AmTrust North America
An AmTrust Financial Company

Oregon
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.

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

Workers' Compensation Posting Requirements

Thank you for placing your Workers' Compensation Coverage with AmTrust.

Oregon Required Posting Notices

Post at place of employment, in a sufficient number of places on the premises to assure that the notice will reasonably be seen by all employees at all business locations and work sites (Break Room, Lunch Room or Time Clock) Employees that may not reasonably be expected to see a posted notice must receive notice of the posting in writing.

- Workers' Compensation Notice of Compliance Poster Employers must submit an order request (at no cost, see link) for new posters whenever they have obtained a new WC Carrier. The posters are custom printed and mailed from a state print shop.

The following forms need to be completed and submitted to AmTrust when a work-related injury occurs:

- **Report of Job Injury or Occupational Disease - Form 440-801.** Your employee must complete the top portion of this form and the employer must complete the bottom half of the form. You need to provide a copy of this form to your injured employee, and you should keep a copy for your records. You need to notify AmTrust within five (5) days of knowledge of the claim. You need to use this form to notify AmTrust of any work-related injury or occupational disease suffered by an employee, regardless of severity. Work-related fatalities and catastrophes must be reported to Oregon OSHA within eight (8) hours and any accident that results in overnight hospitalization must be reported to Oregon OSHA within 24 hours.
- **Optum First Fill Form.** Use of this form will enable quick authorization for your employee's initial medication and ensure that the initial prescription is provided at no cost to the injured employee. Immediately upon receiving notice of injury, fill in the information on this form and give this form to the employee.Your employee will need to provide this completed form along with the prescription for their work-related injury or occupational disease to the pharmacist.
- **Statement of Wages/Salary.** This form enables us to calculate the correct compensation that may be owed to an injured employee. Please complete this form and submit to AmTrust within five days after your knowledge of any accident that has caused your employee to be disabled for more than seven scheduled work calendar days

The following documents need to be provided to your employee when he/she sustains a work-related injury:

- **A Guide for Workers Recently Hurt on the Job - Form 440-3283.** You are required to provide this guide to all employees injured on the job. This guide provides the injured employee with the following types of information: How to file a claim, How to get medical treatment, Limitations on medical treatment, Workers' compensation benefits in general and where to get information about their claim.
- **Notice to Worker, Form 440-3058.** Employer is required to provide this notice to all employees injured on the job.

You may send an email to clientservices@amtrustgroup.com with any Claims Kit related questions. Please make sure to include your policy number along with your request.

I have a question about a claim or injured worker, who do I contact?

Customer Service can direct you to the appropriate person. Please contact them at 888-239-3909.

AmTrust is AmTrust Financial Services, Inc., located at 59 Maiden Lane, New York, NY 10038. Coverages are provided by its affiliated property and casualty insurance companies. Consult the applicable policy for specific terms, conditions, limits and exclusions to coverage. For full legal disclaimer information, including Texas and Washington writing companies, visit: www.amtrustfinancial.com/about-us/legal-disclaimer.

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** Compliance Information **

THE STATE OF OREGON REQUIRES EVERY EMPLOYER POST A NOTICE OF COMPLIANCE POSTER.

THE NOTICE OF COMPLIANCE POSTER CAN ONLY BE OBTAINED BY THE EMPLOYER.

THE EMPLOYER CAN CALL THE OREGON WORKERS COMPENSATION DIVISION TOLL FREE AT **888-877-5670** TO REQUEST THE POSTER OR ORDER ONLINE FROM THE FOLLOWING WEBSITE ADDRESS:

https://wcd.oregon.gov/employer/Pages/noc-poster.aspx

THIS POSTER IS AVAILABLE FREE OF CHARGE

Insert self-insured employer and insurer name, address, phone number, and service company, if any.

Report of Job Injury or Illness

Workers' compensation claim

Worker

To make a claim for a work-related injury or illness, fill out the worker portion of this form and give it to your employer. **If you do not intend to file a workers' compensation claim with the insurance company, do not sign the signature line.** Your employer will give you a copy.

Date of injury or illness:	Date you left work:	Time you began work on day of injury: ☐ a.m. ☐ p.m.	Regularly scheduled days off:	**DEPT USE:** Emp
Time of injury or illness: ☐ a.m. ☐ p.m.	Time you left work: ☐ a.m. ☐ p.m.	Check here if you have more than one job: ☐	☐☐☐☐☐☐☐ M T W T F S S	Ins
What is your illness or injury? What part of the body? Which side? (Example: Sprained right foot) ☐ Left ☐ Right				Occ Nat
What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: Fell 10 feet when climbing an extension ladder carrying a 40-pound box of roofing materials)				Part Ev Src 2src

Information ABOVE this line; date of death, if death occurred; and Oregon OSHA case log number must be released to an authorized worker representative upon request.

