AmTrust North America
An AmTrust Financial Company

Kansas
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

MKT6310 06/23

AmTrust North America
An AmTrust Financial Company

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.

Kansas 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.

- **WORKERS' COMPENSATION RIGHTS AND RESPONSIBILITIES (FORM KWC-40)**

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

- **First Report of Injury (Form LWC-1101-A.** As soon as you have been notified of a work-related injury, please fill out this form and submit it to AmTrust. This form must be completed within three (3) days from notice of a work-related injury. Fatalities must be reported within 24 hours. Please use this form to notify AmTrust of any work-related injury or disease, regardless of the severity. Do not send this form to the Kansas Division of Workers' Compensation, as AmTrust will submit it on your behalf.

- **Information for Injured Employees (Form KWC-27A.** As soon as you have been notified of a work-related injury, please print and complete this form and provide it to your injured employee. You are required to provide this form to an injured employee at the time of injury.

- **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

This notice must be posted and maintained by the employer in one or more conspicuous places.

Workers Compensation Rights and Responsibilities

Your employer is subject to the Kansas Workers Compensation Law which provides compensation for job-related injuries.

This notice applies to dates of accidents on or after April 25, 2013.
Este aviso aplica a las fechas de los accidentes a partir de Abril 25, 2013.

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

NOTIFY YOUR EMPLOYER IMMEDIATELY. Per K.S.A. 44-520, a claim may be denied if an employee fails to notify their employer within the earliest of the following dates: (A) **20 calendar days** from the date of accident or the date of injury by repetitive trauma; (B) if the employee is working for the employer against whom benefits are being sought and such employee seeks medical treatment for any injury by accident or repetitive trauma, **20 calendar days** from the date such medical treatment is sought; or (C) if the employee no longer works for the employer against whom benefits are being sought, **10 calendar days** after the employee's last day of actual work for the employer.

Notice may be given orally or in writing. Where notice is provided orally, if the employer has designated an individual or department to whom notice must be given and such designation has been communicated in writing to the employee, notice to any other individual or department shall be insufficient under this section. If the employer has not designated an individual or department to whom notice must be given, notice must be provided to a supervisor or manager.

Where notice is provided in writing, notice must be sent to a supervisor or manager at the employee's principal location of employment.

The notice, whether provided orally or in writing, shall include the time, date, place, person injured and particulars of such injury. It must be apparent from the content of the notice that the employee is claiming benefits under the workers compensation act or has suffered a work-related injury.

BENEFITS. Benefits are paid by the employer's insurance carrier or self insurance program. Benefits include medical treatment, partial wage replacement for lost time and additional benefits if the injury results in permanent disability. An employer is required to furnish all necessary medical treatment and has the right to designate the treating physician. If the employee seeks treatment from a doctor not authorized by the employer, the employer or its insurance carrier is only liable up to $500.00 dollars for the unauthorized medical treatment.

QUE HACER SI UNA LESIÓN OCURRE EN EL TRABAJO

NOTIFIQUE A SU EMPLEADOR INMEDIATAMENTE. De acuerdo con el artículo de ley K.S.A. 44-520, un reclamo puede ser negado si el empleado no notifica a su empleador dentro de antes de las siguientes fechas: (A) **20 días** a partir de la fecha del accidente o la fecha de la lesión debido a trauma por movimientos repetitivos; (B) si el empleado está trabajando con el empleador en contra del cual se están buscando beneficios y dicho empleado busca tratamiento médico por cualquier lesión por accidente o trauma repetitiva, **20 días** a partir de la fecha que dicho tratamiento médico ha sido obtenido; o (C) si el empleado ya no trabaja para el empleador en contra del cual se están buscando beneficios, **10 días** después del último día de trabajo para dicho empleador.

El aviso puede darse oralmente o por escrito. Donde el aviso se da oralmente, si el empleador ha designado un individuo o departamento a quien el aviso se debe dar y tal designación ha sido comunicada por escrito al empleado, aviso a cualquier otro individuo o departamento deberá ser insuficiente bajo esta sección. Si el empleador no ha designado a un individuo o departamento a quien se debe dar el aviso, el aviso puede darse a un supervisor o gerente.

Donde el aviso se hace por escrito, el aviso debe ser enviado a un supervisor o gerente de la oficina principal de empleo del trabajador.

El aviso, sea que se haga oralmente o por escrito, debe incluir la hora, fecha, lugar, persona lesionada y detalles de tal lesión. Debe ser visible a partir del contenido del aviso, que el empleado está reclamando beneficios bajo la ley de compensación del trabajador o que ha sufrido una lesión relacionada con el trabajo.

