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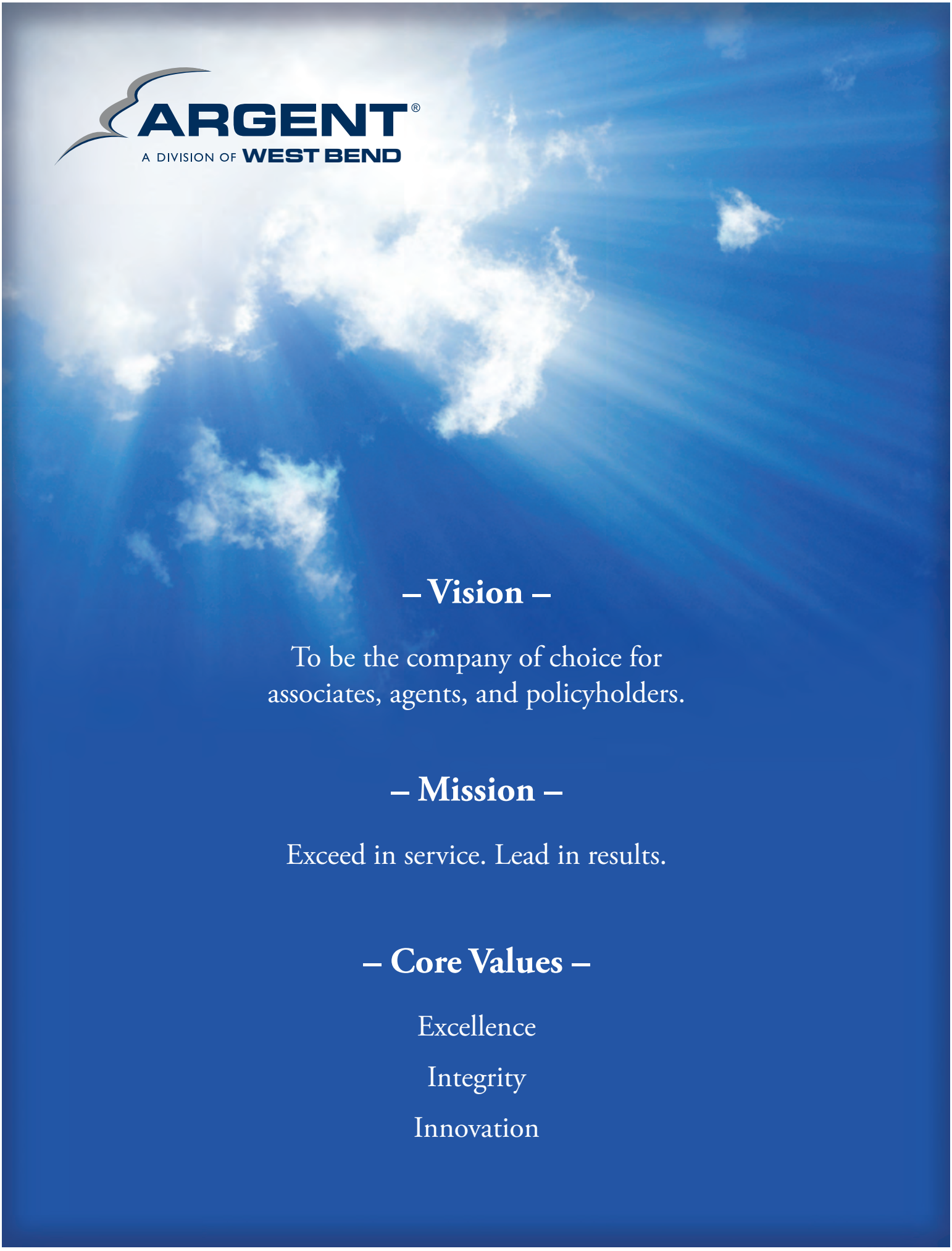

– Vision –

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).

EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
http://www.dwd.state.wi.us/wc/
e-mail: DWDDWC@dwd.state.wi.us

Loc Code _____
Dept Code _____

Fatal Injuries: Employers subject to ch. 102, Wis. Stats., must report injuries resulting in death to the Department and to their insurance carrier, if insured, within one day after the death of the employee.
Non-Fatal Injuries: If the injury or occupational illness results in disability beyond the three-day waiting period, the employer, if insured, must notify its insurance carrier within 7 days after the injury or beginning of disability. Medical-only claims are to be reported to the insurance carrier only, not the Department.
Electronic Reporting Requirement: All work-related injuries and illnesses resulting in compensable lost time, with the exception of fatalities, must be reported electronically to the Department via EDI or Internet by the insurance carrier or self-insured employer within 14 days of the date of injury or beginning of disability. Employer may fax claims for fatal injuries to the Imaging Fax Server number on this form.

The provision of your social security number is voluntary. Failure to provide it may result in an information processing delay.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)]. **(Please read the instructions on Page 2 for completing this form)**

EMPLOYEE

Employee Name (First, Middle, Last)	Social Security Number - -	Sex ☐ M ☐ F	Employee Home Telephone No. ( ) -
Employee Street Address	City	State	Zip Code - / Occupation
Birthdate / Date of Hire	County and State Where Accident or Exposure Occurred?		

EMPLOYER

Employer Name	WI Unemployment Ins. Acc No.	Self-Insured? ☐ Yes ☐ No	Nature of Business (Specific Product)
Employer Mailing Address	City	State / Zip Code -	Employer FEIN -
Name of Worker's Compensation Insurance Co. or Self-Insured Employer **Argent, 1900 South 18th Avenue, West Bend, WI 53095 Fax: 888-926-9299**			Insurer FEIN **39-0698170**
Name and Address of Third Party Administrator (TPA) Used by the Insurance Company or Self-Insured Employer			TPA FEIN -

WAGE INFORMATION

Wage at Time of Injury $	Specify per hr., wk., mo., yr., etc. Per:	In Addition to Wages, Check Box(es) if Employee Received: ☐ Meals ☐ Room ☐ Tips	No. of Meals/wk No. of Days/wk Avg. Weekly Amt. $

Is Worker Paid for Overtime? ☐ Yes ☐ No If Yes, After How Many Hours of Work Per Week?

For The 52 Week Period Prior to the Week the Injury Occurred, Report Below the Number of Weeks Worked in the Same Kind of Work, and the Total Wages, Salary, Commission and Bonus or Premium Earned for Such Weeks.

No. of Weeks:	Gross Amount Excluding Tips: $	If Piece-Work, No. of Hrs. Excluding Overtime:

	Start Time	Hours Per Day	Hours Per Week	Days Per Week
Employee's Usual Work Schedule When Injured:	: ☐ AM ☐ PM			
Employer's Usual Full-Time Schedule for This Type of Work at Time of Employee's Injury:				

Part-Time Employment Information:	Are there Other Part-Time Workers Doing the Same Work With the Same Schedule? ☐ Yes ☐ No If yes, how many?	Number of **Full-Time** Employees Doing The Same Type Of Work:

INJURY INFORMATION

Injury Date	Time of Injury : AM : PM	Last Day Worked	Date Employer Notified	☐ Date Returned to Work ☐ Estimated Date of Return

Did Injury Cause death? ☐ Yes ☐ No	Date of Death	Was This a Lost Time or Other Compensable Injury? ☐ Yes ☐ No	Did Injury Occur Because of: ☐ Substance Abuse ☐ Failure to Use Safety Devices ☐ Failure to Obey Rules

Was Employee Treated in an Emergency Room? ☐ Yes ☐ No Was Employee Hospitalized Overnight as an In-Patient? ☐ Yes ☐ No

Name and Address of Treating Practitioner and Hospital:

Case Number from the OSHA Log:

Injury Description - Describe Activities of Employee When Injury or Illness Occurred and What Tools, Machinery, Objects, Chemicals, Etc. Were Involved.

What Happened to Cause This Injury or Illness? (Describe How The Injury Occurred)

What Was the Injury or Illness? (State the Part of Body Affected and How It Was Affected)

Report Prepared By	Work Phone Number ( ) -	Position	Date Signed

SEND REPORT IMMEDIATELY - DO NOT WAIT FOR MEDICAL REPORT

EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS

The employer must complete all relevant sections on this form and submit it to the employer's worker's compensation insurance carrier or third party claim administrator within seven (7) days after the date of a work-related injury which causes permanent or temporary disability resulting in compensation for lost time. The employer's insurance carrier or the third-party claim's administrator may request that this form also be used to immediately report any injury requiring medical treatment, even though it does not involve lost work time.

