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Texas Workers' Compensation Claim Kit

ARGENT®
A DIVISION OF WEST BEND

– Vision –

To be the company of choice for associates, agents, and policyholders.

– Mission –

Exceed in service. Lead in results.

– Core Values –

Excellence

Integrity

Innovation

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 Argent. **You may be fined if you do not submit the report on time.**

Report online, fax, or email the Employer's First Report of Injury even if you do not have all the information about the injury.

- Do not wait for medical bills.
- Do not withhold the Employer's First Report of Injury because you believe the claim is questionable. Reporting a loss is not an admission of liability.
- Be sure to include the claim number on all correspondence.

Claim Reporting Options for NEW LOSSES ONLY:

- Online Reporting (Insured Access) - Our online reporting system is referred to as Insured Access. Online claim reporting is our **preferred** method, and allows you to instantly obtain confirmation of your report, as well as the claim number. Insured Access also allows you to have limited access to claim notes, claim reserves, and loss control resources. In order to set up Insured Access, please contact your dedicated claim representative. Or,
- Fax: 888-926-9299 or,
- Email: ArgentWCCLossScanCtr@wbmi.com

Do not withhold the Employer's First Report of Injury for any reason. You may be fined if the claim representative cannot make the initial lost time payment because you failed to send the Employer's First Report of Injury on time.

If you need to notify your agent, please send your agent a copy of the Employer's First Report of Injury and indicate the report has been filed with Argent. Direct reporting saves time.

If you have any questions, please call your claim representative.

For any follow up correspondence, please refer to the below instructions:

Submit follow up correspondence with the claim number to:

- Fax: 888-926-9299
- Email: Argent_WCC_scan_ctr@wbmi.com

HOW TO WRITE INJURY DESCRIPTIONS

The following instructions will help you avoid some common errors and save time when describing an injury on the Employer's 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).

DWC FORM-001
(Employer's First Report of Injury or Illness)

The **employer** is required to file an **Employer's First Report of Injury or Illness** [DWC FORM-001 Rev. 10/05] with the injured worker's insurance carrier, and the injured claimant or the claimant's representative within 8 days after the employee's absence from work or receipt of notice of occupational disease.

The **Employer's First Report of Injury or Illness** provides information on the claimant, employer, insurance carrier and medical practitioner necessary to begin the claims process. Details of the claimant's employment and circumstances surrounding the injury or illness are also requested.

Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

[Workers' Compensation Rule 120.2]

INSTRUCTIONS FOR EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC FORM-001)

Type (or print in black ink) each item on this form. Failure to complete each item may delay the processing of the injury claim.

Section 409.005, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (DWC FORM-001 Rev. 10/05 to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death. A copy of this report must be sent to the employee or the employee's representative. For purposes of this section, a report is filed when personally delivered, or postmarked. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

If a report has not been received by the carrier, the employer has the burden of proving that the report was filed within the required time frame. The employer has the burden of proving that good cause existed if the employer failed to file the report on time.

An employer who fails to file the report without good cause may be assessed an administrative penalty. An employer who fails to file the report without good cause waives the right to reimbursement of voluntary benefits even if no administrative penalty is assessed.

Once the employer has completed all information pertaining to the injury the employer should maintain the copy of this report to serve as the Employer's Record of Injury required by Section 409.006. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.** The Division's Health and Safety will use data from this report for the Job Safety Information System established in Section 411.032 of the Texas Workers' Compensation Act.

This report may not be considered admission or evidence against the employer or the insurance carrier in any proceeding before the Division or a court in which facts set out in the report are contradicted by the employer or insurance carrier.

"SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

Items 2,7,8:	Section 402.082, Texas Workers' Compensation Act requires the Division to maintain information as to the race, ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.
Item 4:	If no home phone, please provide a phone number where the employee can be reached.
Items 5,15,17, 26,29,30:	Enter data in month, day, year format. Example: 08-13-54.
Item 18:	List nature of accident or exposure, e.g., fall from scaffold, contact with radiation, etc. If occupational disease, so state.
Item 19:	List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.
Item 20:	Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.
Item 22:	State the exact work-site location of the injury, e.g., construction site, office area, storage area, etc.
Item 24:	List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.
Items 32,33:	Enter date in month-year format. Example: 02-56.
Item 37:	Enter the number of days or hours that make up a full work week for your employees.
Item 45:	Enter the 6-digit North American Industry Classification System (NAICS) Code of the employer. The primary code is the code which appears in block 5 of Form C-3, "Employer's Quarterly Report" to the Texas Workforce Commission.
Item 46:	For companies with a single NAICS code, the specific code is the same as the primary code. For companies with multiple NAICS codes, enter the code that identifies the specific business, activity, or work-site location the employee was working in at the time of the injury. This may or may not be the same as the primary code.