BENEFICIOS. Los beneficios son pagados por la compañía aseguradora del empleador o programa de seguro propio. Los beneficios incluyen tratamiento médico, reemplazo de sueldo parcial por tiempo perdido y beneficios adicionales si la lesión resulta en incapacidad permanente. El empleador debe proporcionar todo el tratamiento médico necesario y tiene el derecho de designar el doctor para dicho tratamiento. Si el empleado busca tratamiento con un doctor que no ha sido autorizado por el empleador, el empleador o su compañía aseguradora serán responsables de pagar solamente los primeros $500.00 dólares para tratamiento médico no autorizado.

WHERE TO GET HELP WITH YOUR CLAIM (DÓNDE CONSEGUIR AYUDA CON SU RECLAMO):

AmTrust North America

Employer's Insurance Carrier (Compañía Aseguradora del Empleador)

(888) 239-3909

Telephone (Teléfono de la Aseguradora)

PO Box 89404, Cleveland, OH 44101

Address (Dirección de la Aseguradora)

For questions about Workers Compensation Law, contact (Para preguntas acerca de la Ley de Compensación del Trabajador):

KANSAS DEPARTMENT OF LABOR
Division of Workers Compensation/Ombudsman
401 SW Topeka Blvd., Suite 2, Topeka, KS 66603-3105

Website: www.dol.ks.gov/workcomp/default.aspx
Email: wc@dol.ks.gov
Phone: (800) 332-0353 or (785) 296-4000

Persons with impaired hearing or speech utilizing a telecommunications device may access the above number(s) by using the Kansas Relay Center at (800) 766-3777.

KANSAS DEPARTMENT OF LABOR
www.dol.ks.gov

ACCIDENT REPORT

K-WC 1101-A (Rev. 1-12)

– SEE INSTRUCTIONS ON PAGE 2 –

Mail or fax ORIGINAL report to:
Division of Workers Compensation
401 SW Topeka Blvd., Suite 2
Topeka, KS 66603-3105
Fax: (785) 296-4216

Direct questions or comments to:
Toll-free (800) 332-0353

There is a $250 penalty for repeated failure to file accident reports within 28 days of the date the employer is informed of the accident. **Submission does not constitute admission of liability.**

OSHA Case or File Number _____

1. Federal Employer's Identification Number_____ Date of hire _____
2. Name of employer_____ Phone _____
3. Mailing address_____
   Street *City* *State* *ZIP Code*
4. Location, if different from mailing address_____
   Street *City* *State* *ZIP Code*
5. Nature of business_____ NAICS or S.I.C. Code_____ Dept. or division _____
6. Name of employee _____ Age_____ Sex_____
   First *Middle* *Last*
7. Home address _____
   Street *City* *State* *ZIP Code*
8. SSN_____ Birth date_____ Employee's occupation_____ Home phone _____
9. Date of injury or occupational disease_____ Time of injury_____ a.m. ☐ p.m. ☐
   Date reported to employer_____ Date disability began_____ Gross average weekly wage $_____
10. Place of accident or last exposure _____
    City *County* *State*
11. Was accident or last exposure on employer's premises? ☐ YES ☐ NO
12. How did accident occur? _____
13. What was employee doing when injured? _____
14. Name substance or object that directly caused injury* _____
15. Describe in detail nature and extent of injury, indicate part of body involved* _____
16. Was worker admitted to hospital? ☐ YES ☐ NO Date_____ Treated by emergency room only? ☐ YES ☐ NO
    Hospital name and address _____
17. Name and address of attending physician or clinic _____
18. Has employee returned to regular duty? ☐ YES ☐ NO Light duty? ☐ YES ☐ NO Date_____
19. Is compensation now being paid? ☐ YES ☐ NO Date first/initial payment_____
20. Weekly compensation rate $_____ Is further medical aid needed? ☐ YES ☐ NO ☐ UNKNOWN
21. Did employee die? ☐ YES ☐ NO If YES, give date of death_____ (File amended report within 28 days if death subsequently occurs.)
22. Name(s) and address(es) of dependents (death cases only) _____
23. Insurance carrier and third party administrator AmTrust North America
    Address PO Box 89404 Cleveland OH 44101 Phone 888-239-3909
    Street *City* *State* *ZIP Code*
    Policy number_____ Name of agent_____
    Claim number_____ Name of claim representative_____
24. Date of report_____ Completed by_____ Title_____

FOR OFFICE USE

COUNTY

CAUSE

NATURE

SEVERITY

0 - NO TIME LOST
1 - TIME LOST
2 - MEDICAL
3 - FATAL

SOURCE

MEMBER

Instructions

You must answer every question; failure to answer all questions may cause the report to be returned to the employer. Returned accident reports may cause a delay of benefits to the injured employees and could subject the employer to fines.

