AmTrust North America
An AmTrust Financial Company

New Hampshire
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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An AmTrust Financial Company

EASY ONLINE CLAIMS REPORTING INSTRUCTIONS

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

First Time Portal Access:

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

Reporting of New Injuries:

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

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

AmTrust North America
An AmTrust Financial Company

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

LAB 500

New Hampshire

Employer's First Report of Injury

WEB-8WC –

Submission Date: _____ **NHDOL# -**

EMPLOYEE INFORMATION					
Employee Name (First & Last)		**Gender**	**Hired Date**		**Hired in NH**
ID Type - Employee ID	**Date of Birth**	**Age**	**Occupation when Injured**		
Employee Address	**Telephone**	**Wages per Hour**	**Hrs per Day**	**Days per Week**	**Average Weekly Earnings**

INJURY INFORMATION		
Injury Date / Time	**Date Employer Notified of Injury**	**Location/Jobsite & Business Name where accident occurred**
Disability Began Date		
Claim Type	**Full Wages Paid on Injury Date**	

Accident Description

Body part Injured	**Cause of Injury**	
Nature of Injury	**Witness Name**	**Witness Phone**

Returned to work?	**If so, what date?**	**If so, at what occupation?**	**If so, at what duty status?**

Initial Treatment	**Initial Treatment Date**

Name of Treating Physician	**Name of Treating Hospital**	**Has injured died? If so, what date**

EMPLOYER INFORMATION		
Employer Name	**Employer FEIN**	**Industry Code**

Employer Contact Name	**Contact Phone Number**	**Employer Business Address**
Managed Care Organization		
Leased Employee? Client Company	**OCIP/Wrap-Up Policy? Name of policy holder**	

INSURER INFORMATION			
Insurance Carrier	**Insurer Type**	**Policy Number**	**Telephone Number**

SUBMITTER INFORMATION			
Submitter Name	**Title of Submitter**	**Represents**	**Telephone Number**

To file this report, email to firstreport@dol.nh.gov Fax Number: (603)271-0126 or
Mail to: NH Department of Labor Workers' Compensation Division 95 Pleasant St. Concord NH 03301

THE STATE OF NEW HAMPSHIRE

DEPARTMENT OF LABOR

Employer's Supplemental Report of Injury

This report, indicating disability of an employee of four or more days, shall be filed as soon as possible after date of knowledge of an occupational injury or disease, but no later than ten days thereafter. Consistent failure to make this report available to the labor commissioner and the nearest claims office of your insurance carrier carries an automatic civil penalty of up to $100.00. (RSA 281-A:53) This report shall also be submitted upon employee's return to work.

1. Name of Employer_____Employer's Identification No._____
(9 digit number assigned by proper Federal Agency)

2. Address_____
(No. and St.) (City and State) (Zip Code)

3. Insured by_____

4. Name of Employee_____
(First Name) (Middle Initial) (Last Name) (S.S. Number)

5. Address
(No. and St.) (City and State) (Zip Code)

6. Date of injury_____ 20 _____

7. Date Disability began _____20 _____ A.M. _____ P.M._____

8. _____
(Specific dates of disability)

_____
(Specific dates of disability)

9. Has injured returned to work?_____ if so, date and hour _____ A.M._____ P.M._____

10. Is injured person earning same wages as before injury?_____ If not, explain_____

Date of Report_____

Signed by_____

Official Title_____

Tel. No._____

Form No. 13 WCA (rev 03/14)

OPTUM®

AmTrust North America
An AmTrust Financial Company

Optum
PO Box 152539
Tampa, FL 33684-2539

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

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

Injured Employee:

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

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

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

Questions? Need Help?

1-866-599-5426

OPTUM®

AmTrust North America
An AmTrust Financial Company

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
CARRIER/TPA

EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER

DATE OF INJURY (YYMMDD)

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

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

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

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

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

Employer:

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

tmesys®

IMP14-1614-109-FFWG

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

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

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

Empleado lesionado:

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

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

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

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
PORTADORA — EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

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

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

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

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

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

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

Empleador:

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

tmesys®

IMP14-1614-109-FFWG

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

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

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

Some Return-to Work Benefits Include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

STATE OF NEW HAMPSHIRE

WORKERS' COMPENSATION LAW

NOTICE OF COMPLIANCE

TO EMPLOYEES

1 You are required by law (RSA 281-A:19) to report promptly to your employer an occupational injury or disease, even if you deem it to be minor. Form No. 8a WCA, Notice of Accidental Injury or Occupational Disease, may be used for that purpose (RSA 281-A:20,21). After you have completed and made it available to him or her, your employer must acknowledge receipt by signing and giving you a copy.

