AmTrust North America
An AmTrust Financial Company

Montana
Worker's Compensation
Claim Kit

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

AmTrust North America
An AmTrust Financial Company

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AmTrust INSURANCE

Workers' Compensation Claim Reporting Information

24/7 Toll Free Claim Reporting for All States

(888)239-3909

WorkersCompClaimReport@AmTrustgroup.com

www.amtrustfinancial.com

Information Required for All Claims Reported

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

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

How do I help my injured worker find a doctor?

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

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

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

Timely Reporting

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

We're Here To Help

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

Relax And Stay Positive

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

877.528.7878 I www.amtrustfinancial.com

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

OSHA Log Case #

First Report

of Injury or Occupational Disease
Montana Department of Labor and Industry
PO Box 8011, Helena, MT 59604-8011

Adjuster Date Stamp

Worker

Last Name	First Name	M.I.	Date of Birth	Social Security Number

Mailing Address	City	State	Postal Code

Phone Number	Education	Gender	Marital Status	Number of Dependents
	☐ Less Than High School ☐ GED or High School Diploma ☐ Beyond High School	☐ Male ☐ Female ☐ Unknown	☐ Married ☐ Separated ☐ Widowed, Divorced, Single, Unmarried ☐ Unknown	

Wages

Date Hired	Gross earnings for four pay periods preceding the injury Date/Amount / Date/Amount / Date/Amount / Date/Amount /

Employment Status	Number of Days worked per week	Wage	Wage Period
☐ Full-Time ☐ Part-Time ☐ Piece Worker ☐ Seasonal ☐ Volunteer ☐ Other			☐ Hour ☐ Week ☐ Month ☐ Day ☐ Bi-Weekly

In addition to gross earnings cited above worker received	Estimated value if any	Time Employee began work
☐ Room & Board ☐ Overtime ☐ Bonus ☐ Commissions ☐ Other:		

Worked next scheduled shift	Off work more than 4 work days	Date Last Worked	Date of Return to Work	Full wages paid for date of injury	Salary Continued
☐ Yes ☐ No	☐ Yes ☐ No ☐ Not Sure			☐ Yes ☐ No	☐ Yes ☐ No

Accident Description

Job Title	Description of Accident

Cause of Injury	Cause Code	Part of Body	Part Code	Nature of Injury	Nature Code	Date of Injury	Time of Injury

Date Disability Began	Date of Death	Names of Witnesses 1) 2) 3)

Accident on Employer's Premises	Accident Address or Location City State Postal code
☐ Yes ☐ No	

Date Employer Notified	Accident Reported to	Safety Equipment Provided	Safety Equipment Used
		☐ Yes ☐ No	☐ Yes ☐ No

Medical

Attending Physician's Name	Address	State	Postal Code	Phone Number

Hospital Name	Address	State	Postal Code	Phone Number

Type of initial medical treatment received ☐ No Treatment ☐ Emergency Room/Urgent Care ☐ Treatment on-site by Employer or Medical Staff ☐ Clinic/Dr. Office ☐ Hospital > 24 hours

Signature

"This is my claim for workers' compensation benefits due to the on-the-job injury, occupational disease, or death of the above named worker. I understand that signing this claim for compensation authorizes the release to the workers' compensation insurer (and its agents) and to the Montana Uninsured Employers' Fund of: Social Security records; rehabilitation records; and all health care information (medical records, pursuant to HIPAA, Public Law 104-191, 42 USC section 1301, et. seq., and section 39-71-604, MCA), that are directly relevant to the claimed injury, disease, or death. I also understand that if I obtain or exert unauthorized control over workers' compensation benefits to which I am not entitled, I may be prosecuted for theft."

Signature of Injured Worker or Beneficiary Date:

Employer

Employer Name	Doing Business as	Federal Employer Identification Number (Tax I.D)

Mailing Address	City	State	Postal Code	Phone Number

Location of operation, if different from mailing address	Nature of Business SIC/NAICS Code	Self-Insured ☐ Yes ☐ No

Employer is a ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company	Injured worker is a ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ A member of the employer's (sole proprietor) family living in the employer's household.