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filling.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☐ M ☐

3. Social Security Number - -

4. Home Phone ( )

5. Date of Birth (m-d-y) - -

6. Does the Employee Speak English? YES ☐ NO ☐ If No, Specify Language

7. Race White ☐ Black ☐ Asian ☐

8. Ethnicity Hispanic ☐ Native American ☐ Other ☐

9. Mailing Address Street or P.O. Box

City State Zip Code County

10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐

11. Number of Dependent Children

12. Spouse's Name

13. Doctor's Name

14. Doctor's Mailing Address (Street or P.O.Box)

City State Zip Code

15. Date of Injury (m-d-y) - -

16. Time of Injury : am ☐ pm ☐

17. Date Lost Time Began (m-d-y) - -

18. Nature of Injury*

19. Part of Body Injured or Exposed*

20. How and Why Injury/Illness Occurred*

21. Was employee doing his regular job? YES ☐ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)*

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site

Street or P.O. Box County

City State Zip Code

24. Cause of Injury(fall, tool, machine, etc.)*

25. List Witnesses

26. Return to work date/or expected (m-d-y) - -

27. Did employee die? YES ☐ NO ☐

28. Supervisor's Name

29. Date Reported (m-d-y) - -

30. Date of Hire (m-d-y) - -

31. Was employee hired or recruited in Texas? YES ☐ NO ☐

32. Length of Service in Current Position Months _____ Years _____

33. Length of Service in Occupation Months _____ Years _____

34. Employee Payroll Classification Code

35. Occupation of Injured Worker

36. Rate of Pay at this Job $_____Hourly $_____Weekly

37. Full Work Week is: _____ Hours _____ Days

38. Last Paycheck was: $_____ for ____ Hours or _____ Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form

41. Name of Business

42. Business Mailing Address and Telephone Number
Street or P.O. Box Telephone ( )

City State Zip Code

43. Business Location (If different from mailing address)
Number and Street

City State Zip Code

44. Federal Tax Identification Number

45. Primary North American Industry Classification System Code:(6 digit)

46. Specific NAICS Code (6 digit)

47. Texas Comptroller Taxpayer No.

48. Workers' Compensation Insurance Company

49. Policy Number

50. Did you request accident prevention services in past 12 months? YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)

X _____ Date _____

WORKERS COMPENSATION
COST CONTAINMENT INITIATIVES

Argent 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 your dedicated claim representative at 888-236-5008.

PHARMACY PROGRAM

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

How the program works:

1. The injured worker files a workers' compensation claim with employer, seeks medical treatment, and receives a prescription from a provider.
2. The injured worker 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 Argent receives notification of the claim from the employer, an employee ID drug card is issued, along with a list of participating pharmacies and instructions on the use of the program.
4. The injured worker presents the ID drug card to a participating pharmacy for any 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 diagnostic tests (i.e., CT scans, MRIs, EMGs, etc.) the treating provider orders for injuries an employee sustains in a work-related incident. Our vendor will schedule the test then notify the injured worker of the date, time, and location. Once the test is performed the films/x-rays will be forwarded to the referring provider.

To make this program successful, we ask that you encourage your employees to contact their Argent claim representative as soon as their provider orders a diagnostic test. 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. In order to control the medical bill costs, 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 PPO Networks. The Preferred Providers have agreed to discount their billings to the agreed upon PPO Network rates for our insured's injured workers. 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.argentworkerscomp.com for a link to the PPO Directory.

myMatrixx™
good medicine for business

P.O. Box 274070
Tampa FL • 33688
877.804.4900

ARGENT™
A DIVISION OF WEST BEND

Joe Sample
123 2nd Street
Anywhere, FL 33635

Thu May 24 12:50 EDT 2007

RE: Argent Workers' Compensation Prescription Drug Program

Dear Joe Sample,

Argent has contracted with myMatrixx to have prescriptions for your work related injury filled at no expense to you.

What is Covered?
Only medication(s) prescribed by your authorized treating physician for your work-related injury will be approved. This program does not cover prescriptions for any other medical condition.

What do I do?
After receiving your prescription from your workers' compensation physician, visit any network pharmacy and present your prescription and prescription card. Your pharmacy will submit the required information to myMatrixx. You do nothing else.

