AmTrust North America
An AmTrust Financial Company

Louisiana
Worker's Compensation
Claim Kit

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

This material is for informational purposes only and is not legal or business advice. Neither AmTrust Financial Services, Inc. nor any of its subsidiaries or affiliates represents or warrants that the information contained herein is appropriate or suitable for any specific business or legal purpose. Readers seeking resolution of specific questions should consult their business and/or legal advisors. Coverages may vary by location. Contact your local RSM for more information.

AmTrust INSURANCE

MKT6310 06/23

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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 – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
INDUSTRY CODE / EMPLOYER FEIN			PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD TO CHECK IF APPROPRIATE SELF INSURANCE ☐	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN
AGENT NAME & CODE NUMBER		

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX ☐ MALE ☐ FEMALE ☐ UNKNOWN	MARITAL STATUS ☐ UNMARRIED SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN	OCCUPATION/JOB TITLE EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE	

RATE PER:	☐ DAY ☐ WEEK	☐ MONTH ☐ OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?	☐ YES ☐ YES	☐ NO ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	☐ AM ☐ PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED	☐ AM ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS	PART OF BODY AFFECTED
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY/ILLNESS CODE	PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?	☐ YES ☐ NO ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT
		☐ NO MEDICAL TREATMENT ☐ MINOR: BY EMPLOYER ☐ MINOR CLINIC/HOSP ☐ EMERGENCY CARE ☐ HOSPITALIZED > 24 HOURS ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED: (eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

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.

The following entities comprise the Optum Workers Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers Compensation Medical Services, collectively and individually referred as "Optum."

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

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.

The following entities comprise the Optum Workers Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers Compensation Medical Services, collectively and individually referred as "Optum."

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!

Workers' Compensation

Reporting Injury

You should report to your employer any occupational disease or personal injury that is work-related, even if you deem it to be minor.

Occupational Disease or Death

In case of an occupational disease, all claims are barred unless the employee files a claim with his/her employer within one year of the date that:

1 the disease manifests itself.

2 the employee is disabled as a result of the disease.

3 the employee knows or has reasonable grounds to believe that the disease is occupationally related.

In case of death arising from an occupational disease, all claims are barred unless the dependent(s) file a claim with the deceased employee's employer within one year of:

1 the date of death.

2 the date the claimant has reasonable grounds to believe that the death resulted from occupational disease.

Filing Notice

In case of injury or death caused by a work-related accident, an injured employee or any person claiming to be entitled to compensation either as a claimant or as a representative of a person claiming to be entitled to compensation, must give notice to the employer within 30 days of the injury. If notice is not given within 30 days, no payments will be made for such injury or death. In addition, any fraudulent action by the employer, employee, or any other person for the purpose of obtaining or defeating any benefit or payment of workers' compensation shall subject such person to criminal as well as civil liabilities.

The above mentioned notice should be filed with the employer at the address shown to the right.

A notice so given shall not be held invalid because of any inaccuracy in stating the time, place, nature or cause of injury, or otherwise, unless it is shown that the employer was in fact misled to his detriment thereby. Failure to give notice may not harm the employee if the employer knew of the accident or if the employer was not prejudiced by the delay or failure to give notice.

Physicians

In the event you are injured, you are entitled to select a physician of your choice for treatment. The employer may choose another physician and arrange an examination which you would be required to attend.

Formal Claim

In order to preserve your right to benefits under the Louisiana Workers' Compensation Law, you must file a formal claim with the Office of Workers' Compensation Administration within one year after the accident if payments have not been made or within one year after the last payment of weekly benefits.

Information

If you desire any information regarding your rights and entitlement to benefits as prescribed by law, you may call or write to the Office of Workers' Compensation Administration, Post Office Box 94040, Baton Rouge, Louisiana 70804-9040 or telephone (225) 342-7555.

Name and Address of Insurance Company

P.O. Box 89453

Cleveland, OH 44101

Notice shall be given by delivering it or sending it by certified mail or return receipt requested to:

Employer Representative

Employer

R.S. 23:1302 states that this notice should be posted in a convenient and conspicuous place in the employer's place of business.

Revised May 2003

LOUISIANA WORKFORCE COMMISSION

An Equal Opportunity Employer Program. Auxiliary aids and services are available upon request to individuals with disabilities. 1-800-259-5154 (TDD)

www.laworks.net

Compensacion del Trabajador

Reportando de lesiones/heridas

Usted debe reportar a su empleador cualquier enfermedad ocupacional o lesión personal que esté relacionada con el trabajo, aún y cuando usted piense que es insignificante o menor.

Enfermedades ocupacionales o muerte

En caso de enfermedad ocupacional, no todos los reclamos son elegibles a menos que el empleado haga el reclamo con su empleador dentro del siguiente año de la fecha que:

1. La enfermedad se manifiesta por si sola.
2. El empleado está desabilitado como resultado de esta enfermedad.
3. El empleado sabe o tiene rezones poderosas para creer que la enfermedad está relacionada con su ocupación.

En caso de muerte que aparece como resultado de una muerte ocupacional, no todos los reclamos son válidos solamente que el o los dependientes hagan un reclamo con el empleador del empleado muerto dentro de 1 (uno) año de:

1. La fecha de muerte.
2. La fecha que el reclamante tenga suficientes pruebas para creer que la muerte fué resultado de muerte ocupacional.

Aviso para reclamar o solicitar

En caso de lesiones o muerte causadas por accidente relacionados al trabajo o accidentes, el empleado lesionado o cualquier persona que haga un reclamando y para tener derecho a la compensación ya sea como reclamante o como el representante de la persona que está reclamando para poder tener derecho a la compensación, deberá dar aviso a su empleador dentro de los 30 días siguientes despues de la lesión. Si el aviso no es dado dentro de los siguientes 30 días, ningún pago será hecho por dicha lesión o muerte. En adición, cualquier acción fraudulenta por el empleador, empleado o cualquier otra persona con el propósito de obtener o buscar cualquier beneficio o pagos a través del Programa de Compensación de Trabajadores dicha persona está sujeta a cargos criminales al igual que a responsabilidad civil.

El aviso arriba mencionado deberá ser presentado con el empleador en la dirección que aparace en el lado derecho.

Un aviso dado no deberá ser invalidado o mantenerse invalidado por cualquier inexactitud en el tiempo, lugar, naturaleza o causa de la lesión al momento de hacer la declaración, o de otra manera, solamente si se demuestra que el empleador fué mal informado para con esto perjudicar. El fallar o faltar de notificar es posible que no perjudique al empleado si el empleador sabe del accidente o si el empleador no es perjudicado por la tardanza o por faltar de hacer la notificación.

Medicos

En caso que usted es lesionado, usted tiene el derecho de elegir al médico para su tratamiento. El empleador puede escoger otro médico y hacer arreglos para otro exámen para el cual usted será requerido para atender.

Reclamo formal

Para poder preservar sus derechos a los beneficios bajo la Ley de Compensación de los Trabajadores del estado de Louisiana, usted debe hacer un reclamo formal con la oficina administrativa del Programa de la Ley de Compensación de los Trabajadores dentro del siguiente año después del accidente si no se han hecho pagos o dentro del año después del último pago de beneficios.

Información

Si usted desea cualquier información relacionada a sus derechos y a los beneficios a los cuales usted tiene derecho descritos por la ley, usted puede llamar o escribir a la Office of Worker's Compensation Administration, PO Box 94040, Baton Rouge, Louisiana 70804-9040 o al teléfono (225) 342-7555.

Nombre y Dirección de la Compañía de Seguros

_____

P.O. Box 89453

Cleveland, OH 44101

_____

La notificación deberá ser dada ya sea lleváandola personalmente o enviándola por correo certificado regresando o regresar el recibo solicitado a:

Representante del empleador

_____

_____

_____

_____

Empleador

_____

_____

_____

_____

R.S. 23:1302 manifiesta que éste aviso debe estar puesto en un lugar visible y conveniente en el negocio del empleador.

Revisado Mayo 2003

LOUISIANA WORKFORCE COMMISSION

RIGHTS AND RESPONSIBILITIES FOR EMPLOYEES AND EMPLOYERS-

This Office of Workers' Compensation Administration's Rights and Responsibilities brochure is sent in compliance with Title 23 of the L.S.A.-R.S. §1307. For questions, please contact: Records Management, Office of Workers' Compensation Administration (OWCA), Louisiana Workforce Commission (LWC), 1001 N 23rd St, Room G28, PO Box 94040, Baton Rouge, LA 70804-9040
800-201-3457 toll free; 225-342-7565 phone; 225-342-7582 fax

WHAT IS WORKERS' COMPENSATION?

Workers' compensation is a legal remedy whereby an employee who is injured on the job may be entitled to certain benefits. The benefits can include medical care for the injury, indemnity wage benefits, vocational rehabilitation services, and/or death benefits. These benefits are the obligation of the employer and are paid directly to the employee by the employer or its workers' compensation insurer. Every employer, unless statutorily exempted, is responsible for the medical care and the payment of indemnity wage benefits to any employee who is injured while in the course and scope of his or her employment.

WHO IS COVERED BY THE WORKERS' COMPENSATION LAW?

Most employees in Louisiana are covered from the day they start employment. Employees may be full-time, part-time, seasonal, or minors. Subcontractors and certain independent contractors may be considered employees if they are involved in the pursuit of the employer's trade, business or occupation or if they are performing substantial manual labor. The law does contain some limited exemptions. Domestic employees, most real estate salespersons, uncompensated officers and directors of certain non-profit organizations, and public officials are specifically exempted. Most volunteer workers would not be entitled to benefits.

Employers are required to have workers' compensation insurance or to be approved to self-insure. If any employee has reason to believe that his or her employer is not covered or if the employer requires an employee to pay for or purchase a workers' compensation insurance policy, this violation should be reported to the Office of Workers' Compensation Administration (OWCA) Fraud & Compliance section at toll free 1-800-201-3362.

Within 10 days of actual knowledge of an on the job injury resulting in death or lost time in excess of one week, the employer must report the injury to their insurer on a Form LWC-WC IA-1 (First Report of Injury or Illness). The insurer will then submit the report to the OWCA. Any employer that fails to report such an injury to its workers' compensation insurer or to the OWCA is subject to a penalty for failure to do so.