2 You are entitled to the services of a physician. This physician shall be within a managed care network, if applicable under RSA 281-A:23a.

3 You may not sue your employer as a result of a work-connected injury or disease by reason of your eligibility for benefits under the Workers' Compensation Law.

TO EMPLOYERS

1 You are required to display this poster so that it will be of the greatest possible benefit to your employees (RSA 281-A:4).

2 You are required to file an Employer's First Report of Injury or Occupational Disease, form No. 8 WC, with the Labor Commissioner, copy to the nearest claims office of your insurance carrier, on all occupational injuries or diseases resulting in one visit to a physician, other than a house physician, as soon as possible but no later than five days after the date of knowledge thereof (RSA 281-A:53, I).

3 You are required to report to the Labor Commissioner, copy as in 2 above, any occupational disability, whether total or partial, of four or more days (RSA 281-A:22), on an Employer's Supplemental Report of Injury, form No. 13 WCA, as soon as possible, but no later than ten days after the date of knowledge thereof (RSA 281-A:53,I and II).

4 You are required to furnish, or cause to be furnished, reasonable medical and hospital services, other remedial care or vocational rehabilitation, and various types of disability compensation, to an injured or disabled employee in accordance with RSA 281-A:23, 25, 26, 28, 29, 31, 32.

5 All employers with 5 or more full time employees shall develop temporary alternative work opportunities for injured employees in accordance with RSA 281-A:23-b. Employers may be obligated to reinstate employees sustaining a compensable injury in accordance with RSA 281-A:25-a.

6 You are required to obtain from the carrier identified below a supply of all required workers' compensation forms.

NOTICE – Violation of the various provisions of the Workers' Compensation Law carries civil penalties, court fines, or both.

Rudolph W. Ogden III
Deputy Commissioner

Ken Merrifield
Commissioner of Labor

The undersigned employer hereby gives notice of compliance with all provisions of the Workers' Compensation Law and Administrative Regulations of the Labor Commissioner of the State of New Hampshire pursuant to Revised Statutes Annotated, Chapter 281-A, as amended.

Name of Insurance Company
Or self-insurer:

Name of Employer:

By _____

_____
Employer Identification No.
(If number unknown, Employer to request from IRS)

This notice must be posted conspicuously in and about the Employer's place or places of business.

Prescribed by Labor Commissioner
State of New Hampshire
WCP-1 (04-14)

ESTADO DE NEW HAMPSHIRE
LEY DE COMPENSACIÓN PARA TRABAJADORES
AVISO DE LA CONFORMIDAD

A LOS EMPLEADOS

1 Cerca le requieren (RSA 281-A:19) divulgar puntualmente a su patrón lesión o una enfermedad ocupacional, incluso si usted la juzga para ser de menor importancia. Forme No. 8a WCA, aviso de lesión accidental o la enfermedad profesional, se puede utilizar para ese propósito (RSA 281-A:20,21). Después de que usted la haya terminado y haya puesto a disposición él o ella, su patrón debe recibo del acknowlege firmando y dándole una copia.
2 Le dan derecho a los servicios de un médico. Este médico estará dentro de una red manejada del cuidado, si RSA inferior aplicable 281-A:23a.
3 Usted no puede demandar a su patrón como resultado de lesión o de una enfermedad trabajar-conectada por causa de su elegibilidad para las ventajas debajo de Workers' Ley De la Remuneración.

