AmTrust North America
An AmTrust Financial Company

Arizona
Worker's Compensation
Claim Kit

(p) 888.239.3909 • (f) 678.258.8399 • www.amtrustfinancial.com

AmTrust North America
An AmTrust Financial Company

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AmTrust INSURANCE

Workers' Compensation Claim Reporting Information

24/7 Toll Free Claim Reporting for All States

(888)239-3909

WorkersCompClaimReport@AmTrustgroup.com

www.amtrustfinancial.com

Information Required for All Claims Reported

1. Name of the insured and policy number
2. Name, social security number and contact information of injured worker
3. Date, time and place of accident
4. Description of accident or incident
5. Name, phone, and/or email of person making the report
6. Any information on the injured workers lost time

Early claim reporting is essential to a better claim outcome. Don't delay reporting if you do not have all the details.

How do I help my injured worker find a doctor?

- We offer an online physician search for all states, www.talispoint.com/amtrust/external
- For California, www-lv.talispoint.com/amtrust/campn
- For CO, GA, PA & TN, please refer to the panel provided by AmTrust via mail or email

How does my injured employee receive prescription medications related to the accident/injury?

- Refer to the claims kit for your state at www.talispoint.com/amtrust/external for a First Fill card for your injured employee to use at the pharmacy to cover the cost of approved medication.

Timely Reporting

When a work-related injury occurs, it is important to act immediately. Timely reporting of a new claim helps to provide a smooth and successful claim process for both you and your injured worker.

We're Here To Help

After your claim has been filed, we may be in touch to obtain additional information. Our goal is to offer a smooth and hassle-free experience – from your first contact to the claims conclusion. Feel free to also call us with any questions. We're here to help.

Relax And Stay Positive

You have the assurance of our knowledge, expertise, and understanding of the claim process. We're with you all the way.

877.528.7878 I www.amtrustfinancial.com

AmTrust INSURANCE

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EASY ONLINE CLAIMS REPORTING INSTRUCTIONS

By logging into AmTrust's web portal, policyholders can access a wide variety of account information including the ability to report injuries online. The following instructions will help get you started.

First Time Portal Access:

1. Go to www.amtrustnorthamerica.com
2. In the upper right corner of the home page, click "LOGIN"
3. In the subsequent AmTrust *Online* drop-down box, click the word "**Register**"
4. On the following screen, enter your policy number, zip code and the security code that appears on that screen and click "**Enter**" at the bottom right of the screen
5. Enter your email address, user name and password to complete the registration process
6. After completing the registration process, go back to www.amtrustnorthamerica.com and log in

Reporting of New Injuries:

1. Go to www.amtrustnorthamerica.com
2. Log in to "AmTrust ***Online***"
3. Click the "**Claims**" icon in the upper middle of your screen to view the screen that lists your policies
4. Click "**View**" next to the policy for which you wish to enter a claim. This brings you to the policy detail screen
5. Click on "**First Reports**" in the upper left corner
6. On the next screen, click "**Add**" to view the "**New First Report of Injury**" screen
7. Click "**Use WebForm**." This brings you to the screen where you will enter all of the detailed information about the injury/injured worker
8. When finished entering all of the data, click "**Submit**" and this report will channel into our intake center to be set up and assigned to a claims adjuster
9. Return to the "**First Reports"** screen and you will see the claim number for the report entered
10. When finished, click on "**Return to Listing**"

For ID/Password issues or if you receive error messages while using this application, please contact our help desk at help.desk@amtrustgroup.com or call 866.427.6150. Please be sure to specify that you are an AmTrust policyholder and provide your AmTrust Online ID.

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Helpful Hints:

- "**Time Employee Began Work**" and "**Time of Occurrence**" must be entered in military time
- Enter the hours in the first box and the minutes in the second box
- All dates must be entered as two-digit day, two-digit month and four-digit year, i.e.: XX/XX/XXXX
- For PEOs, in the "**Location Address**" box, please include the PEO client name and address of the applicable PEO client location. If there is a location code/number, specify in the "**Location #**" box
- If during the entry of a claim you must exit the application, first click on "S**ave as Draft**" and you may return to it later by going back into the "**First Reports"** screen and clicking on "**In Progress**"

For ID/Password issues or if you receive error messages while using this application, please contact our help desk at help.desk@amtrustgroup.com or call 866.427.6150. Please be sure to specify that you are an AmTrust policyholder and provide your AmTrust Online ID.

Thank you for your attention to this matter.

Sincerely,

AmTrust North
America Claims
Department

800 Superior Avenue E • 21st Floor • Cleveland, OH 44114
(p) 866.203.3037 • (f) 800.487.9654 • www.amtrustnorthamerica.com

Workers' Compensation Posting Requirements

Thank you for placing your Workers' Compensation Coverage with AmTrust.

Arizona Required Posting Notices

Post at place of employment, in a sufficient number of places on the premises to assure that the notice will reasonably be seen by all employees at all business locations and work sites (Break Room, Lunch Room or Time Clock) Employees that may not reasonably be expected to see a posted notice must receive notice of the posting in writing.

- **Notice to Employees Re: Arizona Workers' Compensation Law**
- **Notice to Employees Re: Work Exposure to Bodily Fluids**
- **Notice to Employees Re: Work Exposure to Methicillin-Resistant Staphylococcus Aureus (MRSA), Spinal Meningitis or Tuberculosis (TB).** This notice must be displayed immediately next to the Notice to Employees Re: Work Exposure to Bodily Fluids.

To Complete Notice To Employees Re: Arizona Workers' Compensation Law form:

To complete the form, please enter Policy Number and Name of Insurance Carrier in spaces shown.