THE OFFICE OF WORKERS' COMPENSATION ADMINISTRATION

The Office of Workers' Compensation Administration (OWCA) was created in 1983 within the Louisiana Department of Labor (now the Louisiana Workforce Commission) to administer the provisions of the Louisiana Workers' Compensation Act. The OWCA investigates allegations of fraud; monitors compliance with the requirement that employers insure their workers' compensation obligation; compiles information regarding workers' compensation claims; resolves disputes over the necessity, advisability, and cost of hospital care or services, as well as conflicts concerning medical, surgical and

non-medical treatment; provides Occupational Safety & Health Administration (OSHA) consultation services; and assists Louisiana employers in the development and implementation of a safety management plan in their workplace. The OWCA, however, does not pay any benefits to employees as a result of a covered on the job injury.

The OWCA has exclusive original jurisdiction to resolve disputes in workers' compensation matters. There are ten district offices located throughout the state (see attached list) where disputed claims for compensation are filed and which provide the framework for the resolution of disputes regarding claims for benefits, the entitlement to benefits, or other relief under the Louisiana Workers' Compensation Act.

WHAT INJURIES ARE COVERED BY THE WORKERS' COMPENSATION LAW?

The law covers both mental and physical injuries from either accidents or occupational diseases. However, a mental injury must be the result of a physical injury or of a sudden, unexpected and extraordinary stress related to the employment and in either case must be proved by clear and convincing evidence. An accident is defined by the Louisiana Workers' Compensation Act as an unexpected or unforeseen actual, identifiable, precipitous event happening suddenly or violently, with or without human fault, and directly producing at the time objective findings of an injury which is more than simply a gradual deterioration or progressive degeneration. An occupational disease is defined by the Louisiana Workers' Compensation Act as only that disease or illness which is due to causes and conditions characteristic of and peculiar to the particular trade, occupation, process, or employment in which the employee is exposed to such disease.

The event causing the injury must arise out of and be within the course and scope of the employee's employment. Generally, the fault of the employer or employees does not affect the compensability of an injury. However, no compensation may be allowed if the injury was caused by the employee's willful intention to injure himself/herself or others; or by the injured employee's intoxication at the time of the injury, unless resulting from activities in pursuit of the employer's interests or from activities in which the employer procured and encouraged the use of the beverage or substance. An employee may not be entitled to benefits if he is the aggressor in an unprovoked physical altercation. The employee may not be entitled to benefits if it is determined that he/she was a participant in "horseplay" at the time that the injury occurred.

HOW ARE INDEMNITY BENEFITS PAID?

An employee who suffers a covered injury may be entitled to weekly/monthly indemnity benefits if the injury prevents the employee from returning to work for more than seven calendar days. The first installment of benefits payable for Temporary Total Disability (TTD), Permanent Total Disability (PTD) or death shall become due on the fourteenth day after the employer or insurer has knowledge of the injury or death. No compensation shall be paid for the first week after the injury occurs unless the disability from the injury continues for two weeks or longer after the date of the accident. This "waiting period" indemnity payment shall be paid after the first two weeks have elapsed.

During the period of Temporary Total Disability (TTD), the employer or its workers' compensation insurer is responsible for the payment of indemnity benefits to the employee in an amount equal to sixty-six and two-thirds percent of the employee's average weekly wage, subject to a maximum/minimum benefit amount set by the OWCA. Maximum/minimum indemnity benefits are determined according to the date of the accident causing the injury and are not adjusted annually for increases or decreases in the maximum/minimum benefit amount set by the OWCA. (See attached list).

An employee who suffers a covered injury may be entitled to Supplemental Earnings Benefits (SEB) if that employee is able to return to work, but is unable to earn at least ninety percent of the pre-injury wage. Supplemental Earnings Benefits are calculated as sixty-six and two-thirds percent of the difference between the pre-injury average monthly wages and the average monthly wage the employee is capable of earning, subject to the maximum/minimum benefit amount set by the OWCA. Supplemental Earnings Benefits are payable on a monthly basis unless the employee is not receiving any income from employment or self-employment and the employer has not established earning capacity. In that case, the employee may be paid weekly SEB. In either case, SEB is payable for a maximum of 520 weeks including the time for which other indemnity benefits were paid.

If the employee dies within two years of the last treatment as the result of any job-related accident, his or her surviving spouse and/or dependent child(ren) (or other dependents) may be entitled to weekly indemnity benefits pursuant to the Louisiana Workers' Compensation Act. If there are no surviving dependents, the employee's surviving parents are entitled to a one-time benefit of $75,000 each. The employer or its workers' compensation insurer shall also pay, in addition to any other benefits, reasonable expenses of the burial of the employee, not to exceed $8,500.

An employee is entitled to a one-time payment of $50,000 if the injury is determined to be catastrophic. Only the following injuries shall be considered injuries which are catastrophic: Paraplegia or quadriplegia or the total anatomical loss of both hands, both arms, both feet, both legs, both eyes, or one hand and one foot, or any two thereof. Functional loss or loss of use shall not constitute anatomical loss.

If the employee applies for and subsequently receives Social Security disability benefits, employer-provided disability plan benefits, or Social Security Old Age Retirement benefits, his or her workers' compensation indemnity benefits may be reduced in accordance with the Louisiana Workers' Compensation Act. This is not a simple dollar for dollar reduction and must be calculated individually according to the employee's circumstance. In addition, an employee is not entitled to receive workers' compensation indemnity benefits and unemployment insurance benefits at the same time.

On the same day as the first payment of indemnity is made to the employee or **on or before** the effective date of any modification (which may include a change from TTD to SEB benefits), suspension, termination, or controversion of indemnity/medical benefits, a Form LWC-WC 1002 (Notice of Payment, Modification, Suspension, Termination, or Controversion of Compensation or Medical Benefits/Notice of Disagreement) shall be completed by the employer/payor and sent to the injured employee by certified mail, and to the employee's attorney, if applicable, by facsimile. The employer/payor shall also send a copy of the Form LWC-WC 1002 to the OWCA within 10 days from the date the original Form LWC-WC 1002 was sent to the injured employee. Any subsequently completed Form LWC-WC 1002 shall be sent to the OWCA on the same day as the original notice was sent to the injured employee and/or employee's representative.

Any injured employee or employee's representative who disagrees with any information provided on the Form LWC-WC 1002 (Notice of Payment, Modification, Suspension, Termination, or Controversion of Compensation or Medical Benefits) shall notify the employer/payor of the basis for disagreement by completing the Notice of Disagreement portion of the Form LWC-WC 1002 and returning it with the original Form LWC-WC 1002 (Notice of Payment, Modification, Suspension, Termination, or Controversion of Compensation or Medical Benefits) attached thereto, to the employer/payor via mail or facsimile, or by a letter of amicable demand, stating the nature of benefits and amounts of compensation asserted to be correct.

If the employer/payor does not provide the benefit that the employee and/or employee's representative claims is due within seven days, the employee may file a new Form LWC-WC 1008 (Disputed Claim for Compensation) or amend a pending disputed claim. Once the Form LWC-WC 1008 is filed, the employer/payor may in its answer request a preliminary determination hearing with the Workers' Compensation Judge. Failure to request a preliminary determination will result in the disputed claim being set for a trial on the merits.

The Form LWC-WC 1002 (Notice of Payment, Modification, Suspension, Termination, or Controversion of Compensation or Medical Benefits/Notice of Disagreement) does not apply to issues concerning the necessity of recommended medical treatment under La. R.S. 23:1203.1 and the Medical Treatment Schedule. A copy of the Form LWC-WC 1002 (Notice of Payment, Modification, Suspension, Termination, or Controversion of Compensation or Medical Benefits/Notice of Disagreement) is attached and also is available at http://www.laworks.net/Downloads/OWC/1002form.pdf.

HOW ARE MEDICAL BENEFITS PAID?

An employee has the right to select one doctor of his or her choice in each specialty field for treatment of the job-related injury. The employer or its workers' compensation insurer is required to pay all approved necessary expenses for medical treatment and all reasonably and necessarily incurred travel to obtain treatment. Medical benefits payable under the Louisiana Workers' Compensation Act shall be paid within 30 days after the employer or its workers' compensation insurer receives written notice thereof, or within 60 days if the provider of medical services is not utilizing the electronic billing rules and regulations provided for in R.S. 23:1203.2. An itemized list of out of pocket medical expenses and receipts paid by the employee should be sent to the employer or its workers' compensation insurer for reimbursement.

Any non-emergency medical services over $750 and any non-emergency hospitalization must be pre-approved by the employer or its workers' compensation insurer. The healthcare provider seeking authorization to exceed the $750 statutory limit for medical services must submit a request for such authorization to the employer or its workers' compensation insurer on an Form LWC-WC 1010 (Request of Authorization/Carrier or Self Insured Employer Response). The Form LWC-WC 1010 and all supporting medical documentation are to be faxed to the employer or its workers' compensation insurer and/or the designated utilization review representative. Within five business days of receipt of the Form LWC-WC 1010 and the supporting documentation from the healthcare provider, the employer or its workers' compensation insurer will issue a response of either approval, denial, or approval with modification of the requested treatment on the Form LWC-WC-1010 and return the form to the requesting healthcare provider. Failure to act on behalf of the employer or its workers' compensation

insurer within five business days of receipt of the Form LWC-WC 1010 will be deemed a tacit denial of the request for treatment and this denial may be reviewed by the OWCA Medical Director.

The employer or its workers' compensation insurer and/or utilization review representative may initiate the Form LWC-WC-1010A (First Request) when the medical documentation submitted with the Form LWC-WC-1010 does not sufficiently provide the necessary information to complete the review of the requested medical services. The healthcare provider must then respond to the request for additional information within 10 business days from receipt of the Form LWC-WC-1010A. Failure to act on behalf of the healthcare provider within the 10 business days of receipt of the Form LWC-WC 1010A will be deemed a tacit withdrawal of the request for authorization of treatment.

