



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

Dear Insured:

SUBJECT: WORKERS' COMPENSATION CLAIM INFORMATION

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 forms.
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,

Workers' Compensation Claim Department

WB 602 D 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](mailto:directconnect@wbmi.com)

#### General Questions:

Phone: 800-236-5004 or 334-6430  
e-mail: [wccentral@wbmi.com](mailto: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](mailto: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
- Right forearm
- Upper right leg
- 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
- They hurt their back lifting product
- Lifting equipment

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

- Lifting an air conditioner
- Pushing a cart
- Carrying magazines
- 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
- Fracture
- Bruise
- 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).



# Minnesota Workers' Compensation Employee's rights and responsibilities

This notice is required by law to be posted in a conspicuous location wherever the employer is engaged in business.

## If you are injured:

- Report any injury to your supervisor as soon as possible, no matter how minor it may appear. You may lose the right to workers' compensation benefits if you do not timely report the injury to your employer. The time limit may be as short as 14 days, although under certain circumstances, it may be longer.
- Provide your employer with as much information as possible about your injury so that a proper injury report can be filed.
- Get any necessary medical treatment as soon as possible. If you are not covered by a certified managed care organization (CMCO), you may treat with a doctor of your choice. Your employer must notify you if you are covered by a CMCO.
- Cooperate with all requests for information concerning your workers' compensation claim. Please note: the law provides that the workers' compensation insurer can obtain medical information specific to your work injury without your authorization, provided you are sent written notification of this request at the time the request is made.
- Get written confirmation from your doctor on any authorization to be off work.

## What does workers' compensation pay for?

- Medical care for your work injury, as long as it is reasonable and necessary
- Wage-loss benefits for part of your lost income (There is a three-calendar-day waiting period before these benefits start.)
- Compensation for permanent damage to or loss of function of a body part
- Benefits to your spouse and/or dependents if you die as a result of a work injury
- Vocational rehabilitation services if you cannot return to your pre-injury job or to your pre-injury employer due to your work injury

## What the insurance company must do:

- Investigate your claim promptly.
- Within 14 days of when the claimed injury occurred or when your employer became aware of it, either begin payment of benefits due or file a denial of liability, explaining why benefits are being denied.

Insurer name: **West Bend Mutual Insurance Company**

Phone number: **1-800-236-5010**

## If the insurer accepts your claim for wage-loss benefits and you have been disabled for more than three calendar-days:

- The insurer will send you a copy of the Notice of Insurer's Primary Liability Determination form stating your claim is accepted.
- The insurer must start paying wage-loss benefits within 14 days of the date your employer knows about your work injury and lost wages. The insurer must pay benefits on time. Wage-loss benefits are paid at the same intervals as your work paychecks.

## If the insurer denies your claim for wage-loss benefits:

- The insurer will send you a copy of the Notice of Insurer's Primary Liability Determination form stating it is denying primary liability for your claim. The form must clearly explain the facts and reasons why the insurer believes your injury or illness did not result from your work.
- If you disagree with the denial, you should talk with the insurance claims adjuster who is handling your claim. Your employer's insurance company can answer most questions about your claim.
- If you are not satisfied with the response you receive from the insurer and still disagree with the denial, you should contact the Department of Labor and Industry at one of the numbers listed below to discuss your options.

## Fraud

Collecting workers' compensation benefits you are not entitled to is theft. Any theft of more than \$500 is a felony.

Any person who, with intent to defraud, receives workers' compensation benefits to which the person is not entitled by knowingly misrepresenting, misstating, or failing to disclose any material fact is guilty of theft and shall be sentenced pursuant to section 609.52, subdivision 3.

A suspected fraud can be reported by anyone. If you have reason to suspect someone is committing workers' compensation fraud, call 1-888-FRAUD MN (1-888-372-8366). All suspected violations will be investigated.

## If you have questions or need more help, call the Minnesota Department of Labor and Industry:

**Worker's Compensation Hotline**  
**1-800-DIAL-DLI**  
**(1-800-342-5354)**  
**8 a.m. to 4:30 p.m.,**  
**Monday-Friday**

Department of Labor and Industry  
Workers' Compensation Division  
443 Lafayette Road N.  
St. Paul, MN 55155  
Phone: (651) 284-5032  
TDD: (651) 297-4198

Department of Labor and Industry  
Workers' Compensation Division  
5 N. Third Ave. W., Suite 400  
Duluth, MN 55802  
Phone: (218) 733-7810  
Toll-free: 1-800-365-4584

Your claim will be answered by experienced workers' compensation specialists who will provide instant, accurate information and assistance. Additional workers' compensation information is available on the department Web site at [www.doli.state.mn.us](http://www.doli.state.mn.us).