Please complete and submit the following forms to AmTrust when a work-related injury occurs:

- **Employer's Report of Industrial Injury (Form ICA 0101).** This form must be submitted within 10 days from notice of an accident. Fatalities must be reported within 24 hours. You must use this form to notify AmTrust of every work-related injury or disease by an employee, regardless of severity.
- **Report of Significant Work Exposure to Bodily Fluids (Form ICA 0124).** This form is completed by employer and must be signed by the employee. Employer should keep original and provide copy to AmTrust. This copy will serve as our notice that your employee experienced a significant work-related exposure to bodily fluids of another individual.
- **Optum First Fill Form.** Use of this form will enable quick authorization for your employee's initial medication and ensure that the initial prescription is provided at no cost to the injured employee. Immediately upon receiving notice of injury, fill in the information on this form and give this form to the employee.Your employee will need to provide this completed form along with the prescription for their work-related injury or occupational disease to the pharmacist.
- **Statement of Wages/Salary.** This form enables us to calculate the correct compensation that may be owed to an injured employee. Please complete this form and submit to AmTrust within five days after your knowledge of any accident that has caused your employee to be disabled for more than seven scheduled work calendar days.

You may send an email to clientservices@amtrustgroup.com with any Claims Kit related questions. Please make sure to include your policy number along with your request.

I have a question about a claim or injured worker, who do I contact?

Customer Service can direct you to the appropriate person. Please contact them at 888-239-3909.

59 Maiden Lane, New York, NY 10038 I 877.528.7878 I www.amtrustfinancial.com

AmTrust FINANCIAL

TO BE POSTED BY EMPLOYER **POLICY NUMBER** _____

NOTICE TO EMPLOYEES

RE: ARIZONA WORKERS' COMPENSATION LAW

All employees are hereby notified that this employer has complied with the provisions of the Arizona Workers' Compensation Law (Title 23, Chapter 6, Arizona Revised Statutes) as amended, and all the rules and regulations of The Industrial Commission of Arizona made in pursuance thereof, and has secured the payment of compensation to employees by insuring the payment of such compensation with: _____

All employees are hereby further notified that in the event they do not specifically reject the provisions of the said compulsory law, they are deemed by the laws of Arizona to have accepted the provisions of said law and to have elected to accept compensation under the terms thereof; and that under the terms thereof employees have the right to reject the same by written notice thereof prior to any injury sustained, and that the blanks and forms for such notice are available to all employees at the office of this employer.

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PARA SER COLOCADO POR EL PATRON **NUMERO DE POLIZA** _____

AVISO A LOS EMPLEADOS

RE: LEY DE COMPENSACION PARA LOS TRABAJADORES DE ARIZONA

A todos los empleados se les notifica por este medio que este patron ha cumplido con las provisiones de la Ley de Compensacion para los Trabajadores de Arizona (Titulo 23, Capitulo 6, Estatutos Enmendados de Arizona) tal como han sido enmendados, y con todas las reglas y ordenanzas de La Comision Industrial de Arizona hechas en cumplimiento de esta, y ha asegurado el pago de compensacion a los empleados garantizando el pago de dicha compensacion por medio de: _____

Ademas, a todos los empleados se les notifica por este medio que en caso de que especificadamente ellos no rechazen las disposiciones de dicha ley obligatoria, se les considerara bajo las leyes de Arizona de haber aceptado las provisiones de dicha ley y de haber escogido aceptar la compensacion bajo estos terminos; tambien bajo estos terminos los empleados tienen el derecho de rechazar la misma por medio de una notificacion por escrito antes de que sufran alguna lesion, todos los formularios o formas en blanco para tal notificacion por escrito estaran disponibles para todos los empleados en la oficina de este patron.

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KEEP POSTED IN A CONSPICUOUS PLACE.

COLOQUESE EN LUGAR VISIBLE.

WORK EXPOSURE TO BODILY FLUIDS

NOTICE TO EMPLOYEES

Re: Human Immunodeficiency Virus (HIV),
Acquired Immune Deficiency Syndrome (AIDS) & Hepatitis C

Employees are notified that a claim may be made for a condition, infection, disease, or disability involving or related to the Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or Hepatitis C within the provisions of the Arizona Workers' Compensation Law, and the rules of The Industrial Commission of Arizona. Such a claim shall include the occurrence of a significant exposure at work, which generally means contact of an employee's ruptured or broken skin or mucous membrane with a person's blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. **AN EMPLOYEE MUST CONSULT A PHYSICIAN TO SUPPORT A CLAIM.** Claims cannot arise from sexual activity or illegal drug use.

Certain classes of employees may more easily establish a claim related to HIV, AIDS, or Hepatitis C if they meet the following requirements:

1. The employee's regular course of employment involves handling or exposure to blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. Included in this category are health care providers, forensic laboratory workers, fire fighters, law enforcement officers, emergency medical technicians, paramedics and correctional officers.

2. **NO LATER THAN TEN (10) CALENDAR DAYS** after a possible significant exposure which arises out of and in the course of employment, the employee reports in writing to the employer the details of the exposure as provided by Commission rules. Reporting forms are available at the office of this employer or from the Industrial Commission of Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 or 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5181. If an employee chooses not to complete the reporting form, that employee may be at risk of losing a prima facie claim.

3. **NO LATER THAN TEN (10) CALENDAR DAYS** after the possible significant exposure the employee has blood drawn, and **NO LATER THAN THIRTY (30) CALENDAR DAYS** the blood is tested for **HIV OR HEPATITIS C** by antibody testing and the test results are negative.

4. **NO LATER THAN EIGHTEEN (18) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are HIV positive or the employee has been diagnosed as positive for the presence of HIV, or **NO LATER THAN SEVEN (7) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are positive for the presence of Hepatitis C or the employee has been diagnosed as positive for the presence of Hepatitis C.