Any request for review by the OWCA Medical Director shall be filed on a Form LWC-WC 1009 (Disputed Claim for Medical Treatment). The Form LWC-WC 1009 must be filed within 15 calendar days of the date of denial by the employer or its workers' compensation insurer or the date the denial is received. A copy of the completed Form LWC-WC 1009 must be mailed to all involved parties.

The Form LWC-WC 1009 must be accompanied by a copy of the Form LWC-WC 1010 (and Form LWC-WC 1010A, if applicable), a copy of the peer review denial from the employer and/or its workers' compensation insurer, and a copy of the medical records substantiating the medical necessity of the requested treatment. Any incomplete Form LWC-WC 1009 or a completed Form LWC-WC 1009 that is not submitted with the supporting documentation will be rejected and returned to the requesting party.

Within 30 days after receipt of the Form LWC-WC 1009 and supporting documentation, the OWCA Medical Director will determine whether the treatment prescribed by the healthcare provider is in accordance with the Louisiana Workers' Compensation Medical Treatment Guidelines. Any party feeling aggrieved by the determination of the OWCA Medical Director shall seek a judicial review by filing a Form LWC-WC 1008 (Disputed Claim for Compensation) with the appropriate OWCA district office within 15 days of the date of said determination is mailed to the parties. The filed Form LWC-WC 1008 shall include a copy of the Form LWC-WC 1009, and a copy of the determination of the OWCA Medical Director. A party filing such appeal must simultaneously notify the other party that an appeal of the medical director's decision has been filed. The determination of the OWCA Medical Director may be overturned if it is shown by clear and convincing evidence that the determination was not in accordance with the provisions of the Louisiana Workers' Compensation Medical Treatment Guidelines.

WHAT IS AN INDEPENDENT MEDICAL EXAMINATION (IME)?

In the event that there are opposing medical opinions regarding claimant's condition or capacity to work, the Office of Workers' Compensation Administration will appoint an independent medical examiner of the appropriate licensure class to examine the claimant, or review the medical records at issue. The expense of this examination will be set by the director and will be borne by the carrier/self-insured employer.

WHAT IF A PROBLEM DEVELOPS WITH A CLAIM?

An employee, who has a problem with his or her claim, should first contact the employer or its workers' compensation insurer. If the employee and the employer (or the employer's workers' compensation insurer) are unable to resolve the problem, either party has the right to request a mediation conference with an Office of Workers' Compensation mediator who is a licensed attorney specially trained in the

mediation process with knowledge of resolution techniques and experienced in Louisiana workers' compensation law. For more information on the right to a mediation conference, please refer to the Mediation Rights form which is attached and also is available at http://www.laworks.net/downloads/owc/MediationRightsForm.pdf.

If the problem does not resolve at the mediation conference, an employee should contact the nearest OWCA district office to file a Form LWC-WC 1008 (Disputed Claim for Compensation). The district office can provide the employee with a Form LWC-WC 1008 or that form is also available for download at http://www.laworks.net/Downloads/OWC/1008form.pdf. A filing fee of $50 plus any applicable service fees are charged at the time of filing. If the employee is unable to afford these fees, a request may be made for approval by the Workers' Compensation Judge to proceed without paying costs in advance.
An employee may consult an attorney if he or she wishes, but it is not required. If an employee hires an attorney, the employee can be charged up to twenty percent of the amount recovered plus the attorney's expenses. These fees and expenses may be deducted from the employee's indemnity payments. The local bar association may be able to recommend an attorney who is experienced in workers' compensation.

The employer (or its workers' compensation insurer) also shall be permitted the right to file a Form LWC-WC 1008 (Disputed Claim for Compensation) to controvert benefits or concerning any other dispute arising under the Act.

WHEN SHOULD THE FORM LWC-WC 1008 (DISPUTED CLAIM FOR COMPENSATION) BE FILED?

There are separate time limits for filing claims for medical and indemnity benefits. Filing a claim for one type of benefit usually does not stop the clock from running on any other type of benefit.

Claims for medical benefits generally must be filed within one year of the date of the accident causing the injury. If the employer or its workers' compensation insurer has paid medical expenses, the period for asserting a claim is extended for three years from the last payment of a medical benefit.

Claims for indemnity benefits, often called weekly benefits, generally must be filed within one year of the date of the accident causing the injury. If the employer or insurer has paid indemnity benefits, the employee may still assert a claim for Temporary Total Disability (TTD), Permanent Total Disability (PTD), or Permanent Partial Disability (PPD) benefits if done within one year after the last payment of indemnity benefits.

Claims for Supplemental Earnings Benefits (SEB) may be made for up to three years after the last payment of any claim of indemnity benefits.

Claims for occupational diseases, including carpal tunnel, may be filed up to one year from the date of knowledge of the disease, related disability, or a reasonable belief that the disease is work related, whichever occurs last.

MAY I SETTLE MY CLAIM?

You may enter into a lump sum or compromise settlement upon agreement of all of the parties and with the approval of the Workers' Compensation Judge, provided that, (a) the settlement is clearly in the best

interest of all of the parties, and (b) six months have passed since the end of Total Temporary Disability (TTD). However, the six months waiting period may be waived by the consent of the parties.

AM I ENTITLED TO MY OLD JOB?

An employer may not be required to hold a job open for you while you are unable to perform the duties of your job or to create a new job for you when you are able to return to work. However, your employer cannot terminate your employment solely because you filed a workers' compensation claim.

WHAT IF I CANNOT RETURN TO MY OLD JOB?

Under certain circumstances, you may qualify for vocational rehabilitation. An employee who is unable to earn wages equal to the wages he was earning before his workers' compensation accident is entitled to prompt vocational rehabilitation services. The goal of vocational rehabilitation is to return the employee back to work as soon as possible after the injury occurs with a minimum amount of retraining if deemed necessary. The employer is responsible for selecting a licensed professional vocational rehabilitation counselor to evaluate and assist the employee in job placement or vocational retraining.

Appropriate options to consider when returning an employee back to work at the earliest possible moment are: (1) return the employee to the same position; (2) return the employee to a modified position; or (3) return the employee to a related occupation suited to the employee's education and marketable skills. Whenever possible, employment in the employee's local job pool must be considered and selected prior to consideration of employment in a worker's statewide job pool. If all of the previous options fail, a vocational rehabilitation counselor may seek on–the-job training for the employee, as well as a minimum amount of retraining or self-employment.

When it does appear that retraining is necessary and desirable to restore the employee to suitable gainful employment, the employee shall be entitled to reasonable and proper retraining not to exceed 26 weeks. The request for retraining must be made and begun by the employee within two years from the date of termination of temporary total disability as determined by the treating physician. The employee's retraining may be extended for an additional period not to exceed 26 weeks if the retraining is determined to be necessary and proper by the workers' compensation judge. The employer or insurer shall pay the reasonable cost of board, lodging, or travel if the retraining program requires residence at or near the facility or institution and away from the employee's customary residence. However, a retraining program shall be performed at facilities within the state when such facilities are available.

If the employer refuses to provide vocational rehabilitation services or a dispute arises concerning the quality of services being provided, the employee may file a disputed claim with the workers' compensation court to have it review the necessity and/or quality of the services being provided. The employee shall have the right to an expedited hearing on the matter. Similarly, the employee must cooperate with the vocational rehabilitation counselor. An employee's refusal may reduce his weekly workers' compensation benefits, including supplemental earnings benefits, by fifty (50%) percent for each week during the period of refusal.

EMPLOYER CERTIFICATE OF COMPLIANCE

You must submit this Certification to your workers' compensation insurer. Failure to submit this Certification as required may result in your being penalized by a fine of $500, payable to your insurer.

You must secure workers' compensation for your employees through insurance or by becoming an authorized self-insured. If you fail to provide security for workers' compensation, you must pay an additional 50% in weekly benefits to your injured workers.

If you willfully fail to provide security for workers' compensation, then you are subject to a fine of up to $10,000, imprisonment with or without hard labor for not more than 1 year, or both. If you have been previously fined and again fail to provide security for workers' compensation, then you are subject to additional penalties, including a court order to cease and desist from continuing further business operations.

You must not collect, demand, request, or accept any amount from any employee to pay or reimburse for the workers' compensation insurance premium. If you violate this provision, you may be punished with a fine of not more than $500, or imprisoned with or without hard labor for not more than one year, or both.

It is unlawful for you to willfully make, or to assist or counsel someone else to make, a false statement or representation in order to obtain or to defeat workers' compensation benefits. If you violate this provision, you may be fined up to $10,000, imprisoned with or without hard labor for up to 10 years, or both depending on the amount of benefits unlawfully obtained or defeated. In addition to these criminal penalties, you may be assessed a civil penalty of up to $5,000.

EMPLOYER CERTIFICATION

I certify that I have read this entire document and understand its contents, and that I understand I am held responsible for this information. I certify my compliance with the Louisiana Workers' Compensation Act.

Preparer Name (PRINT) _____ Signature _____ Date _____

Company Name _____ Company Address _____

( ) _____ Phone Number _____ Insurance Policy Number

Employee Name _____ Employee Social Security Number ___ - ___ - ____

LWC-WC-1025.ER
REV. 03/16

EMPLOYEE
CERTIFICATE OF COMPLIANCE

You must submit this form to your employer's workers' compensation insurer or to your employer within 14 days of its receipt. Your workers' compensation benefits **may be suspended if you do not timely submit this Certification.** You would be entitled to all suspended benefits after this Certification is provided to your insurer, if you are otherwise eligible for benefits.

It is unlawful for you to work and received workers' compensation indemnity benefits, except for supplemental earnings benefits. Supplemental earnings benefits are paid when an employee is able to work, but is unable to earn 90% or more of his pre-injury wages as a result of a job related accident. As an injured worker, you must notify your employer or insurer of the earning of any wages, changes in employment or medical status, receipt of unemployment insurance benefits, receipt of social security benefits and receipt of retirement benefits. If you receive benefits for more than 30 days, you will be required to certify your earnings to your insurer quarterly.

It is unlawful for you to receive workers' compensation indemnity disability benefits and unemployment benefits at the same time, except for permanent partial disability benefits. Permanent partial disability benefits are paid solely for amputation or for anatomical loss of use of a body part or function. If you violate this provision, you may be fined up to $10,000, imprisoned up to 90 days, or both.