Mail or fax the **original** report only. If not completed using the fillable PDF form, the report must be printed neatly in black ink or typewritten. If not legible, the report will be returned which will delay timely processing.

The employer must send this accident report to its insurance carrier, third party administrator or pool association as indicated in the employer's insurance contract. **The employer is responsible for submitting the original report to the Division of Workers Compensation within 28 days of the date the employer is informed of the accident.**

*Instructions for Questions 14 and 15

14: Name the object or substance which directly injured the employee. Example: machine or object employee struck or struck employee; vapor or poison employee inhaled or swallowed; chemicals or radiation which irritated employee's skin; if hernia, the object employee was lifting or pulling; etc.

15: Be as specific as possible indicating all that is known about the injury. Name the part of body injured.

Definition of an Incapacitating Injury

The Workers' Compensation Act sets forth a strict time frame for filing accident reports with the division. The controlling statute is K.S.A. 44-557(a), which reads as follows:

> (a) it is hereby made the duty of every employer to make or cause to be made a report to the director of any accident, or claimed or alleged accident, to any employee which occurs in the course of the employee's employment and of which the employer or the employer's supervisor has knowledge, which report shall be made upon a form to be prepared by the director, within 28 days, after the receipt of such knowledge, if the personal injuries which are sustained by such accidents are sufficient wholly or partially to incapacitate the person injured from labor or service for more than the remainder of the day, shift or turn on which such injuries were sustained.

Accident reports are not required for every work-related injury. The statute requires a report to be filed when the worker's whole or partial incapacity continues beyond the "day, turn, or shift which such injuries are sustained" as the result of accident. "Incapacity" is not specifically defined within the law, but the division believes that the Legislature's intent was to reference a worker's whole or partial loss of the ability to perform his or her ordinary job tasks. When in doubt, keep in mind the law contains no penalty for filing a report that ultimately proves to be unnecessary. **There are penalties, however, for failing to file a report when one was required.** The penalties include fines and limitations on the defenses the employer may assert if a claim is filed.

OSHA Recordkeeping

The employer must complete an Injury and Illness Incident Report, OSHA Form 301, within seven (7) days of learning that a work-related injury or illness has occurred. According to OSHA's recordkeeping rule, you must keep Form 301, or an equivalent substitute on file for five (5) years.

To learn more about OSHA's recordkeeping requirements and download forms, visit:
www.osha.gov/recordkeeping/RKforms.html

INFORMATION FOR INJURED EMPLOYEES

K-WC 27-A (Rev. 06-18-24)

* THIS NOTICE APPLIES TO ACCIDENTS ON OR AFTER JULY 1, 2024 *

Employers are required to provide this information to each injured worker.

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

If you have any questions about workers compensation benefits, contact the Division of Workers Compensation at the phone number at the bottom of the page. **Assistance in Spanish is available.**

(1) NOTIFY YOUR EMPLOYER IMMEDIATELY: Per K.S.A. 44-520, a claim may be denied if an employee fails to notify their employer within the earliest of the following dates: (A) 30 calendar days from the date of accident or the date of injury by repetitive trauma; (B) if the employee no longer works for the employer against whom benefits are being sought, 20 calendar days after the employee's last day of actual work for the employer.

Notice may be given orally or in writing. Where notice is provided orally, if the employer has designated an individual or department to whom notice must be given and such designation has been communicated in writing to the employee, notice to any other individual or department shall be insufficient under this section. If the employer has not designated an individual or department to whom notice must be given, notice must be provided to a supervisor or manager.

Where notice is provided in writing, notice must be sent to a supervisor or manager at the employee's principal location of employment.

The notice, whether provided orally or in writing, shall include the time, date, place, person injured and particulars of such injury. It must be apparent from the content of the notice that the employee is claiming benefits under the workers compensation act or has suffered a work-related injury.

(2) FOLLOW YOUR EMPLOYER'S INSTRUCTIONS for getting medical aid and follow the doctor's instructions.