KEEP POSTED IN CONSPICUOUS PLACE
NEXT TO WORKERS' COMPENSATION NOTICE TO EMPLOYEES

THIS NOTICE IS APPROVED BY THE INDUSTRIAL
COMMISSION OF ARIZONA FOR CARRIER USE

EXPOSICION A FLUIDOS CORPORALES EN EL TRABAJO

AVISO A LOS EMPLEADOS

Re: El Virus de la Inmunodeficiencia Humana (VIH),
Síndrome de la Inmundeficiencia Adquirida (SIDA) y Hepatitis C

Se les notifica a los empleados que se puede hacer una reclamación por una condición, infección, enfermedad o incapacidad relacionada con o derivada del Virus de Inmunodeficiencia Humana (VIH), Síndrome de Inmunodeficiencia Adquirida (SIDA), o Hepatitis C bajo lo provisto por la Ley de Compensación para los Trabajadores de Arizona y las reglas de La Comisión Industrial de Arizona. Tal reclamación debe incluír el suceso de una exposición importante en el trabajo, la que por lo general significa contacto de alguna ruptura de la piel o mucosa del empleado con la sangre, semen, fluido vaginal, fluido(s) quirúrgico(s) o cualquier otro fluido de una persona que contenga sangre. **EL EMPLEADO DEBE CONSULTAR A UN MEDICO PARA CONFIRMAR SU RECLAMACION.** Las reclamaciones no pueden resultar de actividad sexual o uso ilícito de drogas.

Ciertas clases de empleados pueden establecer más fácilmente una reclamación relacionada con el VIH, SIDA O Hepatitis C si reúnen los requisitos siguientes:

1. El curso regular del empleo del empleado requiere el manejo de o la exposición a sangre, semen, fluido vaginal, fluido(s) quirúrgico(s) o cualquier otro fluido que contenga sangre. Incluídos en esta categoría son los proveedores de cuidados de la salud, trabajadores de laboratorios forenses, bomberos, agentes policiales, técnicos médicos de emergencia, paramédicos y agentes correccionales.

2. **NO MAS DE DIEZ (10) DIAS DE CALENDARIO** después de una possible exposición importante que resulta de y en el curso de su trabajo, el empleado reporta a su patrón por escrito los detalles de la exposición como lo proveen las reglas de la Comisión. Las formas de reporte están disponibles en la oficina de este patrón o de la Comisión Industrial de Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 o 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5181. Si un empleado elige no llenar la forma de reporte, ese empleado corre el riesgo de perder una reclamación de prima facie.

3. **NO MAS DE DIEZ (10) DIAS DE CALENDARIO** después de una posible exposción importante el empleado va a que le saquen sangre, y **NO MAS DE TREINTA (30) DIAS DE CALENDARIO** la sangre es analizada para **VIH O HEPATITIS C** por medio de análisis de anticuerpos y el análisis resulta negativo.

4. **NO MAS DE DIECIOCHO (18) MESES** después de la fecha de la posible exposición importante en el trabajo, el empleado es examinado nuevemente y los resultados del análisis son positivos por VIH o el empleado ha sido diagnosticado como positivo por la presencia de VIH, o **NO MAS DE SIETE (7) MESES** después de la fecha de la posible exposición importante en el trabajo, el empleado es examinado nuevamente y los resultados del análisis son positivos por la presencia de Hepatitis C o el empleado ha sido diagnosticado como positivo por la presencia de Hepatitis C.

MANTENER FIJO EN UN LUGAR SOBRESALIENTE JUNTO AL AVISO A LOS EMPLADOS SOBRE COMPENSACION PARA TRABAJADORES

ESTE AVISO HA SIDO APROBADO POR LA COMISION INDUSTRIAL
DE ARIZONA PARA USO DE LAS ASEGURADORAS

Este documento es una traduccion del texto original escrito en ingles. Esta traduccion no es oficial y no es vinculante para este estado o para una subdivision politica de este estado.

This document is a translation from original text written in English. This translation is unofficial and is not binding on this state or a political subdivision of this state.

WORK EXPOSURE TO METHICILLIN-RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA), SPINAL MENINGITIS, OR TUBERCULOSIS (TB)

Notice to Employees

Employees are notified that a claim may be made for a condition, infection, disease or disability involving or related to MRSA, spinal meningitis, or TB within the provisions of the Arizona Workers' Compensation Law. (A.R.S. § 23-1043.04) Such a claim shall include the occurrence of a significant exposure at work, which is defined to mean an exposure in the course of employment to aerosolized MRSA, spinal meningitis or TB bacteria. Significant exposure also includes exposure in the course of employment to MRSA through bodily fluids or skin.

Certain classes of employees (as defined below) may more easily establish a claim related to MRSA, spinal meningitis or TB by meeting the following requirements:

1. The employee's regular course of employment involves handling or exposure to MRSA, spinal meningitis or TB. For purposes of establishing a claim under this section, "employee" is limited to firefighters, law enforcement officers, correction officers, probation officers, emergency medical technicians and paramedics who are not employed by a health care institution;

2. No later than thirty (30) calendar days after a possible significant exposure, the employee reports in writing to the employer the details of the exposure;

3. A diagnosis is made within the following time-frames:

    a. For a claim involving MRSA, the employee must be diagnosed with MRSA within fifteen (15) days after the employee reports pursuant to Item No. 2 above;

    b. For a claim involving spinal meningitis, the employee must be diagnosed with spinal meningitis within two (2) to eighteen (18) days of the possible significant exposure; and

    c. For a claim involving TB, the employee is diagnosed with TB within twelve (12) weeks of the possible significant exposure.

Expenses for post-exposure evaluation and follow-up, including reasonably required prophylactic treatment for MRSA, spinal meningitis, and TB is considered a medical benefit under the Arizona Workers' Compensation Act for any significant exposure that arises out of and in the course of employment if the employee files a claim for the significant exposure or the employee reports in writing the details of the exposure. Providing post-exposure evaluation and follow-up, including prophylactic treatment, does not, however, constitute acceptance of a claim for a condition, infection, disease or disability involving or related to a significant exposure.

Employers must post this notice in a conspicuous place next to the Workers' Compensation Notice to Employees.

EMPLOYER'S REPORT OF INDUSTRIAL INJURY

COMPLETE AND SUBMIT THIS REPORT WITHIN 10 DAYS FROM NOTICE OF ACCIDENT. FATALITIES MUST BE REPORTED WITHIN 24 HOURS.