Your legal name:	Language preference:	Birthdate:	Gender: M ☐ F ☐
Your mailing address:			
Home phone:	Work phone:	Occupation:	
Names of witnesses:			

Name and phone number of health insurance company:	Name and address of health care provider who treated you for the injury or illness you are now reporting:
Were you hospitalized overnight? ☐ Yes ☐ No	
Were you treated in the emergency room? ☐ Yes ☐ No	

By my signature, I am making a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers and other custodians of claim records to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. **Notice:** Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law requires separate authorization.

I understand I have a right to see a health care provider of my choice subject to certain restrictions under ORS 656.260 and ORS 656.325.

Worker signature:	Completed by (please print):	Date:

Employer

Complete the rest of this form and give a copy of the form to the worker. Even if the worker does not want to file a claim, keep a copy of this form.

Employer legal business name:	Phone:	FEIN:
If worker leasing company, list client business name:		Client FEIN:
Address of principal place of business (not P.O. Box):		Insurance policy no.:
Street address from which worker is/was supervised:	ZIP:	Nature of business in which worker is/was supervised:
Address where event occurred:		
Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No		

Were other workers injured? ☐ Yes ☐ No			OSHA 300 log case no:	
Date employer knew of claim:	Date worker returned to work:	Worker's weekly wage: $	Date worker hired:	If fatal, date of death:

By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. **I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.**

Employer signature:	Name and title (please print):	Date:

OSHA requirements: Employers must report work-related fatalities and catastrophes to Oregon OSHA either in person or by telephone within eight hours. In addition, employers must report any in-patient hospitalization, loss of an eye, and any amputation or avulsion that results in bone or cartilage loss to Oregon OSHA within 24 hours. See OAR 437-001-0704. Call 800-922-2689 (toll-free), 503-378-3272, or Oregon Emergency Response, 800-452-0311 (toll-free), on nights and weekends.

Insert self-insured employer and insurer name, address, phone number, and service company, if any.

Reporte de Lesión o Enfermedad en el Trabajo

(Report of Job Injury or Illness)

Reclamación de compensación para trabajadores

(Workers' compensation claim)

Trabajador (Worker)

Para hacer una reclamación por una lesión o enfermedad ocupacional, llene la parte de esta forma que corresponde al trabajador y entregela a su empleador. **Si usted no quiere hacer una reclamación de compensación para trabajadores con la aseguradora, no firme en la línea dejada para su firma.** Su empleador le dará una copia. (To make a claim for a work-related injury or illness, fill out the worker portion of this form and give to your employer. **If you do not intend to file a workers' compensation claim with the insurance company, do not sign the signature line.** Your employer will give you a copy.)

Fecha de la lesión o enfermedad (Date of injury or illness):	Fecha que dejó el trabajo (Date you left work):	Hora que empezó a trabajar el día de la lesión (Time you began work on day of injury): ☐ a.m. ☐ p.m.	Días que regularmente no trabaja (Regularly scheduled days off) ☐☐☐☐☐☐☐ M T W T F S S	**DEPT USE:** Emp
Hora en la que ocurrió la lesión o enfermedad (Time of injury or illness): ☐ a.m. ☐ p.m.	Hora que dejó el trabajo (Time you left work): ☐ a.m. ☐ p.m.	Marque este casillero si usted tiene más de un trabajo. (Check here if you have more than one job): ☐		Ins
¿Cuál es su lesión o enfermedad? ¿En qué parte del cuerpo? ¿En qué lado? (Ejemplo: torcedura del pie derecho) What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) ☐ Izquierdo (Left) ☐ Derecho (Right)				Occ
				Nat
				Part
¿Cuál fue la causa? ¿Qué estaba haciendo? Incluya vehículo, maquinaria o herramienta usada. (Ejemplo: caí diez pies mientras subía una escalera de extención cargando una caja de materiales que pesaba 40 libras) What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: fell ten feet when climbing an extension ladder carrying a 40-lb. box of roofing materials)				Ev
				Src
				2src

Information ABOVE this line; date of death, if death occurred; and OR-OSHA case log number must be released to an authorized worker representative upon request.