(3) MEDICAL BENEFITS: An injured worker is entitled to all medical services reasonably necessary to cure and relieve the worker from the effects of the injury. The employer has the right to select the doctor who will treat the injury. A worker may seek the services of an unauthorized doctor up to a limit of $800.00. A worker may apply to the Workers Compensation Director to change the authorized treating doctor. Reimbursement for travel to obtain medical treatment is payable at a rate set by law for trips that are five miles or more (round trip).

(4) WEEKLY BENEFITS: Benefits are paid by the employer's insurance carrier or self insurance program. Injured workers are not entitled to compensation for the first week they are off work unless they lose three consecutive weeks. The first compensation payment is normally due at the end of the 14th day of lost time. An injured employee is entitled to a weekly amount of 66 ⅔ percent of his/her average weekly wage up to a maximum of 75 percent of the state's average weekly wage. These benefits are subject to legislative changes. If the injury results in permanent disability, the Kansas Workers Compensation law provides for additional benefits.

RESPONSIBILITIES OF THE EMPLOYER

1. Unless self-insured, the employer must advise its insurance carrier or group-funded pool of employee's injury.

   Per K.S.A. 44-557, it is the duty of every employer to make or cause to be made a report to the director of any accident, or claimed or alleged accident, to any employee which occurs in the course of the employee's employment and of which the employer or the employer's supervisor has knowledge, which report shall be made upon a form to be prepared by the director, within 28 days, after the receipt of such knowledge, if the personal injuries which are sustained by such accidents, are sufficient wholly or partially to incapacitate the person injured from labor or service for more than the remainder of the day, shift or turn on which such injuries were sustained.

As outlined in K.A.R. 51-9-17, all insurance carriers, group pools and self-insurers are required to use Electronic Data Interchange (EDI) to file First Reports of Injury (FROI) and Subsequent Reports of Injury (SROI) using the Release 3.1 Standards. For details contact the Technology and Statistics section of the Division of Workers Compensation at (785) 296-4000 or (800) 332-0353. You may access our website at https://www.dol.ks.gov/workers-compensation/electronic-data-interchange-edi.

2. Employers must provide for the payment of workers compensation claims without any charge to employees.

3. Employers must post the Workers Compensation Notice prepared by the Director.

4. Employers must pay compensation benefits, regardless of insurance coverage.

5. Upon receiving notice of an injury, the employer must provide the employee written information to assist the injured worker in understanding his/her rights and responsibilities in obtaining compensation.

Pursuant to K.S.A. 44-5,102(a) EMPLOYERS MUST COMPLETE THE FOLLOWING INFORMATION FOR INJURED WORKERS

Your claim will be handled by:

Company AmTrust North America

Address PO Box 89404, Cleveland, OH 44101

888-239-3909

Contact Person _____

Phone _____ **Fax:** _____

Email _____

INFORMACIÓN PARA TRABAJADORES LESIONADOS

K-WC 270-A (Revisado 06-18-24)

* ESTE AVISO APLICA A FECHAS DE ACCIDENTE A PARTIR O DESPUÉS DE Julio 1, 2024 *

Empleadores son requeridos de proveer ésta información a cada trabajador que se lesiona

¿QUÉ HACER SI LE SUCEDE UN ACCIDENTE EN EL TRABAJO?

Si tiene preguntas acerca de beneficios de compensación del trabajador, contacte la unidad mencionada al final de página. **Asistencia en Español está disponible.**

(1) NOTIFIQUE A SU EMPLEADOR INMEDIATAMENTE: De acuerdo con el artículo de la ley K.S.A. 44-520, un reclamo puede ser negado si el empleado no notifica a su empleador antes de las siguientes fechas: (A) 30 días a partir de la fecha del accidente o la fecha de la lesión debido a trauma por movimientos repetitivos; (B) si el empleado ya no trabaja para el empleador en contra del cual se están buscando beneficios, 20 días después del último día de trabajo para dicho empleador.

El aviso puede darse oralmente o por escrito. Donde el aviso se da oralmente, si el empleador ha designado un individuo o departamento a quien el aviso se debe dar y tal designación ha sido comunicada por escrito al empleado, aviso a cualquier otro individuo o departamento deberá ser insuficiente bajo esta sección. Si el empleador no ha designado a un individuo o departamento a quien se debe dar el aviso, el aviso puede darse a un supervisor o gerente.

Donde el aviso se hace por escrito, el aviso debe ser enviado a un supervisor o gerente de la oficina principal de empleo del trabajador.