Employer must, on this form, notify his insurance carrier of every injury or disease suffered by an employee, fatal or otherwise, which is claimed to arise out of or in the course of employment.
ARIZONA REVISED STATUTES 23-908 & 23-1061

INDUSTRIAL COMMISSION OF ARIZONA
P.O. BOX 19070
PHOENIX, ARIZONA 85005-9070

FOR CARRIER USE ONLY

FOR OSHA PURPOSES ONLY

OSHA Case #: _____

RECORDABLE INJURY _____

NON-RECORDABLE INJURY _____

EMPLOYEE

1. LAST NAME | FIRST | M.I. | 2. SOCIAL SECURITY NUMBER * | 3. BIRTH DATE

4. HOME ADDRESS (NUMBER & STREET) | CITY | STATE | ZIP CODE | 5. TELEPHONE

6. SEX ◯ MALE ◯ FEMALE | 7. MARITAL STATUS: ◯ SINGLE ◯ MARRIED ◯ DIVORCED ◯ WIDOWED

EMPLOYER

8. EMPLOYER'S NAME | 9. POLICY NUMBER | 10. NATURE OF BUSINESS (MANUFACTURING, ETC.)

11. OFFICE ADDRESS (NUMBER & STREET) | CITY | STATE | ZIP CODE | 12. TELEPHONE

ACCIDENT

13. DATE OF INJURY OR ILLNESS | 14. TIME OF EVENT | 15. TIME EMPLOYEE BEGAN WORK | 16. DATE EMPLOYER NOTIFIED OF INJURY

17. LAST DAY OF WORK AFTER INJURY | 18. DATE OF RETURN TO WORK | 19. EMPLOYEE'S OCCUPATION (JOB TITLE) WHEN INJURED

20. CLASS CODE ON PAYROLL REPORT | 21. EMPLOYEE'S ASSIGNED DEPARTMENT | 22. DEPARTMENT NUMBER | 23. DID INJURY OCCUR ON EMPLOYER PREMISES? ◯ YES ◯ NO

24. ADDRESS OR LOCATION OF ACCIDENT | CITY | COUNTY | STATE | ZIP CODE

25. WHAT WAS THE INJURY OR ILLNESS? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or sore." *Examples:* "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."

26. PART OF BODY INJURED | 27. FATAL ◯ YES ◯ NO | 28. IF THE EMPLOYEE DIED, WHEN DID THE DEATH OCCUR? DATE OF DEATH

29. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? ◯ YES ◯ NO | NAME OF PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL | ADDRESS | CITY | STATE | ZIP CODE

30. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? ◯ YES ◯ NO | IF HOSPITALIZED, HOSPITAL NAME | ADDRESS | CITY | STATE | ZIP CODE

31. IS VALIDITY OF CLAIM DOUBTED ◯ YES ◯ NO | 31.a IF YES, STATE REASON

CAUSE OF ACCIDENT

32. **WHAT HAPPENED?** Tell us how the injury occurred. *Examples:* "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."

33. **WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE?** *Examples:* "concrete floor"; "chlorine"; "radial arm saw." *If this question does not apply to the incident, leave it blank.*

34. **WHAT WAS EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."

35. IF ANOTHER PERSON NOT IN COMPANY EMPLOY CAUSED ACCIDENT, GIVE NAME AND ADDRESS

EMPLOYEE'S WAGE DATA

36. WAS WORKER IN YOUR EMPLOY WHEN INJURED? ◯ YES ◯ NO | 37. HOURS PER DAY EMPLOYEE WORKED FROM THRU | 38. WAS EMPLOYEE ON OVERTIME WHEN INJURED? ◯ YES ◯ NO | 39. NUMBER OF DAYS PER WEEK USUALLY WORKED EMPLOYEE COMPANY

IMPORTANT

IF WORK LOSS IS EXPECTED TO EXCEED SEVEN CALENDAR DAYS, COMPLETE ITEMS 40 THRU 47

40. DATE OF LAST HIRE | 41. WAS WORKER PAID FOR DAY OF INJURY? ◯ YES ◯ NO IF YES, $ | 42. WAS EMPLOYEE HIRED FOR PERMANENT EMPLOYMENT? ◯ YES ◯ NO

43. NUMBER OF MONTHS EMPLOYMENT AVAILABLE DURING THE YEAR | 44. GIVE EMPLOYEE'S WAGE STATUS AS APPLICABLE HOUR DAY WEEK MONTH $ PER ◯ ◯ ◯ ◯ | 45. IS EMPLOYEE FURNISHED VALUE ◯ LODGING ◯ BOARD ◯ BOTH $

46. ACTUAL GROSS EARNINGS OF EMPLOYEE FOR THE 30 CALENDAR DAYS PRECEEDING INJURY (EXAMPLE: IF INJURED APRIL 8, GIVE EARNINGS FROM MARCH 9 THRU APRIL 7)

47. DOES EMPLOYEE CLAIM DEPENDENTS? ◯ YES ◯ NO

IMPORTANT

IF EMPLOYEE IS PAID OTHER THAN FIXED WEEKLY OR MONTHLY SALARY, COMPLETE ITEMS 48 THRU 55

48. IF EMPLOYEE EARNS EXTRA PAY FOR OVERTIME, WHAT IS BASIS OF PAYMENT? PER HOUR | 49. NUMBER OF HOURS OVERTIME CONSIDERED NORMAL PER WEEK

50. GROSS WAGES OF EMPLOYEE DURING 12 MONTHS PRECEEDING INJURY FROM THRU $

51. IF EMPLOYEE WORKED LESS THAN 12 MONTHS, SHOW GROSS WAGES FROM DATE OF HIRE THROUGH DAY PRIOR TO INJURY FROM THRU $

52. DATE OF LAST WAGE INCREASE IF WITHIN 12 MONTHS PRIOR TO INJURY | 53. WAGE BEFORE INCREASE $ | 54. WAGE AFTER INCREASE $ | 55. GROSS EARNINGS FROM DATE OF INCREASE THRU DAY PRIOR TO INJURY $

AUTHORIZED SIGNATURE

DATE | AUTHORIZED SIGNATURE | TITLE

SUBMITTER EMAIL ADDRESS

NOTE TO EMPLOYER:

1. Submit one copy to the Industrial Commission within 10 days.
2. Submit one copy to your insurance carrier within 10 days.
3. Keep one copy, for not less than five (5) years, as your supplementary record of injuries required by the Federal Occupational Safety and Health Act of 1970.

