AmTrust North America
An AmTrust Financial Company

Connecticut
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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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

State of Connecticut
Workers' Compensation Commission

Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011

Rev. 7-13-2009

FRI

Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT IN INK.

Date filed in Chairman's Office

(for WCC use only)

Employer *(Name, Address & Zip)* | Phone #

Carrier / Administrator Claim # | OSHA Log Case # | Report Purpose Code

Jurisdiction | Jurisdiction Claim #

Employer's Location Address *(if different)* | Phone #

SIC Code | FEIN

Carrier *(Name, Address & Zip)* | Phone # **888-239-3909**

P.O. BOX 6935
CLEVELAND, OH 44101-6935

Claims Administrator *(Name, Address & Zip)* | Phone #

Policy / Self-Insured # | ☐ Check, if Self-Insured

Policy Period *(MM/DD/YY)*
FROM: TO:

Employee: Last Name First Name Middle Name

D.O.B. *(required)* | Phone #

Address *(incl. Zip)*

Gender
☐ Male
☐ Female

Date Hired *(MM/DD/YY)* | State of Hire

Occupation / Job Title

Rate of Pay $ _____ . _____ per
☐ Hour ☐ Day ☐ Week ☐ Bi-Weekly ☐ Other

NCCI Class Code

Date of Injury / Illness *(MM/DD/YY)*

Time Employee Began Work ☐ a.m. ☐ p.m.

Time of Occurrence ☐ cannot be determined ☐ a.m. ☐ p.m.

Date Employer Notified *(MM/DD/YY)*

Date Disability Began *(MM/DD/YY)*

Date Last Worked *(MM/DD/YY)*

Date Return(ed) to Work *(MM/DD/YY)*

If Fatal, Date of Death *(MM/DD/YY)*

All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:

Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:

Contact Name

Phone #

Town of Injury / Illness

Did Injury / Illness occur on Employer's Premises? ☐ Yes ☐ No

Type of Injury / Illness

Part of Body Affected

Type of Injury / Illness Code

Part of Body Affected Code

Were Safeguards or Safety Equipment provided? ☐ Yes ☐ No

If provided, were they used? ☐ Yes ☐ No

How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:

Cause of Injury Code

Physician / Health Care Provider *(Name, Address & Zip)*

Hospital *(Name, Address & Zip)*

Initial Treatment

☐ No Medical Treatment
☐ Emergency Care
☐ Minor — by Employer
☐ Hospitalized More Than 24 Hours
☐ Minor — by Clinic / Hospital
☐ Future Major Medical — Lost Time Anticipated

Date Administrator Notified *(MM/DD/YY)* | Date Prepared *(MM/DD/YY)*

Preparer's Name & Title | Phone #

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

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.

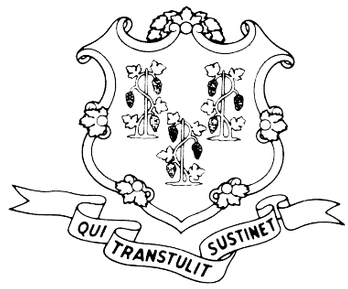
Misconception: *We're a union company. Our union won't allow us to pay lower rates, or move employees between classifications, or between bargaining groups.*

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!

NOTICE
TO EMPLOYEES



State of Connecticut Workers' Compensation Commission **Revised 10-01-2021**

The Workers' Compensation Act (Connecticut General Statutes Chapter 568) requires your employer,

_____

to provide benefits to you in case of injury or occupational disease in the course of employment.

Section 31-294b of the Workers' Compensation Act states "Any employee who has sustained an injury in the course of his employment shall immediately report the injury to his employer, or some person representing his employer. If the employee fails to report the injury immediately, the administrative law judge may reduce the award of compensation proportionately to any prejudice that he finds the employer has sustained by reason of the failure, provided the burden of proof with respect to such prejudice shall rest upon the employer."

An injury report by the employee is NOT an official written notice of claim for workers' compensation benefits; the Workers' Compensation Commission's Form 30C is necessary to satisfy this requirement.

NOTE: You must comply with P. A. 17-141 (see next box, below) when filing a compensation claim.

The INSURANCE COMPANY or SELF-INSURANCE ADMINISTRATOR is:

Name _____

Address P.O. BOX 6935 **Telephone** 888-239-3909

City/Town CLEVELAND **State** OH **Zip Code** 44101-6935

Approved Medical Care Plan ☐ **Yes** ☐ **No**

The State of Connecticut Workers' Compensation Commission office for this workplace is located at:

Address _____ **Telephone** _____

City/Town _____ **State** _____ **Zip Code** _____

Public Act 17-141 allows an employer the option to designate and post – "in the workplace location where other labor law posters required by the Labor Department are prominently displayed" and on the Workers' Compensation Commission's website [wcc.state.ct.us] – a location where employees must file claims for compensation.