Do you have any reason to question this accident? ☐ Yes ☐ No If yes, please explain fully. Use separate sheet if you need additional space	Was worker injured while in your employ ☐ Yes ☐ No

Prepared By	Official Title	Phone Number	Date

Payroll Classification Code under which you report Employee's wages	Authorized Employer's Signature _____ Date_____

Insurer

Claim Administrator Claim Number	Date Reported to Claim Administrator:	The above information is correct with the following exceptions ☐ (Attach extra sheets if box at right is checked)

Claim Administrator Name	Claim Administrator Address	Claim Administrator FEIN
AmTrust North America	P.O. Box 89453, Cleveland, Oh 44101	

Insurer Name	Insurer FEIN

Policy Number	Policy Effective Date	Policy Expiration Date

First Report of Injury or Occupational Disease

Instructions

Workers' compensation insurance is a state-required insurance, which provides medical benefits, wage compensation and rehabilitation to workers injured on the job. Severe penalties can be assessed against an uninsured employer. Neither general liability nor health and accident insurance policies are substitutes for workers' compensation insurance.

The worker and employer may complete this form together or they may each submit a separate form.

Injured Worker's Instructions

Workers have two reporting requirements: 1) Notify your employer of an on-the-job injury within 30 days of its occurrence and 2) Complete this form as a claim for compensation. The form must be signed and submitted to the employer's insurer or the Department of Labor and Industry within 12 months of the accident. The form must be submitted for all injuries in order to protect your right to benefits in the event a seemingly minor injury develops into a more serious condition.

Complete a report of the injury

Be thorough in completing all areas except the gray shaded areas. It is important to you that we have complete information. You must provide your Social Security Number (SSN). This is a mandatory requirement that is permitted under Section 7(a) the Privacy Act of 1974 because the Montana Department of Labor and Industry's forms, prescribed by department rules in existence prior to January 1, 1975, have required disclosure of the SSN. The SSN is used as a key identifier of the claimant and is needed because of the number of persons who have similar names and birth dates, and whose identities can only be distinguished by the SSN. Use extra sheets of paper if needed. Type or print with a ballpoint pen.

To ensure that workers' compensation systems will not be disrupted, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, 42 USC 1301, et. seq., **permits the disclosure of protected health care information pursuant to the provisions of state laws regarding workers' compensation.** 45 CFR 164.512(l) states:

> "Standard: Disclosures for workers' compensation: A covered entity may disclose protected health information **as authorized by and to the extent necessary to comply with laws relating to workers' compensation** or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault."

Employer's Instructions

Montana law requires employers to complete this form within six days after notice of every on-the-job accident, injury and/or occupational disease (OD) by a worker. Ensure all areas are completed except the gray shaded areas, which your insurer will complete. **It is important that we have complete information.**

Type or print with a ballpoint pen. If you are completing with WORD software, you may tab through the fields. If the injured worker is available to do so, they may file a claim for workers' compensation by completing and signing their portions of this form. You may then complete the employer section.

Send the original immediately to your workers' compensation insurer. If you don't know whom your insurer is, contact the Montana Department of Labor and Industry (see below). **SEND THIS FORM WITHIN THE 6-DAY LIMIT EVEN IF THE WORKER IS NOT AVAILABLE TO SIGN.** This form must be submitted even if the employer questions whether or not the reported injury and/or OD are job-related. Additional sheets of paper may be attached, if needed to fully explain all conditions concerning the injury and/or OD.

The United States Department of Labor, OSHA, requires employers to maintain a record of occupational injuries in the employer's office. Please copy the completed form for your records.

Insurer/Adjuster (not submitting electronically)

Please complete all gray shaded areas, and mail a completed copy immediately to the Montana Department of Labor and Industry at the address shown below. Boxes that have been **BOLDED** are mandatory in order to file this report. If you wish to file First Report information electronically, please contact the Employment Relations Division.

Presumptive Claims (ex: firefighter)

For filing a presumptive claim, especially for retirees, the department recommends working directly with the insurer or the department, as the existing claim form was designed based on a national standard that does not currently include claims of this nature. Following is a couple of helpful hints for filling out the form for retiree presumptive claims.

1) Employee/Volunteer Dates of Service can be entered into the Date of Hire and Last Day Worked fields on the existing form. Use Date of Hire for the begin date of service and Last Day Worked for the end date of service.
2) The Date of Diagnosis can be entered into the Date of Injury field on the form.
3) Fire agency worked/volunteered for should be entered into the Employer Name field on the form.
4) The Accident Description Field on the form can be used to collect miscellaneous data such as date of last physical, number of years as a firefighter or any other data the insurer feels is pertinent to adjudicating the claim. This data element allows for up to 512 characters.