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

INDUSTRIAL COMMISSION OF ARIZONA

REPORT OF SIGNIFICANT WORK EXPOSURE TO BODILY FLUIDS OR OTHER INFECTIOUS MATERIAL

(This form is not a claim form, but a report of exposure. Forms to report a claim to the Industrial Commission are available at: www.azica.gov .)

1. Exposed Employee _____ (Last Name) _____ (First) _____ (M.I.) Birth Date _____ Job Title _____
2. Address _____ Phone No. _____
3. Employer's Full Name _____
4. Employer's Address _____
5. Date of Exposure _____ Time of Exposure _____
6. Address or Location of Exposure _____
7. Describe the circumstances surrounding the exposure, including (if applicable) personal protective equipment worn and the names of any witnesses to the exposure (be specific)

8. What were you exposed to? (Directly or indirectly via bandages, personal items, etc.) Check all that apply.

☐ Blood ☐ Vaginal fluid ☐ Broken skin ☐ Urine ☐ Any other fluid(s) containing blood or infectious material (Describe) _____
☐ Semen ☐ Surgical fluid(s) ☐ Mucous membrane ☐ Feces ☐ Airborne/Respiratory/Oral Secretions Other (specify): _____
☐ Saliva ☐ Vomitus ☐ Skin infection (e.g. abscesses, boils, or pus-filled/red/swollen/painful skin lesions)

9. Source person(s) information ◉ Unknown ○ Known
Name _____ DOB _____ Phone No. _____
Address _____ City _____ State _____ Zip _____

10. What part(s) of your body was exposed to bodily fluids/infectious material? Did exposure take place through your skin or mucous membrane (be specific)?

11. Did you have any open cuts, sores, rashes, or other breaks/ruptures in your skin or mucous membrane that were exposed to bodily fluids/infectious material (please describe)?

I HAVE GIVEN THIS FORM TO MY EMPLOYER AND HAVE RECEIVED A COPY OF THIS COMPLETE FORM.

EMPLOYEE SIGNATURE _____ DATE _____

Other Required Steps to Establish Prima Facie Claim for HIV, AIDS or Hepatitis C (A.R.S. §§ 23-1043.02, -03; A.A.C. R20-5-164)

1. **You must file this report with your employer no later than ten (10) days after your exposure.**
2. **You must have blood drawn no later than ten (10) calendar days after exposure.**
3. **You must have blood tested for HIV or Hepatitis C by Antibody Testing no later than thirty (30) calendar days after exposure and test results must be negative.**
4. **You must be tested or diagnosed as HIV positive no later than eighteen (18) months after the exposure, or tested and diagnosed as positive for the presence of Hepatitis C within seven (7) months after the exposure.**
5. **You must file a workers' compensation claim with the Industrial Commission of Arizona no later than one (1) year from the date of diagnosis or positive blood test if you wish to receive benefits under the workers' compensation system.**

Other Required Steps to Establish Prima Facie Claim for MRSA (A.R.S. § 23-1043.04; A.A.C. R20-5-164)

1. **You must file this report with your employer no later than thirty (30) days after your exposure.**
2. **For a claim involving MRSA, you must be diagnosed with MRSA within fifteen (15) days after you report in writing to your employer the details of the exposure.**
3. **You must file a workers' compensation claim with the Industrial Commission of Arizona no later than one (1) year from the date of diagnosis if you wish to receive benefits under the workers' compensation system.**

Other Required Steps to Establish Prima Facie Claim for Spinal Meningitis or TB (A.R.S. § 23-1043.04; A.A.C. R20-5-164)

1. **You must file this report with your employer no later than ten (10) days after your exposure.**
2. **For a claim involving spinal meningitis, you must be diagnosed within two (2) to eighteen (18) days of the possible significant exposure and for a claim involving tuberculosis, you must be diagnosed within twelve (12) weeks of the possible significant exposure.**
3. **You must file a workers' compensation claim with the Industrial Commission of Arizona no later than one (1) year from the date of diagnosis if you wish to receive benefits under the workers' compensation system.**

Employer: Keep Original (Notify Carrier) Employee: Keep Copy
THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA

AmTrust North America
An AmTrust Financial Company

Bodily Fluids Work Exposure Form

Instructions

This instruction has been prepared by the Industrial Commission of Arizona solely to provide general guidance concerning the topics addressed herein. The information contained in this document is not intended to create rights or obligations and is not intended to expand, limit, or in any manner modify applicable law, statutes or rule. The information contained in this document is believed to be accurate based on the information available as of January 2015. Page 1 Revised January 2015

Significant Exposure Under the Arizona Workers' Compensation Act

In 2011, the Arizona Legislature amended the reporting requirements for a possible significant exposure to Methicillin-Resistant Staphylococcus Aureus (MRSA), which are found in Arizona Revised Statutes section 23-1043.04(B). Effective July 20, 2011, employees must report a possible significant exposure to MRSA that occurs at work to their employers within thirty calendar days after the possible significant exposure. Employees must also be diagnosed with MRSA within fifteen days after the employee reports the possible significant exposure to their employer(s). Employees should use the updated form to report significant exposure. Employers must display the updated Notice to Employees (poster) titled "Work Exposure to Methicillin-Resistant Staphylococcus Aureus, Spinal Meningitis or Tuberculosis (TB)."

What is a Significant Exposure Under the Arizona Workers' Compensation Act?