El aviso, sea que se haga oralmente o por escrito, debe incluir la hora, fecha, lugar, persona lesionada y detalles de tal lesión. Debe ser visible a partir del contenido del aviso, que el empleado está reclamando beneficios bajo la ley de compensación del trabajador o que ha sufrido una lesión relacionada con el trabajo.

(2) SIGA LAS INSTUCCIONES DE SU EMPLEADOR para conseguir ayuda médica y siga las instrucciones del doctor.

(3) BENEFICIOS MÉDICOS: El trabajador lastimado tiene derecho a todo servicio médico razonablemente necesario para curar y aliviar al trabajador de los efectos de la lesión. El empleador tiene el derecho de seleccionar el doctor quien dará el tratamiento necesario. El trabajador tiene derecho de escoger los servicios de otro doctor no autorizado hasta llegar al límite de 800.00 dólares. El trabajador puede solicitar al Director de Compensación de Trabajadores el cambio del doctor autorizado. Los gastos incurridos en viajes hechos para obtener tratamiento médico serán reembolsados según sean estipulados por ley por viajes que incluyen más de cinco millas, viaje redondo.

(4) BENEFICIOS SEMANALES: Los beneficios son pagados por la compañía aseguradora del empleador o programa de seguro propio. Los trabajadores lesionados no tienen derecho a compensación por la primera semana, a menos que estén sin trabajar tres semanas consecutivas.

El primer pago de compensación normalmente se vence al fin de los 14 días de estar sin trabajar. Un trabajador lesionado tiene derecho a una cantidad semanal de 66 2/3 por ciento de su sueldo promedio semanal hasta un máximo de 75 por ciento del sueldo promedio semanal del estado. Estos beneficios están sujetos a cambios por la legislatura. Si la lesión resulta en incapacidad permanente, la ley del Estado de Kansas para Compensación de Trabajadores provee beneficios adicionales.

RESPONSABILIDADES DEL EMPLEADOR

1. A menos que esté auto-asegurado, el empleador debe informar a su compañía de seguros o grupo financiero mancomunado de la lesión el empleado.
   Por K.S.A. 44-557, es deber de cada empleador hacer o causar que se haga un informe al director de cualquier accidente, reclamo o supuesto accidente a cualquier empleado que le ocurra en el curso de su empleo, y del cual el empleador o su supervisor tienen conocimiento, dicho informe deberá ser hecho en un formulario preparado por el director, dentro de los próximos 28 días después de la recepción de dicho conocimiento, si las lesiones sufridas por tales accidentes, son suficientes para incapacitar parcial o totalmente a la persona lesionada ya sea en trabajo de mano de obra o prestando algún servicio por más que el resto del día o turno en el que tales lesiones fueron sufridas.
   Como se describe en K.A.R. 51-9-17, todas las compañías de seguros, grupos mancomunados y auto-asegurados, están obligados a utilizar el Intercambio Electrónico de Datos (EDI, por sus siglas en Ingles) para presentar le Primer Reporte de Accidente (FROI, por sus siglas en Ingles) y Subsecuentes Reportes de Lesiones (SROI, por sus siglas en Ingles) utilizando el Lanzamiento de Nivel 3.1. Puede acceder a nuestro sitio web en http://www.dol.ks.gov/wc/insurer/electronic-data-interchange-(edi)
2. Los empleadores deben suministrar el pago de los reclamos sin costo a los empleados.
3. Los empleadores deben exhibir un Aviso de Compensación al trabajador, preparado por el Director.
4. Los empleadores deben pagar beneficios de compensación sin importar la cobertura de seguro.
5. Tan pronto como se reciba el aviso de una lesión, el empleador debe proveer información por escrito para ayudar al trabajador lesionado a entender sus derechos y responsabilidades al obtener compensación.

Conforme a la Ley K.S.A. 44-5,102(a)
EMPLEADORES DEBEN COMPLETAR LA SIGUIENTE INFORMACIÓN PARA LOS TRABAJADORES LESIONADOS

SU RECLAMO SERÁ MANEJADO POR:

Compañía AmTrust North America

Dirección PO Box 89404, Cleveland, OH 44101

888-239-3909

Persona de Contacto _____

Teléfono _____ **Fax** _____

Correo electrónico _____

KANSAS DEPARTMENT OF LABOR
www.dol.ks.gov

EMPLOYEE NOTIFICATION FORMS AVAILABLE ONLINE

K-WC 530 (Rev. 03-24)

Important Information for Employers Regarding Forms
K-WC 27-A and K-WC 270-A (Spanish)

Kansas law requires employers to provide information to employees about what to do if they experience a work-related accident. Employers must provide form K-WC 27-A or K-WC 270-A which advises workers about their rights and responsibilities if injured on the job. These forms are available for employees online at www.dol.ks.gov.