A LOS PATRONES

1 Le requieren exhibir este cartel de modo que esté de la ventaja posible más grande a sus empleadso (RSA 281-A:4).
2 Le requieren archivar un informe de Employer's primer de lesión o de la enfermedad profesional, WC de la forma No. 8, con la comisión de trabajo, copia a la oficina más cercana de las demandas de su portador de seguro, en todas las lesiones o enfermedades ocupacionales dando por resultado una visita a un médico, con excepción de un médico de la casa, cuanto antes pero no más adelante de de cinco días después de la fecha del conocimiento (RSA 281-A:53i).
3 Le requieren divulgar a la comisión de trabajo, copia como en 2 arriba, cualquier inhabilidad ocupacional, si total o parcial, de cuatro o más días (RSA 281-A:22), en un informe suplemental de Employer's de lesión, forma No. 13 WCA, cuanto antes, pero no más adelante de diez días después de la fecha del conocimiento (RSA 281-A:53, i e II).
4 Le requieren equipar, o haga ser equipado, los servicios médicos y del hospital razonables, el otro cuidado remediador o los tipos vocacionales del rehabilitación, y varios de pensión por invalidez, a un empleado dañado o lisiado de acuerdo con RSA 281-A:23, 25, 26, 28, 29, 31, 32.
5 Todos los patrones con empleados 5 o más a tiempo completo desarrollarán las oportunidades alternativas temporales del trabajo para los empleados dañados de acuerdo con RSA 281-A:23-b. Los patrones pueden ser obligados reinstalar a empleados que sostienen lesión compensable de acuerdo con RSA 281-A:25-a.
6 Le requieren obtener del portador identificado debajo de una fuente de las formas de la remuneración de todos los trabajadores requeridos. AVISO - la violación de las varias provisiones de la ley de la remuneración de los trabajadores lleva penas, multas de la corte, o ambas civiles.

Rudolph W. Ogden III
Deputy Commissioner

Ken Merrifield
Commissioner of Labor

El patrón infrascrito da por esté medio el aviso de la conformidad con todas las provisiones de la ley de la remuneración de los trabajadores y de las regulaciones administrativas de la comisión de trabajo del estado de New Hampshire conforme a los estatutos revisados anotados, capítulo 281-A, según la enmienda prevista.

Nombre de la compañía de seguros
O uno mismo-asegurador:

Nombre del patrón:

Por _____

_____
No. De la Identificación Del Patrón.
(si desconocido, patrón del número a solicitar el IRS)

Este aviso se debe fijar visible en y sobre el lugar de Employer's o los lugares del negocio
Prescrito por la comisión de trabajo
Estado de New Hampshire
WCP-1 (04-14)

State of New Hampshire
Department of Labor

Criteria to Establish an Employee or Independent Contractor

"Employee" means and includes every person who may be permitted, required, or directed by any employer, in consideration of direct or indirect gain or profit, to engage in any employment, but shall not include any person exempted from the definition of employee as stated in RSA 281-A:2, VI(b)(2), (3), or (4), or RSA 281-A:2, VII(b), or a person providing services as part of a residential placement for individuals with developmental, acquired, or emotional disabilities, or any person who meets all of the following criteria:

(a) The person possesses or has applied for a federal employer identification number or social security number, or in the alternative, has agreed in writing to carry out the responsibilities imposed on employers under this chapter.

(b) The person has control and discretion over the means and manner of performance of the work, in that the result of the work, rather than the means or manner by which the work is performed, is the primary element bargained for by the employer.

(c) The person has control over the time when the work is performed, and the time of performance is not dictated by the employer. However, this shall not prohibit the employer from reaching an agreement with the person as to completion schedule, range of work hours, and maximum number of work hours to be provided by the person, and in the case of entertainment, the time such entertainment is to be presented.

(d) The person hires and pays the person's assistants, if any, and to the extent such assistants are employees, supervises the details of the assistants' work.

(e) The person holds himself or herself out to be in business for himself or herself or is registered with the state as a business and the person has continuing or recurring business liabilities or obligations.

(f) The person is responsible for satisfactory completion of work and may be held contractually responsible for failure to complete the work.

(g) The person is not required to work exclusively for the employer.

INSPECTION DIVISION
P O BOX 2076
CONCORD NH 03302-2076
(603) 271-1492 & 271-3176

Rudolph W. Ogden, III
Deputy Commissioner

Ken Merrifield
Commissioner

THIS NOTICE MUST BE POSTED IN A CONSPICUOUS PLACE

Rev. 02-01-18

STATE OF NEW HAMPSHIRE
DEPARTMENT OF LABOR

WORKER'S RIGHT TO KNOW ACT

Revised Statutes Annotated Chapter 277-A, as amended

EMPLOYEES

YOU HAVE A RIGHT TO KNOW ABOUT TOXIC SUBSTANCES USED IN THIS WORKPLACE

The New Hampshire "Right to Know" law (RSA 277-A) guarantees that:

- You be notified by a posting of the long and short-term health hazards of all toxic substances that you may come into contact with.
- You be trained by your employer in the safe use and handling of these toxic materials.
- You have the right to request complete information, in the form of a Material Safety Data Sheet, from your employer on any toxic substance you may have contact with. Your employer must respond to this request within five working days.