A report of significant work exposure to blood, bodily fluids, or other potentially infectious materials may be made by completing a form that reports this exposure. This form may be obtained from your employer or on the Industrial Commission of Arizona website at http://www.azica.gov. But, what is a "significant exposure"? In some instances, such as an exposure to bloodborne pathogens, you may not know if the blood, bodily fluids or other material to which you are exposed is infectious. In other instances, such as exposure to Tuberculosis, MRSA, or Meningitis, you may know if the exposure is "significant" based on the symptoms of the person to whom you are exposed. Understanding the pathogens involved and how they are spread will help you answer the question, but if you have any concern as whether you should report the exposure, then you should "play it safe." Talk to your doctor , talk to your HR Department, or simply use this form to report what you believe to be a significant exposure. For more information regarding the requirements for filing a workers' compensation claim for significant work exposure, and the presumptions that are available to certain classes of employees, please read the posters that are required to be posted at your workplace that contain this information.

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Bodily Fluids Work Exposure Form (Page 2)

Instructions

Bloodborne Pathogens

Bloodborne pathogens ("BBP") are disease causing organisms such as human immunodeficiency virus ("HIV"), hepatitis B, or hepatitis C that may be present in human blood or bodily fluids that are considered "other potentially infectious material." "Human Blood" includes human blood components and products made from human blood. "Other potentially infectious material" ("OPIM") includes semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, and any bodily fluid that is visibly contaminated with blood. Unless visibly contaminated with blood, these pathogens are not transferred through tears, saliva (except in dental procedures), or perspiration. An easier way to think about this is to remember that OPIM are bodily fluids that are intended to always remain inside the body, sexual fluids, and any human tissue that is intended to be covered by skin. A significant exposure to BBP may occur when you come into contact with blood or OPIM through a break or rupture in your skin (e.g., needlestick injury or you cut yourself with a sharp instrument contaminated with blood), or your mucous membranes (e.g. blood or OPIM gets in your eyes, nose, mouth, or you engage in sexual activity with an infected person). The CDC indicates that a human bite that breaks the skin should also be considered a significant exposure. Additional information on HIV and Hepatitis may be found at www.cdc.gov.

The information contained in this document is not intended to create rights or obligations and is not intended to expand, limit, or in any manner modify applicable law, statutes or rule. The information contained in this document is believed to be accurate based on the information available as of January 2015. Page 2 Revised January 2015

MRSA

Methicillin-Resistant Staphylococcus Aureus, also known as MRSA, is a potentially dangerous type of staph bacteria that has become resistant to one family of common antibiotics. MRSA is a contact risk. You can get MRSA through direct contact with an infected person, sharing personal items (such as towels or razors that have touched infected skin) or touching shared items (clothing, door knobs, workout benches, etc.). Most staph skin infections, including MRSA, appear as a bump or infected area on the skin that may be red, swollen, painful, warm to the touch, full of pus or other drainage, and accompanied by a fever. Many people describe it as looking like a spider bite. Additional information on MRSA can be found at www.cdc.gov.

Meningitis

This form can be used to report significant exposure. Please follow the instructions on the form very carefully.

INDUSTRIAL COMMISSION OF ARIZONA

EMPLOYEE'S NOTICE OF REJECTION OF TERMS OF THE ARIZONA WORKERS' COMPENSATION LAW

POLICY NO. _____ DATE _____

To _____
Full Name of Employer

_____ _____ _____ _____
Employer Address City State Zip Code

YOU ARE HEREBY NOTIFIED THAT THE UNDERSIGNED ELECTS TO REJECT THE TERMS, CONDITIONS AND PROVISIONS OF THE LAW FOR THE PAYMENT OF COMPENSATION, AS PROVIDED BY THE COMPULSORY COMPENSATION LAW OF THE STATE OF ARIZONA, AND ACTS AMENDATORY THERETO.

_____ _____ _____
(Employee First Name) (Last Name) (Social Security Number of Employee)

_____ _____
(Address of Employee) (Signature of Employee)

_____ _____ _____
(City) (State) (Zip Code)

NOTE: This notice is of no effect unless it is filled out in duplicate and served upon the employer. The employer shall, in all cases, within five days of receipt of the notice, file a copy with the workers' compensation insurance carrier.

AmTrust North America
An AmTrust Financial Company

Employee Rejection of Terms Form

Instructions

Arizona law presumes that all employees have elected to be subject to the provisions of Arizona's workers' compensation laws. However, an employee is permitted to reject the provisions of Arizona's workers' compensation laws by completing the Employee's Notice of Rejection of Terms of the Arizona Workers' Compensation Law. See A.R.S. § 23-906(B)-(C).

To be valid, the Employee's Notice of Rejection of Terms of the Arizona Workers' Compensation Law must be filled out in duplicate (i.e., two times) and must be filed with the employer prior to the employee sustaining workplace injuries.

The employer must, in all cases, file a copy of the Employee's Notice of Rejection of Terms of the Arizona Workers' Compensation Law with the employer's workers' compensation insurance carrier.

INDUSTRIAL COMMISSION OF ARIZONA

EMPLOYEE'S NOTICE TO REVOKE REJECTION OF TERMS OF THE ARIZONA WORKERS' COMPENSATION LAW

POLICY NO. _____ DATE _____

To _____
Full Name of Employer

_____ _____ _____ _____
Employer Address City State Zip Code

I HEREBY REVOKE THE NOTICE OF REJECTION OF THE TERMS OF THE ARIZONA WORKERS' COMPENSATION LAW SIGNED BY ME ON _____.

_____ _____ _____
(Employee First Name) (Last Name) (Social Security Number of Employee)

_____ _____
(Address of Employee) (Signature of Employee)

_____ _____ _____
(City) (State) (Zip Code)

NOTE: This notice is of no effect unless it is filled out in duplicate and served upon the employer. The employer shall, in all cases, within five days of receipt of the notice, file a copy with the workers' compensation insurance carrier.