In the event there is a problem processing your prescription(s) please call or have the pharmacist call myMatrixx 24 hours a day, 7 days a week at 877-804-4900.

Which pharmacies can I use?
Your prescription Card is honored at over 60,000 pharmacies nationwide. Here are just a few in your area. For more network pharmacy locations, please call 877-804-4900.

Walgreens Pharmacy
1211 Hillsborough Ave.

CVS #5196
11670 Country Way Blvd.

CVS Pharmacy
8801 W. Linebaugh Ave.

Publix Pharmacy
8975 Race Track Rd.

Publix Pharmacy
12139 W. Linebaugh Ave.

Publix Pharmacy
7835 Gunn Highway

Walgreens Pharmacy
7925 Gunn Highway

Kash N Kerry Pharmacy
10617 Sheldon Road

CVS Pharmacy
7920 Gunn Highway

Answers to your questions.

1. What is this card?
This card is for your workers' compensation prescription needs. Please take this card to the pharmacy when you are filling medications for your work-related injury.

2. Why did I receive this card?
You received this card due to an injury that occurred on the job.

3. What if I am not currently taking any medications due to the injury?
Please put the card in a safe place in case you start taking medications for your current injury.

4. When should I use this card?
Anytime you need to fill a medication for your work-related injury.

5. Are all medications pre-approved?
Your insurance company may have pre-selected medications that will go through without authorization. If you drop off a prescription at the pharmacy and it rejects for any reason the pharmacy should call us and we will call your insurance co. for approval. If you would like to know the types of medications that are pre-approved before going to the pharmacy, please call 877-804-4900 and a customer service rep will be happy to assist you.

6. Can my family members use this card?
No, this is only for your work-related injury.

7. What should I do if there is a problem with my card when I take it to the pharmacy?
Your pharmacy should call us with any problems they are having with the card. If for ANY reason they do not call us, or if you have any questions regarding your work-related medications, please call our customer service team at 877-804-4900.

8. Are you my workers' compensation insurance company?
No, we were contracted by your workers' compensation insurance company to handle all of your work-related prescription needs.

9. What happens if my medication doesn't provide any relief from my symptoms or pain?
You should contact your doctor or our pharmacist to verify that the medication prescribed for your pain is the most appropriate for your condition.

10. Should I tell my doctor about other medications I am taking not related to my injury?
Yes, it is very important that your physician and pharmacist know ALL the medications you are currently taking. Some medications may counter the effect of other medications you are taking and some may even be harmful or life threatening when taken together. If you are unsure of your current medications, call our myMatrixx pharmacist.

11. Can I talk to one of your pharmacists if I have a question?
Yes, our pharmacists are available to answer all of your medication related questions.

For any additional questions please contact myMatrixx at 877-804-4900

Patient - You must present this identification card each time you go to the pharmacy for your authorized prescriptions only. If you are denied medication, please call.

Pharmacist - For questions, please call 24 hours a day, 365 days a year. Dispensed quantity of medications is limited to a 30 day supply. Do not send patient home without first contacting myMatrixx for all rejections.

Note: Insurance company has pre-approved certain medications for this patient; these medications will process without an authorization. Any medications that are rejecting, must be called into myMatrixx for authorization.

Any questions or problems, please call:
877.804.4900

ARGENT
A DIVISION OF WEST BEND

THE BEST REMEDY FOR WORKERS' COMPENSATION™

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

TO:

Patient Name:
Claim Number:
Birth Date:
Social Security Number:

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 Argent, a division of West Bend Mutual Insurance Company. Argent, a division of 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 Argent's, a division of West Bend Mutual Insurance Company, evaluation of my claim.

Argent, a division of West Bend Mutual Insurance Company, may re-disclose my records to others retained by Argent, a division of 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 any federal or state privacy law.

The type of information to be disclosed may include, but not limited to, x-rays, x-ray reports, summaries, reports, narratives, test results, notes and any other health care record from all in-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 privileges 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 affect 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 Patient/Claimant Date

WR-0210(7-18)

Regardless of normal job duties, light duty work will be accommodated.
Please prepare restrictions below:

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
Print name:	Phone number
Facility Name:	

Argent, a Division of West Bend
FAX: 1-888-926-9299
EMAIL: Argent_WCC_Scan_Ctr@WBMI.COM

The Silver Lining® ADVANTAGE

With the **Silver Lining Advantage,** you benefit from the expertise and guidance of qualified nurse case managers. Using their experience in the medical field, these professionals carefully examine the medical aspects of your company's workers' compensation claims to reduce the claim costs and the duration of the disability. This not only helps control the cost of these claims, it results in a more positive outcome for your employees and your company.