It is unlawful for you to willingly make, or to assist or counsel someone to make, a false statement or representation in order to obtain or to defeat workers' compensation benefits. If you violate this provision, you may be fined, imprisoned, or both, as follows:

Unlawful Benefits Paid or Claimed	**Fine**	**Imprisonment**
$10,000 or more	up to $10,000	up to 10 years, with or without hard labor
$2,500 or more but less than $10,000	up to $5,000	up to 5 years, with or without hard labor
less than $2,500	up to $500	up to 6 months

In addition to these criminal penalties, you may be assessed a civil penalty of up to $5,000 and may forfeit your right to receive workers' compensation benefits.

Warning: Per LA.R.S.23:1208 of the Louisiana Workers' Compensation Statute, it shall be unlawful for a person, for the purpose of obtaining or defeating any benefit payment under the provisions of this Chapter, either for himself or for any other person, to willfully make a false statement or representation. Penalties for violations include imprisonment, fines, and/or the forfeiture of benefits.

EMPLOYEE CERTIFICATION

I certify that I understand the contents of this entire document, and understand I am held responsible for this information. I certify my compliance with the above stated requirements regarding receipt of workers' compensation benefits.

_____ _____ _____
Print Name Signature Social Security Number Date

_____ ___( ) _
Address City State/Zip Phone Number

Note: Only one copy is required per case from the employee.

LDOL-WC 1025.EE
Revised 03/2016

OWCA MEDIATORS:	
Statewide	Judy Franklin 1001 N 23rd St. Baton Rouge, LA 70802 Phone: (225) 342-0184 Fax: (225) 342-4790
District 1E	Tikisha Smith 1401 Hudson Ln., Ste. 301 Monroe, LA 71201 Phone: (318) 362-3078 Toll-free: (800) 209-7321 Fax: (318) 362-3083
District 1W	Rosa Whitlock 9234 Linwood Shreveport LA 71106-7001 Phone: (318) 676-5331 Toll-Free: (800) 209-7173 Fax: (318) 676-5332
District 2	Amy Brown 3724 Government St. Alexandria, LA 71302 Phone: (318) 487-5966 Toll-Free: (800) 209-7329 Fax: (318) 487-5967
District 3	Chantell Smith 120 W Pujo St., Ste. 200 Lake Charles, LA 70601 Phone: (337) 214-6800 Toll-free: (888) 768-8745 Fax: (337) 491-2208
District 4	Dianne Mayo 556 Jefferson St., 1st Flr. Lafayette, LA 70501-6947 Phone: (337) 262-1057 Toll-free: (800) 209-7174 Fax: (337) 262-1106
District 5	Denise Lee 224 Florida Blvd., Ste. 100 Baton Rouge, LA 70801 Phone: (225) 219-4378 Toll-free: (800) 209-7175 Fax: (225) 219-4377
District 6	Myles Donahue 112 Innwood Dr., Ste. E Covington, LA 70433 Phone: (985) 871-1258 Toll-Free: (888) 575-6149 Fax: (985) 871-1264
District 7	Caroline Minor 880 West Commerce Rd., Ste. 401 Harahan, LA 70123 Phone: (504) 736-8606 Toll-Free: (866) 253-5830 Fax: (504) 736-8608
District 8	Kelly James 1450 Poydras St. Ste. 838, Mail Box 24 New Orleans, LA 70112-2001 Phone: (504) 568-6952 Toll-Free: (800) 209-7232 Fax: (504) 568-8706
District 9	Julia Marie DeFusco 8026 Main St., Ste. 404 Houma, LA 70360 Phone: (985) 857-3775 Toll-free: (800) 262-1497 Fax: (985) 857-3781

You Have a Right to a Mediation Conference

• A mediation conference is an informal meeting of the parties with a neutral person, called a mediator, who attempts to resolve the issues in dispute.

• The Office of Workers' Compensation mediators are licensed attorneys who are specially trained in the mediation process with knowledge of resolution techniques and experienced in workers' compensation law.

• The Office of Workers' Compensation mediators assist the parties in a workers' compensation dispute in settling claims before they are heard by a workers' compensation judge.

• Your right to a mediation conference exists both prior to as well as after a Disputed Claim for Compensation (LWC-WC 1008) is filed. A mediation conference requested prior to the filing of a Disputed Claim for Compensation (LWC-WC 1008) is referred to as a "pre-1008" mediation conference and a mediation conference requested after the filing of a Disputed Claim for Compensation (LWC-WC 1008) is referred to as a "post-1008" mediation conference.

• Parties who agree to a mediation conference may make a request, in writing, to any of the Office of Workers' Compensation mediators listed on this page.

• Upon receipt of a written request, your selected mediator will contact the parties to schedule the mediation conference at a time that is convenient to all parties. The mediation conference will take place in the district where the selected mediator is located.

• If the claim is not resolved by mediation, one of two things can happen: (1) if the mediation conference was held prior to filing a Disputed Claim for Compensation (LWC-WC 1008), the injured worker then must file a Disputed Claim for Compensation (LWC-WC 1008) to preserve any rights he may have to receive workers' compensation benefits; or (2) if the mediation conference was held after the filing of a Disputed Claim for Compensation (LWC-WC 1008), the disputed claim then will proceed to a trial on the merits before a workers' compensation judge.

• Any party may request additional mediation conferences at any time in the process, but all parties must agree to the mediation conference, unless it is ordered by a workers' compensation judge.

•Your right to a mediation conference is in accordance with Revised Statute 23:1310.3(D).

• Please feel free to contact any Office of Workers' Compensation mediator if you have questions regarding your right to a mediation conference.

DISTRICT OFFICE TELEPHONE DIRECTORY
Revised 04/11/16

OFFICE OF WORKERS' COMPENSATION TEL (225) 342-7970 (800) 201-2499
ADMINISTRATIVE OFFICE FAX (225) 342-4790
P.O. Box 94040
1001 North 23rd Street
Baton Rouge, Louisiana 70804-9040

CHIEF JUDGE:	**Diane Lundeen**
STATEWIDE MEDIATOR:	Judy S. Franklin
DISPUTE RESOLUTION SPECIALIST:	Mikal Pippins
ADMINISTRATIVE PROGRAM SPECIALIST:	Laurise W. Thomas
ADMIN. ASSISTANT 3:	Shalanda Murphy

OFFICE OF WORKERS' COMPENSATION TEL (318) 676-5331 (800) 209-7173
DISTRICT 1W FAX (318) 676-5332
9234 Linwood
Shreveport, Louisiana 71106-7001

Parishes Served: Bossier, Bienville, Caddo, DeSoto, Red River, Webster, Claiborne

DISTRICT JUDGE:	**Vacant**
MEDIATOR:	Rosa Whitlock
DISPUTE RESOLUTION SPECIALIST:	LaTonya Martin
ADMIN. COORDINATOR 4:	Vacant
ADMIN. ASSISTANT 4:	Whitney Lott
ADMIN. ASSISTANT 3:	Julia Hines

OFFICE OF WORKERS' COMPENSATION TEL (318) 362-3078 (800) 209-7321
DISTRICT 1E FAX (318) 362-3083
1401 Hudson Lane, Suite 301
Monroe, Louisiana 71201-5730

Parishes Served: Caldwell, Catahoula, Concordia, East Carroll, Franklin, Jackson, LaSalle, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, West Carroll

DISTRICT JUDGE:	**Brenza Irving-Jones**
MEDIATOR:	Tikisha Smith
DISPUTE RESOLUTION SPECIALIST:	Camelia Antie
ADMIN. COORDINATOR 4:	Judy Williams
ADMIN. ASSISTANT 4:	Sophie Price
ADMIN. ASSISTANT 3:	Renee McDowell

OFFICE OF WORKERS' COMPENSATION TEL (318) 487-5966 (800) 209-7329
DISTRICT 2 FAX (318)-767-6085
3724 Government Street
Alexandria, Louisiana 71302-3327

Parishes Served: Avoyelles, Grant, Natchitoches, Rapides, Vernon, Winn, Sabine

DISTRICT JUDGE:	**James Braddock**
MEDIATOR:	Amy Brown
DISPUTE RESOLUTION SPECIALIST:	Brandi Mason-Iles
ADMIN. COORDINATOR 4:	Kathy Ducote
ADMIN. ASSISTANT 4:	Deborah Nugent
ADMIN. ASSISTANT 3:	Cindy Tyler

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120 W. Pujo Street, Suite 200
Lake Charles, Louisiana 70601

Parishes Served: Allen, Beauregard, Calcasieu, Cameron, Jefferson Davis

DISTRICT JUDGE:	**Charlotte Bushnell**
MEDIATOR:	Chantell Smith
DISPUTE RESOLUTION SPECIALIST:	Deborah Garriet
ADMIN. COORDINATOR 4:	Olishia Conner
ADMIN. ASSISTANT 4:	Bershonica Sam
ADMIN. ASSISTANT 3:	Rachel Walker
ADMIN. ASSISTANT 3:	Jessica Crawford

WESTERN DIVISION

DIVISION JUDGE:	**Vacant**
ADMIN. ASSISTANT 4:	Stephanie McCown

DISTRICT OFFICE TELEPHONE DIRECTORY
Revised 04/11/16
(Continued)

OFFICE OF WORKERS' COMPENSATION
DISTRICT 4
556 Jefferson Street, First Floor
Lafayette, Louisiana 70501-6947

TEL (337) 262-1057
FAX (337) 262-1106

(800) 209-7174

Parishes Served: Acadia, Evangeline, Lafayette, St. Landry, Vermillion

DISTRICT JUDGE:	**Sharon Morrow**
MEDIATOR:	Dianne Mayo
DISPUTE RESOLUTION SPECIALIST:	Vacant
ADMIN. COORDINATOR 4:	Lisa Sterling
ADMIN. ASSISTANT 4:	Sharon Francis
ADMIN. ASSISTANT 3:	Asisa Brothers
ADMIN. ASSISTANT 3:	Jaclyn Louvierre