Claims ICA 0114-Rev 03.20.25

AmTrust North America
An AmTrust Financial Company

Employee Revocation of Rejection of Terms Form

Instructions

Arizona law presumes that all employees have elected to be subject to the provisions of Arizona's workers' compensation laws. However, an employee is permitted to reject the provisions of Arizona's workers' compensation laws by completing the Employee's Notice of Rejection of Terms of the Arizona Workers' Compensation Law. See A.R.S. § 23-906(B)-(C).

An employee who has completed and filed with his employer the Employee's Notice of Rejection of Terms of the Arizona Workers' Compensation Law make revoke the terms of that Notice by completing the Employee's Notice to Revoke Rejection of Terms of the Arizona Workers' Compensation Law. See A.R.S. § 23-906(B)-(C).

To be valid, the Employee's Notice to Revoke Rejection of Terms of the Arizona Workers ' Compensation Law must be filled out in duplicate (i.e., two times) and must be filed with the employer prior to the employee sustaining any workplace injuries. The employer must, in all cases, file a copy of the Notice to Revoke Rejection of Terms of the Arizona Workers' Compensation Law with the employer's workers' compensation insurance carrier.

Workers' Report of Injury

Information for Completing Workers' Report of Injury

A completed and submitted claim for workers' compensation benefits will be used to notify your employer's workers' compensation carrier or self-insured employer of your claim for workers' compensation benefits. If this form is submitted incomplete, there may be delays in processing the notification to the insurance carrier or self-insured employer to accept or deny the claim.

FAQ

Does the Industrial Commission of Arizona Claims Division (ICA) pay my claim?

- No, the Industrial Commission (ICA) Claims Division and Ombudsman office provide regulatory oversight and is available to assist you through the claims process. Please call us at 602-542-4661 or email us at Help@azica.gov, Ayuda@azica.gov or Claims@azica.gov for assistance.

How long does the Insurance Carrier or Self-Insured Employer take to accept or deny the claim.

- The Industrial Commission of Arizona will promptly notify the claim as soon as possible. From the date of notification, the Insurance Carrier of Self-Insured Employer have 21 days to investigate and make the decision on the claim.

When do I get paid for the time loss due to the accident?

- On a newly accepted claim for time loss (either light duty with loss of earnings or off work status), the first payment is due 21 days from the date of ICA's notification. There is a 7-day waiting period to qualify for benefits which, after 14 days, are retroactive to the first day.

What should I do if I am getting medical bills for my workers' compensation claim.

- When a claim is accepted for benefits, the medical benefits are payable immediately and you should have no out of pocket costs. Please contact your medical provider to ensure the correct insurance is billed for your treatment.

Right to choose physician

When an injury occurs, an employer has the right to have an injured worker seen by a doctor of the employer's choice one time. If you return to that physician a second time, that physician becomes your attending physician. After one visit to the employer's designated physician, you may select a physician of your choice. Exception: if your employer is self-insured and directs medical care you must follow the self-insured employer's directed care program. To determine if your employer is self-insured and directs medical care, you may contact the Industrial Commission of Arizona Claims Division at (602) 542-4661 or visit azica.gov/divisions/claims-division

Form available in alternative format: The Industrial Commission complies with the Americans with Disabilities Act of 1990. If you need this document in alternative format, contact Claims at (602) 542-4661.

Call Us
602-542-4661

Email Us
Help@azica.gov
Ayuda@azica.gov
Claims@azica.gov

INDUSTRIAL COMMISSION OF ARIZONA
Workers' Report of Injury

E-File visit www.azica.gov - Mail: Industrial Commission of Arizona PO BOX 19070 Phoenix AZ 85005 - Fax: 602-542-3373
Questions with the * are required, failure to complete may delay processing. Please call or email with any questions.

1. Injured Worker

First Name*:	Middle Initial:	Last Name*:
Last Four Social Security*:		Date of Birth*:
Gender: ◯ Male ◯ Female ◯ Nonbinary ◯ Prefer not to say		Legal Dependents at time of Injury*: ◯ Yes ◯ No
Dominant Hand: ◯ Right ◯ Left ◯ Ambidextrous		Marital Status*: ◯ Single ◯ Married ◯ Divorced
Telephone Number*: ###-###-####		Email Address:
Mailing Address*:		
City*:	State*:	Zip Code*:
Check to elect to receive notices and documents from the Industrial Commission by Email*: ☐		

2. Employment

Job Title*:		Date Hired at Employer*:
Employer Name* (from Paycheck Stub or Tax Document):		
Employer Address*:		
City*:	State*:	Zip Code*:
Employer Phone Number: ###-###-####		Supervisor Name*:
Supervisor Phone Number: ###-###-####		Supervisor Email Address:
Workers' Compensation Insurance Carrier: **C/O Amtrust North America**		Policy Number:
Base Rate of Pay Rate:		Per: ◯ Hourly ◯ Monthly ◯ Salary
Other earnings or other explanation of earnings from employer at time of injury:		
Did you have other employment in the last year? ◯ Yes ◯ No		

3. Injury

Date of Injury*:	Time of Injury:
Describe where and how the accident or cause of disab occurred (Limit 255 characters)*:	Describe what part(s) of body were injured (Limit 255 characters) *:
Did the injury include tooth loss or laceration on or about the face? ◯ Yes ◯ No	
Name of treating physician for the injury?	
Name of treating Clinic/Hospital for the injury?	
Who directed you to the treating physician?	◯ Myself ◯ Employer ◯ Insurance Carrier

4. Signature

I make application for all benefits to which I may be entitled under the law. I certify, with full knowledge that pursuant to A.R.S. § 23-1028 it is a class 6 felony to make wilful, false statements to obtain compensation and that all my statements on this form are true, accurate and complete.

I hereby authorize each physician and person in the medical field and each hospital, clinic, or place rendering me any medical care, to provide The Industrial Commission of Arizona, my employer, the insurance carrier, and their authorized representative, any and all information, records and X-rays, regarding **my physical condition and treatment for this industrial injury**, to be used for a proper understanding of the case and a determination of the rights involved. I do not authorize the release of medical information from any source pertaining to conditions unrelated to the pending industrial claim. (see A.R.S. § 23-908(D))

Signature*:	Date*:

AmTrust North America
An AmTrust Financial Company

Worker's Report of Injury Form

Instructions

An injured worker must file a workers' compensation claim in writing with the Commission within one year after the injury occurred or when the injury becomes manifest which means that the injured worker knows or in the exercise of reasonable diligence should know that he or she has sustained a compensable work related injury.