The **Silver Lining Advantage** program offers a variety of services customized to help your company reduce your workers' compensation claim costs. These services include:

- Reducing medical and disability costs through a collaborative approach;
- Expert medical resources available to all accounts;
- An average of 24 years of experience for each member of your nurse case manager team;
- A focus on building relationships with the medical community; and
- The ability to capture and report cost savings.

WEST BEND®

THE SILVER LINING®

WB-2593 (4-13)

ARGENT- Claim Practices

Initial Contacts – Within 24 hours of receipt of claim, contacts made to employee, employer and medical provider.

Investigation – Investigation of claims is to include, but not limited to: recorded statements of employees and witnesses, requesting prior and present medical records, obtaining job descriptions or videos, subrogation potential, Independent Medical Evaluations, and other investigative services when necessary.

Transitional Return to Work - Will be addressed immediately. Consult with employer as to availability and the importance of prompt return to work.

Reserves - Set for known and probable exposures based on the facts of the case. If the reserves exceed $25K the Claims Representative will complete a reserve letter explaining the basis for the numbers and send to Employer, Agent, Underwriter, Loss Control and Claims Assistant Vice President.

Denials – After claim is denied, it will remain open based on the merits of the case. Upon denial, letters will be sent from Claims Representative to employee, employer, and medical provider.

Dedicated Claim Team- Lost time and medical only claim professionals will be assigned to your account.

Managed Care Program- We have a team of highly knowledgeable nurses who are proficient in treatment protocols and in getting the right care at the right time to injured workers.

Narcotic Program – Comprehensive internal program to mitigate the use of narcotic medications through education, early intervention and evaluation to facilitate favorable outcomes.

Subrogation

What is subrogation? Subrogation is process by which an insured/insurer can recover the amount paid on a claim from a legally-liable party. The workers' compensation policy grants the insurer subrogation recovery rights.

Why is subrogation important to your business? Subrogation allows the first- party payer (typically the insurer) to recover money paid from the liable party, thereby reducing the total costs incurred, as well as your experience modifier. This means your premium will not increase if an employee is injured in an accident for which someone else is liable.

How can you help our subrogation efforts to maximize recoveries?

- Discuss/explain the subrogation process in your safety committee meetings.
- Advise employees who work at or travel to other worksites to notify you and the off-premises property owner of any unsafe exposures, such as accumulated snow/ice, cluttered walkways, unsafe stairways, generally slippery floors, poor lighting, etc.
- Educate employees who work at or travel to other worksites to take photographs of off-premises accidents, such as motor vehicle accidents, falls from ladders, construction scene accidents, etc.
- For construction site accidents, provide the name of the general contractor and a list of all subcontracts involved.
- Advise your employees to immediately notify the property owner when/where the accident occurred.
- Report the workers' compensation claim to Argent immediately; subrogation investigations are extremely time sensitive.
- When applicable, provide Argent or our representative with copies of rental agreements, contracts, owner's manuals, maintenance records, photographs, diagrams, invoices, certificates of insurance, etc.
- Do not discard or repair any equipment that may have led to your employee's injury (i.e., broken ladder). The item may need to be inspected/tested by an independent engineer.

Subrogation considerations:

- Would the at-fault party pursue a liability claim against your company if the tables were turned?
- If the injury to your employee and its effect on your employee's family were life changing, would that influence your decision to subrogate?
- Should your insurance premiums increase because of exposures you can't control?

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [Name of employer] _____ has workers' compensation insurance coverage from [name of commercial insurance company] _____ in the event of work-related injury or occupational disease. This coverage is effective from [effective date of workers' compensation insurance policy] _____. Any injuries or occupational diseases which occur on or after that date will be handled by [name of commercial insurance company] _____ _____. An employee or a person acting on the employee's behalf, must notify the employer of an injury or occupational disease not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an occupational disease, unless the Texas Department of Insurance, Division of Workers' Compensation (Division) determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

EMPLOYEE ASSISTANCE: The Division provides free information about how to file a workers' compensation claim. Division staff will answer any questions you may have about workers' compensation and process any requests for dispute resolution of a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031. The Office of Injured Employee Counsel (OIEC) also provides free assistance to injured employees and will explain your rights and responsibilities under the Workers' Compensation Act. You can obtain OIEC's assistance by contacting an OIEC customer service representative in your local Division field office or by calling 1-866-EZE-OIEC (1-866-393-6432).