- The Insurer and/or the department is here for any questions or to provide assistance in filing these types of claims.

Further Information

Department of Labor & Industry
Employment Relations Division
Workers' Compensation Claims Assistance Bureau
PO Box 8011
Helena MT 59604-8011
(406) 444-6543
http://erd.dli.mt.gov

The United States Department of Labor, OSHA, requires employers to maintain a record of occupational injuries in the employer's office.

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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

AmTrust North America
PORTADORA — EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

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

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

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

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

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

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

Empleador:

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

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!

State of Montana

Department of Labor & Industry
Brian Schweitzer, Governor

Employment Relations Division

WC Regulation Bureau
Carrier Compliance

ATTENTION

Effective: July 1, 2011

IMPORTANT NOTICE REGARDING THE REVISION OF THE MONTANA WORKERS' COMPENSATION EMPLOYEE NOTICE

The following change has been made to the Workers' Compensation Insurance Coverage Employee Notice due to the 2011 Legislation.

"Prior to the Insurer's designation or approval of a Treating Physician you may choose your initial Health Care Provider.
You may continue to receive treatment from your initial health care provider unless the insurer designates a treating physician other than your initial health care provider. After providing you with a notice of a designated or approved treating physician, the insurer is no longer liable for treatment provided by other health care providers unless authorization is obtained to continue treatment."

POSTING REQUIREMENTS (39-71-401 (6) MCA)
When insurers issue a policy to employers, they must also provide the employers with an Employee Notice, which employers in turn must post at each worksite. The Department of Labor can provide the standardized format to insurers, and insurers are responsible for having the Employee Notice reprinted in the same format and distributed to employers.

I have enclosed a copy of the revised Employee Notices. Please incorporate the necessary changes into your system.

If you have any questions concerning this issue please contact Connie Ferriter at 406-444-6532 or by e-mail at cferriter@mt.gov.

Phone (406) 444-0564
TDD (406) 444-5549
Fax (406) 444-7710
"An Equal Opportunity Employer"
P.O. Box 8011
Helena, MT 59604-8011

WORKERS' COMPENSATION

INSURANCE COVERAGE

EMPLOYEE NOTICE

Date:

Policy Number:

The above-named employer's workers' compensation insurance coverage is active and in good standing for the period of / / to / / , provided the employer meets all premium and reporting requirements.

IF YOU ARE INJURED

You should report any on-the-job injury to your supervisor, employer, or insurer as soon as possible. You must report the accident within 30 days. A sole proprietor, partner, manager of a manager-managed limited liability company, member of a member-managed limited liability company, or corporate officer covered under the Montana Workers' Compensation Act must report an accident to the insurer within 30 days.

Report minor injuries to your employer whether or not you receive medical treatment. After you report the injury, your employer has 6 days to notify their insurer. You must submit a written First Report of Injury within 12 months from the date of the accident or within one (1) year from the knowledge of an occupational disease. You can submit this form to your employer, insurer, or the Department of Labor and Industry.

All employees sustaining a compensable work related injury or occupational disease, other than those who are exempted by statute (Section 39-71-401, MCA), are covered for medical and wage-loss benefits.

Prior to the Insurer's designation or approval of a Treating Physician you may choose your initial Health Care Provider.

You may continue to receive treatment from your initial health care provider until the insurer designates a treating physician other than your initial health care provider. After providing you with a notice of a designated or approved treating physician, the insurer is no longer liable for treatment provided by other health care providers unless authorization is obtained to continue treatment.

For specific information about this policy, call or write your employer's insurance carrier:

For general information about workers' compensation, call or write: Montana Department of Labor and Industry, Employment Relations Division, P.O. Box 8011, Helena, MT 59604-8011, Phone (406) 444-6543.

FAILURE TO POST THIS SIGN OR POSTING AN ALTERED SIGN IN THE WORKPLACE WILL RESULT IN A $50 FINE AGAINST THE EMPLOYER!