The Legislature mandated under K.S.A. 44-5,102 (c): “The commissioner of insurance shall distribute a copy of such information to each insurance company authorized to transact workers compensation insurance in this state and each group-funded self-insurance plan. Each such insurance company and group-funded self-insurance plan shall reproduce or arrange for the reproduction and distribution of such information in sufficient quantities and in both English and Spanish language versions, when requested, to continuously accommodate the needs of their respective insured employers and members in order to comply with this section and shall provide such information to such insured employers and members therefore.” The Director of the Division of Workers Compensation provides the same information to each of the approved self-insured employers.

In an effort to continue assisting employers in reaching compliance, the Division encourages employers to make copies of these two-page forms (without changing the content). Employers should contact their insurance company if they haven’t received this material or visit the Division of Workers Compensation website.

Recurring questions from employers have been: “How do we prove that we gave the employee a copy of the form? Do we have to send it certified? Do we have to make them sign a piece of paper stating they received the form?”

Most employers keep a personnel log on employees. Generally, an entry in the log stating there was an alleged injury on this date and that a K-WC 27-A or K-WC 270-A form was given or sent to the employee should be adequate documentation of compliance with the requirement.

Questions regarding the form and its usage can be directed to the Ombudsman unit. A Spanish interpreter is available to explain the form if an employer/employee needs assistance in Spanish.

WORKERS COMPENSATION DIVISION
401 SW Topeka Blvd., Suite 2, Topeka, KS 66603-3105 • Phone (785) 296-4000, (800) 332-0353 • kdol.wc@ks.gov

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!

BEFORE THE WORKERS COMPENSATION DIVISION
STATE OF KANSAS

_____,
Claimant,

v. **Case No. CS-00-_____**

_____,
Respondent,

and

_____, ☐ **Workers Compensation Fund**
Insurance Carrier.

SETTLEMENT AWARD BY WRITTEN STIPULATION

It is hereby stipulated and agreed by and between the parties hereto:

1. That on or about _____, the above-named claimant met with personal injury/occupational disease arising out of and in the course of claimant's employment with respondent.

2. That the claimant and respondent are subject to the provisions of the Kansas Workers Compensation Act.

3. That notice of the accident was given and timely claim made by claimant.

4. That the AWW on the date of accident was $_____, making a compensation rate of $_____.

5. That temporary total was paid from _____ to _____ for a total of _____ weeks at $_____/week in the total amount of $ _____ (or see attached).

6. That medical has been paid in the total amount of $_____.

7. That respondent agrees to pay all valid and authorized medical up to the date of this settlement award.

   Additional comments:

8. That the following medical reports are attached to the Settlement Award by Written Stipulation and should be considered by the judge in approving this agreement:

9. That the basis of the settlement is as follows:

10. That the following additional information or conditions are part of this award:

The claimant understands that by entering into this settlement award he/she is forever closing out this claim under the Kansas Workers Compensation Act and will receive no further compensation or medical treatment as a result of this accident(s), other than any benefit that may have been left open as outlined in the basis of settlement above. The claimant understands that he/she would have the right to a full hearing in front of the administrative law judge and as a result of that hearing, he/she may receive more, or may get less, than what has been offered under this Settlement Award by Written Stipulation. Claimant also understands that they are giving up any right of appeal by accepting this settlement.

The parties request that the administrative law judge approve this settlement and also approve the claimant's attorney's fee in the amount of $_____, representing _____% plus expenses incurred in the claimant's attorney's handling of the claim. The claimant's contract with his/her attorney is attached, as well as the attorney's Statement Regarding Attorney Fees.

By signature on this document, the claimant acknowledges that he/she has read the Settlement Award and attached medical or had the Settlement Award and attached medical read to them, they understand the medical and terms of the settlement, and that they voluntarily agreed to accept the terms of this Settlement Award by Written Stipulation.

_____
Claimant

_____
Dated

_____
Attorney for Claimant

_____
Printed Name

_____
Bar No.

_____
Date

_____
Attorney for Respondent/Insurance Carrier

_____
Printed Name

_____
Bar No.

_____
Date

_____
Attorney for Kansas Workers Compensation Fund

_____
Printed Name

_____
Bar No.

_____
Date

I have reviewed the Settlement Award by Written Stipulation and find that such settlement is in the claimant's best interest, will avoid undue expense, litigation or hardship to the parties and hereby approve the same.

