pushing a cart
- Bending over to pick up a wrench

If a machine caused the injury, tell us what kind.

- A grinder
- A shear
- A hoist

Again, avoid jargon or trade names.

5. What injury appears to have resulted?

- Strain
- Bruise
- Fracture
- Cut

Please be sure to include the injured person's birthdate or age and Social Security number. Also, indicate the geographical location of the accident (city, county and state).

NSI
A DIVISION OF
WEST BEND
A MUTUAL INSURANCE COMPANY™

YOUR RETURN-TO-WORK PROGRAM

What Is A Return-To-Work Program?

A return-to-work program is a proactive way to help injured workers return to productive and safe employment as soon as physically possible. It is a partnership involving employers, workers, health care providers, and the insurance company. The partnership has one shared goal: to return injured workers to safe and suitable work.

Why Introduce A Return-To-Work Program?

Workplace injuries are costly to all members of today's workplace partnership. While accident prevention is the best way to reduce overall injury costs, the implementation of an effective return-to-work program helps to guarantee that each injured worker receives prompt health care and early assistance during both the initial stages of recovery and the subsequent return to productive employment

Key Steps to a Successful Return-To-Work Program

- Involve and communicate with your workforce
- Organize a Joint Return-To-Work Committee
- Select a Return-To-Work Manager
- Evaluate the needs of your workplace
- Develop a Return-To-Work policy and define the program's scope
- Formulate the objectives of your Return-To-Work Program
- Review your worksite accident history
- Create rules and processes
- Conduct a job task analysis
- Develop light duty activities
- Create and utilize an information package
- Facilitate communication, education and promotion
- Evaluate the results of your program

The Claim Process:

1. Injury occurs and employee reports a claim.
2. Employers First Report of Injury is filed with the insurance carrier within 24 hours.
3. Employee incident report is completed by the injured employee.
4. Supervisor incident report is completed by the supervisor.
5. File the Employee and Supervisors Reports, along with any other investigation results to the insurance carrier.
6. Employer explains WC rights and responsibilities to the employee.
7. Employer provides the employee a restricted duty form for the physician to complete. One of the following will occur;
   A. The employee will return to fulltime, unrestricted work.
   B. The employee will be authorized off of work by the physician.
      * The employer should contact the physician regarding the R-T-W policy and procedure.
      * Follow up with the injured employee weekly to discuss R-T-W options.
      * Once R-T-W restrictions become available, advise the claimant in writing of odder to provide restricted work.
   C. The employee will return to work within restricted duty.
      * W/C Coordinator communicates restrictions to supervisor and insurance carrier.
      * Follow up with employee weekly to monitor progress.
   D. The employee will return to work without a release or clear restrictions. The employer should do one of the following:
      * Call the physician to clarify restrictions and request R-T-W forms.
      * Fax, mail or deliver a letter outlining the availability of restricted work, along with R-T-W form to the physician.
8. Employer continues to monitor and gather information regarding treatment and R-T-W. Provide this information to the insurance carrier to ensure prompt handling of the claim and coordinated R-T-W efforts.
9. Review progress of the claim with the insurance carrier on a quarterly basis or until closure of the claim.

COMPLETING THE EMPLOYERS FIRST REPORT OF INJURY

1. Each time an employee alleges a work-related condition, a First Report of Injury should be completed by Management not Employees.
2. The report should be filled out as completely as possible without holding up or delaying the reporting. If there is something you don't know – leave it blank – do not hold up the report.
3. If there are any questions on filling out the report do not hesitate to call our office.
4. The most important areas which need to be completed are:
   a. Employee's Information: address, social security number, phone number, date of birth, and occupation.
   b. Employer's Information: name, address, phone number of contact person, etc.
   c. The date of injury
   d. The date the injury was reported to the employer
   e. The last day worked (applies to time loss claims)
   f. Area of body injured
   g. Name and number of contact
   h. Location and Department codes (if applicable)

FOLLOW ATTACHED EXAMPLES . . .