August 2003 This document can be made available in alternative formats, such as Braille or audiotape, by calling (651) 284-5042 or (651) 297-4198/TDD.



# MINNESOTA WORKERS' COMPENSATION SYSTEM EMPLOYEE INFORMATION SHEET

## What does workers' compensation pay for?

- Medical care for the work injury, as long as it is reasonable and necessary
- Wage-loss benefits for part of your lost income (there is a three-calendar-day waiting period before these benefits start)
- Benefits for permanent damage or loss of function of a body part
- Benefits to your spouse and/or dependents if you die of a work injury
- Vocational rehabilitation services if you cannot return to your pre-injury job or to your pre-injury employer

## How are workers' compensation benefits paid?

Your workers' compensation benefits are paid by an insurance company or your employer, if your employer is self-insured. State law sets the benefit levels. Please note: pursuant to statute, the insurer can obtain medical information specific to your work injury without your authorization.

## If the insurer accepts your claim for wage loss benefits and you have been disabled for more than three calendar days:

- The insurer will send you a copy of the *Notice of Insurer's Primary Liability Determination* form stating your claim is accepted.
- The insurer must start paying wage-loss benefits within 14 days of the date your employer knows about your work injury and lost wages. The insurer must pay benefits on time. Wage-loss benefits are paid at the same intervals as your work paychecks.

## If the insurer denies your claim for wage loss benefits:

- The insurer will send you a copy of the *Notice of Insurer's Primary Liability Determination* form stating it is denying primary liability for your claim. The form must clearly explain the facts and reasons why the insurer believes your injury or illness did not result from your work.
- If you disagree with the denial, you should talk with the insurance claims adjuster who is handling your claim. Your employer's insurance company can answer most questions about your claim.

**Insurer Name:** West Bend Mutual Insurance Company    **Phone:** 800-236-5004

- If you are not satisfied with the response you receive from the insurer and still disagree with the denial, you should contact the Department of Labor and Industry at one of the numbers listed below to see what to do next.

## If you have other questions or need more help, call the Minnesota Department of Labor and Industry Workers' Compensation Hotline:

Twin Cities and Southern Minnesota:    **(651) 284-5005 or 1-800-342-5354; TTY (651) 297-4198**

Duluth and Northern Minnesota:        **(218) 733-7810 or 1-800-342-5354**

Your call will be answered by experienced workers' compensation specialists, who will provide **instant, accurate information and assistance**.

Additional workers' compensation information is available on the department's Web site at:

[www.dli.mn.gov/WorkComp.asp](http://www.dli.mn.gov/WorkComp.asp).

**Your employer is required by law to give you this information. This material can be made available in different formats, such as large print, Braille, or on audiotape, by calling the numbers printed above.**

Updated June 2009 (Web address change only). This form may be copied or reproduced electronically. Do not file this form with the department.



# First Report of Injury

See Instructions on Reverse Side  
 PRINT or TYPE your responses.  
 Enter dates in MM/DD/YYYY format.



FR 01

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #		2. OSHA Case #	
3. DATE OF CLAIMED INJURY		4. Time of injury <input type="checkbox"/> am <input type="checkbox"/> pm	
5. Time employee began work on date of injury <input type="checkbox"/> am <input type="checkbox"/> pm		6. EMPLOYEE Name (last, first, middle)	
7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Unmarried	
9. Home address		10. Home phone #	
11. Date of birth		12. Occupation	
13. Regular department		14. Date hired	
15. Average weekly wage		16. Rate per hour	
17. Hours per day		18. Days per week	
19. Employment Status <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer		20. Weekly value of: Meals <input type="checkbox"/> Lodging <input type="checkbox"/> 2 <sup>nd</sup> Income <input type="checkbox"/>	
21. Apprentice <input type="checkbox"/> Yes <input type="checkbox"/> No		22. Tell us how the injury occurred and what the employee was doing before the incident (give details). Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."	
23. What was the injury or illness (include the part(s) of body)? Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.		24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.	
25. Did injury occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, indicate name and address of place of occurrence		26. Date of first day of any lost time	
27. Employer paid for lost time on day of injury (DOI) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No lost time on DOI		28. Date employer notified of injury	
29. Date employer notified of lost time		30. Return to work date	
31. Date of death		32. TREATING PHYSICIAN (name, address, and phone)	
33. HOSPITAL/CLINIC (name and address) (if any)		34. Emergency Room Visit <input type="checkbox"/> Yes <input type="checkbox"/> No	
35. Overnight in-patient <input type="checkbox"/> Yes <input type="checkbox"/> No		36. EMPLOYER Legal name	
37. EMPLOYER DBA name (if different)		38. Mailing address	
39. Employer FEIN		40. Unemployment ID#	
41. Employer's contact name and phone #		42. Physical address (if different)	
43. Witness (name and phone)		44. NAICS code	
45. Date form completed		46. INSURER name <b>West Bend Mutual Insurance Company</b>	
51. CLAIMS ADMIN COMPANY (CA) name (check one) <input checked="" type="checkbox"/> Insurer <input type="checkbox"/> TPA <b>West Bend Mutual Insurance Company</b> Phone: 800-236-5004 Fax: 262-334-6378		47. Insured legal name	
52. CA address 1900 South 18th Avenue		48. Policy # or self-insured certificate #	
City <b>West Bend</b>		State <b>WI</b>	
Zip Code <b>53095</b>		49. Insurer FEIN	
53. CA FEIN <b>39-0698170</b>		50. Date insurer received notice	
54. Claim #			