SAFETY VIOLATIONS HOTLINE: The Division has a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 1-800-452-9595.

COVERED EMPLOYER

Texas Workers' Compensation Rule 110.101(e)(1) requires employers who are covered by workers' compensation through a commercial insurance company to advise their employees that they do have workers' compensation insurance coverage and to advise their employees of the Texas Department of Insurance, Division of Workers' Compensation's toll free number to obtain additional information about their workers' compensation rights.

Notices in English, Spanish and any other language common to the employer's employee population must be posted and:

1. Prominently displayed in the employer's personnel office, if any;
2. Located about the workplace in such a way that each employee is likely to see the notice on a regular basis;
3. Printed with a title in at least 26 point bold type, subject in at least 18 point bold type, and text in at least 16 point normal type; and
4. Contain the exact words as prescribed in Rule 110.101(e)(1).

The notice on the reverse side meets the above requirements. Failure to post or to provide notice as required in the rule is a violation of the Act and Division rules. The violator may be subject to administrative penalties.

Do Not Post This Side

AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [Name of the employer] _____ _____tiene cobertura de seguros de compensación para trabajadores con [name of the commercial insurance company] _____ para protegerle en caso de una lesión o enfermedad ocupacional relacionada con el trabajo. Esta cobertura está vigente desde [effective date of workers' compensation insurance policy] _____. Cualquier lesión o enfermedad ocupacional que ocurra en o después de esta fecha será manejada por [name of commercial insurance company]_____ _____. Un empleado o una persona que actúe en nombre del empleado, debe notificar al empleador sobre una lesión o una enfermedad ocupacional a no más tardar de treinta (30) días, a partir de la fecha en que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad ocupacional, al menos que el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation – TDI-DWC, por su nombre y siglas en inglés) (División) determine que existió una buena causa para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador tiene la obligación de proporcionarle a usted información por escrito sobre la cobertura cuando usted es contratado o cuando su empleador adquiere o deja de tener una cobertura de seguro de compensación para trabajadores.

ASISTENCIA AL EMPLEADO: La División proporciona información gratuita sobre cómo presentar una reclamación de compensación para trabajadores. El personal de la División contestará cualquier pregunta que usted pueda tener sobre la compensación para trabajadores y procesará cualquier solicitud de resolución de disputas relacionada con una reclamación. Usted puede obtener este tipo de asistencia comunicándose con su oficina local de la División o llamando al teléfono 1-800-252-7031. La Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés) también ofrece asistencia gratuita a los empleados lesionados y ellos le explicarán cuáles son sus derechos y responsabilidades bajo la Ley de Compensación para Trabajadores. Usted puede obtener la asistencia de OIEC comunicándose con un representante de servicio al cliente de OIEC en su oficina local de la División o llamando al 1-866-EZE-OIEC (1-866-393-6432).

LÍNEA DIRECTA PARA REPORTAR VIOLACIONES DE SEGURIDAD: La División cuenta con una línea gratuita telefónica que está en servicio las 24 horas del día para reportar condiciones inseguras en el área de trabajo que podrían violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen en contra de cualquier empleado porque él o ella de buena fe reporta una alegada violación ocupacional de salud o seguridad. Comuníquese con la División al teléfono 1-800-452-9595.

EMPLEADOR CON COBERTURA

El Reglamento 110.101 (e)(1) de Compensación para Trabajadores de Texas requiere que los empleadores que cuentan con una cobertura de compensación para trabajadores mediante una compañía de seguros comercial notifiquen a sus empleados que ellos cuentan con una cobertura de seguro de compensación para trabajadores e informen a sus empleados sobre el número de la línea telefónica gratuita del Departamento de Seguros de Texas, División de Compensación para Trabajadores para obtener información adicional sobre sus derechos de compensación para trabajadores.

Avisos en inglés, español y cualquier otro idioma común para la población de los trabajadores del empleador deben ser puestos a la vista y:

1. Mostrarse en un lugar prominente de la oficina de personal del empleador, si es que la hay;
2. Ubicar este aviso en el área de trabajo de tal manera que los empleados lo vean regularmente;
3. El título debe ser impreso en tamaño 26, en letra negrita de punto, el tema debe ser impreso en tamaño 18, en letra negrita de punto, y el texto, por lo menos en tamaño 16 en letra negrita de punto normal; y
4. Contener las palabras exactas según lo señalado en el Reglamento 110.101 (e)(1).