"NOTICE ONLY"	"MEDICAL ONLY"	"TIME LOSS"
No medical treatment	Medical treatment	Medical treatment
No time loss from work	No time loss from work	Loss time from work

Sample - Notice Only

DIVISION OF WORKERS' COMPENSATION

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

REPORT OF INJURY

P.O. Box 58
Jefferson City, MO 65102-0058
(To complete form, see attached instructions)

GENERAL

EMPLOYER *(NAME, ADDRESS, INCL ZIP CODE)*
X

CARRIER ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE
00

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYERS LOCATION ADDRESS *(IF DIFFERENT)*
X

LOCATION #

SIC CODE
X

EMPLOYER FEIN
X

PHONE #
X

CARRIER / CLAIMS ADMIN

CARRIER *(NAME, ADDRESS & PHONE NO.)*
NSI, A Division of West Bend Mutual Insurance Company
8401 Greenway Blvd, Suite 1100
Middleton, WI 53562
Phone: 800-760-9250
Fax: 877-434-9585

POLICY PERIOD
to

CLAIMS ADMINISTRATOR *(NAME, ADDRESS & PHONE NO.)*

CHECK IF APPROPRIATE
☐ SELF INSURANCE

CARRIER FEIN
39-0698170

INSURANCE POLICY NUMBER
X

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE

NAME *(LAST, FIRST, MIDDLE)*
X

DATE OF BIRTH
X

SOCIAL SECURITY #
X

DATE HIRED
X

STATE OF HIRE

ADDRESS *(INCLUDE ZIP)*
X

SEX X
☐ MALE
☐ FEMALE
☐ UNKNOWN

MARITAL STATUS X
☐ UNMARRIED
SINGLE DIVORCED
☐ MARRIED
☐ SEPARATED
☐ UNKNOWN

OCCUPATION JOB TITLE
X

EMPLOYMENT STATUS

PHONE #
X

OF DEPENDENTS

NCCI CLASS CODE

WAGE

RATE PER
☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER

OF DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY / ILLNESS
X

TIME OF OCCURRENCE ☐ AM ☐ PM
X

LAST WORK DATE

DATE EMPLOYER NOTIFIED
X

DATE DISABILITY BEGAN
No Lost Time

CONTACT NAME PHONE NUMBER
X

TYPE OF INJURY ILLNESS
X

PART OF BODY AFFECTED
X

DID INJURY ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? X ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

ZIP CODE OF THE LOCATION WHERE THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED
X

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.
X

CAUSE OF INJURY CODE

DATE RETURN TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

TREATMENT

PHYSICIAN HEALTH CARE PROVIDER *(NAME & ADDRESS)*
No medical treatment

HOSPITAL *(NAME & ADDRESS)*

INITIAL TREATMENT
☐ 0 - NO MEDICAL TREATMENT
☐ 1 - MINOR: BY EMPLOYER
☐ 2 - MINOR CLINIC HOSPITAL
☐ 3 - EMERGENCY CASE
☐ 4 - HOSPITALIZED > 24 HOURS
☐ 5 - FUTURE MAJ. MED. LOST TIME ANTICIPATED

OTHERS

WITNESS *(NAME & PHONE #)*

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

NOTE > This form constitutes both the original notification of injury and detailed report of injury required by §287.380, RSMo (2000) and rules applicable thereto. An injury that requires immediate first aid, which does not result in further medical treatment or lost time from work, need not be reported to the Division. Employers should report all injuries to their workers' compensation insurance carrier or third-party administrator (TPA) within five days of the date of the injury or within five days of the date on which the injury was reported to the employer by the employee, whichever is later. See §287.380, RSMo. If the employer has been granted self-insurance authority by the Division pursuant to §287.280, RSMo, and rules applicable thereto, please report all injuries to your TPA or Service Company to enable them to file this report with the Division.

PRINT QUALITY > All reports of injury and supporting documents received by the Division will be processed electronically. All forms submitted to the Division MUST be of clear and legible quality. Handwritten forms will not be accepted. Computer generated forms shall use a **minimum** type size of **10 points**. All documents not meeting the above criteria will be returned.