ACADIANA DIVISION

DIVISION JUDGE:	**Adam Johnson**
ADMIN. ASSISTANT 4	Dawn Seward

CAJUN DIVISION

DIVISION JUDGE:	**Anthony Palermo**
ADMIN. ASSISTANT 4:	Tameka Pete

OFFICE OF WORKERS' COMPENSATION
DISTRICT 5
224 Florida Boulevard, Suite 100
Baton Rouge, Louisiana 70801-1718

TEL (225) 219-4378
FAX (225) 219-4377

(800) 209-7175

Parishes Served: East Baton Rouge, East Feliciana, Pointe Coupee, West Feliciana, West Baton Rouge, Iberville

DISTRICT JUDGE:	**Pam Moses-Laramore**
MEDIATOR:	Denise Lee
DISPUTE RESOLUTION SPECIALIST:	Shameeka Kaufman
ADMIN. COORDINATOR 4:	Jerrena Brown
ADMIN. ASSISTANT 4:	Latonya Brown
ADMIN. ASSISTANT 3:	Tricia Madere
ADMIN. ASSISTANT 3:	Quenisha Thomas

CENTRAL DIVISION

DIVISION JUDGE:	**Jason Ourso**
ADMIN. ASSISTANT 4:	Trikina Talbert

OFFICE OF WORKERS' COMPENSATION
DISTRICT 6
112 Innwood Drive, Suite E
Covington, Louisiana 70433-8813

TEL (985) 871-1258
FAX (985) 871-1264

(888) 575-6149

Parish Served: Livingston, St. Helena, St. John the Baptist, St. Tammany, Tangipahoa, Washington

DISTRICT JUDGE:	**Gwendolyn Thompson**
MEDIATOR:	Myles Donahue
DISPUTE RESOLUTION SPECIALIST:	Janice Westereng
ADMIN. COORDINATOR 4:	Harold Tresch
ADMIN. ASSISTANT 4:	Rachel Hryniewich
ADMIN. ASSISTANT 3:	Vacant

OFFICE OF WORKERS' COMPENSATION
DISTRICT 7
880 West Commerce Road, Suite 401
Harahan, Louisiana 70123-3330

TEL (504) 736-8606
FAX (504) 736-8608

(866) 253-5830

Parishes Served: Jefferson, Plaquemines, St. Bernard

DISTRICT JUDGE:	**Shannon Bruno-Bishop**
MEDIATOR:	Caroline Minor
DISPUTED RESOLUTION SPECIALIST:	Sloane Sullen
ADMIN. COORDINATOR 4:	Dora Breaux
ADMIN. ASSISTANT 4:	Tina Boudreaux
ADMIN. ASSISTANT 3:	Laurett Price

DISTRICT OFFICE TELEPHONE DIRECTORY
Revised 04/11/16
(Continued)

OFFICE OF WORKERS' COMPENSATION
DISTRICT 8
1450 Poydras Street, Suite 838
Mail Box 24
New Orleans, Louisiana 70112-2001

TEL (504) 568-6952 (800) 209-7232
FAX (504) 568-8706

Parishes Served: Orleans

JUDGE:	**Robert Varnado**
MEDIATOR:	Kelly James
DISPUTED RESOLUTION SPECIALIST:	Christine Melford
ADMIN. COORDINATOR 4:	Nina Pierre
ADMIN. ASSISTANT 4:	Latokia Sami
ADMIN. ASSISTANT 3:	Rosalee Boudreaux
ADMIN. ASSISTANT 3:	Glenda Square

EASTERN DIVISION

DIVISION JUDGE:	**Vacant**
ADMIN. ASSISTANT 4:	Patrick Fremin

OFFICE OF WORKERS' COMPENSATION
DISTRICT 9
8026 Main Street, Suite 404
Houma, Louisiana 70360-3407

TEL (985) 857-3775 (800) 262-1497
FAX (985) 857-3781

Parishes Served: Iberia, Lafourche, St. Charles, St. Martin, St. Mary, Terrebonne, Ascension, Assumption, St. James

DISTRICT JUDGE:	**Elizabeth Lanier**
MEDIATOR:	Julia DeFusco
DISPUTED RESOLUTION SPECIALIST:	Debra Duplantis
ADMIN. COORDINATOR 4:	Chelita Woods
ADMIN. ASSISTANT 4:	Bridgette Martin
ADMIN. ASSISTANT 3:	Victoria Martin

DERECHOS Y RESPONSABILIDADES PARA EMPLEADOS Y EMPLEADORES

Este folleto de los Derechos y Responsabilididades fué preparado por La Oficina de Administración de Compensación a los Trabajadores (OWCA) en cumplimiento con el Título 23 de la L.S.A.-R.S. §1307. Para preguntas, por favor ponerse en contacto con: Records Management, Office of Workers' Compensation Administration (OWCA), Louisiana Workforce Commission (LWC), 1001 N 23rd St, Room G28, PO Box 94040, Baton Rouge, LA 70804-9040 800-201-3457 toll free; 225-342-7565 phone; 225-342-7582 fax

QUE ES LA COMPENSACION A LOS TRABAJADORES?

Compensación a los trabajadores es un recurso legal por el cual un empleado que se lesiona en el trabajo podría tener ciertos beneficios. Los beneficios pueden incluir atención médica por lesión, beneficios salariales de indemnización, servicios de rehabilitación vocacional, y/o beneficios por muerte. Estos beneficios son obligación de el empleador y son pagados directamente al empleado por el empleador o la aseguradora de compensación a los trabajadores. Todos los empleadores, a menos que estén reglamentariamente exentos por ley, son reponsables de los cuidados médicos y el pago de beneficios salariales por indemnización a cualquier empleado que se lesione en el transcurso y durante el cumplimiento de su trabajo.

QUIEN ESTA CUBIERTO POR LA LEY DE COMPENSACION A LOS TRABAJADORES?

La mayoría de los empleados en Louisiana están cubiertos desde el día que inician en el trabajo. Los empleados pueden ser de tiempo completo, medio tiempo, de temporada, o menores de edad. Los subcontratistas y ciertos contratistas independientes pueden considerarse como empleados si están involucrados en la búsqueda de actividad comercial del empleador, negocio o profesión de el empleador o si ellos están realizando trabajo manual considerable. La ley contiene algunas exenciónes limitadas. Los empleados domésticos, la mayoría de vendedores de bienes raíces, funcionarios y directores no compensados de ciertas organizaciones sin fines de lucro, y funcionarios públicos están específicamente exentos. La mayoría de trabajadores voluntarios no tendrán derecho a beneficios.

Los empleadores están obligados a tener seguro de compensación a los trabajadores o tener aprobación para autoasegurarse. Si algún empleado tiene razones para creer que su empleador no esta cubierto o si el empleador require que un empleado pague o compre una póliza de seguro de compensación a los trabajadores, esta violación debe ser reportada a la Oficina de Administración de Compensación a los Trabajadores (OWCA), Sección de Fraude y Cumplimiento al número gratuito 1-800-201-3362.

Dentro de los 10 días desde el conocimiento real de una lesión en el trabajo que dé como resultado la muerte o tiempo perdido por más de una semana, el empleador debe reportar la lesión a su compañía de seguros en el formulario LWC-WC IA-1 (Primer Reporte de Lesión o Enfermedad). La aseguradora luego presentará el reporte a la OWCA. Cualquier empleador que falte en reportar una lesión a su aseguradora de compensación a los trabajadores o a la OWCA está sujeto a una multa por no hacerlo.

OFICINA DE ADMINISTRACION DE COMPENSACION A LOS TRABAJADORES

La oficina de Administración de Compensación a los Trabajadores (OWCA) fué creada en 1983 dentro de el Departamento de Trabajo de Louisiana (ahora la Comisión Laboral de Louisiana) para administrar las condiciones de el Acta de Compensación a los Trabajadores de Louisiana. El OWCA investiga las denuncias de fraude; vigila que se cumpla el requisito que los empleadores aseguren su obligación de compensación para sus trabajadores; recopila información relacionada con los reclamos de compensación a los trabajadores; resuelve disputas sobre la necesidad, conveniencia y costo de los servicios o la atención hospitalaria, así como conflictos relacionados con tratamiento médico, quirúrgico y no médicos; proporciona asesoría en Administración de Seguridad y Salud Ocupacional (OSHA); y apoya a los empleadores de Louisiana en el desarrollo e implementación de un plan en el manejo de la seguridad en el lugar de trabajo. La OWCA, sin embargo, no paga ningún beneficio a los empleados cubiertos que resulten con lesiones en el trabajo.

La OWCA tiene la jurisdicción original y exclusiva para resolver disputas en asuntos de compensación a los trabajadores. Hay diez oficinas distritales ubicadas a lo largo de el estado (ver la lista adjunta) donde se presentan reclamos de compensación en disputa y que proporciona el marco de referencia para la resolución de disputas relacionadas con reclamos de beneficios, el derecho a los beneficios, u otra ayuda bajo el Acta de Compensación a los Trabajadores de Louisiana.

QUE LESIONES ESTAN CUBIERTAS POR LA LEY DE COMPENSACION A LOS TRABAJADORES?

La ley cubre ambas lesiones físicas y mentales ya sean por accidentes o enfermedades ocupacionales. Sin embargo, una lesión mental debe de ser por el resultado de una lesión física o por un estrés repentino, inesperado y extraordinario relacionado con el empleo y en cualquiera de los casos deberá comprobarse por medio de evidencia clara y convincente. Un accidente es definido por el Acta de Compensación a los Trabajadores de Louisiana como un evento real inesperado o imprevisto, identificable y precipitado que sucede repentinamente o violentamente, con o sin culpa humana, y que produce directamente en el momento hallazgos objetivos de una lesión que es más que un simple deterioro gradual o degeneración progresiva. Una enfermedad ocupacional es definida por el Acta de Compensación a los Trabajadores de Louisiana solo únicamente aquella enfermedad que se debe a causas y condiciones características de y peculiares con el tipo de ocupación, profesión u oficio, proceso, o empleo en el cual el empleado está expuesto a dicha enfermedad.