El aviso que se muestra al reverso de esta página cumple con los requisitos que se han señalado en la parte de arriba. El negarse a mostrar o proporcionar esta información, según lo requerido en el reglamento es una falta a la ley y a los reglamentos de la División. El infractor podría estar sujeto a sanciones administrativas.

NO MOSTRAR ESTE LADO

Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4001 fax • www.tdi.texas.gov

YOU MAY USE YOUR OWN LETTERHEAD WITH THE FOLLOWING INFORMATION

Reference Rule 110.101

(a) In addition to the posted notice required by subsection (e) of this section, employers, as defined by Labor Code Section 406.001, shall notify their employees of workers' compensation insurance coverage status, in writing. This additional notice:

(1) shall be provided at the time an employee is hired, meaning when the employee is required by federal law to complete both a W-4 form and an I-9 form or when a break in service has occurred and the employee is required by federal law to complete a W-4 form on the first day the employee reports back to duty;

(2) shall be provided to each employee, by an employer whose workers' compensation insurance coverage is terminated or cancelled, not later than the 15th day after the date on which the termination or cancellation of coverage takes effect;

(3) shall be provided to each employee, by an employer who obtains workers' compensation insurance coverage, not later than the 15th day after the date on which coverage takes effect, as necessary to allow the employee to elect to retain common law rights under Labor Code Chapter 406;

(4) shall include the text required in the posted notice (see rule 110.101 (e)(1), (e)(2), (e)(3), (e)(4) for appropriate language); and

(5) if the employer is covered by workers' compensation insurance (subscriber) or becomes covered, whether by commercial insurance or through self-insurance as provided by the Texas Workers' Compensation Act (Act), shall include the following statement:

NOTICE TO NEW EMPLOYEES

"You may elect to retain your common law right of action if, no later than five days after you begin employment or within five days after receiving written notice from the employer that the employer has obtained workers' compensation insurance coverage, you notify your employer in writing that you wish to retain your common law right to recover damages for personal injury. If you elect to retain your common law right of action, you cannot obtain workers' compensation income or medical benefits if you are injured."

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YOU MAY USE YOUR OWN LETTERHEAD WITH THE FOLLOWING INFORMATION

Reglamento de Referencia 110.101

(a) Además del aviso que debe ponerse a la vista, el cual es requerido por la sub sección (e) de esta sección, los empleadores, según lo definido por la Sección del Código Laboral 406.001, deberán notificar por escrito a sus empleados sobre el estado de la cobertura de compensación para trabajadores. Además, este aviso:

(1) deberá ser proporcionado al momento en que el empleado es contratado, es decir, cuando la ley federal requiere que el empleado complete el formulario W-4 y el formulario I-9, o cuando haya ocurrido una interrupción en el servicio y la ley federal requiere que el empleado complete el formulario W-4 en el primer día en que el empleado se reporta de regreso a sus deberes;

(2) deberá ser proporcionado a cada empleado, por un empleador cuya cobertura de seguro de compensación para trabajadores ha sido anulada o cancelada, a no más tardar del día 15, después de la fecha en la cual la anulación o cancelación entra en vigor;

(3) deberá ser proporcionado a cada empleado, por un empleador que obtiene una cobertura de seguro de compensación para trabajadores, a no más tardar del día 15, después de la fecha en la cual la cobertura entra en vigor, según lo necesario para permitir que el empleado opte por conservar su derecho común (common law right, por su nombre en inglés) bajo el Capítulo 406 del Código Laboral;

(4) deberá incluir el texto que es requerido en el aviso que debe ponerse a la vista (ver el reglamento 110.101 (e)(1), (e)(2), (e)(3), (e)(4) para obtener el lenguaje apropiado); y

(5) si el empleador está cubierto por un seguro de compensación para trabajadores (subscriptor) u obtiene una cobertura, ya sea mediante un seguro comercial o se convierte en auto asegurado según lo proporcionado por la Ley de Compensación para Trabajadores de Texas (Ley), deberá incluir la siguiente declaración:

AVISO A LOS NUEVOS EMPLEADOS

"Usted puede optar por conservar su derecho común de acción de ley (common law right of action, por su nombre en inglés) si, a no más tardar de cinco días después que usted comienza su empleo o dentro de cinco días después de recibir aviso por escrito por parte del empleador donde se informa que el empleador ha obtenido una cobertura de seguro de compensación para trabajadores, usted le notifica a su empleador por escrito que desea conservar su derecho común de acción de ley para recuperarse de daños por lesiones personales. Si opta por conservar su derecho común de acción de ley, usted no puede obtener beneficios médicos o de ingresos de compensación para trabajadores si se ha lesionado."