TO BE ANSWERED ONLY IN CASE OF DEATH

DATE OF DEATH

EMPLOYEE'S DEPENDENTS

NAME OF DEPENDENT	RELATION TO EMPLOYEE	ADDRESS OF DEPENDENT			
		ADDRESS	CITY	STATE	ZIP CODE

Sample - Medical Only

DIVISION OF WORKERS' COMPENSATION

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

REPORT OF INJURY

P.O. Box 58
Jefferson City, MO 65102-0058
(To complete form, see attached instructions)

GENERAL

EMPLOYER *(NAME, ADDRESS, INCL ZIP CODE)*
X

CARRIER ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE
00

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYERS LOCATION ADDRESS *(IF DIFFERENT)*
X

LOCATION #

SIC CODE
X

EMPLOYER FEIN
X

PHONE #
X

CARRIER / CLAIMS ADMIN

CARRIER *(NAME, ADDRESS & PHONE NO.)*
NSI, A Division of West Bend Mutual Insurance Company
8401 Greenway Blvd, Suite 1100
Middleton, WI 53562
Phone: 800-760-9250
Fax: 877-434-9585

POLICY PERIOD
to

CHECK IF APPROPRIATE
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR *(NAME, ADDRESS & PHONE NO.)*

CARRIER FEIN
39-0698170

INSURANCE POLICY NUMBER
X

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE

NAME *(LAST, FIRST, MIDDLE)*
X

DATE OF BIRTH
X

SOCIAL SECURITY #
X

DATE HIRED
X

STATE OF HIRE

ADDRESS *(INCLUDE ZIP)*
X

SEX X
☐ MALE
☐ FEMALE
☐ UNKNOWN

MARITAL STATUS X
☐ UNMARRIED
SINGLE DIVORCED
☐ MARRIED
☐ SEPARATED
☐ UNKNOWN

OCCUPATION JOB TITLE
X

EMPLOYMENT STATUS

PHONE #
X

OF DEPENDENTS

NCCI CLASS CODE

WAGE

RATE PER
☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER

OF DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY / ILLNESS
X

TIME OF OCCURRENCE ☐ AM ☐ PM
X

LAST WORK DATE

DATE EMPLOYER NOTIFIED
X

DATE DISABILITY BEGAN
No Lost Time

CONTACT NAME PHONE NUMBER
X

TYPE OF INJURY ILLNESS
X

PART OF BODY AFFECTED
X

DID INJURY ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? X ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

ZIP CODE OF THE LOCATION WHERE THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED
X

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.
X

CAUSE OF INJURY CODE

DATE RETURN TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

TREATMENT

PHYSICIAN HEALTH CARE PROVIDER *(NAME & ADDRESS)*
X

HOSPITAL *(NAME & ADDRESS)*
X

INITIAL TREATMENT
☐ 0 - NO MEDICAL TREATMENT
☐ 1 - MINOR: BY EMPLOYER
☐ 2 - MINOR CLINIC HOSPITAL
☐ 3 - EMERGENCY CASE
☐ 4 - HOSPITALIZED > 24 HOURS
☐ 5 - FUTURE MAJ. MED. LOST TIME ANTICIPATED

OTHERS

WITNESS *(NAME & PHONE #)*

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

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TO BE ANSWERED ONLY IN CASE OF DEATH

DATE OF DEATH

EMPLOYEE'S DEPENDENTS

NAME OF DEPENDENT	RELATION TO EMPLOYEE	ADDRESS OF DEPENDENT			
		ADDRESS	CITY	STATE	ZIP CODE

Sample - Time Loss Only

DIVISION OF WORKERS' COMPENSATION

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

REPORT OF INJURY

P.O. Box 58
Jefferson City, MO 65102-0058
(To complete form, see attached instructions)

GENERAL

EMPLOYER *(NAME, ADDRESS, INCL ZIP CODE)*
X

CARRIER ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE
00

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYERS LOCATION ADDRESS *(IF DIFFERENT)*
X

LOCATION #

PHONE #
X

SIC CODE
X

EMPLOYER FEIN
X

CARRIER / CLAIMS ADMIN

CARRIER *(NAME, ADDRESS & PHONE NO.)*
NSI, A Division of West Bend Mutual Insurance Company
8401 Greenway Blvd, Suite 1100
Middleton, WI 53562
Phone: 800-760-9250
Fax: 877-434-9585