El evento que originó la lesión debe surgir y estar dentro de el curso y campo de acción de trabajo de el empleado. Generalmente, la culpa de el empleador o de los empleados no afecta la compensación de una lesión. Sin embargo, ninguna compensación será permitida o autorizada si la lesión fué causada con intención deliberada de él empleado para lastimarse a sí mismo (a) u otros; o por intoxicación de él empleado lesionado en el momento de la lesión, a menos que sea el resultado de actividades en pro de los intereses de el empleador o de las actividades en que el empleador adquirió y fomentó el uso de bebidas o sustancias. Un empleado podría no tener derecho a beneficios si él es el agresor en un altercado físico no

provocado. El empleado podría no tener derecho a beneficios si se determina que él/ella participó en “juegos de manos o payasadas” en el momento que ocurrió la lesión.

COMO SE PAGAN LOS BENEFICIOS DE INDEMNIZACION?

Un empleado que sufre una lesión cubierta podría tener derecho a beneficios de indemnización semanal/mensual si la lesión impide que el empleado regrese a trabajar por más de siete días calendario. El primer pago de beneficios pagados por Incapacidad Total Temporal (TTD), (por sus siglas en inglés), Incapacidad Total Permanente (PTD), (por sus siglas en inglés) o muerte debe ser pagado el catorceavo día después de que el empleador o aseguradora tenga conocimiento de la lesión o muerte. No se deberá pagar ninguna compensación durante la primera semana después de que ocurre la lesión a menos que la discapacidad derivada de la lesión continúe por dos semanas o más después de la fecha del accidente. Este pago de indemnización por “período de espera” se pagará después de que las dos primeras semanas hayan transcurrido.

Durante el período de Incapacidad Total Temporal (TTD), el empleador o su aseguradora de compensación a los trabajdores es responsable de el pago de beneficios de indemnización a él empleado en una cantidad igual a sesenta y seis y dos tercios por ciento del salario semanal promedio de el empleado, sujeto a un monto de beneficios máximo/mínimo establecido por la OWCA. Los beneficios máximos/mínimos de indemnización se determinan de acuerdo con la fecha de el accidente que causó la lesión y no hay ajustes anuales para incrementar o disminuir el monto máximo/mínimo de el beneficio establecido por la OWCA. (ver lista adjusta).

Un empleado que sufre una lesión cubierta podría tener derecho a Beneficios de Ingresos Suplementarios (SEB), (por sus siglas en inglés) si ese empleado es capaz de regresar a trabajar, pero no es capaz de ganar por lo menos el noventa por ciento del salario antes de la lesión. Los Beneficios de Ingresos Suplementarios se calculan a sesenta y seis y dos tercios por ciento de la diferencia entre los salarios mensuales promedio antes de la lesión y el salario mensual promedio que el trabajador es capaz de ganar, sujeto al monto de beneficios máximo/mínimo establecido por la OWCA. Los Beneficios de Ingresos Suplementarios son pagados mensualmente a menos que el empleado no esté recibiendo ningún ingreso por parte de el empleo o trabajo por su propia cuenta, y que el empleador no haya establecido la capacidad de ingresos. En tal caso, se le podría pagar al empleado semanalmente con SEB. En cualquier caso, SEB se puede pagar por un máximo de 520 semanas incluyendo el tiempo en el cual se pagaron otros beneficios de indemnización.

Si el empleado muere dentro de dos años de el último tratamiento como resultado de un accidente relacionado con el trabajo, su cónyuge y/o hijo(s) dependientes (u otros dependientes) podrían tener derecho a beneficios de indemnización semanales conforme a la Ley de el Acta de Compensación a los Trabajadores de Louisiana. De no haber dependientes sobrevivientes, los padres sobrevivientes de el empleado tienen derecho a un beneficio único de $75,000 cada uno. El empleador o la compañía de seguros de compensación a los trabajadores también deberá pagar, además de cualquier otro beneficio, los gastos rasonables de la sepultura de el empleado, que no excedan $8,500.

Un empleado tiene derecho a un pago único de $50,000 si se determina que la lesión es catastrófica. Solamente las siguientes lesiones son consideras lesiones catastróficas: paraplegia o cuadriplejia o la pérdida total anatómica de ambas manos, ambos brazos, ambos piés, ambas piernas, ambos ojos, o una mano y un pié, o cualquiera de los dos antes mencionados. La pérdida funcional o pérdida de el uso no constituirá pérdida anatómica.

Si el empleado solicita y subsecuentemente recibe beneficios de el Seguro Social por incapacidad, beneficios de el plan de discapacidad proporcionados por el empleador o beneficios de el Seguro Social de Retiro por Vejez, los beneficios de indemnización por compensación a los trabajadores de él o ella pueden reducirse de acuerdo con la ley de el Acta de Compensación a los Trabajadores de Louisiana. Esto no es una simple reducción de dólar por dólar y debe calcularse de manera individual de acuerdo a las circunstancias de el empleado. Adicionalmente, un empleado no tiene derecho a recibir beneficios de indemnización de compensación a los trabajadores y beneficios de el seguro por desempleo al mismo tiempo.

El mismo día en que se hace el primer pago de indemnización al empleado **o en o antes** de la fecha efectiva de cualquier modificación (el cuál puede incluir un cambio de TTD a beneficios de SEB), suspención, terminación, o controversia de indemnización/beneficios médicos, el Formulario LWC-WC 1002 (Aviso de Pago, Modificación, Suspención, Terminación, o Controversia de Indemnización o Beneficios Médicos/Nota de Inconformidad) deberá ser completada por el empleador/pagador y enviarse al empleado lesionado por correo certificado, y al abogado de el empleado, si aplicara, por fax. El empleador/pagador deberá también enviar una copia de el formulario LWC-WC 1002 a la OWCA dentro de los 10 días de la fecha en que se envió el original de el formulario LWC-WC 1002 al empleado lesionado. Cualquier Formulario LWC-WC 1002 posteriormente completado deberá ser enviado a la OWCA en el mismo día en que el aviso original se envio al empleado lesionado y/o representante de el empleado.

Cualquier empleado lesionado o representante de el empleado, que no esté de acuerdo con la información proporcionada en el Formulario LWC-WC 1002 (Aviso de Pago, Modificación, Suspención, Terminación, o Controversia de Compensación o Beneficios Médicos) deberá notificar al empleador/pagador la base de el porqué de el desacuerdo completando la porción en el Aviso de Desacuerdo de el Formulario LWC-WC 1002 y devolverlo con el Formulario original LWC-WC 1002 (Aviso de Pago, Modificación, Suspensión, Terminación o Controversia de Compensación o Beneficios Médicos) adjunto al mismo, al empleador/pagador por correo o fax, o mediante carta de demanda amistosa, indicando la naturaleza de los beneficios y montos de compensación declarados como correctos.

Si el empleador/pagador no proporciona el beneficio que el empleado y/o representante reclama dentro de los siete días señalados, el empleado puede llenar un nuevo formulario LWC-WC 1008 (Reclamo en Disputa por Compensación) o enmendar el reclamo en disputa que esta pendiente. Una vez que el formulario LWC-WC 1008 es presentado, el empleador/pagador en su respuesta podría solicitar una audiencia de determinación preliminar

con el Juez de Compensación a los Trabajadores. El faltar en solicitar una determinación preliminar dará como resultado establecer un proceso con méritos de el reclamo en disputa.

El formulario LWC-WC 1002 (Aviso de Pago, Modificación, Suspención, Terminación, o Controversia de Compensación o Beneficios Médicos/Aviso de Desacuerdo) no aplica a disputas concernientes a la necesidad de un tratamiento médico recomendado bajo La. R.S. 23:1203.1 y el Tratamiento Médico Programado. Adjunto una copia de el formulario LWC-WC 1002 (Aviso de Pago, Modificación, Suspención, Terminación, o Controversia de Compensación o Beneficios Médicos/Aviso de Desacuerdo) y también está disponible en http://www.laworks.net/Downloads/OWC/1002form.pdf.

COMO SE PAGAN LOS BENEFICIOS MEDICOS?

Un empleado tiene derecho a seleccionar un médico de su elección en cada campo de especialidad para el tratamiento de la lesión relacionada con el trabajo. El empleador o aseguradora de compensación a los trabajadores están obligados a pagar todos los gastos necesarios aprobados para tratamientos médicos y los viajes razonables y necesarios incurridos para obtener el tratamiento. Los beneficios médicos pagados bajo el Acta de Compensación a Los Trabajadores deberán ser pagados dentro de los siguientes 30 días después que el empleador o su compañía de seguros de compensación a los trabajadores reciba el aviso por escrito de el mismo, o dentro de los siguientes 60 días si el proveedor de servicios médicos no utiliza las normas y regulaciones de facturación electrónicas proporcionadas en R.S. 23:1203.2. Una lista específica de los gastos médicos pagados de su bolsillo y los recibos pagados por el empleado deberán enviarse al empleador o su compañía de seguros de compensación a los Trabajadores para el reembolso.

Cualquier servicio médico que no sea una emergencia mayor a $750 y cualquier hospitalización que no sea una emergencia deben ser aprobados con anterioridad por el empleador o por su aseguradora de compensación a los trabajadores. El proveedor de atención médica que busca autorización para exceder el límite legal de $750 para los servicios médicos debe presentar una solicitud para dicha autorización a el empleador o a su aseguradora de compensación a los trabajadores en el Formulario LWC-WC 1010 (Solicitud de Autorización/Portador o Empleador Auto Asegurado). El Formulario LWC-WC 1010 y toda la documentación médica tiene que ser enviada por fax al empleador o compañía de seguros de compensación a los trabajadores y/o el representante de revisión de utilización designado. Dentro de los cinco días hábiles al recibo de el Formulario LWC-WC 1010 y la documentación de respaldo de el Proveedor de atención médica, el empleador o su aseguradora de compensación a los trabajadores emitirá una respuesta, ya sea de aprobación, negación o aprobación con modificación de el tratamiento requerido en el Formulario LWC-WC 1010 y devolverá el formulario a el proveedor de atención médica que lo solicitó. El faltar en actuar en nombre de el empleador o compañía de seguros de compensación a los trabajadores dentro de los cinco días hábiles de recibo de el Formulario LWC-WC 1010 se considerará una negación tácita de la solicitud de tratamiento y dicha negación podría ser revisada por el Director Médico de OWCA.