Loss Control Services

Argent offers a comprehensive, proactive approach to managing your workers compensation exposures. Our goal is to enhance the current safety culture within your organization. This is a sample of the variety of services Argent's Loss Control Department may provide.

- Comprehensive assessment of exposures specific to the operations that may impact workers safety:
  - Assessment of established controls for the physical environment;
  - Assessment of management approach to safety;
  - Employee responsibilities for safety;
  - In depth analysis of losses; and
  - Identification of loss drivers.
- Development of a comprehensive, collaborative safety plan to address those factors affecting the workers compensation program.
- Onsite and job site specific assessments of physical exposures:
  - Machine guarding;
  - Ergonomics;
  - PPE use; and
  - Identification of hazards in the workplace.
- Training of management, supervisors, and key personnel:
  - Accident investigation;
  - Costs and effects of workers compensation insurance;
  - Transitional return to work programs;
  - Safety roles;
  - Accountability; and
  - Loss drivers, observations, and opportunities to improve operational safety.

- Development of specific safety recommendations based on observations and interactions with management and employees.
- Hands-on approach for assisting in the development and implementation of safety recommendations.
- Personalized consultation for management based on the customer's individual needs.
- Hands-on assistance with developing:
    - Transitional return to work program;
    - Slip/fall prevention programs;
    - Safe patient/resident handling programs for medical facilities;
    - Effective safety committee;
    - Ergonomic committee;
    - Injury review committee; and
    - Fleet safety programs.
- Periodic service review meetings are provided to assure your needs are being addressed.
- Resources available for OSHA programs, training videos, and training documents.

Management Accident Investigation Report

To Be Completed By One Of The Following: Supervisor / Plt Manager / HR. Director

Employee	Dept.	Job Title
Shift:	Date of Injury Time AM or PM	
Location of Incident		
Date Reported / / Time Reported	Reported to Whom?	

NAME OF WITNESS	DEPARTMENT/ADDRESS	PHONE
(1)		
(2)		

Have witnesses fill out separate forms and give attach.

1. What was employee doing when injured? BE SPECIFIC

2. How did the injury/illness occur?

3. Was employee performing function alone? ☐ yes ☐ no

Employee was assisting with the operations?

4. Did injury occur because of: Failure to follow safety rules ☐

Failure to use safety device ☐ Other ☐

5. How long has employee been doing this job? (days, months, years)

6. What safety equipment is required on the job the employee was performing?

7. Was the employee using all required safety equipment? Yes ☐ No ☐

8. If No, which specific personal protective equipment was not used & why?

9. Does an unsafe condition exist that contributed to the cause, if so, what is that condition?

10. How could the accident have been prevented? BE SPECIFIC

RECOMMENDED ACTION			**Person Responsible**	**Assigned Date/Completed Date**
Re-instruction	Yes ☐	No ☐	_____	_____/_____
Equipment repair/replacement	Yes ☐	No ☐	_____	_____/_____
Reduce Clutter	Yes ☐	No ☐	_____	_____/_____
Improve design/construction	Yes ☐	No ☐	_____	_____/_____
Workstation Modification	Yes ☐	No ☐	_____	_____/_____
Discipline of person(s) involved	Yes ☐	No ☐	_____	_____/_____
Other				