POLICY PERIOD
to

CHECK IF APPROPRIATE
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR *(NAME, ADDRESS & PHONE NO.)*

CARRIER FEIN
39-0698170

INSURANCE POLICY NUMBER
X

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE

NAME *(LAST, FIRST, MIDDLE)*
X

DATE OF BIRTH
X

SOCIAL SECURITY #
X

DATE HIRED
X

STATE OF HIRE

ADDRESS *(INCLUDE ZIP)*
X

SEX X
☐ MALE
☐ FEMALE
☐ UNKNOWN

MARITAL STATUS X
☐ UNMARRIED
SINGLE DIVORCED
☐ MARRIED
☐ SEPARATED
☐ UNKNOWN

OCCUPATION JOB TITLE
X

EMPLOYMENT STATUS
X

PHONE #
X

OF DEPENDENTS
X

NCCI CLASS CODE

WAGE

RATE X PER
☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER

OF DAYS WORKED/WEEK
X

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? X ☐ YES ☐ NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM
X

DATE OF INJURY / ILLNESS
X

TIME OF OCCURRENCE ☐ AM ☐ PM
X

LAST WORK DATE
X

DATE EMPLOYER NOTIFIED
X

DATE DISABILITY BEGAN
X

CONTACT NAME PHONE NUMBER
X

TYPE OF INJURY ILLNESS
X

PART OF BODY AFFECTED
X

DID INJURY ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? X ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

ZIP CODE OF THE LOCATION WHERE THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED
X

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
X

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.
X

CAUSE OF INJURY CODE

DATE RETURN TO WORK
X

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

TREATMENT

PHYSICIAN HEALTH CARE PROVIDER *(NAME & ADDRESS)*
X

HOSPITAL *(NAME & ADDRESS)*
X

INITIAL TREATMENT
☐ 0 - NO MEDICAL TREATMENT
☐ 1 - MINOR: BY EMPLOYER
☐ 2 - MINOR CLINIC HOSPITAL
☐ 3 - EMERGENCY CASE
☐ 4 - HOSPITALIZED > 24 HOURS
☐ 5 - FUTURE MAJ. MED. LOST TIME ANTICIPATED

OTHERS

WITNESS *(NAME & PHONE #)*

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

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TO BE ANSWERED ONLY IN CASE OF DEATH

DATE OF DEATH

EMPLOYEE'S DEPENDENTS

NAME OF DEPENDENT	RELATION TO EMPLOYEE	ADDRESS OF DEPENDENT			
		ADDRESS	CITY	STATE	ZIP CODE

DIVISION OF WORKERS' COMPENSATION

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

REPORT OF INJURY

P.O. Box 58
Jefferson City, MO 65102-0058
(To complete form, see attached instructions)

GENERAL

EMPLOYER *(NAME, ADDRESS, INCL ZIP CODE)*

SIC CODE | EMPLOYER FEIN

CARRIER ADMINISTRATOR CLAIM NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYERS LOCATION ADDRESS *(IF DIFFERENT)* | LOCATION # | PHONE #

CARRIER / CLAIMS ADMIN

CARRIER *(NAME, ADDRESS & PHONE NO.)*
NSI, A Division of West Bend Mutual Insurance Company
8401 Greenway Blvd, Suite 1100
Middleton, WI 53562
Phone: 800-760-9250
Fax: 877-434-9585

POLICY PERIOD
to

CHECK IF APPROPRIATE
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR *(NAME, ADDRESS & PHONE NO.)*

CARRIER FEIN
39-0698170

INSURANCE POLICY NUMBER | ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE

NAME *(LAST, FIRST, MIDDLE)* | DATE OF BIRTH | SOCIAL SECURITY # | DATE HIRED | STATE OF HIRE

ADDRESS *(INCLUDE ZIP)*

SEX
☐ MALE
☐ FEMALE
☐ UNKNOWN

MARITAL STATUS
☐ UNMARRIED
SINGLE DIVORCED
☐ MARRIED
☐ SEPARATED
☐ UNKNOWN

OCCUPATION JOB TITLE

EMPLOYMENT STATUS

PHONE # | # OF DEPENDENTS | NCCI CLASS CODE

WAGE

RATE PER ☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER

OF DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE

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

ZIP CODE OF THE LOCATION WHERE THE 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 TO WORK | IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