El empleador o la aseguradora de compensación a los trabajadores y/o representante de revisión de utilización pueden iniciar el Formulario LWC-WC 1010A (Primera Solicitud) cuando

la documentación médica enviada con el Formulario LWC-WC1010 no proporciona la información necesaria y suficiente para completar la revisión de los servicios médicos solicitados. El proveedor de atención médica debe entonces responder a la solicitud de información adicional dentro de los 10 días laborables de recibir la Forma LWC-WC 1010A. La falta de acción por parte de el proveedor de atención médica dentro de los 10 días laborables de haber recibido el Formulario LWC-WC 1010A se considerará un retiro tácito de la solicitud de autorización de tratamiento.

Cualquier solicitud de revisión por parte de el Director Médico de OWCA se presentará en un Formulario LWC-WC 1009 (Reclamo en Disputa para Tratamiento Médico). El Formulario LWC-WC 1009 debe presentarse dentro de los siguientes 15 días calendario de la fecha de negación de el reclamo por el empleador o compañía de seguros de compensación a los trabajadores o la fecha en que se reciba la negación. Una copia completa de la Forma LWC-WC 1009 debe ser enviada por correo a todas las partes involucradas.

El Formulario LWC-WC 1009 debe de ir acompañado de una copia de el Formulario LWC-WC 1010 (y el Formulario LWC-WC 1010A, si aplicara), una copia revisada de negación por otro profesional de el mismo campo por parte de el empleador y/o compañía de seguros de compensación a los trabajadores, y una copia de la historia clínica que justifique la necesidad médica de el tratamiento solicitado. Cualquier Formulario LWC-WC 1009 incompleto o Formulario LWC-WC 1009 completo que no sea sometido con la documentación de apoyo será rechazada y regresada a la parte solicitante.

Dentro de los 30 días después de recibir el Formulario LWC-WC 1009 y documentación de apoyo, el Director Médico de OWCA determinará si el tratamiento prescrito por el proveedor de atención médica está de acuerdo con las Guías Generales para Tratamiento Médico de Compensación a los Trabajadores de Louisiana. Cualquiera de las partes que se considere agraviado por la determinación de el Director Médico de OWCA deberá buscar una revisión judicial presentando la Forma LWC-WC 1008 (Reclamo en Disputa de Compensación) con la oficina de el distrito OWCA correspondiente dentro de los 15 días de la fecha en que dicha determinación se envía por correo a las partes. El Formulario LWC-WC 1008 deberá incluir una copia de el Formulario LWC-WC 1009, y una copia de la determinación de el Director Médico de OWCA. La parte que presente dicha apelación deberá notificar simultáneamente a la otra parte que una apelación de la decisión de el director médico a sido presentada. La determinación de el Director Médico de OWCA puede ser revocada si se demuestra clara y convincentemente que la determinación no estaba de conformidad con las provisiones de las Guías Generales para Tratamiento Médico de Compensación a los Trabajadores de Louisiana.

QUE ES UN EXAMEN DE UN MEDICO INDEPENDIENTE? (IME)

En el caso de que hallan opiniones médicas opuestas con respecto a la condición o capacidad para trabajar de el demandante, La Oficina de Administración de Compensación a los Trabajadores designará a un médico examinador independiente con la clase de licencia apropiada para examinar al demandante, o revisar los expedientes médicos en disputa. El costo de este exámen se establecerá por el director y será asumido por la compañía de seguro o empleador autoasegurado.

QUE PASA SI SURGE UN PROBLEMA CON UN RECLAMO?

Un empleado, quien tiene un problema con su reclamo, primero deberá contactar al empleador o aseguradora de compensación a los trabajadores. Si el empleado y el empleador o (la aseguradora de compensación a los trabajadores del empleador) no pueden resolver el problema, cualquiera de las partes tiene el derecho de solicitar una conferencia de mediación con un mediador de la Oficina de Compensación a los Trabajadores quien es un abogado autorizado especialmente capacitado en el proceso de mediación con el conocimiento de técnicas de resolución y experimentado en la ley de compensación de trabajadores de Louisiana. Para mayor información sobre el derecho a tener una conferencia de mediación, consulte el Formulario de Derechos de Mediación que se adjunta y que también está disponible en http://www.laworks.net/downloads/owc/MediationRightsForm.pdf.

Si el problema no se resuelve en la conferencia de mediación, el empleado deberá contactar la oficina de el distrito de OWCA más cercana para presentar la Forma LWC-WC 1008 (Reclamo en Disputa para Compensación). La oficina de el distrito puede proporcionar al empleado la Forma LWC-WC 1008 o la forma también está disponible para descargarla en http://www.laworks.net/Downloads/OWC/1008form.pdf. Se cobra una tarifa de $50 mas cualquier cargo aplicable por servicios al momento de presentar la demanda. Si el empleado no puede pagar estos costos, se debe hacer una petición para la aprobación de el Juez de Compensación a los Trabajadores de proceder sin tener que pagar costos por adelantado. Un empleado puede consultar con un abogado si él o ella así lo desean, pero no es requisito. Si el empleado contrata un abogado, al empleado se le puede cobrar hasta un 20% de la cantidad recuperada mas el pago a el abogado. Estas tarifas y gastos pueden ser deducidas de los pagos de indemnización de el empleado. El colegio de abogados local puede recomendar un abogado con experiencia en la compensación a los trabajadores.

El empleador (o Aseguradora de Compensación a los Trabajadores) también se le permite el derecho de presentar un Formulacio LWC-WC 1008 (Reclamo por Disputa por Compensación) para contravertir los beneficios o cualquier otra disputa que surja bajo el Acta o ley.

CUANDO SE DEBE PRESENTAR LA FORMA LWC-WC 1008 (RECLAMO EN DISPUTA DE COMPENSACION)?

Existen diferentes plazos para la presentación de reclamos por beneficios médicos e indemnización. Cuando presenta un reclamo para un tipo de beneficio usualmente no detiene el tiempo en cualquier otro tipo de beneficio.

Reclamos por beneficios médicos generalmente deben presentarse dentro de un año de la fecha de el accidente que causó la lesión. Si el empleador o aseguradora de compensación a los trabajadores han pagado los gastos médicos, el período para hacer un reclamo se extiende por 3 años desde el último pago por tratamiento médico.

Reclamos por beneficios de indemnización, a menudo llamados beneficios semanales, generalmente deben presentarse dentro de un año de la fecha de el accidente que causó la lesión. Si el empleador o aseguradora de compensación han pagado beneficios de

indemnización, el empleado todavía puede realizar un reclamo por Incapacidad Total Temporal (TTD), Incapacidad Permanente Total (PTD), o Incapacidad Permanente Parcial (PPD) si se hace dentro de un año después de el último pago de beneficios de indemnización.

Reclamos para Beneficios de Ingresos Suplementarios (SEB) se pueden hacer hasta por tres años después de el último pago de cualquier reclamo de prestaciones indemnizatorias.

Reclamos por enfermedades ocupacionales, incluyendo túnel carpiano, puede ser presentada hasta un año después de la fecha de conocimiento de la enfermedad, discapacidad relacionada, o creencia razonable de que la enfermedad está relacionada con el trabajo, o lo que ocurra de último.

PUEDO RESOLVER MI RECLAMO?

Usted puede llegar a un convenio de un pago único o establecer un compromiso una vez que todas las partes estén de acuerdo y con la aprobación de el Juez de Compensación a los Trabajadores, siempre y cuando que, (a) que el acuerdo es claramente ventajoso para todas las partes, y (b) han pasado seis meses desde el final de la Incapacidad Total Temporal (TTD). Sin embargo, el período de espera de seis meses se puede dispensar o exonerar con el consentimiento de todas las partes.

TENGO DERECHO A MI ANTIGUO PUESTO DE TRABAJO?

Al empleador no se le puede exigir tener un puesto disponible para usted mientras usted no pueda realizar las funciones de su trabajo o crear un nuevo trabajo para cuando usted este capacitado para regresar a trabajar. Sin embargo, su empleador no puede despedirlo de su empleo solo porque usted presentó un reclamo de compensación a los trabajadores.

QUE PASA SI NO PUEDO REGRESAR A MI ANTIGUO TRABAJO?

Bajo ciertas circunstancias, usted puede calificar para rehabilitación vocacional. Un empleado que no puede ganar salarios iguales a los salarios que ganaba antes de el accidente de compensación a los trabajadores tiene derecho a servicios de pronta rehabilitación vocacional. La meta de la rehabilitación vocacional es que el empleado regrese a su trabajo lo antes posible después que la lesión ocurre con una mínima cantidad de re-entrenamiento si se considera necesario. El empleador es responsable de seleccionar un consejero de rahabilitación vocacional professional con licensia para evaluar y asistir al empleado en la colocación de trabajo o re-entrenamiento vocacional.

Opciones apropiadas a considerar cuando un empleado regresa a trabajar en el menor tiempo posible son: (1) regresarle al empleado la misma posición; (2) que el empleado regrese a una posición modificada; o (3) regresar al empleado a una ocupación afín de acuerdo a su educación y habilidades en el campo de profesión u oficio. Cuando sea posible, un empleo en la piscina laboral local debe ser considerado y seleccionado antes de considerar un empleo en una piscina laboral de el estado. Si todas las opciones anteriores fallan, un asesor de rehabilitación profesional puede buscar entrenamiento en el sitio de trabajo, así como la cantidad mínima de re-entrenamiento o trabajo por cuenta propia.

Cuando parece que el re-entrenamiento es necesario y deseable para restaurar el empleado a un trabajo adecuado y bien remunerado, el empleado tendra derecho a un re-entrenamiento apropiado que no exceda 26 semanas. La solicitud de re-entrenamiento se debe hacer y comenzar por el empleado dentro de los dos años a partir de la fecha que termina la incapacidad total temporal según lo determinado por el medico tratante. El re-entrenamiento de el empleado puede ser extendido por un período adicional que no exceda 26 semanas si se determina que el re-entrenamiento es necesario y apropiado por un juez de compensación a los trabajadores. El empleador o asegurador deberá pagar el costo razonable de alojamiento, manutención, o viajes si el programa de re-entrenamiento require residencia en o cerca de las facilidades o institución y lejos de la residencia habitual de el empleado, sin embargo, un programa de re-entrenamiento deberá ser llevado acabo en las instalaciones dentro de el estado cuando dichas instalaciones están disponibles.