ERD 800.(Rev 03/2021)

Compensación de Trabajadores

Cobertura De Seguro

AVISO DEL EMPLEADO

Fecha:

Número de la Política:

La cobertura de compensación para trabajadores de la antedicha compañia esta vigente por el periodo de , mientras tanto que la compañía halla reunido todos los requisitos de reportes y la prima.

SI USTED ES HERIDO

Usted debe informar cualquiera lesion que ocurre en el trabajo a su supervisor, el empleador o el asegurador tan pronto posible. Usted tiene que reportar el accidente dentro de 30 días. Un propietario único, el socio, el director de una compañía manejado por el director de obligación limitada, el miembro de una compañía miembro-manejado por obligación limitada, o oficial corporativo cubierta bajo el Acto de Compensación de Trabajadores de Montana debe informar un accidente al asegurador dentro de 30 días.

Informe las lesiones secundarias a su empleador aunque usted no reciba tratamiento médico. Después que usted informa la lesión, su empleador tiene 6 días para notificar a su asegurador. Usted tiene que entregar un escrito "Primer Informe de la Lesion" dentro de 12 meses de la fecha del accidente o dentro de un (1) año del conocimiento de una enfermedad profesional. Usted le puede entregar esta forma a su empleador, al asegurador, o al Departamento de Labor y de Industria.

Todos los empleados que sostienen una lesion compensable relacionada al trabajo o la enfermedad profesional, con excepción de las que sean eximidas por el estatuto (la Sección 39-71-401, MCA), son cubierta por médico y por los beneficios de perdida de salario.

Antes de la designación de la Aseguradora o aprobación de un médico tratante puede elegir su proveedor de atención médica inicial. Usted puede continuar recibiendo tratamiento de su proveedor de atención médica inicial a menos que el asegurador designa un médico tratante que no sea su proveedor de atención médica inicial. Después de proporcionarle con un aviso de un designado o aprobado médico tratante, el asegurador es no más obligado para el tratamiento proporcionado por otros proveedores de asistencia médica a menos que autorización sea obtenida para continuar el tratamiento.

Para información específica sobre esta políza, llame o escriba al portador del seguro de su empleador:

Para información general acerca la compensación de los trabajadores, llame o escriba:
Departamento de Trabajo e Industria de Montana, División de Relaciones Laborales, P.O. Box 8011, Helena, MT 59604-8011, Teléfono (406) 444-6543.

¡EL FRACASO DE ANUNCIAR ESTE LETRERO O ANUNCIAR UN LETRERO MODIFICADO EN EL LUGAR DE TRABAJO RESULTA EN UNA MULTA DE $50 CONTRA EL EMPLEADOR!

ERD800.(Rev 03/2021)

BEFORE THE DEPARTMENT OF LABOR & INDUSTRY
Employment Relations Division

PETITION FOR SETTLEMENT
(Permanent Total Disability)
INJURY/OCCUPATIONAL DISEASE
MEDICAL BENEFITS CLOSED BY SETTLEMENT
ON AN ACCEPTED CLAIM

Claimant

Employer

Insurer's Primary Claim #:

Insurer

Additional Claims:

ACN #(s):

The claimant suffered an injury arising from a work-related accident or occupational disease occurring on . The insurer accepted liability for the claim(s).

The claimant and insurer have agreed to settle all compensation payments due the claimant under the Workers' Compensation/Occupational Disease Acts. The claimant has agreed to accept the lump sum of: **($). Paid by the Insurer** The settlement amount shall be paid in a lump sum in addition to all sums previously paid by the insurer, unless otherwise indicated in this Petition.*

The basis for settlement of this claim is that the claimant is permanently and totally disabled as defined in the Acts. This settlement is based on the claimant's total disability benefit rate after the rate has been reduced as a result of the offset taken against the claimant's social security disability benefits, if any.

The claimant and insurer petition the Department of Labor & Industry for approval of this settlement allowing the claim to be fully and finally closed. **Coverage for medical benefits are closed by this settlement.** The **claimant**, in signing and submitting this Petition to the Department of Labor & Industry, **further understands** that if this Petition is approved, this insurer is forever released from payment of compensation, medical and hospital benefits under the Workers' Compensation and Occupational Disease Acts for the claim(s) specified above. The **claimant understands** this Petition represents a settlement and, if approved, cannot be reopened by the Department.
***Special Provisions:**

Vocational Rehabilitation Provisions:

I understand and acknowledge this settlement will end all workers' compensation coverage for medical care for the claim(s) included above and my medical benefits will terminate. I further understand this settlement of medical benefits may or may not result in secondary payers, such as Medicare, Medicaid, or health insurers, denying coverage for medical expenses for condition(s) related to the claims included above.