To learn more about the toxic materials used in this workplace, and to obtain Material Safety Data Sheets, contact the employer representative listed below.

_____

(EMPLOYER REPRESENTATIVE'S NAME)

NH DEPARTMENT OF LABOR
PO BOX 2076
CONCORD NH 03302-2076

Rudolph W. Ogden, III
Deputy Commissioner

Ken Merrifield
Commissioner

Rev. 02-01-18

STATE OF NEW HAMPSHIRE DEPARTMENT OF LABOR

THE WHISTLEBLOWERS' PROTECTION ACT - RSA 275-E

An employer shall not discharge, threaten, or discriminate against any public or private employee

- If the employee, in good faith, reports or causes to be reported an alleged violation of any law or rule adopted under the laws of this state, a political subdivision of this state, or the United States;
- OR, the employee objects to or refuses to participate in any activity that the employee, in good faith, believes is a violation of the law or rule ;
- OR, the employee refuses to execute a directive which the employee, in good faith, believes violates any law or rule adopted under the laws of this state, a political subdivision of this state or the United States;
- OR, the employee participates in an investigation, hearing, or inquiry conducted by any governmental entity or any court action which concerns allegations that the employer has violated any law or rule adopted under the laws of this state, a political subdivision of this state, or the United States.

RIGHTS AND REMEDIES - RSA 275-E:4

After the employee has made a reasonable effort to maintain or restore his/her rights through any grievance procedure or similar process available with the employer

And has filed the written complaint with the New Hampshire Department of Labor.

He/she may request a hearing with the New Hampshire Department of Labor, which can result in a judgment to order reinstatement, payment of fringe benefits, seniority rights, and injunctive relief.

ADDITIONAL RIGHTS AND REMEDIES FOR PUBLIC EMPLOYEES ONLY - RSA 275-E:8 and 9

Public employees can issue complaints to the New Hampshire Department of Labor, who has the authority to investigate complaints or information concerning the possible existence of any activity constituting fraud, waste, or abuse in the expenditure of any public funds, whether state or local, or relating to programs and operations involving the procurement of any supplies, services, or construction by governmental entities within the state.

The identity of the person who filed the complaint shall not be disclosed without his or her written consent, unless such disclosure is to a law enforcement agency that is conducting a criminal investigation.

No governmental entity shall take any retaliatory action against a public employee who, in good faith, files a complaint under this section and the public employee shall be afforded all protections under RSA 275-E:2.

No governmental entity shall threaten, discipline, demote, fire, transfer, reassign, or discriminate against a public employee who files a complaint with the department of labor under RSA 275-E:8 or otherwise discloses or threatens to disclose activities or information that the employee reasonably believes violates RSA 275-E:2, represents a gross mismanagement or waste of public funds, property, or manpower, or evidences an abuse of authority or a danger to the public health and safety.

Inspection Division
PO Box 2076
Concord NH 03302-2076
Telephone – (603) 271-1492 & 271-3176

Rudolph W. Ogden, III
Deputy Commissioner

Ken Merrifield
Commissioner

Rev. 02-01-18

THIS NOTICE MUST BE POSTED IN A CONSPICUOUS PLACE

THE STATE OF NEW HAMPSHIRE
DEPARTMENT OF LABOR
SPAULDING BUILDING
95 PLEASANT STREET
CONCORD, NEW HAMPSHIRE 03301

NOTICE OF ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE 8aWCA

(Please print or type)

To_____ Phone #_____
(Name of **Employer**)

_____
(Business Name and Address)

IN ACCORDANCE WITH RSA 281-A:20, This is to notify you that an injury occurred.

_____ SS #_____
(Name of Injured **Employee**)

_____Daytime Phone #_____
(Address of Injured Employee)

_____
(Date of Accident or First Treatment)

_____
(Place Accident Happened)

Describe your injury or disease, and how it happened. Identify the body part(s) affected._____

_____

_____

_____

I have been unable to work since my injury. ☐ Yes ☐ No

I have incurred the following medical bills.

_____ Name of Doctor	_____ Dates of Service	_____ Amount
_____ Name of Hospital	_____ Dates of Service	_____ Amount
_____ Other	_____ Dates of Service	_____ Amount

_____ **(Employer's Signature)**

_____ **(Employee's Signature)**

_____ **(Date)**

_____ **(Date)**

This form can be returned to DOL with or without employer's signature.