If your employer has listed a location below, you <u>MUST</u> file your compensation claim there.
When filing your claim, you are also required – by law – to send it by certified mail.

If blank below, ask your employer where to file your claim.

Employer Name _____

Address _____ **Telephone** _____

City/Town _____ **State** _____ **Zip Code** _____

THIS NOTICE MUST BE IN TYPE OF NOT LESS THAN TEN POINT BOLD-FACE AND POSTED IN A CONSPICUOUS PLACE IN EACH PLACE OF EMPLOYMENT. FAILURE TO POST THIS NOTICE WILL SUBJECT THE EMPLOYER TO STATUTORY PENALTY (Section 31-279 C.G.S.).

Date Posted: _____

Any questions as to your rights under the law or the obligations of the employer or insurance company should be addressed to the employer, the insurance company, or the Workers' Compensation Commission (1-800-223-9675).

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					

State of Connecticut Workers' Compensation Commission

This form prepared by the WCC is proper for ordinary use and is recommended, but any other notice complying with Section 31-294c shall be deemed sufficient.

Rev. 06-01-2022

30C

Notice of Claim for Compensation

(Employee to Administrative Law Judge and to Employer)

Notice is hereby given that the injured worker, while in the employ of the employer, sustained injuries arising out of and in the course of his/her employment as follows, and makes claim for compensation benefits.

Please TYPE or PRINT IN INK

WCC File #

Date filed in District

(for WCC use only)

INJURED WORKER

Name _____
(first) *(middle)* *(last)*

D.O.B. *(required)* _____

Check, if a Minor ❑ *(under 18 yrs. of age)*

Address _____

Town _____ State _____

Zip Code _____ Tel.# _____

EMPLOYER

Employer _____

Address _____

Town _____ State _____

Zip Code _____ Tel.# _____

Was Injury ON Premises of Employer? ❑ YES ❑ NO

If NO, where? _____

Address _____

Town _____

Zip Code _____ Tel.# _____

INJURY

Date of Injury _____

Town of Injury _____

Body Part(s) _____

Describe Injury, including how it happened:

❑ Check, if Occupational Disease / Repetitive Trauma
❑ Check, if Post-Traumatic Stress Injury pursuant to C.G.S. Section 31-294k
❑ Check, if Cancer Diagnosis of a Firefighter
❑ Check, if MORE THAN ONE Employer

SIGNATURE OF INJURED WORKER OR REPRESENTATIVE

Signature _____

Date _____

Print name & address below, if other than injured worker:

Name _____

Name of Firm _____

Address _____

Town _____ State _____

Zip Code _____ Tel.# _____

This notice must be served upon the Administrative Law Judge and *Employer by personal presentation or by registered or certified mail. For the protection of both parties, the employer should note the date when this notice was received and the claimant should keep a copy of this notice with the date it was served.

* *Persons employed by the State of Connecticut must serve the employer by serving this notice upon the Commissioner of Administrative Services, 450 Columbus Boulevard, Hartford, CT 06103.*

* *Persons employed by a municipality must serve the employer by serving this notice upon the town clerk of the municipality in which he or she is employed.*

* *If your employer pursuant to statute has posted the location where this notice is to be filed, it is your obligation to file it at that location, using certified mail.*

WARNING: If an employer does not file a notice contesting liability (e.g. Form 43) for this claim OR begin making workers' compensation benefit payments "without prejudice" within 28 calendar days from the date when this claim is received by personal delivery or by registered or certified mail, COMPENSABILITY SHALL BE PRESUMED and cannot thereafter be contested. If an employer chooses to begin making workers' compensation benefit payments "without prejudice" within 28 calendar days from the date of receipt of this claim and still wishes to contest this claim, it must do so by filing a notice contesting liability for this claim within one year from receipt of this claim [See Sec. 31-294c(b)] OR, in the case of a claim for PTSD pursuant to P.A. 19-17, within 180 days.

A 30C Form should be filed promptly after a work-related injury or illness takes place. There is a statute of limitation for filing workers' compensation claims: within **one** year of the date of an accidental injury or within **three** years from the first manifestation of a symptom of an occupational disease.

[**NOTE**: If, within the applicable time period described above, (1) there has been a hearing or a written request for a hearing or an assignment for a hearing or (2) your employer's insurance carrier has already signed a Voluntary Agreement, you do **NOT** need to file a 30C Form for the injury or illness it covers.]

You Should File A 30C Form Because . . .