Claimant's Signature **Date Signed** **Witness Signature**

Claimant's Address:
Street/PO Box:

Email Address:

City:

State: Zip Code:

Subsequent Injury Fund Certified
Yes ☐ **NO** ☐

The concurs and joins in the Petition for Settlement.

Insurer Authorized Representative **Date**

Order

The Department of Labor & Industry hereby orders that the above settlement is approved.

Dated the day of , .

Signature of Authorized Department Representative

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					

COMPENSATION RATES				
These following rates are the maximum allowed by law for TTD and PPD for claims incurred in the corresponding years				
BY INJURY DATE				
Fiscal Year	Timeframe Covered	TTD (Temporary Total Disability)	PPD (Permanent Partial Disability (PPD)	PPD Weeks
Medical Benefits Close 60 Months from the Date of Injury				
23	07/01/22 - 06/30/23	$974.00	$487.00	400
22	07/01/21 - 06/30/22	$917.00	$458.50	400
21	07/01/20 - 06/30/21	$849.00	$424.50	400
20	07/01/19 – 06/30/20	$819.00	$409.50	400
19	07/01/18 – 06/30/19	$793.00	$396.50	400
18	07/01/17 – 06/30/18	$768.00	$384.00	400
17	07/01/16 – 06/30/17	$756.00	$378.00	400
16	07/01/15 – 06/30/16	$733.00	$366.50	400
15	07/01/14 – 06/30/15	$708.00	$354.00	400
14	07/01/13 – 06/30/14	$698.00	$349.00	400
13	07/01/12 – 06/30/13	$672.00	$336.00	400
12	07/01/11 – 06/30/12	$649.00	$324.50	400
Medical Benefits Close After 60 Consecutive Months				
11	07/01/10 – 06/30/11	$633.00	$316.50	375
10	07/01/09 – 06/30/10	$626.00	$313.00	375
09	07/01/08 – 06/30/09	$604.00	$302.00	375
08	07/01/07 – 06/30/08	$573.00	$286.50	375
07	07/01/06 – 06/30/07	$545.00	$272.50	375
06	07/01/05 – 06/30/06	$520.00	$260.00	375
05	07/01/04 – 06/30/05	$504.00	$252.00	375
04	07/01/03 – 06/30/04	$487.00	$243.50	375*
03	07/01/02 – 06/30/03	$473.00	$236.50	350
02	07/01/01 – 06/30/02	$454.00	$227.00	350
01	07/01/00 – 06/30/01	$439.00	$219.50	350
00	07/01/99 – 06/30/00	$425.00	$212.50	350
99	07/01/98 – 06/30/99	$411.00	$205.50	350
98	07/01/97 – 06/30/98	$396.00	$198.00	350
97	07/01/96 – 06/30/97	$384.00	$192.00	350
96	07/01/95 – 06/30/96	$380.00	$190.00	350
95	07/01/94 – 06/30/95	$373.00	$186.50	350
94	07/01/93 – 06/30/94	$362.00	$181.00	350
93	07/01/92 – 06/30/93	$349.00	$174.50	350
92	07/01/91 – 06/30/92	$336.00	$168.00	350
Medical Benefits Reserved				
91	07/01/90 – 06/30/91	$323.00	$161.50	500
89	07/01/89 – 06/30/90	$318.00	$159.00	500
88	07/01/88 – 06/30/89	$308.00	$154.00	500
Settlements – to Workers' Compensation Court / Medical Benefits Reserved				
87	07/01/86 – 06/30/87	$299.99	$149.50	500
86	07/01/85 – 06/30/86	$293.00	$146.50	500
85	07/01/84 – 06/30/85	$286.00	$143.00	500

COST OF LIVING ADJUSTMENT (COLA)

3% - Date of Injury Prior to 03/26/03 6.22% - Date of Injury Post 3/26/03 Agreements Made Between 07/01/21 – 06/30/22 Present Value Rate is 1.45% No Present Value Rate for Claims with a D/A prior to 04/15/85 Contact the Department of Labor & Industry for previous COLAs

What happens if I am partially disabled because of the injury or occupational disease?