Signature of Person Completing Investigation: _____

Date: _____

Employee Accident Report

Name: _____ Accident Location: _____

Date of Injury: _____Time: _____a.m.☐ p.m.☐ Date Reported: _____

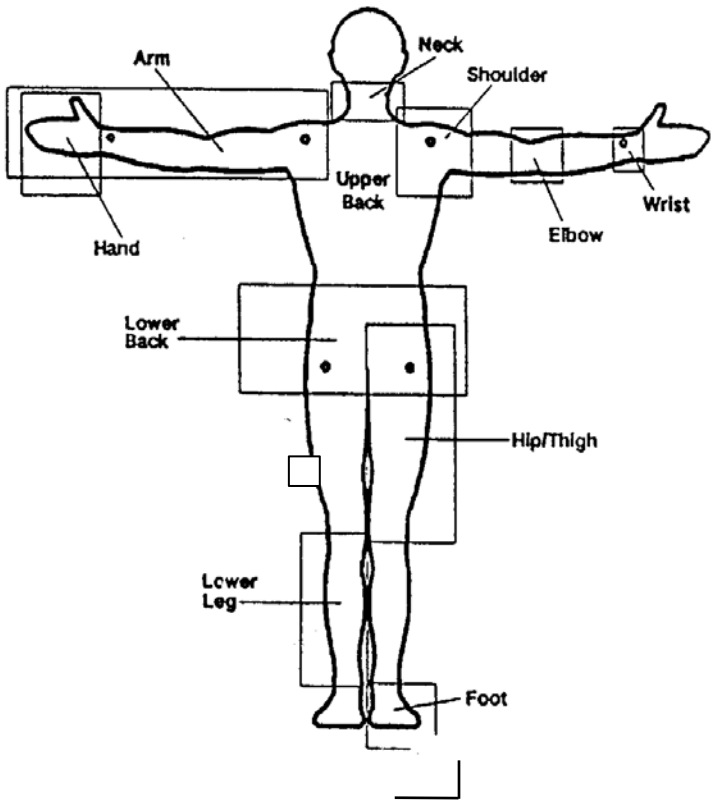
Witnesses:_____

Accident Description: _____

_____

_____

_____

Injured Area	Indicate Area of Injury	Type of Injury
1 ☐ Head 2 ☐ Eye: L / R 3 ☐ Shoulder L / R 4 ☐ Arm L / R 5 ☐ Elbow L / R 6 ☐ Wrist L / R 7 ☐ Hand L / R 8 ☐ Finger: Specify _____ 9 ☐ Back 10 ☐ Chest 11 ☐ Abdomen 12 ☐ Pelvis 13 ☐ Hip L / R 14 ☐ Leg L / R 15 ☐ Knee L / R 16 ☐ Ankle L / R 17 ☐ Foot L / R 18 ☐ Toe: Specify _____ 19 ☐ Other: _____ _____		1 ☐ Abrasion 2 ☐ Amputation 3 ☐ Bite: _____ 4 ☐ Bruise 5 ☐ Burn 6 ☐ Concussion 7 ☐ Cut / Laceration 8 ☐ Foreign Body 9 ☐ Fracture 10 ☐ Hearing Impaired 11 ☐ Infection 12 ☐ Pain: _____ _____ 13 ☐ Puncture 14 ☐ Rash/Derm. 15 ☐ Respiratory 16 ☐ Strain/Sprain 17 ☐ Other: _____ _____ _____

Have you ever injured this body part before? _____ if so, when? _____

Are you currently receiving medical treatment for the prior injury? _____

What do you believe caused this accident? _____

What can be done to prevent this from happening in the future? _____

_____

Signature: _____

Date: _____

WITNESS REPORT OF INCIDENT

Name: _____ Injured Employee Name: _____

Date of Injury: _____ Time of Accident: _____ (AM/PM)

Location where injury occurred:

_____

_____

_____

Describe activity prior to the accident:

_____

_____

_____

Describe the accident:

_____

_____

_____

What do you believe caused the accident:

_____

_____

_____

What part of the body was injured? _____

What do you think could prevent this type of accident from occurring again?

_____

_____

_____

Signed: _____ Date: _____

Temporary Work Schedule

DEFINITION: A form used by an employee returning to work in the Temporary Work Program.

POLICY
Every employee returning to temporary restricted work duty must use a Temporary Work Schedule. It is the employee's immediate supervisor's responsibility to thoroughly explain the use of the Temporary Work Schedule. The Temporary Work Schedule must be completed daily.
The temporary tasks assigned to you may or may not be normal and customary job duties.

The **employee's responsibility** to complete:

- Restrictions
- Symptom Control Techniques
- Date
- Hours Worked - Log Breaks, Rest and Lunch
- Duties Performed
- Employee Comments
- Employee Signature

The **supervisor's responsibility** to complete:

- Supervisor's Comments (document discussion of problems and actions taken)
- Supervisor's Signature

*The supervisor and employee must sign schedule daily.

Supervisors turn Work Schedule into Human Resources Department at end of week.

Employee should retain a copy for their file.

The Human Resources Department will forward copy to Argent Claims Representative and, if necessary, to treating physician

Temporary Work Schedule

Name:			Restrictions:	
Supervisor:			Symptom Control Techniques:	
Date	**Work Log (include breaks/lunch)**	**Tasks Assigned/Completed**	**Employee Signature and Comments**	**Supervisor Signature and Comments**
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 work program.

_____

(Signature and Date)