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 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

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
West Bend Mutual Insurance Company
1900 S. 18th Avenue
West Bend, WI 53095
Phone: 800-236-5010, extension 5247
FAX: 262-334-6378
e-mail: directconnect@wbmi.com

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

West Bend Mutual Insurance Company
West Bend, Wisconsin 53095

Employer Name: _____

Employer Contact: _____

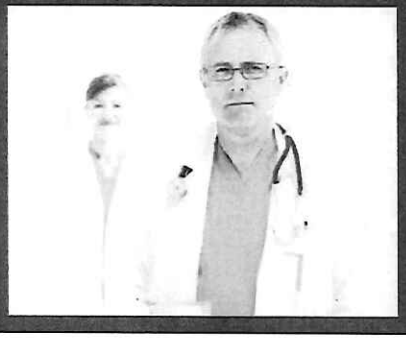
Work Comp Insurer: _____

After an injury is reported to your employer, the workers' compensation insurance company may contact you and ask questions about the injury. They will want to know:

- **What is the injury?**
- **How did it happen?**
- **When did you report the injury?**
- **Who did you report it to?**
- **Did you get medical care from an EPO health care provider? Who?**
- **Did you get a release to return to work with or without restrictions?**

If the insurance company accepts the claim you will get your medical care covered and you may also be entitled to other benefits, including wage-replacement. **Workers' compensation does not pay any of your fringe benefits.**

To discuss any questions or concerns, contact Elliot Herland, Dispute Resolution Facilitator, at 952-851-3501/ eherland@wilson-mcshane.com.



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Serving the interests of the Union Construction Industry since 1997.

Like other health, welfare and pension plans, Wilson-McShane administers the UCWCP under the direction of a Board of Trustees appointed by contractors and participating trade unions.

Plan Administrators for Taft-Hartley Trust Funds:
Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425
(952) 854-0795
Toll Free: (800) 535-6373

UCWCP

Union Construction Workers' Compensation Program

Making Workers' Compensation Work Right for Minnesota's Union Construction Industry.

Union Employee's Guide

www.ucwcp.com

This guide is for the exclusive use of union employees whose collectively-bargained contract includes a provision for participation in the Union Construction Workers' Compensation Program (UCWCP). You are covered by the program and are entitled to its benefits if both your employer and your union have joined.

The mission of the UCWCP is to:

- **Eliminate and resolve disputes about work comp**
- **Provide accurate work comp information**
- **Ensure payment of medical and wage-loss benefits without delay**
- **Create prompt and safe return to union work, wages and benefits**
- **Reduce the cost of work comp injuries for you and your employer**

This mission is accomplished by giving injured workers access to the best medical care through an Exclusive Provider Organization, and providing a simple dispute resolution process if a problem arises. Your Labor-Management program is here to make sure you get everything you need if you get hurt at work.

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SPONSORING ORGANIZATIONS

Trade Unions

Bricklayers Local Union #1
Carpet and Linoleum Layers Local #596
Cement Masons (Finishers) Local #633
Electrical Workers Locals #110, 292 & 343
Glaziers Local #1324
Heat & Frost Insulators Local #34
Ironworkers Local #512
Laborers District Council of MN & ND
Millwrights (all locals)
N. Central States Council of Carpenters (all crafts)
Operating Engineers Local #49
Painters District Council #82 (all crafts)
Pipefitters Locals #455, 539, 11 & 589
Plasterers Local #265
Plumbers Locals #15, 34, 11 & 589
Roofers & Waterproofers Local #96
Sheet Metal Workers' Local #10
Teamsters (Highway/Heavy) (all locals)

Management Associations

Associated General Contractors of MN
Carpentry Contractors Association
Minnesota Concrete & Masonry Contractors
Minnesota Drywall & Plasterers Association
Minnesota Mechanical Contractors
Minnesota Painting & Wallcovering Employers
National Electrical Contractors
Sheet Metal, Air Cond. & Roofing Contractors
Thermal Insulation Contractors

AN INJURY OCCURRED: NOW WHAT?

If you or a co-worker is injured it is important to take the right steps.

1. **If this is a life-threatening emergency, call 911 and notify your employer ASAP.**
2. **Except for minor first-aid/ urgent care, medical care must be obtained from a clinic in the UCWCP's medical network.**
3. **Our employers are encouraged to designate a UCWCP clinic for work-injury care- ask them for a referral.**
4. **Or, you or your employer can contact a Registered Nurse 24 hours a day for INJURY ASSESSMENT & REFERRAL to the most appropriate clinic for care. Call HealthPartners CareLine at 952-883-7475. Tell the nurse you're a member of the UCWCP.**

Minnesota Department of Labor and Industry
Workers' Compensation Division
443 Lafayette Road North
St. Paul, Minnesota 55155-4305
(651) 284-5030

First Report of Injury

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

FR01

DO NOT USE THIS SPACE

UCWCP CLAIM

Collectively Bargained Agreement

1. EMPLOYEE SOCIAL SECURITY # - -	2. OSHA Case #	UCWCP CLAIM	
3. DATE OF CLAIMED INJURY	4. Time of Injury ☐ a.m. ☐ p.m.	5. Time Employee Began Work on Date of Injury ☐ a.m. ☐ p.m.	
6. EMPLOYEE Name (last, first, middle) ,		7. Gender ☐ M ☐ F	8. Marital Status ☐ Married ☐ Unmarried
9. Home Address		10. Home Phone # ( ) -	11. Date of Birth
City	State MN / ZIP Code	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 ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer
20. Weekly Value of: $	Meals $ / Lodging $	2nd Income $	21. Apprentice ☐ Yes ☐ 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? ☐ Yes ☐ 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) ☐ Yes ☐ No ☐ 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 ☐ Yes ☐ No 35. Overnight In-Patient ☐ Yes ☐ No

36. EMPLOYER Legal Name		37. EMPLOYER DBA Name (if different)
38. Mailing Address		39. Employer FEIN / 40. Unemployment ID
City	State / ZIP Code	41. Employer's Contact Name and Phone #
42. Physical Address (if different)		43. Witness (Name and Phone)
City	State / ZIP Code	44. NAICS Code / 45. Date Form Completed

46. INSURER Name		51. CLAIMS ADMIN COMPANY (CA) Name (check one) ☐ Insurer ☐ TPA
47. Insured Legal Name		52. CA Address
48. Policy # or Self-Insured Certificate #		City / State / ZIP Code
49. Insurer FEIN	50. Date Insurer Received Notice	53. CA FEIN / 54. Claim #

COLLECTIVELY BARGAINED AGREEMENT

SUPERVISOR'S INCIDENT REPORT

☐ Injury (work related) ☐ Illness (work related)

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 ☐Estimated Date of Return Mo. Day Yr.

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 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 to contain cost is through the use of the MN Union Construction Work Comp Programs Exclusive Provider Organization (EPO). The program's Web site, www.ucwcp.com, has a list of the EPO providers and is updated monthly. Your support in directing your injured worker to use an EPO provider is important.

Again, for a list of doctors within the EPO, please visit the program's Web site, www.ucwcp.com and click "Find a Treating Doctor" at the middle of the webpage to select a physician. These doctors have extensive experience treating construction injuries and they are noted for keeping employees, employers and insurers informed about treatment plans and work restrictions.

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:

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

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.