## GENERAL INSTRUCTIONS TO THE EMPLOYER

**Filing this form is not an admission of liability.** You must report a claim to your insurer whenever anyone believes that a work-related injury or illness that requires medical care or lost time from work has occurred. If the claimed injury wholly or partially incapacitates the employee for more than **three** calendar days, the claim must be made on this form and reported to your insurer within **ten** days. Your insurer may require you to file it sooner. Failure to file within the **ten** days may result in penalties. Self-insured employers have 14 days to file this form with the Department of Labor and Industry (Department). It is important to file this form quickly to allow your insurer time to investigate the claim. **Your insurer will forward a copy of this form** to the Department, if necessary.

If the claim involves death or serious injury (including injuries that later result in death), you must notify the Department and your insurer within 48 hours of the occurrence. The claim can be reported initially to the Department by telephone (651-284-5041), fax (651-284-5731), or personal notice. The initial notice must be followed by the filing of this form within **seven** days of the occurrence.

Employers are required to complete this form. Each piece of information is needed to determine liability and entitlement to benefits. Failure to complete the form may result in delayed processing and possible penalties. You must file this form with your insurer, and give a copy to the employee and the employee's local union office. You are required to provide the employee with a copy of the Employee Information Sheet, which is available on the Department's web site at [www.doli.state.mn.us](http://www.doli.state.mn.us). Employees are not responsible for completing this form.

### SEND REPORT TO INSURER IMMEDIATELY — DO NOT WAIT FOR DOCTOR'S REPORT

#### SPECIFIC INSTRUCTIONS FOR COMPLETING THIS FORM

1. Item 2: OSHA Case #. Fill in the case number from the OSHA 300 log. This form contains all items required by the OSHA form 301.
2. Items 15-20: Fill in all the wage information. If the employee does not work a regularly scheduled work week, attach a 26 week wage statement so your insurer can calculate the appropriate average weekly wage.
3. Items 22-24: Be as specific as possible in describing: the events causing the injury; the nature of the injury (cut, sprain, burn, etc.), and the part(s) of body injured (back, arm, etc.); and the tools, equipment, machines, objects or substances involved.
4. Item 26: Fill in the first day the employee lost any time from work (including time lost for medical treatment), even if you paid the employee for the lost time.
5. Item 27: Check the appropriate box to indicate if there was lost time on the date of injury and whether you paid for that lost time.
6. Item 28: Fill in the date you first became aware of the injury or illness.
7. Item 29: Fill in the date you became aware that the lost time indicated in Item 26 was related to the claimed injury.
8. Item 30: Leave the box blank if the employee has not returned to work by the time you file this form. If the employee has returned to work, fill in the date and notify your insurer if the employee misses time due to this injury after that date.
9. Item 39: Fill in your Federal Employment ID number (FEIN). For information on this number, see [www.firstgov.gov](http://www.firstgov.gov) and click on Employer ID Number under Business.
10. Items 40 and 44: Fill in your Unemployment ID number and North American Industry Classification System (NAICS) code which are both assigned by the Minnesota Unemployment Insurance Program (651-296-6141).
11. Items 46-54: Your insurer or claims administrator will complete this information.

#### INSTRUCTIONS TO THE INSURER/CLAIMS ADMINISTRATOR/SELF-INSURED EMPLOYER

The following data elements must be completed on this form prior to filing with the Department of Labor and Industry: employee's name and social security number; date of injury; and the names of the employer and insurer. If any of this information is missing, the First Report will be rejected and returned to you (per Minn. Stat. § 176.275). Providing the name of the third party administrator does not meet the statutory requirement to provide the name of the insurer. NOTE: If the claim does not involve lost time beyond the waiting period or potential PPD, the form does **NOT** need to be filed with the Department.

