

Dear Insured:

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,

Workers' Compensation Claim Department

WORKERS' COMPENSATION REPORTING TIPS

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

If an accident occurs at your workplace, you must complete an Employers First Report of Injury form IMMEDIATELY and forward the form to us even if you don't have all the information about the injury. If the form isn't submitted to us soon after the injury occurs, you may be fined by the State.

When reporting an injury:

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

You can report an injury by mail, phone, fax, or email.

Workers' Compensation Claims Department
PO Box 620978
Middleton, WI 53562
Phone: 800-760-9250, option 1, then option 7
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
- 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 and Social Security number. Also, indicate the geographical location of the accident (city, county and state).

EMPLOYER'S BASIC REPORT OF INJURY
Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
PO Box 30016, Lansing, MI 48909

An employer shall report immediately to the agency on Form WC-100 all injuries, including diseases, which arise out of and in the course of the employment, or on which a claim is made and result in any of the following: (a) Disability extending beyond seven (7) consecutive days, not including the date of injury; (b) Death; (c) Specific losses. In case of death, an employer shall also immediately file an additional report on WC-106. See instructions on reverse side for filing/mailling procedures.

I. EMPLOYEE DATA

1. Social Security Number	2. Date of injury	3. Employee name (Last, First, MI)		
4. Address (Number & Street)		5. City	6. State	7. ZIP Code
8. Date of birth (MM/DD/YYYY)	9. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	10. Number of dependents	11. Telephone number	
12. Tax filing status: <input type="checkbox"/> A. Single <input type="checkbox"/> B. Single, Head of Household <input type="checkbox"/> C. Married, Filing Joint <input type="checkbox"/> D. Married, Filing Separate				

II. EMPLOYER/CARRIER DATA

13. Employer name		14. Federal ID Number		
15. Injury location code	16. Mailing location code	17. UI number	18. Type of business (SIC/NAICS)	
19. Employer street address		20. City	21. State	22. ZIP code
23. Insurance company name (if employer not self-insured)			24. Insurance company telephone number (if known)	

III. INJURY/MEDICAL DATA

25. Last day worked	26. Date employee returned to work (if applicable)	27. Did employee die? <input type="checkbox"/> Yes <input type="checkbox"/> No	28. If yes, date of death
29. Injury city	30. Injury state	31. Injury county	32. Did injury occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, see item 53)
33. Case number from OSHA/MIOSHA log		34. Time employee began work <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	35. Time of event <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. If time cannot be determined, check here <input type="checkbox"/>
36. What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific.			
37. How did the injury occur? Examples: "When ladder slipped on wet floor, worker fell 20 feet;" "Worker was sprayed with chlorine when gasket broke during replacement"			
38. Describe the nature of injury or illness		39. Part of body directly affected by the injury or illness	
40. What object or substance directly harmed the employee? Examples: concrete floor, chlorine, radial arm saw. If this question does not apply to the incident, leave it blank.			
41. Name of physician or other health care professional	42. Was employee treated in an emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No	43. Was employee hospitalized overnight as an in-patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
44. If treatment was given away from the worksite, where was it given? (Include name, address, city, state and ZIP code of facility)			

IV. OCCUPATION AND WAGE DATA

45. Date hired	46. Total gross weekly wage (highest 39 of 52)	47. Number of weeks used	48. Value of discontinued fringes
49. Occupation (Be specific)	50. Was employee a volunteer worker? <input type="checkbox"/> Yes <input type="checkbox"/> No	51. Was employee certified as vocationally handicapped? <input type="checkbox"/> Yes <input type="checkbox"/> No	
52. Date employer notified by employee		53. If temporary service agency, provide name/address of employer where injury occurred.	

V. PREPARER DATA

I CERTIFY THAT A COPY OF THIS REPORT HAS BEEN GIVEN TO THE EMPLOYEE

<i>Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.</i>			
54. Preparer's name (Please print or type)	55. Preparer's signature	56. Telephone number	57. Date prepared

Notice to employee: Questions or errors should be reported immediately to the individual listed above in space 54

If you are using this form as a replacement for the Form 301 to document the specifics of an injury or illness for purposes of compliance with the work-related injury and illness logging requirements, follow the instructions in Section A only.