If your medical provider determines you have reached MMI, you may be eligible for **Permanent Partial Disability (PPD)** benefits if you meet certain requirements.

What if I can no longer work because of the injury or occupational disease?

If your medical provider determines you have reached MMI and you cannot return to any regular employment, you may be eligible for **Permanent Total Disability (PTD)** benefits. Regular employment means recurring work performed for remuneration in a trade, business, profession, or other occupation in the state.

The benefit rate is the same as for **Temporary Total Disability (TTD)**. Benefits are available until you are eligible to receive Social Security retirement benefits or retirement benefits from a system that is an alternative to Social Security retirement. Benefits are subject to a cost-of-living increase. If you also receive Social Security disability payments because of your workers' compensation claim, your weekly compensation payments may be reduced by up to half of your Social Security payment.

Stay at Work/Return to Work

DLI and workers' compensation insurers assist Montana workers in efforts to stay at work or return to work quickly after a work-related injury. To request stay at work or return to work assistance, contact your workers' compensation insurer or DLI by visiting erd.dli.mt.gov or by phone (406) 444-6543.

Death Benefits

If an on-the-job injury or occupational disease is the cause of death, contact the workers' compensation insurance provider or ESD for information.

Rehabilitation Benefits

You may be eligible for rehabilitation benefits if:

- You have a permanent medical impairment resulting from your injury or occupational disease and cannot return to your time of injury job or a job with similar physical requirements
- You suffer an actual wage loss
- You have a permanent medical impairment rating 15% or greater and have no actual wage loss

The Importance of Providing Accurate & Truthful Information

When you sign your FROI, you are confirming the information on the claim is true. If you obtain benefits to which you are not entitled, you may be guilty of theft, and criminal proceedings can be initiated. Helping someone else to fraudulently obtain benefits is also a crime.

Can I report suspected fraud?

Yes, you can report suspected fraud by calling the Montana State Fund Fraud Hotline at (888) 682-7463 (if the employer is insured by Montana State Fund) or the DLI at (406) 444-6543.

Who provides coverage for my claim?

Ask your employer for the name of the company providing coverage for the employer, or you may contact ESD at (406) 444-6543.

Rights & Remedies

If you disagree with a decision made by your insurer regarding benefits, you may request mediation through the ESD at (406) 444-6534.

Upon satisfying the mediation requirements, the parties have two years from the date of the denial of benefits to petition the Workers' Compensation Court for a determination of the dispute. Mediation requirements must be met before petitioning the court.

Additional Benefits Outside the Workers' Compensation System:

Kids' Chance of Montana – Provides scholarships to children affected by a workplace injury by helping them pursue and achieve their educational goals. Visit kidschanceofmontana.org for details.

This brochure is not all-inclusive of every situation in workers' compensation.

For more information:

ERD.DLI.MT.GOV
(406) 444-6543
Fax: (406) 444-4140

P.O. Box 8011
Helena, MT 59604-8011

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Montana Department of LABOR & INDUSTRY

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WORKERS' COMPENSATION

Benefits Summary

For dates of injury occurring on or after July 1, 2024 through June 30, 2025.

Montana Department of LABOR & INDUSTRY

What is Workers' Compensation?

Workers' Compensation in Montana is designed to:

- Provide, without regard to fault, wage loss and medical benefits to workers suffering from a work-related injury or occupational disease
- Return the worker to the workforce as soon as possible
- Provide coverage at reasonably constant rates to employers

Montana has specific laws about limits of liability. Employers are not obligated to make payments beyond those limits.

Who is covered?

Workers' compensation insurance is required for most types of employment. If you are injured on the job, you may be eligible for workers' compensation benefits provided you submit notice and the proper claim form on time.

Reporting Requirements

What do I have to do?

Report all on-the-job injuries to your supervisor, insurer, or employer as soon as possible, regardless of if you receive medical treatment. You must give notice within **30 days** of the accident. The notice must include the time and place of the accident and the nature of the injury. This 30-day notice requirement does not apply to occupational diseases.

You must submit a signed **First Report of Injury (FROI)** within **12 months** of the accident. You can submit this form to your employer, the workers' compensation insurer, or the **Montana Department of Labor & Industry (DLI)** - **Employment Standards Division (ESD)**. FROI forms are available from your employer, insurer, or the DLI website erd.dli.mt.gov.