TREATMENT

PHYSICIAN HEALTH CARE PROVIDER *(NAME & ADDRESS)*

HOSPITAL *(NAME & ADDRESS)*

INITIAL TREATMENT
☐ 0 - NO MEDICAL TREATMENT
☐ 1 - MINOR: BY EMPLOYER
☐ 2 - MINOR CLINIC HOSPITAL
☐ 3 - EMERGENCY CASE
☐ 4 - HOSPITALIZED > 24 HOURS
☐ 5 - FUTURE MAJ. MED. LOST TIME ANTICIPATED

OTHERS

WITNESS *(NAME & PHONE #)*

DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER

NOTE > This form constitutes both the original notification of injury and detailed report of injury required by §287.380, RSMo (2000) and rules applicable thereto. An injury that requires immediate first aid, which does not result in further medical treatment or lost time from work, need not be reported to the Division. Employers should report all injuries to their workers' compensation insurance carrier or third-party administrator (TPA) within five days of the date of the injury or within five days of the date on which the injury was reported to the employer by the employee, whichever is later. See §287.380, RSMo. If the employer has been granted self-insurance authority by the Division pursuant to §287.280, RSMo, and rules applicable thereto, please report all injuries to your TPA or Service Company to enable them to file this report with the Division.

PRINT QUALITY > All reports of injury and supporting documents received by the Division will be processed electronically. All forms submitted to the Division MUST be of clear and legible quality. Handwritten forms will not be accepted. Computer generated forms shall use a **minimum** type size of **10 points**. All documents not meeting the above criteria will be returned.

TO BE ANSWERED ONLY IN CASE OF DEATH

DATE OF DEATH

EMPLOYEE'S DEPENDENTS

NAME OF DEPENDENT	RELATION TO EMPLOYEE	ADDRESS OF DEPENDENT			
		ADDRESS	CITY	STATE	ZIP CODE

SUPERVISOR'S INCIDENT REPORT

☐ Injury (work related) ☐ Illness (work related) ☐ Property Damage ☐ Incident

Employee Name (First, Middle, Last)	Social Security Number	Sex ☐ Male ☐ Female	Employee Home Telephone Number

Employee's Street Address	City	State	Zip

Age	Birthdate Mo. Day Yr.	Job Title	Department

Employee's Scheduled Work Week When Injured	Start Time AM PM	End Time AM PM	Hrs. Per Day	Hrs. Per Wk.	Days Per Wk.	Normal Full-Time Schedule for Injured's Work	Start Time AM PM	End Time AM PM

Injury Date Mo. Day Yr.	Hour of Day AM PM	Last Day Worked Mo. Day Yr.	Start Date Mo. Day Yr.	☐ No Lost Time ☐ Date Returned to Work Mo. Day Yr. ☐ Estimated Date of Return

Did employee seek medical attention? ☐ Yes ☐No If yes, name of treating physician: _____

Name of clinic or hospital: _____

Will the employee complete a drug screening? ☐ Yes ☐No

Names of Witnesses (Attach witness statements.)

1. _____ 2. _____

Injured Employee's statement of what happened. (Identify circumstances and equipment involved.)

_____

_____

_____

How could this incident have been prevented?

_____

_____

_____

What corrective action has been taken?

_____

_____

_____

What is the injury/illness? (Be specific.)

Part of Body Affected

☐ Eye
☐ Head
☐ Neck
☐ Back
☐ Arm
☐ Shoulder
☐ Fingers
☐ Leg
☐ Knee
☐ Hip
☐ Foot
☐ Wrist
☐ Hand
☐ Toes
☐ Ankle
☐ Elbow
☐ Trunk (Other than back)
☐ Other

Type of Injury

☐ Cut/Abrasion
☐ Bruise/Contusion
☐ Foreign Object
☐ Burn
☐ Break
☐ Sprain/Strain
☐ Exposure
☐ Repetitive Motion
☐ Other

I believe that the answers to the above questions are true to the best of my knowledge.

Employee's Signature _____ Date _____

Supervisor's Signature _____ Date _____
Notified

EMPLOYEE INCIDENT REPORT

Employee Name: _____ Facility: _____

Incident Date: _____ Incident Time: _____

Date Supervisor Notified: _____

Exact Body Part Injured: _____

Describe What Happened:

What do you think caused your incident?