For any work injury resulting in a **fatality**, the employer must also submit this form directly to the Department of Workforce Development **within 24 hours of the fatality**.

An employer exempt from the duty to insure under s. 102.28, Wis. Stats., and an insurance carrier administering claims for an insured employer are required to submit this form to the Department of Workforce Development within 14 days of the date of work injury.

MANDATORY INFORMATION

In order to accurately administer claims, each of the following sections of this form must be completed. The First Report of Injury will be returned to the sender if the mandatory information is not provided.

Employee Section: Provide all requested information to identify the injured employee. If an employee has multiple dates of employment, the "Date of Hire" is the date the employee was hired for the job on which he or she was injured.

Employer Section: Provide all requested information to identify the injured worker's employer at the time of injury. Provide the name and Federal Employer Identification Number (FEIN) for the insurance carrier or self-insured employer responsible for the worker's compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

Wage Information Section: Provide the information requested regarding the injured employee's wage and hours worked for the job being performed at the time of injury.

Injury Information Section: Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the body injured, the specific nature of the injury (i.e., fracture, strain, concussion, burn, etc.) and the use of any objects or tools (i.e., saw, ladder, vehicle, etc.) that may have caused the injury. Provide the name of the person preparing this report and the telephone number at which they may be reached, if additional information is needed. This form was designed to include information required by OSHA on form 301. If this section is completed and retained, the employer will not have to complete the OSHA 301 form.

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.

Argent
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#:	10602464
Member ID (SSN):	
Date of Injury:	
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:

Employee:

Argent 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 5 to 15 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 others will require prior approval.

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

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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

Voluntary and Informed Consent for Disclosure of Health Care Information

The provision of your social security number is mandatory under Wisconsin Statutes and will be used to identify the claimant. Failure to provide it may result in penalties or delayed payment of benefits. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://dwd.wisconsin.gov/wc/
e-mail: DWDDWC@dwd.wisconsin.gov

By law, all health care providers must provide to any employee, employer, worker's compensation insurer or their representative any information reasonably related to any alleged work injury. However, determining the relationship of prior medical records to a work injury can be difficult and time-consuming. Therefore, to assist in the timely investigation of your claim, this document authorizes the health care provider to release medical information without attempting to determine the extent of its relationship to your alleged work injury.

You are not required to sign this document. You may refuse to sign this document without jeopardizing your right to collect worker's compensation benefits. However, by assisting in the investigation of your claim, you are likely to receive benefits quicker than if you refuse to authorize the release of medical information.

Health Care Provider Name **All Providers**		Street Address	
P. O. Box	City	State	Zip Code
Patient (Employee) Name	Employer Name		
Patient Social Security Number	Patient Birth Date	WC Claim No.	

The patient named above hereby authorizes the health care provider named above to disclose all records checked below in its possession relating to the patient's health, treatment and evaluation to:

Name and Address of Party Authorized to Receive Protected Information
Argent, 1900 South 18th Avenue, West Bend, WI 53095

or its designated representatives, and to furnish to them a legible, certified duplicate of all records, writings, reports, test results and x-rays in its possession containing such information. This authorization includes *all* records, reports, correspondence, or other materials in the possession of the health care provider authorized, even if those materials were not generated by the health care provider, and the redisclosure of such materials is hereby authorized. This release is for use in the investigation, preparation, evaluation, and/or hearing of the worker's compensation claim described above.

CHECK ONE:

☐ **A. Physical Only.** Release all records, correspondence, and any other information from whatever source regarding the patient's physical health, treatment and evaluation including, but not limited to, any made or provided by any physician, nurse, chiropractor, osteopath, dentist, physical therapist, hospital, or any other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited to Wis. Stat. §§ 146.81 and 146.82, and 45 C.F.R. § 164.508.

☐ **B. Physical and Other.** Release all records, correspondence, and any other information from whatever source regarding the patient's physical and mental health, drug and alcohol abuse, HIV and AIDS tests, treatment, and evaluation including, but not limited to, any made or provided by any physician, psychiatrist, psychologist, nurse, chiropractor, osteopath, dentist, physical therapist, hospital or any other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited to Wis. Stat. §§ 51.30, 146.025, 146.81 and 146.82, 42 C.F.R., Chap. 1, subpart C, § 2.31 and 45 C.F.R. § 164.508.