To claim an occupational disease, you must submit a signed FROI to your employer, insurer, or DLI within **one year** from the date you knew or should have known your condition resulted from an occupational disease. An occupational disease is a condition caused by events occurring on more than a single day or work shift.

Upon receipt of your signed FROI, the insurer has **30 days** to either accept or deny your claim.

What medical benefits are provided?

Once the insurer accepts your injury or occupational disease claim, you are entitled to reasonable medical costs, including doctor, hospital, and prescription payments. You do not have to pay the balance between what the medical provider charges and the insurance company pays.

You may choose the treating physician for initial treatment. However, any time after the insurer accepts liability, they may designate a different treating physician, or approve your choice of the treating physician. The treating physician is responsible for the management and coordination of your medical care and must treat you within the recommendations of the Montana Utilization and Treatment Guidelines including prescribing medications pursuant to the Montana Workers' Compensation Drug Formulary. An insurer is not responsible for treatment or services that do not fall within the utilization and treatment guidelines unless the provider obtains prior authorization from the insurer.

Are my medical benefits open forever?

No. Medical benefits terminate **60 months** from the date of injury or diagnosis of an occupational disease. A worker may request reopening of terminated medical benefits within **five years** of the termination by filing a petition with DLI. Repair or replacement of a prosthesis or permanently disabled workers are exempt from the closure of medical benefits.

What charges do I have to pay?

After your first visit to an emergency room, you are responsible for **$25** of the cost of each subsequent visit to an emergency room. An insurer will only pay for the purchase of generic name drugs if the generic product is a therapeutic equivalent unless the generic product is unavailable. If you choose to use a name brand product you may be responsible for the cost difference.

If I have to travel for treatment of my injury or occupational disease, who pays for the travel?

The insurer is required to pay reasonable travel expense. Your first **100 miles** of travel per month are excluded.

Workers will not receive payment for travel outside their community if equal treatment is available within the community unless the insurer requests you attend a medical appointment. You may not receive a travel reimbursement if you travel to unauthorized or disallowed treatment or procedures. Travel claim forms are provided by the insurer.

What do I have to do to qualify for reimbursed travel expenses?

You must submit the travel claim to the insurer within **90 days** of the travel.

Wage Loss

If your medical provider does not permit you to return to work because of your injury or occupational disease, and your claim has been accepted by the insurer, you may be eligible for wage loss benefits. Compensation is not paid for the first **32 hours** or **four days** of wage loss, whichever is less. You are eligible for compensation starting with the **33rd hour** or **fifth day of wage loss**. If you are totally disabled and unable to work for **21 days** or longer, compensation may be paid retroactively to the first day of total wage loss.

What if I cannot work at all for an extended period?

Suppose you suffer a total loss of wages due to your injury or occupational disease. You may be eligible for **Temporary Total Disability (TTD)** benefits until your medical provider determines you have reached **Maximum Medical Improvement (MMI)** or you are released to return to the employment in which you were injured or a job with similar physical requirements. You may receive weekly compensation of 66 2/3% of your gross wages at the time of injury – up to the maximum rate of $1,084 a week. Wages may include lodging, rent, or housing if it constitutes part of the employee's remuneration.

If I can work with a temporary work restriction, am I eligible for benefits?

Possibly. If prior to reaching maximum medical improvement, you have a physical restriction, suffer an actual wage loss and are approved to return to modified or alternative employment, you may be eligible for **Temporary Partial Disability benefits (TPD)**. The benefits are:

- May not exceed your temporary total disability rate of $1,084 a week
- The difference between your average weekly wage at the time of injury, subject to the maximum of 40 hours a week, and the actual wages you earn in the modified or alternative employment

Benefits through Montana's Workers' Compensation System are intended to assist a worker who suffers a work-related injury or occupational disease. The medical provider's diagnosis, treatment plan, and return to work decisions help define what benefits may be available to an injured worker. Following the medical provider's directions, prompt communication with your claims examiner and your employer can expedite the recovery process.

Injured workers can expect limited benefits for medical, wage replacement and rehabilitation to help with recovery from a work-related injury or occupational disease. The workers' compensation system does not make monetary awards for pain and suffering.