What do you think could be done to prevent this type of incident from occurring again?

Employee Name: _____

Date Report Completed: _____

WORKERS COMPENSATION
COST CONTAINMENT INITIATIVES

West Bend Mutual Insurance Company participates in several medical cost containment initiative programs. The use of these programs helps reduce your workers' compensation expenses. A brief summary of each program is outlined below.

If you have any questions about any of the programs we offer, please call our Workers' Compensation Claim Department at 1-800-236-5004.

PHARMACY PROGRAM

This program is designed to provide discounts on workers' compensation prescriptions submitted by your injured employees. This service is provided by a national pharmaceutical management company using a network of retail pharmacies.

How the program works:

1. The injured employee files a workers' compensation claim with employer, seeks medical treatment, and receives a prescription from a physician.
2. The injured employee presents the prescription along with the temporary ID form to a participating pharmacy where the claim is electronically submitted by the pharmacy to our vendor.
3. Once West Bend receives notification of the claim from the employer, an employee-specific ID drug card is issued, along with a list of participating pharmacies and instructions on the use of the program.
4. The injured employee presents the ID drug card to a participating pharmacy for any future workers' compensation prescriptions.
5. High-cost/long-term-use medications are conveniently supplied through our vendor's mail service pharmacy.

DIAGNOSTIC TESTING PROGRAM

Using the services of a diagnostic management vendor, we can save money on any diagnostic test (i.e., CT scans, MRIs, EMGs, etc…) the treating doctor orders for injuries an employee sustains in a work-related injury. Our vendor will schedule the test, then notify the injured employee of the date and time. Once the test is performed, the films/x-rays will be forwarded to the referring physician.

To make this program successful, we ask that you encourage your employees to contact their West Bend claim representative as soon as they know a test will be ordered. We will handle it from there.

MEDICAL COST CONTAINMENT

Strong medical management brings about the early and safe return to work of your employees and reduces claim costs. To accomplish this, we contract with a medical bill review service. All of our medical provider charges (hospital, physician, physical therapist, chiropractor, and pharmaceutical) are verified for the appropriateness of the charge, and to determine if they adhere to state mandated fee schedules or local usual and customary (U&C) reimbursement levels. This process often reduces our medical expenses by 10-30%.

Another way we are containing costs is through the use of a PPO Network. The Preferred Providers have agreed to discount their billings for the treatment of your industrially injured employees. This in turn keeps your premium costs down.

Your support in encouraging your injured workers to use a PPO provider is important. It sends an important message to the medical care providers that we support them in their effort to offer quality, cost effective care to patients.

For a list of PPO's in your area, please visit our website, www.thesilverlining.com for a link to the PPO list. Click on "Claims" and then on "How to Report A Claim" for the link to our vendor.

QUALITY MEDICAL CARE (Applicable in Indiana and Iowa only)

As your workers' compensation insurer, we share your goal of providing quality medical care to your injured workers so that they may return to the work force as soon as possible. In Indiana and Iowa, the employer and its insurance carrier have the responsibility for providing reasonable and necessary medical care when there is an injury and the ability to choose which physician or other medical practitioner that will provide the service. **In other words, it is the employer and insurance carrier who select the physician to treat an injury, not the injured employee.** If the employee refuses to accept medical services as instructed by the carrier, the right to receive compensation may be suspended during the period of refusal.

It has been our experience that one of the most effective ways to carry out our mutual responsibilities under the Indiana and Iowa Workers' Compensation Laws for an injured worker is for you, as an employer, to designate a company physician who is authorized to treat work-related injuries. This designation should be part of our internal procedure for reporting on-the-job injuries. Each employee should be instructed, particularly when first hired, on how to report an on-the-job injury and what physician is authorized for treatment. It should be made clear that except in cases of an emergency, no other medical or chiropractic care is authorized and charges incurred for those services will not be honored. Many of our employers put this policy in writing and have the employee sign and date this document.

There are many benefits to this policy. First, injured employees know exactly where to go for medical care when needed. Second, a good working relationship is established between the physician, you as an employer, and us as an insurance company. We find we get prompt answers to our questions and are able to better manage both medical costs and claims for weekly benefits. Referrals, particularly when an independent medical exam is needed, are greatly simplified. Where rehabilitation is needed, company physicians can assist our rehabilitation nurses and our vocational counselors.