An injured worker can make a claim for workers' compensation benefits by filling out and signing a Worker's and Physician's Report of Injury at the doctor's office or by completing this form as follows:

An injured worker or authorized representative may file a workers' compensation claim for benefits by filing this form with the Commission.

IMPORTANT: This form must be completed in its entirety, including the name and address of the injured worker's employer at the time of the alleged injury as well as the address or location of the accident. Failure to do so may cause a delay in processing it.

OPTUM®

AmTrust North America
An AmTrust Financial Company

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM®

AmTrust North America
An AmTrust Financial Company

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
CARRIER/TPA

EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER

DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®

IMP14-1614-109-FFWG

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias, incluyendo Walgreens, nuestro proveedor preferido, y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
PORTADORA — EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL — FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-1614-109-FFWG

STATEMENT OF WAGES/SALARY

IMPORTANT: PLEASE COMPLETE ALL INFORMATION REQUESTED

Employee: Employer: Claim Number:
Social Security Number: Date of Hire: Position/Job Title

EMPLOYMENT TYPE: Full Time ☐ Part Time ☐ Seasonal ☐ Temp ☐
If Temporary or Seasonal worker, last day of season or job end date _____
WAGE TYPE: Hourly ☐ Salary ☐ Commission ☐
WAGE INFORMATION:
$_____ per hour ; Monthly Wage $_____ ; Does monthly wage include commission ☐ Yes ☐ No
Hours per Week _____ ; Overtime Rate $_____ per hour ; Overtime Hours Regularly Worked per week ____
Tips reported: $_____ per week

If employees' compensation package includes an allowance for any of the following, please indicate the actual or estimated value:
Meals: $_____ per week Auto: $_____ Rent/Lodging: $_____ per week Bonus $_____ per ☐ wk ☐ mth ☐ yr

PLEASE COMPLETE THE BELOW FOR THE PERIOD _____ TO _____

WK	Pay Rate	Hrs Worked	Begin Date	End Date	Gross Salary	WK	Pay Rate	Hrs Worked	Begin Date	End Date	Gross Salary
1						27					
2						28					
3						29					
4						30					
5						31					
6						32					
7						33					
8						34					
9						35					
10						36					
11						37					
12						38					
13						39					
14						40					
15						41					
16						42					
17						43					
18						44					
19						45					
20						46					
21						47					
22						48					
23						49					
24						50					
25						51					
26						52					

RETURN-TO-WORK; A **GREAT** IDEA

We at the AmTrust Group, are convinced that an employer who provides light, or restricted work for injured employees, enjoys numerous benefits. This is not just an opinion, it's something we see day in and day out. Consider:

- Unless an injured worker returns to the workplace within 60 days, chances of him/her ever returning drop dramatically. (resulting in a very expensive permanent disability situation.)
- After 6 months away from the workplace, only 50% chance of return.
- After 12 months, only a 10% chance of return.

Some Return-to Work Benefits Include:

- "Test" of malingering potential. Injured employees who refuse light duty are more prone to being malingerers.
- Opportunity for employer to demonstrate true concern for workers' well-being.
- Promotion of rehabilitation and recovery.
- Lower medical and rehabilitation costs.
- Productivity.
- Morale improvement for the injured worker.
- Ability for the employer to monitor the injured employee's recovery progress.
- Decrease of WC claims costs, with resultant downstream WC premium savings.

(Notice we're not just talking about 'feel-good' issues, but also hard dollars !)

Some common misconceptions (and truths) about Return-to-Work / Light Duty:

Misconception: *We've already got too many "programs" around here, and don't need any more paper*.

Truth: While it is true a written, planned program works best, in many cases a Light Duty "program" can be nothing more than a management understanding of the benefits and principles of Return-to-Work, how it works, and the commitment to 'just do it', when light-duty recommendations are made by WC physicians.

Misconception: *It will get me into an Americans With Disabilities (ADA) "situation".*

Truth: Light-duty and ADA "reasonable accommodation" are two entirely separate issues. Generally, light duty is a temporary assignment, for a relatively short period. ADA accommodations are made for serious, permanent disabilities that impair major life activities.

Misconception*: I'll have to devise a whole new job each time an employee needs light duty.*

Truth: The vast majority of light-duty restrictions require accommodating only one or two factors, such as "no lifting over 10 pounds", or the like. In many cases, if you break the jobs down into individual **tasks**, you'll see that only one or two tasks within the employee's normal job are affected, and can be handled in some other way.

Misconception: *Once an employee gets into a "cushy" light-duty job, s/he'll never leave it, and I'll be stuck with it.*

Truth: Light duty is always defined by, and monitored by the attending physician. An employee on light duty is periodically monitored by the physician for improvement, and is released for full-duty as soon as medically indicated.

Misconception: *We're a union company. Our union won't allow us to pay lower rates, or move employees between classifications, or between bargaining groups.*

Truth: Any Local that objects to a Return-to-Work program should be referred to its national body for guidance. Return to Work is universally recognized as a very positive influence on an injured worker (as well as benefiting the employer). Labor unions, whose major purpose for existence is the benefit of the workers they represent, should not only "tolerate" Return-to-Work programs, but enthusiastically promote, and assist in such programs' implementation and operation. It is strongly suggested that management approach labor representatives to solicit their input, and assistance in making Return to Work a positive force in your workplace.

Misconception: *I might be willing to place a worker in a light-duty position, but I can't afford pay them their full pay, for the decreased productivity.*

Truth: Talk to your WC insuror's claims professional. In many cases, states' WC plans provide for "make-up" pay to replace some, or all of the injured employees' decreased earnings. The goal of getting them back to the workplace, and doing some productive work is that important!