Si el empleador se rehusa a proporcionar los servicios de rehabilitación vocacional o una disputa surge concerniente a la calidad de servicios que estan siendo proporcionados, el empleado puede presentar un reclamo de disputa en una Corte de Compensación a los Trabajadores para que se revise la necesidad y/o la calidad de los servicios que han sido proporcionados. El empleado tendrá derecho a una audiencia acelerada sobre el reclamo. De igual forma el empleado debe cooperar con el consejero de rehabilitación vocacional. La negative de un empleado puede reducir sus beneficios semanales de compensación a los trabajadores, incluyendo beneficios de ingresos suplementarios, en un cincuenta por ciento (50%) por cada semana durante el período de rechazo.

What Is Workers' Compensation Fraud?

Contrary to what most people believe, workers' compensation fraud is more that just an employee exaggerating his medical condition or working for cash while supposedly disabled. While these things do occur, employers are also committing fraud by underreporting their payrolls to receive lower premiums and health care providers are billing for services they've never performed. Workers compensation fraud is costing the industry and citizens of our state billions of dollars each year.

But what is workers' compensation fraud? Workers' compensation fraud occurs when someone willfully makes a false statement or conceals information in order to receive workers' compensation benefits or prevents someone from receiving benefits to which they might be entitled. Below are a just few examples of how workers' compensation fraud can be committed. If, after reading these indicators, you feel you know someone who may be committing fraud, contact the Office of Workers' Compensation's Fraud Division at 1-800-201-3362, or click here to report fraud.

Claimant Fraud

- Malingering or exaggeration of symptoms
- Working while allegedly disabled and not reporting income
- Claiming a job-related injury that never occurred
- Claiming a non-work related injury as a work-related injury
- Falsifying mileage reports

Employer Fraud

- Underreporting payroll or misclassifying employees for lower insurance premiums
- Deducting premium dollars from employee's wages
- Employer knowingly fails to have necessary workers' compensation coverage

Medical or Health Care Provider Fraud

- Providing unnecessary testing or treatment of injured workers to reap financial benefit
- Billing for services or treatment never performed
- Billing the workers' compensation insurer and the workers' health insurer for the same services

Is someone you know cheating the system?

Everyone pays the price for

Workers' Compensation Fraud

Nationwide Toll–free Fraud Hotline

1.800.201.3362

(all information remains anonymous)

Louisiana Workforce Commission

www.LAWORKS.net

Office 225.342.7558
Fax 225.342.1880
Email WCFraud@ldol.state.la.us

An Equal Opportunity Employer/Program. Auxiliary aids and services are available upon request to individuals with disabilities. 1-800-259-5154 (TDD)

182202

WORKERS' COMPENSATION RECORDS REQUEST FORM

Mail completed form to:
Louisiana Workforce Commission
OWCA Records Management Section
1001 N. 23rd Street
P.O Box 94040
Baton Rouge, LA 70804-9040
Telephone No.: 225-342-7565

Status of your records request: (Office use only.)
- ☐ **Will be processed.**
- ☐ **Is being returned.** ***See Section III, Page 2.***
- ☐ **Has been processed. You owe a copying fee,** ***See Section III, Page 2.***
- ☐ **Is complete.** ***See Section III, Page 2.***

Note: Copies of documents provided through this request shall adhere to the provisions of La. R.S. 23:1020.1, *et seq.* and La. R.S. 44:1, *et seq*., which limits the inspection and copying of workers' compensation records. ***A $25.00 fee is required per employee search. (Exception: Requests for LWC-WC-1002 will NOT be assessed a $25.00 search fee.) Copying fees are $0.25 per page.*** Make all checks payable to the ***OWCA Administrative Fund***.

SECTION I: TO BE COMPLETED BY REQUESTOR

1. Select all that apply:

- ☐ I am the Employee **OR** Legal Representative of the Employee. (*Attach letter of representation*.)
- ☐ I am the Employer/Insurer **OR** Legal Representative of the Employer/Insurer. (*Attach letter of representation*.)
- ☐ I am NOT a party to a workers' compensation claim. (*Attach employee authorization, LWC-WC- 1151*.) (**Must be notarized**)
- ☐ I am a Prospective Employer. (*Attach employee authorization, LWC-WC- 1151*.) (**Must be notarized**)

2. Name of Requestor (Please Print)	**3. Phone Number**
4. Company Name (If Applicable)	**5. Fax Number**
6. Address, City, State ZIP	**7. Email**

SECTION II: RECORDS REQUESTED

1. Employee's Name (*Please use a separate form for each employee*.)	**2. Employee's Social Security Number**
3. Identify the workers' compensation claim you are requesting : ☐ Workers' Compensation Claim Docket #_____ Date of Injury_____ ☐ **ALL** cases for this injured worker. - If known, list the Docket # and Date of Injury for each claim in the Additional Comments Section, see right. *You will be assessed a $25.00 search fee for each workers' compensation docket number.*	**Additional Comments:**

4. Additional records I am requesting:

☐ Notice Of Payment, Modification, Suspension, Termination or Controversion of Compensation or Medical Benefits (LWC-WC-1002).
*Only available to Employee or Employee Representative per La. R.S. 23:1201.1. *You will **NOT** be assessed a $25.00 search fee for this records request.*

☐ Other documents requested. *Please specify in the Additional Comments section*.

5. Need records certified? (If certified, you will be assessed $25.00.)
☐ Yes ☐ No

I have read and understand this form and the accompanying instructions. I certify that all information provided by me to the Office of Workers' Compensation Administration is accurate and correct to the best of my knowledge. I understand that providing false or misleading information may subject me to prosecution.

Signature of Requestor_____ **Date** _____

SECTION III: TO BE COMPLETED BY OWCA RECORDS MANAGEMENT SECTION

☐ **1. This records request will NOT be processed due to the following:**

☐ $25.00 Search fee not received.
☐ No Social Security Number/incomplete number.
☐ Employee Authorization form required.
☐ Incomplete information. Please provide:_____
*Your request will NOT be processed until the information is provided.

☐ **2. Your request has been processed.**

_____ Pages of responsive records have been found. Please submit a check in the amount of $_____ to the OWCA Administrative Fund. ***No** records will be sent until the check is received by the OWCA.

Your request has produced more than one employee claim._____ claims have been found. Please submit a check in the amount of $_____to the OWCA Administrative Fund. ***No** records will be sent until the check is received by the OWCA.

☐ **3. Your request is complete. The records search has:** ☐ No Records Found ☐ See Attached records.

Records request completed by _____ Date: _____

EMPLOYEE AUTHORIZATION FOR OWCA TO RELEASE
CONFIDENTIAL WORKERS' COMPENSATION RECORDS

EMPLOYEE: Please be aware that you **DO NOT** have to release all of your confidential information and you have a right to refuse to sign this document. You can choose to release only your public records, which includes: any final decision, award, or order of a workers' compensation judge. However, if you choose to release all of your confidential workers' compensation information, you **MUST** authorize the Office of Workers' Compensation Administration to release your confidential records information to anyone not a party to your workers' compensation claim. ***This release must be attached to the Employee Workers' Compensation Records Request Form.**

SECTION I: TO BE COMPLETED BY EMPLOYEE	
1. Employee's Full Name (Please Print)	**2. Social Security Number**
3. Street Address	**4. Date of Birth**
5. City, State, Zip	**6. Phone Number**

7. **What records do you want to release?**

☐ Only my workers' compensation claim(s) information that is considered public record under La. R.S. 23:1293(B)(1) which only includes: final decision(s), award(s), or order(s) of a workers' compensation judge.

OR

☐ Any and all of my workers' compensation claim(s) information, including confidential information, medical records, wage information, etc. in the possession of the Office of Workers' Compensation Administration, Records Management.

I understand that the Louisiana Workers' Compensation Act, La. R.S. 23:1020.1, *et seq*., provides that certain information regarding prior work related injuries may be released to a requesting party. By signing this authorization, I hereby voluntarily authorize the State of Louisiana, Office of Workers' Compensation Administration, Records Management Section to release only the information selected above in Section I and contained in my workers' compensation records, if any, to the Recipient named in Section II. This release may contain public and non-public records in my workers' compensation file(s) depending on my selection in Section I. This release is only for the recipient named in Section II and shall not be released to any third parties or any party not specifically named on this authorization.

This authorization will expire thirty (30) days from the date of signature.

Employee's Signature_____ **Date** _____

SECTION II: RECORDS TO BE DISCLOSED TO	
1. Name of Recipient (Please Print)	**2. Company Name (if applicable)**
3. Street Address	**4. Phone Number**
5. City, State, Zip	**6. Please state Recipient's relationship to the employee: **See Section III, Page 2.***

SECTION III: IF THE RECIPIENT IS A PROSPECTIVE EMPLOYER

You must certify and sign the following:

I hereby certify the information sought by this authorization is made on an applicant for employment only after a conditional job offer has been made and accepted, or on a current employee for a purpose which is job related and consistent with business necessity. I further certify the information obtained in the authorization will **NOT** be used to discriminate in any manner against the individual who is the subject of this authorization on any basis, in violation of the Americans with Disabilities Act of 1990, 42 U.S.C. §12101, *et seq*., or any other state or federal law, as applicable.

I am aware of the confidential and privileged nature of an employee's Workers' Compensation records, pursuant to La. R.S. 23: 1293.

Employer's Signature_____ **Date** _____

Sworn and subscribed before me this_____day of_____, 20___at_____, Louisiana.

_____

Notary Public's Signature
Print Name: _____
Notary ID: _____
My commission expires: _____

SECTION IV: IF THE REQUESTOR IS NOT A PARTY TO THE CASE

You must certify and sign the following:

I hereby certify the information sought by this authorization is made on a claimant who is aware I have requested their records.

I am aware of the confidential and privileged nature of an employee's Workers' Compensation records, pursuant to La. R.S.23: 1293.

Requestor's Signature_____ **Date** _____

Sworn and subscribed before me this_____day of_____, 20___at_____, Louisiana.

_____

Notary Public's Signature
Print Name: _____
Notary ID: _____
My commission expires: _____

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					