We will be happy to work with you in designating a company physician and helping you implement this program. Please feel free to call the Workers' Compensation Claim Department with any questions or comments.

WEST BEND MUTUAL INSURANCE COMPANY
WORKERS' COMPENSATION PRESCRIPTION INFORMATION

Employer:

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

Employee Name:	
Group #:	10602270
Member ID (SSN):	
Date of Injury:	
Claim Number:	
Processor:	myMatrixx
Bin #:	014211
Day supply is limited to 3 days for a new injury	
myMatrixx Help Desk: (877) 804-4900	

Employer Signature:	Phone:	Date:

Injured Worker:

West Bend has partnered with ***myMatrixx*** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. ***myMatrixx*** has a network of over 60,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call ***myMatrixx*** toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATIONS(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist: Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only. Document only valid if signed and dated by employer above.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling ***myMatrixx*** for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All other will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

AUTHORIZATION TO INSPECT AND/OR COPY MEDICAL RECORDS

Injury Number
Checked By

TO:

Employee	Employer
Insurer	Date of Accident

Place and County of Accident

Description of Injury (Must include part of body affected)

You are hereby authorized to permit _____
(NAME)

in behalf of _____, to inspect and/or copy any and all medical
(PARTY)

records you have in your possession in regard to the above captioned case, which is now pending before the Division of Workers' Compensation.

NOTE: The medical records which may be released according to this authorization are limited to medical treatment for the injury suffered on the date of accident listed above. **ONLY records that relate to the injury listed above,** as to the type of injury and the part of the body injured, **may be included.** Medical records from before the date of accident or medical records after the date of accident, which do not relate to **this** injury, may not be released pursuant to this authorization.

This authorization is made in accordance with Section 287.140, RSMo., which reads as follows:

> "Every hospital or other person furnishing the employee with medical aid shall permit its record to be copied by and shall furnish full information to the Commission, the employer, the employee or his dependents and any other party to any proceedings for compensation under this act, and certified copies of such records shall be admissible in evidence in any such proceedings."

Date	Signature (Division of Workers' Compensation)

JOB ANALYSIS

Name	Claim Number
Employer	Address

Date of Hire	Date of Injury	Job Title	Check One ☐Skilled ☐Unskilled
Training Required to Learn Job			

Was Employee Working as a Supervisor? ☐Yes ☐No	If Yes, Number of People Supervised	Employee Worked: ☐Alone ☐Small Group (3-5) ☐Large Group

Days Worked Per Week (Circle) M Tu W Th F Sat Sun	Hours Worked During Week From To Shift

Work Breaks (Daily Rest Periods and Lunch)		
Morning	Lunch	Afternoon
— Minutes	— Minutes	— Minutes

Overtime Per Week Number of Hours	How Often	Was Employee Hired With Any Restrictions? (Check) ☐Yes ☐No
If Yes, Specify		

Body Movements – Amount Spent Each Day

Sitting % Standing % Walking %

Check Appropriate Column	None	Occasionally (1/3 or Less)	Frequently (1/3 – 2/3)	Continuously (2/3 or more)
Reaching above shoulder length				
Working with body bent over at waist				
Working in kneeling position				
Crawling				
Bending, stooping, squatting				
Repetitive foot movements as in foot controls – L/R or both				
Climbing stairs				
Climbing Ladders				
Working with arms extended at shoulder level				
Working with arms above shoulder height				

Height from floor of object to be reached and/or worked on (use space for drawing, if needed):

Object Height

Weights Handled	Item	Alone or Assisted	Push, Pull Or Lift	Times Per Hour	Times Per Day	Times Per Week	Times Per Month
1 – 10 lbs.							
15 – 20 lbs.							
25 – 35 lbs.							
45 – 60 lbs.							
65 – 80 lbs.							
85 – 100 lbs.							

☐No lifting required for this job.