Su nombre legal (Your legal name):	Idioma de preferencia (Language preference):	Fecha de nacimiento (Birthdate):	Sexo (Gender): M ☐ F ☐
Su dirección postal (Your mailing address):			
Teléfono del domicilio (Home phone):	Teléfono del trabajo (Work phone):	Ocupación (Occupation):	
Nombres de testigos (Names of witnesses):			

Nombre y número de teléfono de la compañía aseguradora de salud (Name and phone number of health insurance company):	Nombre y dirección del proveedor médico que le trató de la lesión o enfermedad que usted está ahora reportando (Name and address of health care provider who treated you for the injury or illness you are now reporting):
¿Estuvo hospitalizado como paciente durante la noche? (Were you hospitalized overnight as an inpatient?) ☐ Si ☐ No	
¿Recibió tratamiento en la sala de emergencia? (Were you treated in the emergency room?) ☐ Si ☐ No	

Con mi firma, estoy presentando una reclamación para beneficios de compensación para trabajadores. La información arriba provista es verdadera en el mejor de mi conocimiento y creencia. Yo autorizo a proveedores médicos y a otros custodios de los récords de mi reclamación para emitir los expedientes médicos pertinentes a la aseguradora de compensación para trabajadores, empleador asegurado por sí mismo, administrador de reclamaciones, y al Departamento para Consumidores y Negocios de Oregon. **Aviso:** Los expedientes médicos pertinentes incluyen registros de tratamiento anterior por las mismas condiciones o lesiones a la misma parte del cuerpo. Una autorización de HIPAA no es requerida (45 CFR 164.512(I)). Para emitir récords sobre el HIV/AIDS (SIDA), ciertos récords de tratamiento de drogadicción o alcoholismo, y otros récords protegidos por la ley estatal o federal se requiere una autorización separada.

Yo entiendo que tengo el derecho de ver un proveedor para el cuidado de salud de mi elección sujeto a ciertas restricciones bajo ORS 656.260 y ORS 656.325.

(**By my signature,** I am making a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers and other custodians of claim records to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. **Notice:** Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization.)

I understand I have a right to see a health care provider of my choice subject to certain restrictions under ORS 656.260 and ORS 656.325.

Firma del trabajador (Worker signature):	Completada por (Completed by) Por favor escriba (please print):	Fecha (Date):

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

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:

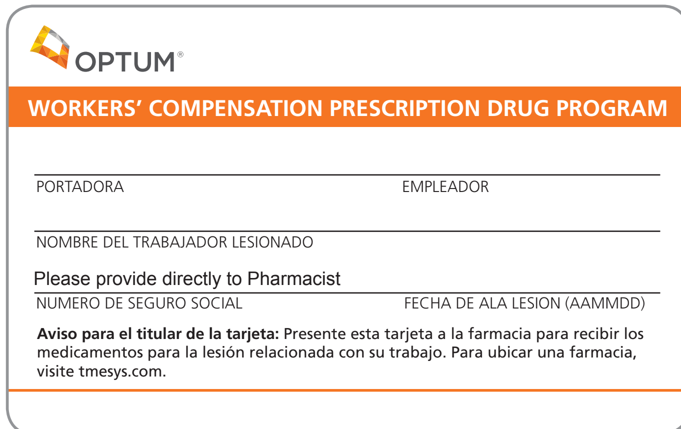
Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

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

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					

Workers' Compensation Division
Department of Consumer and Business Services

A Guide for Workers Recently Hurt on the Job

How do I file a claim?

- Notify your employer and a health care provider **of your choice** about your job-related injury or illness as soon as possible. Your employer cannot choose your health care provider for you.
- Ask your employer the name of its workers' compensation insurer.
- Complete **Form 801, "Report of Job Injury or Illness,"** available from your employer and **Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claims,"** available from your health care provider.

How do I get medical treatment?

- You may receive medical treatment from the health care provider **of your choice**, including:
  - Authorized nurse practitioners
  - Chiropractic physicians
  - Medical doctors
  - Naturopathic physicians
  - Oral surgeons
  - Osteopathic physicians
  - Physician associates
  - Podiatric physicians
  - Other health care providers
- The insurance company may enroll you in a managed care organization at any time. If it does, you will receive more information about your medical treatment options.

Are there limitations to my medical treatment?

- **Health care providers may be *limited* in how long they may treat you and whether they may authorize payments for time off work.** Check with your health care provider about any limitations that may apply.
- **If your claim is denied, you may have to pay for your medical treatment.**

If I can't work, will I receive payments for lost wages?

- You may be unable to work due to your job-related injury or illness. In order for you to receive payments for time off work, your health care provider must send written authorization to the insurer.
- Generally, you will not be paid for the first three calendar days for time off work.
- You may be paid for lost wages for the first three calendar days if you are off work for 14 consecutive days or hospitalized overnight.
- If your claim is denied within the first 14 days, you will not be paid for any lost wages.
- Keep your employer informed about what is going on and cooperate with efforts to return you to a modified- or light-duty job.

What if I have questions about my claim?