Patient Signature (or Person Authorized to Sign for Patient) — for Option B

Patient Signature (or Person Authorized to Sign for Patient)	Date

WKC-9488 (R. 03/2009)

In signing this consent form, I acknowledge that I understand that:

- I am authorizing release of the records and information listed above.
- I am waiving any privilege that may otherwise prevent disclosure of the records and information listed above.
- I understand that the health care provider named above, whom I am authorizing to disclose my protected health information, may not condition my treatment, payment, enrollment or eligibility for benefits (if applicable) on whether I sign this authorization, except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.
- I may revoke this authorization at any time by a written request to the party authorized above to receive information, except that the party authorized above to receive such information may rely upon any personal health information received before the revocation of this authorization.
- I may obtain a copy of the disclosed records and information, upon written request to the party authorized above to receive information, at no charge to me.
- My personal health information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by federal law. My personal health information may be released to any of the following: the employer, the worker's compensation insurer, the Department of Workforce Development, other parties to this matter or their attorneys; the Labor and Industry Review Commission; any court on any action or proceeding relating to this matter; experts retained or consulted by any party; and any of their agents, employees, or representatives. I specifically authorize and consent to any such disclosure and redisclosure.
- I am entitled to a copy of this consent form after I sign it.

If you have any questions about this document, you should contact the Worker's Compensation Division at (608) 266-1340. You should not sign this document if the name of the health care provider is blank.

This consent is subject to revocation at any time. If not revoked, this consent is effective for two (2) years from date signed. This authorization expressly waives any requirement that it must be used within a certain number of days after the date of signing, or that it must be dated within any time period before the date it is used. This authorization shall also extend to records of future treatment, after the date of signing of this authorization, as long as such treatment occurs while this authorization is still in effect. A photocopy copy shall be as valid as the original.

Patient Signature (or Person Authorized to Sign for Patient)	Date
If not signed by patient, authority/designation to sign is based on the fact that the patient is ☐ A minor ☐ Incompetent ☐ Disabled ☐ Deceased ☐ Other:	

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

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.

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.

Argent, a Division of West Bend
Waukesha, Wisconsin 53188

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?

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: _____

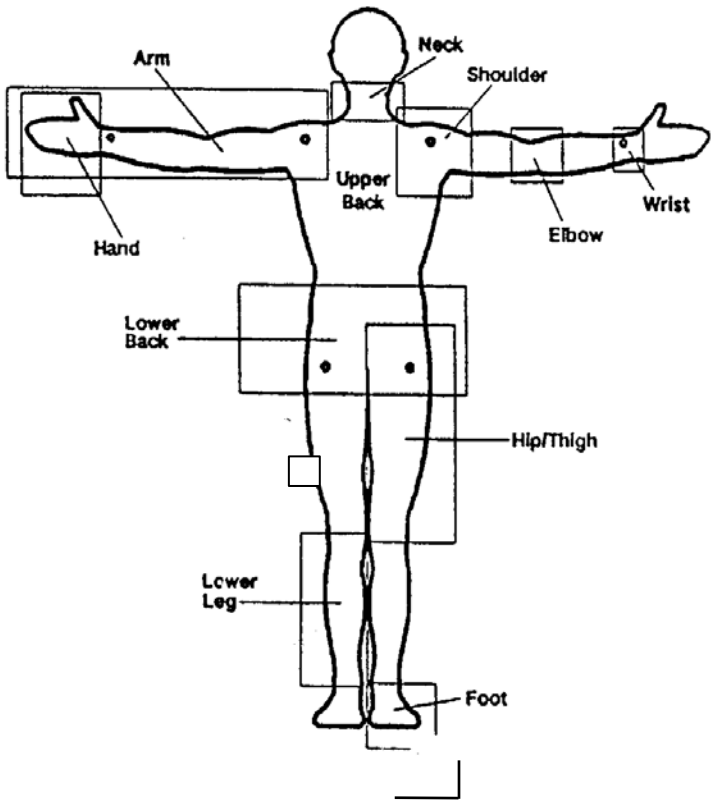
Witnesses:_____

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)