Hand Coordination Activities (Check Appropriate Column)				
Movement Required	Tool/Machine	Right	Left	Both
Major hand				
Fine Manipulation				
Gross Manipulation				
Simple Grasping				
Power Grip				
Hand Twisting				
Pushing				
Pulling				

Tools Used By Worker	Weight	No. of Hands Needed To Move

Objects Worker Must Move During Day	Weight	Distance	No. of Workers Needed To Move

Physical Surroundings Does Employee Work ☐Inside ___% ☐Outside ___%	Does Employee Walk On Uneven Ground? ☐Yes ☐ No

Does Employee Work Around Moving Machinery? ☐Yes ☐No
Does Employee Drive Automotive Equipment? ☐Yes ☐No
If yes, describe:

Does the Employee Come In Contact With The Following? (Indicate Type)	Yes	No	Type
Fumes			
Dust			
Mist			
Steam			
Strong Odors			
Poor Ventilation			
Air Conditioning			

Characteristics Of Job That Cannot Be Modified By Employer For This Employee

Comments And/Or Observations

☐Job Site Evaluation Done	☐Narrative Discussion Only
Name(s) of Person(s) Interviewed	Title

Person Completing Analysis	Title	Date

West Bend Mutual Insurance Company
West Bend, Wisconsin 53095

ATTENDING PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS RECORD

Claim No.

Patient's Name (First) (Middle Initial) (Last) | Date of Injury/Illness

TO BE COMPLETED BY ATTENDING PHYSICIAN – PLEASE CHECK

Diagnosis/Condition (Brief Explanation)

I saw and treated this patient on _____ (date) and based on the above description of the patient's current medical problem:

1. ☐Recommend his/her return to work with no limitations on _____ (date)

2. ☐He/She may return to work on _____ (date) **capable of performing the degree of work checked below with the following limitations:**

☐ **Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

☐ **Light Work.** Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

☐ **Light Medium Work.** Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.

☐ **Medium Work.** Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.

☐ **Medium Heavy Work.** Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.

☐ **Heavy Work.** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.

1. In an 8 hour work day patient may:
   a. Stand/Walk
      ☐None ☐1-4 hours ☐4-6 hours ☐6-8 hours
   b. Sit
      ☐1-3 hours ☐3-5 hours ☐5-8 hours
   c. Drive
      ☐1-3 hours ☐3-5 hours ☐5-8 hours
2. Patient may use hand(s) for repetitive:
   ☐Single Grasping
   ☐Pushing & Pulling
   ☐Fine Manipulation
3. Patient may use foot/feet for repetitive movement as in operating foot controls:
   ☐Yes ☐No
4. Patient is able to:

	Frequently	Occasionally	Not At All
a. Bend	☐	☐	☐
b. Squat	☐	☐	☐
c. Climb	☐	☐	☐
d. Twist	☐	☐	☐
e. Reach	☐	☐	☐

Other Instructions and/or Limitations Including Prescribed Medications:

These restrictions are in effect until _____ (date) or until patient is re-evaluated on _____ (date)

3. ☐He/She is totally incapacitated at this time. Patient will be re-evaluated on _____ (date)

Physician's Signature | Date

West Bend Mutual Insurance Company
1900 South 18th Avenue
West Bend, Wisconsin 53095

RETURN TO WORK LOG

EMPLOYEE NAME _____ SUPERVISOR _____

Date	Hours Worked In	Hours Worked Out	Tasks Performed	Comments Regarding Employee's Tolerance of Modified Duty Tasks	Employee Initials	Supervisor's Initials
Sunday / /						
Monday / /						
Tuesday / /						
Wednesday / /						
Thursday / /						
Friday / /						
Saturday / /						

I clearly understand, take responsibility for, and acknowledge the limitations my physician, Dr. _____ has placed on me while participating in this temporary transitional work program.

_____ _____
Employee Signature Date

RETURN TO WORK LOG INFORMATION

The Return To Work Log is an efficient method used to monitor and document the specific tasks your employees are performing while on modified duty. It helps eliminate potential conflicts should the question arise regarding the employee performing work in excess of their restrictions.

- A supply of forms should be centrally located and provided to each department supervisor/manager.
- Attach a copy of the employee's restrictions to the log.
- Have employee write name on top of log and the Supervisor write their name.
- Remind employee it is their responsibility to follow the restrictions.
- Remind employee that the restrictions apply to occupational AND non-occupational activities.
- Employee and supervisor review all tasks completed each day, indicate any concerns and everyone signs the form.