1. Item 46: Fill in the name of the insurance company. If the employer is self-insured, indicate the name of the licensed or public self-insured company or group.
2. Items 47-48: Fill in the legal name of the employer who purchased the policy from the insurer (named in Item 46) and the policy number. If the employer is licensed to self-insure, fill in the certificate number.
3. Item 49: Fill in the insurer's Federal Employment ID number (FEIN) number.
4. Item 51: Fill in the name and address of the company administering the claim (either the insurer or third party administrator). Be sure to mark either the "Insurer" or "TPA" box.
5. Item 53-54: Fill in the claims administrator's FEIN and claim number.

***This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/ Voice or TDD (651) 297-4198.***

**ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.**

# SUPERVISOR'S INCIDENT REPORT

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

Employee Name (First, Middle, Last)			Social Security Number			Sex <input type="checkbox"/> Male <input type="checkbox"/> 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.		<input type="checkbox"/> No Lost Time <input type="checkbox"/> Date Returned to Work Mo. Day Yr. <input type="checkbox"/> 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



# 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](http://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.

Table with employee information: Employee Name, Group # (10602270), Member ID (SSN), Date of Injury, Claim Number, Processor (myMatrixx), Bin # (014211). Includes notes: Day supply is limited to 3 days for a new injury and 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



# AUTHORIZATION TO DISCLOSE NON-PUBLIC PERSONAL HEALTH INFORMATION AND WAIVER OF PRIVILEGE

TO: Patient Name:  
Claim Number:  
Birth Date:  
Social Security No.:

I, \_\_\_\_\_, hereby authorize the above named health care provider to give to, release, and permit copies to be made of all health care records that are in your possession.

The health care records should be disclosed to any authorized representative of West Bend Mutual Insurance Company. West Bend Mutual Insurance Company is the insurer for the employer and acts as its agent for insurance purposes.

The purpose of the disclosure of these records is to aid West Bend Mutual Insurance Company's evaluation of my claim.

West Bend Mutual Insurance Company may re-disclose my records to others retained by West Bend Mutual Insurance Company to assist in the evaluation of my claim. Re disclosure of this protected health information will no longer be protected under the federal privacy rule.

The type of information to be disclosed may include, but is not limited to, x-rays, x-ray reports, summaries, reports, narratives, test results, notes and any other health care records from all in-patient and out-patient visits at your institution or facility.

This authorization also permits release of all information relating to treatment for:

- (a) drug and/or alcohol abuse;
- (b) any mental disease, defect, or psychological/psychiatric condition;
- (c) any communicable disease, AIDS, or AIDS-related disease.

I understand that executing this authorization is a waiver of my privilege of physician-patient confidentiality, and I freely and voluntarily waive that privilege.

The above-named health care provider may not condition treatment, payment, enrollment or eligibility of benefits on obtaining your authorization.

A photocopy or facsimile of this authorization shall be valid and effective just as the original.

I understand that I may revoke this authorization in writing to the records department of the above named health care provider at any time, except where information has already been released as a result of this authorization.

Unless revoked, this authorization shall remain in effect for the period of one year beyond the date of patient's signature, or until my claim is closed, whichever is later. Records may be disclosed whether dated before or after the date of this authorization.

I understand that I or my authorized representative is entitled to receive a copy of the completed authorization form.

\_\_\_\_\_  
Signature of Patient/Claimant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian/Representative

\_\_\_\_\_  
Date





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 <input type="checkbox"/> Inside ___% <input type="checkbox"/> Outside ___%			Does Employee Walk On Uneven Ground? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does Employee Work Around Moving Machinery? <input type="checkbox"/> Yes <input type="checkbox"/> No			Does Employee Drive Automotive Equipment? <input type="checkbox"/> Yes <input type="checkbox"/> 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					
<input type="checkbox"/> Job Site Evaluation Done			<input type="checkbox"/> Narrative Discussion Only		
Name(s) of Person(s) Interviewed			Title		
Person Completing Analysis		Title		Date	

# 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 \_\_\_\_\_ and based on the above description of the patient's current medical problem:  
(date)

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

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

- 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Instructions and/or Limitations Including Prescribed Medications:

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

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

Physician's Signature

Date



# RETURN TO WORK LOG

EMPLOYEE NAME \_\_\_\_\_ SUPERVISOR \_\_\_\_\_

Date	Hours Worked		Tasks Performed	Comments Regarding Employee's Tolerance of Modified Duty Tasks	Employee Initials	Supervisor's Initials
	In	Out				
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.