Dated this _____ day of _____, 20____.

_____
Administrative Law Judge

(Rev. 07-24)

SETTLEMENT AGREEMENT – FINAL RECEIPT AND RELEASE OF LIABILITY

K-WC Form D (Rev. 03-24)

MAIL: Workers Compensation Division
401 SW Topeka Blvd., Suite 2
Topeka, KS 66603-3105

FAX: (785) 296-0025

The Kansas Workers Compensation law provides that compensation due may be settled by agreement and that the employer is entitled to a receipt and release of liability upon final payment of compensation due, and that such final receipt and release of liability shall be filed by the employer in the office of the Director of Workers Compensation within sixty (60) days after the date of the execution of the same, and that such agreement, final receipt and release of liability is made subject to the approval of the Director that the correct amount of compensation has been paid as required by law, and will automatically become approved by law unless disapproved by the Director within twenty (20) days of the date it is received by that office.

COMPLETION OF THIS REPORT IS REQUIRED BY LAW.

K.A.R. 51-3-2 Final receipt and release of liability. A final receipt and release of liability shall cover all compensation paid and shall not be taken until the disability has terminated, or in case of permanent partial disability, until a final determination of the percentage of that permanent partial disability can be definitely ascertained. No compromise settlements shall be made on a final receipt and release of liability. The physician's report or reports accompanying the final receipt and release of liability shall conform to the amount paid for the disability except when the rating is an average of the ratings expressed by the doctors.

Dates and figures required shall be specific and accurate, and only in exceptional instances where explanation is necessary may insertions or additions be made.

The final receipt and release of liability shall be signed by the claimant and the signature shall be notarized. The final receipt and release of liability form shall be accompanied by a physician's final report and by an accident report if the report has not already been filed with the Division of Workers Compensation. (Authorized by K.S.A. 44-573; implementing K.S.A. 44-527; effective Jan. 1, 1966; amended Jan. 1, 1973; amended Feb. 15, 1977; amended May 1, 1978; amended May 1, 1983; amended June 21, 2002.)

NOTE (1): A physician's final report must accompany this agreement when it is filed with the Director for approval.

NOTE (2): No compensation other than medical is payable for the first week following the injury, except cases of amputation or death, unless temporary total loss continues for three consecutive weeks.

Federal Privacy Act Disclosure Section 7(a)(2)(B)

The mandatory requirement that Social Security numbers be included on forms filed with the Division of Workers Compensation is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, since our regulations which require its disclosure were in existence before January 1, 1975. The number is used as a means of identifying all the various records in the Division of Workers Compensation pertaining to an individual.

The use of Social Security numbers is made necessary because of the large number of applicants who have similar names and birth dates, and whose identities can only be distinguished by the Social Security number.

Settlement Agreement – Final Receipt and Release of Liability

K-WC Form D (Rev. 03-24)

1. Employer's name: _____

   Address: Street _____ City _____ State _____ ZIP _____

2. Insurance carrier: _____ Phone: _____ (Ext.) _____

   Address: _____ Ins. Co. File No.: _____

3. Injured worker: _____ Social Security number: _____

   Address: Street _____ City _____ State _____ ZIP _____

4. Nature of injury by accident, repetitive trauma or disease for which this claim for compensation is made: _____

   _____

   _____

5. Date(s) of injury by accident, repetitive trauma or disease:

   _____

6. Last day employee worked: _____

7. Date employee was able to return to work: _____

8. Date employee returned to work: _____

9. If employee worked between date(s) of injury by accident, repetitive trauma or disease and last date of disability, give dates:

   _____

   _____

10. Average weekly wage: $_____

11. Weekly compensation rate: $_____

NOTE: No compromise settlements shall be made on a final receipt and release of liability.

Compensation paid on the following basis:

12. _____weeks _____days
    Temporary total disability ..... $ _____

13. _____weeks _____days
    _____% temporary partial disability
    @_____ per week ..... $ _____

14. _____weeks permanent partial disability for:
    Percent of amputation to _____
    _____
    _____% loss of use of _____ $ _____

TOTAL COMPENSATION ..... $ _____

15. Hospital expense ..... $ _____

16. Medical expense ..... $ _____

17. Other (specify): _____ $ _____

    Total Medical ..... $ _____

18. Is this a Release and Receipt for payments made on award of Director? _____
    If hearing(s) held, give date(s) and place(s) of hearing(s): _____
    _____

FINAL RECEIPT AND RELEASE OF LIABILITY

Received from (name of employer or insurance carrier) _____

the sum of _____ ($_____) making in all, with payments

already received a total sum of _____ ($_____)
IN FINAL RECEIPT AND RELEASE OF LIABILITY of this claim for compensation and any other claims for compensation heretofore made on account of any and all injuries and disability incurred by reason of the accident, repetitive trauma or disease referred to in this instrument.