- There will be no doubt that you are claiming that you have a work-related injury or occupational disease.
- It is the best way to insure that you have met the statute of limitations for filing a workers' compensation claim.
- A simple "accident report" filed with the employer is not an official claim for workers' compensation.
- Your claim will be more likely to receive prompt attention from your employer or insurance carrier.
- Once your employer receives an official claim, they have only 28 calendar days in which to either deny your claim or to begin making workers' compensation benefit payments "without prejudice." If an official denial is not issued within 28 calendar days or if benefit payments are not initiated within 28 calendar days, your employer must accept the compensability of your claim. (If your employer has opted to post a location where you must file your claim, this 28-day period begins when your employer has received your claim *at the location posted* per statute.)

Directions for Completing the 30C Claim Form

Please pay close attention to these directions. Remember to Type or Print Neatly In Ink (except for signatures).

In filling out the 30C Form, please note the following:

1. **In the "INJURED WORKER" box** at the upper left side of the form, **type or neatly print the name of the injured worker (If YOU are the injured worker, print YOUR name here.). Also fill in the injured worker's D.O.B.** (date of birth), **put a check in the box if the worker is a minor** (under the age of 18), **and fill in the injured worker's street address, town, state, zip code, and telephone number**.
2. **In the "EMPLOYER" box** at the lower left side of the form, **type or neatly print the name of the employer** ("Name of employer" means the name of the organization for which you work, NOT your boss or supervisor.) **and its street address, town, state, zip code, and telephone number**. **Next indicate** (YES or NO) **whether the injured worker's injury occurred at the employer's location just listed; *if the injury took place at a location other than that listed*, fill in the location, street address, town, state, zip code, and telephone number where the injury actually occurred**.
3. **In the "INJURY" box** at the upper right side of the form, **type or neatly print the date of the injured worker's injury and the town in which the injury occurred** (Note the city or town in which the injury actually occurred. This will not necessarily be the same location as the employer's business address!). I**ndicate the part(s) of the worker's body injured and how the injury occurred** (In the blank space describe your injury in simple terms, specifying the part(s) of your body affected and the type(s) of injury. For example: "sprain to the right shoulder", "amputation of the left thumb", "fracture of the right ankle", "severe strain to lower back", etc.). **Next check the first box**, *if the injury is an occupational disease or a repetitive trauma*, **check the second box** *if you have more than one employer*, **and check the third box** *if you are a police officer, parole officer, or firefighter claiming benefits for PTSD pursuant to Public Act 19-17*.
4. **In the "SIGNATURE OF INJURED WORKER OR REPRESENTATIVE" box** at the lower right side of the form, **sign your name and fill in the date of your signature, if you are the injured worker. *If you are NOT the injured worker*, then sign your name, fill in the date of your signature, and then type or neatly print your name, the name** (if any) **of your firm, your street address, town, state, zip code, and your telephone number**.
5. **In the "WCC File #" box** at the upper right side of the form (just below the "30C" number in the upper right corner), **type or neatly print the WCC File Number, ONLY IF YOU KNOW IT**. In most instances, this number will be assigned to your claim by the Workers' Compensation Commission only after you send the 30C Form in, so **it is okay to leave this one area of the form blank, if you are not absolutely sure of the number**.