NOTICE TO EMPLOYER

YOU MUST FILE AN EMPLOYER'S FIRST REPORT, Form No. 8WC, WITH THE LABOR COMMISSIONER AND THE NEAREST CLAIMS OFFICE OF YOUR INSURANCE CARRIER, AS SOON AS POSSIBLE AFTER ACQUIRING KNOWLEDGE OF THE OCCURRENCE OF AN OCCUPATIONAL INJURY OR DISEASE TO ONE OF YOUR EMPLOYEES OR UPON PRESENTATION OF THIS NOTICE BY HIM, BUT NO LATER THAN FIVE DAYS THEREAFTER. FAILURE TO COMPLY CARRIES AN AUTOMATIC CIVIL PENALTY OF UP TO $2500. (RSA 281-A:53)

THE SECOND INJURY FUND

The Second Injury Fund was established by the State of New Hampshire to encourage employers to employ people with previous injuries, illnesses or disabilities by offering the employer a limitation on workers' compensation liability with respect to these health conditions. This law is good for the employees who have previous impairments, restrictions, injuries, illnesses or disabilities and for the companies who employ them. All employers doing business in the State of New Hampshire are required to pay workers' compensation insurance. Insurance companies that write workers' compensation insurance in the State of New Hampshire pay into the Second Injury Fund based on the percentage of workers' compensation insurance business they write in the state. The amount of money in this fund is determined yearly, based on the amount of money needed to reimburse the insurance companies.

We can apply for the Second Injury Fund only when an employee injured on the job has a **documented** previous impairment, restriction, injury, illness or disability. By applying for the Second Injury Fund, we may be able to recoup some of the money paid on the claim, thereby reducing the cost of our workers' compensation insurance. It is important to point out that an application to the Second Injury Fund by us in **no way** affects an employee's workers' compensation benefits.

We need your voluntary cooperation to place us in a position to be able to reduce our workers' compensation insurance costs. In order to take advantage of this fund, we must have prior written documentation of any previous impairment, restriction, injury, illness, or disability. This information will be handled in a strictly confidential manner.

Please describe any preexisting impairments, restrictions, limitations, injuries, illnesses or disabilities with dates: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature: _____ Date: _____

SECOND INJURY FUND SWORN STATEMENT OF EMPLOYER

Pursuant to N.H. RSA 281-A:54, III and N.H. Admin. Rule Lab 506.04(d)(1), I, the undersigned,

_____, of _____
(Name) (Company)

under the penalties of perjury, attest that the attached documents are true copies of the records of

said company regarding _____
(employee's name)

I further attest that these attached records pre-date the date of the work-related injury that is the basis for reimbursement by the Second Injury Fund.

_____ _____
Employer's Signature Date

****

I hereby certify that _____appeared before me on this _____day of _____in the year____ and attested, under penalty of perjury, that the attached record(s) are true copies of the employer's records.

By _____
(Notary Public)

LAB 500

THE STATE OF NEW HAMPSHIRE

DEPARTMENT OF LABOR

CONCORD, NH 03301

WAGE SCHEDULE

Employee_____
(Name)

Date of hire_____ Wages per hour_____ Avg. wkly. earnings_____

Employer_____
(Name)

Address_____ _____ _____
(No.) (Street) (City – State)

EMPLOYER MUST FORWARD TO INSURANCE CARRIER A COPY OF THIS WAGE SCHEDULE OR A PRINTOUT OF GROSS WAGES NO LATER THAN EMPLOYEE'S FIFTEENTH DAY OF DISABILITY RESULTING FROM INDUSTRIAL ACCIDENT.PER LAB 506.02(b)

THIS WAGE SCHEDULE IS FOR 52 WEEKS PRIOR TO DATE OF INJURY AND MUST BE FILED WITH DEPARTMENT OF LABOR BY INSURANCE CARRIER TOGETHER WITH 9 WCA.

WEEK ENDING		1 GROSS WAGES (See Wages Definition)	WEEK ENDING		2 GROSS WAGES
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		

CarrierName_____ _____
(Employer's Signature)

Address_____
(Title)

Dept. Approval _____ Date _____

GROSS WAGES: In addition to money payments, means reasonable value of board, rent, housing, lodging, fuel or similar advantage received in the course of employment plus gratuities from others, but not including any sum paid by the employer to cover any special expenses entailed by the employee by the nature of his employment. Please provide a brief explanation for weeks with no wages. RSA 281-A:2, Par XV