SIGNED, ACKNOWLEDGED AND AGREED by Employer and Worker this _____ day of _____ A.D., 20_____

_____ Employer or Agent of employer and insurance carrier

_____ Worker

JURAT

State of Kansas, County of _____ ss.

BE IT REMEMBERED, that on this _____ day of _____, 20_____, before me, the undersigned, a Notary Public in and for said county and state, came the above named worker, to me personally known to be the same person who signed, acknowledged and agreed to the foregoing instrument of writing and duly acknowledged that he understood and executed the same as of the date above written.

My commission expires: _____

Notary Public: _____

WAIVER OF RIGHTS

Initial
Below

____ 1. I am aware I have the right to a hearing before an Administrative Law Judge where I may receive an award of more, less or the same amount of money that I am receiving in this settlement. By settling this case I give up my right to a hearing.

____ 2. If I do not like the decision of that judge, I have a right to appeal the decision to the Kansas Workers Compensation Board. By settling this case I give up my right to an appeal.

____ 3. By giving up my right to a trial before an Administrative Law Judge, I understand that if my condition worsens, I cannot later ask the court to increase the amount of money awarded and received.

____ 4. I understand that I am giving up my right to any more medical treatment related to this injury by accident, repetitive trauma or disease. I understand I will be responsible for unpaid medical bills, even if they are related to this injury by accident, repetitive trauma or disease, that are not included in the *Settlement Agreement Final Receipt and Release of Liability* (Form D) or medical treatment expenses incurred after today's date relating to this injury by accident, repetitive trauma or disease.

____ 5. I understand I am giving up my right to use my $500.00 for unauthorized medical expenses to obtain a second opinion, but not a rating, from any doctor that I choose for medical conditions related to this injury by accident, repetitive trauma or disease.

____ 6. I understand that even though a doctor releases me and/or provides an impairment rating to my employer, I am not required to give up any right that I have under the Kansas Workers Compensation Act.

____ 7. I have read, or have had it read to me, and fully understand my impairment and/or disability rating.

____ 8. I have read, or have had them read to me, and understand the medical reports attached to this Form D,

____ 9. I have read, or have had it read to me, and understand the Form D entirely. I agree that the facts contained therein are true and acccurate and understand the terms of the settlement. I believe that this settlement is in my best interest and want this Form D approved by the Division of Workers Compensation.

_____
Worker

CERTIFICATION

State of _____, County of _____ ss.

BE IT REMEMBERED that on this _____ day of _____, 20 _____, before me the undersigned, a Notary Public in and for said county and state, came the above named worker, to me personally known to be the same person who signed, acknowledged and agreed to the *Settlement Agreement Final Receipt and Release of Liability* (Form D) and duly acknowledged that he/she understood and executed the same as of the date above written.

My commission expires: _____

Notary Public: _____

KANSAS DEPARTMENT OF LABOR
www.dol.ks.gov

REPORT OF FRAUD OR ABUSE (CONFIDENTIAL)

K-WC 44 (04-24)

Form can be filed through OSCAR (without an account)
or
EMAIL: kdol.wcfraud@ks.gov

NOTE: You may choose to submit this form anonymously; however, this may limit the scope of the investigation.

Date of report: _____

Your name: _____ SSN: _____ Date of birth: _____

Street: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____

Name of person or entity suspected of committing fraud or abuse: _____

Street: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____

Identifying information if applicable and available (not required): SSN: _____ Date of birth: _____

Driver's license: _____ Other (e.g., FEIN, etc.): _____

Name of person or entity the fraud or abuse was committed against: _____

Street: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____

Identifying information if applicable and available (not required): SSN: _____ Date of birth: _____

Driver's license: _____ Other (e.g., FEIN, etc.): _____

County in which the accidental injury, repetitive trauma or occupational disease occurred: _____

Date(s) on which the accidental injury, repetitive trauma or occupational disease occurred: _____

_____

Give details below of the fraudulent or abusive act(s). Attach additional pages if necessary.

Supporting documentation: ☐ Attached ☐ Can submit upon request