If you are using this form to report a workers' compensation injury, follow the instructions in Section A and B.

Section A

This form can be used in lieu of the MIOSHA Form 301, *Injury and Illness Incident Report*. It is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the *Log of Work-Related Injuries and Illnesses* (Form 300) and the accompanying *Summary* (Form 300A), these forms help the employer and MIOSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out questions 1-9, 27-28, 33-45 and 54-57.

According to Public Law of 1970 (P.L. 91-596) and Michigan Occupational Safety and Health Act 154, P.A. 1974, Part 11, Michigan Administrative Rule for Recording and Reporting of Injuries and Illnesses, you must keep this form on file for 5 years following the year to which it pertains. **DO NOT mail this form to the Workers' Compensation Agency unless it meets the conditions listed below in Section B.**

Section B

You must complete all questions on this form if the injury or disease results in any of the following: (a) Disability extending beyond seven (7) consecutive days, not including the date of injury; (b) Death; (c) Specific loss. The original form must be mailed to the Workers' Compensation Agency, P.O. Box 30016, Lansing, MI 48909.

Authority: Workers' Disability Compensation Act, 408.31(1)(3) Completion: Mandatory Penalty: Workers' Disability Compensation Act, 418.631	LARA is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.
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SUPERVISOR'S INCIDENT REPORT

Injury (work related) Illness (work related)

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.

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 the "Claims" tab and then on the "[How to Report A Claim](#)" tab for the link to our vendor.



**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 30 days for a new injury	
myMatrixx Help Desk: (877) 804-4900	

Employer Signature:	Phone:	Date:
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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 MEDICATION(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

Michigan Department of Community Health

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Instructions to FAMILY:

- Please complete this form and retain the PINK copy for your records.
- Send the WHITE copy to the specialty doctor, hospital, or clinic treating the person who is seeking CSHCS coverage.

Instructions to PROVIDER:

- Retain the WHITE copy for your records.
- Fax a copy of this form along with the ***most recent*** comprehensive medical information (less than 12 months old) related to the diagnosis(es) requiring specialty care to:
517-335-9491

Patient's Name			Date of Birth		
Patient Address (Number and Street)			CSHCS/ Medicaid ID Number		
City	State	ZIP Code	County		
Parent/ Guardian Name			Parent/ Guardian Phone Number () -		
Parent/ Guardian Address (If Different Than Patient's)			City	State	ZIP Code

I authorize _____
(Name of Specialty Doctor, Hospital, or Clinic)

located at _____
(Complete Address of Specialty Doctor, Hospital or Clinic)

to release the most current medical information (from the past 12 months), which may include medical reports, letters from physician specialists, office or hospital inpatient or outpatient summaries that review status of medical problems and ongoing treatment plans, to the Michigan Department of Community Health, Children's Special Health Care Division or their agents for the purposes of determining program eligibility. These records may include any information about Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC); and any other communicable diseases as defined by the Michigan Department of Community Health.

I understand that if I give permission, I have the right to change my mind and revoke it. This must be in writing to you. I understand that if this authorization is required as a condition of demonstrating criteria for eligibility in the CSHCS program and I revoke the authorization, then CSHCS has a right to contest my claim(s). I also understand that I cannot take back any uses or disclosures already made with my permission.

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services or eligibility unless the information is necessary to demonstrate that I meet the criteria required to establish eligibility.

By signing this Authorization, I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by Federal privacy rules. I further understand I may request a copy of this signed authorization.

Unless revoked, this authorization expires 12 months from the date signed.

Signature of Patient, Parent or Legal Guardian	Date Signed	Signature of Witness (any Adult over the age of 18)	Date Signed
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AUTHORITY: Public Act 368, P.A. of 1978
COMPLETION: Is Voluntary

The Department of Community Health is an equal opportunity employer, services and programs provider.

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.