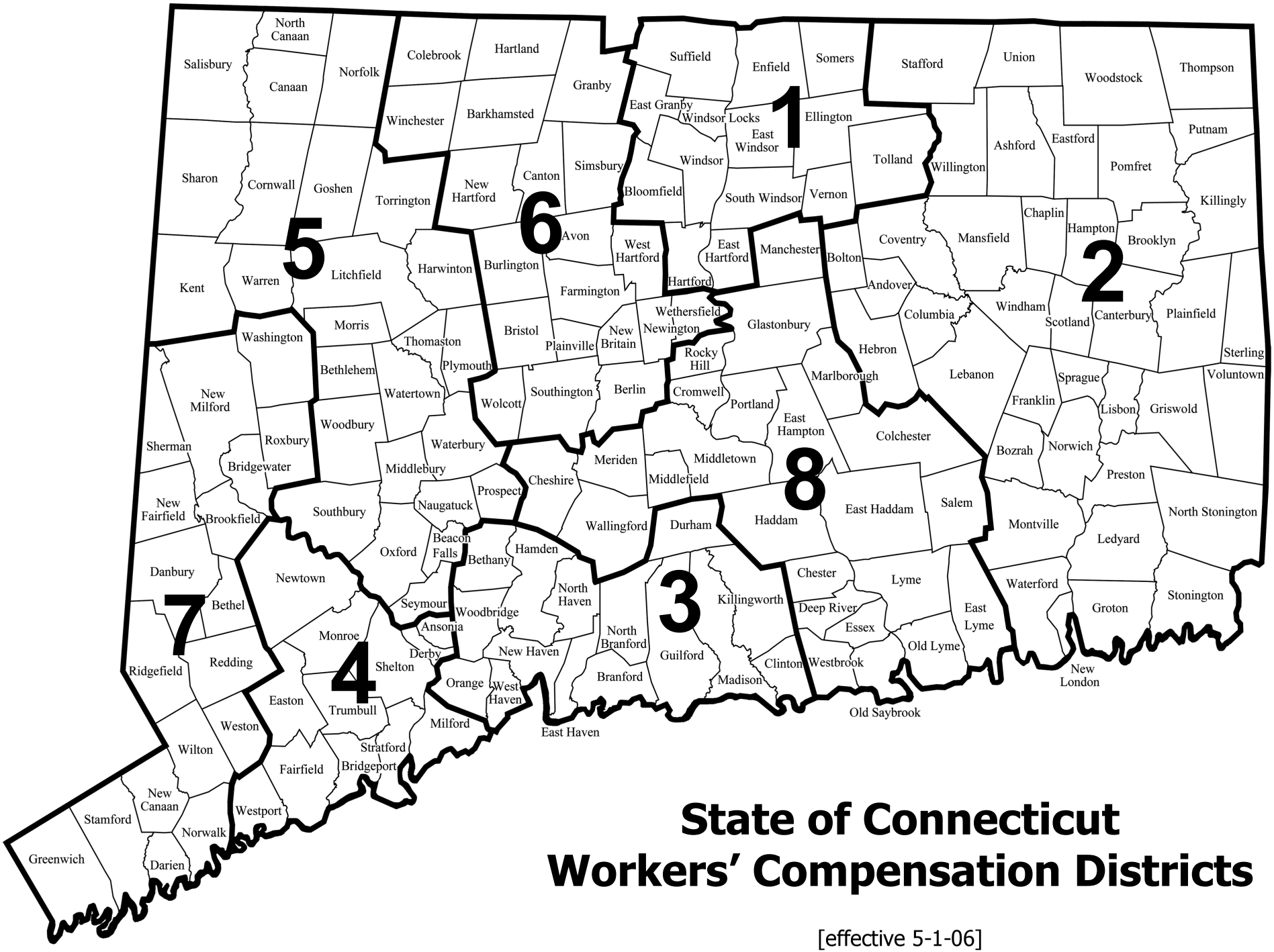
Once you have completed the 30C Form, follow these procedures:

6. **Make two (2) extra copies of your completed 30C Form** (this can be done at many quick-copy printers).
7. **Send the original 30C to your employer* by Certified or Registered mail, return receipt requested. The claim may also be delivered in person but if so, have the employer acknowledge in writing the receipt of the claim.**

   **** State employees**' work-related injuries and illnesses are reported on Form PER-WC 207, entitled "Report of Occupational Injury or Disease to an Employee". If a State employee elects to file a 30C Form, then he or she must send the 30C Form to the Commissioner of Administrative Services, 450 Columbus Boulevard, Hartford, CT 06103, NOT to the particular office where employed. (The Form PER-WC 207 is ONLY an accident report and is NOT the official claim form for workers' compensation benefits — State employees, like any other employees, must file a 30C Form in order to file an official workers' compensation claim.)*

   **** Municipal employees**, like any other employees, must file a 30C Form in order to file an official workers' compensation claim; if a municipal employee elects to file a 30C Form, then he or she must send the 30C Form to the town clerk of the municipality in which he or she is employed.*

   **** Employees (other than State or municipal employees):** if your employer pursuant to statute has posted the location where you must file a 30C Form, it is your obligation to file it at that location, using certified mail.*
8. **Send a copy of the 30C to the appropriate Workers' Compensation Commission District Office by Certified or Registered mail, return receipt requested, or deliver by personal presentation.** Addresses for all Workers' Compensation Commission District Offices may be found in this packet of material. **The "District Office"refers to the number given to the District Workers' Compensation Commission Office for the town in which you were injured**. Refer to the Connecticut map provided with the Form 30C for the number of the Compensation District for the town in which you were injured.
9. **Keep the remaining copy of the 30C for your own file.**



State of Connecticut
Workers' Compensation Districts

[effective 5-1-06]

Workers' Compensation Commission District Offices

District 1 — Hartford

999 Asylum Avenue
Hartford, CT 06105

Phone: (860) 566-4154
Fax: (860) 566-6137

District 2 — Norwich

55 Main Street
Norwich, CT 06360

Phone: (860) 823-3900
Fax: (860) 823-1725

District 3 — New Haven

700 State Street
New Haven, CT 06511-6500

Phone: (203) 789-7512
Fax: (203) 789-7168

District 4 — Bridgeport

350 Fairfield Avenue
Bridgeport, CT 06604

Phone: (203) 382-5600
Fax: (203) 335-8760

District 5 — Waterbury

55 West Main Street
Waterbury, CT 06702

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District 8 — Middletown

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