- The insurance company or your employer should be able to answer your questions.
- If you have questions, concerns, or complaints, you may also call any of the numbers below:

  Ombuds Office for Oregon Workers:
  An advocate for injured workers
  Toll-free: 800-927-1271
  Email: oow.questions@dcbs.oregon.gov

  Workers' Compensation Resolution Section
  Toll-free: 800-452-0288
  Email: workcomp.questions@dcbs.oregon.gov

The collection and use of your Social Security number (SSN): You do not need to have an SSN to get workers' compensation benefits. If you have an SSN, the Workers' Compensation Division (WCD) of the Department of Consumer and Business Services will get it from your employer, the workers' compensation insurer, or other sources. WCD may use your SSN for the following: quality assessment, correct identification and processing of claims, compliance, research, injured worker program administration, matching data with other state agencies to measure WCD program effectiveness, injury prevention activities, and to provide to federal agencies in the Medicare program for their use as required by federal law. The following laws authorize WCD to get your SSN: the Privacy Act of 1974, 5 USC § 552a, Section (7)(a)(2)(B); Oregon Revised Statutes chapter 656; and Oregon Administrative Rules chapter 436 (Workers' Compensation Board Administrative Order No. 4-1967).

440-3283 (6/24/DCBS/WCD/WEB)

WCD | División de Compensación para Trabajadores
Departamento de Servicios para Consumidores y Negocios

Una Guía para Trabajadores Lesionados Recientemente en el Trabajo

¿Cómo presento un reclamación?

- Lo más pronto posible notifique de su lesión o enfermedad en el trabajo a su empleador y a un proveedor médico **de su elección**. Su empleador no puede elegir el proveedor médico para usted.
- Pregunte a su empleador el nombre de su compañía de compensación para trabajadores.
- Complete la **Forma 801, "Reporte de Lesión o Enfermedad en el Trabajo"** la forma puede ser obtenida de su empleador. También llene la **Forma 827, "Reporte del Trabajador y del Proveedor Médico para Reclamaciones de Compensación para Trabajadores"** esta forma puede ser obtenida de su proveedor médico.

¿Cómo obtengo tratamiento médico?

- Usted puede recibir tratamiento médico de un proveedor médico **de su elección,** incluyendo:
  - Enfermeras(os) practicantes autorizadas(os)
  - Médicos Quiroprácticos
  - Médicos
  - Médicos Naturopáticos
  - Cirujanos Orales
  - Médicos Osteopáticos
  - Médicos Asociados
  - Médicos Podólogos
  - Otros proveedores médicos
- La compañía de seguros puede inscribirlo en una organización de manejo del cuidado médico a cualquier momento. Si la compañía lo hace, usted recibirá más información acerca de las opciones para tratamiento médico.

¿Existen limitaciones en mi tratamiento médico?

- **Los proveedores de cuidado médico pueden tener *limitaciones* en cuanto a la duración de su tratamiento y en cuanto a la autorización de pago por tiempo fuera del trabajo.** Pregunte a su proveedor médico cuales son las limitaciones que pueden aplicarse.
- **Si su reclamación es negada, es posible que usted tenga que pagar por su tratamiento médico.**

Si no puedo trabajar, ¿recibiré pagos por salario perdido?

- Es posible que no pueda trabajar debido a su lesión o enfermedad relacionada con el trabajo. Para que usted pueda recibir pago por tiempo fuera del trabajo, su proveedor médico debe enviar una autorización escrita a la aseguradora.
- Generalmente, usted no recibirá pagos por tiempo perdido por los tres primeros días calendarios.
- Es posible que reciba pago por los tres primeros días calendarios, si usted pierde de trabajar por 14 días consecutivos, o es hospitalizado durante un día incluyendo la noche.
- Si su reclamación es negada dentro de los primeros 14 días, no se le pagará por ningún salario perdido.
- Mantenga informado a su empleador acerca del estado de la reclamación y coopere con los esfuerzos para que regrese a trabajar en un trabajo modificado o liviano.

¿A quién puedo llamar si tengo preguntas acerca de mi reclamación?

- La compañía de seguros o su empleador pueden responder a sus preguntas.
- También puede llamar a los siguientes números:

  Oficina del Ombuds para Trabajadores de Oregon:
  Número gratuito: 800-927-1271
  Email: oow.questions@dcbs.oregon.gov

  Sección de Resolución de Compensación para Trabajadores:
  Número gratuito: 800-452-0288
  Email: workcomp.questions@dcbs.oregon.gov

La colección y uso de su número de seguro social: Usted no necesita tener un número de seguro social para recibir beneficios de compensación para trabajadores. Si usted tiene número de seguro social, la División de Compensación para Trabajadores (WCD) del Departamento de Servicios para Consumidores y Negocios lo obtendrá de su empleador, de su aseguradora de compensación para trabajadores, o de otros recursos. WCD puede usar su número de seguro social para lo siguiente: intercambio de datos con el Departamento de Empleo, corregir identificación y procesamiento de reclamaciones, cumplimiento, investigación, administración de un programa para trabajadores lesionados, comparación de datos con otras agencias del estado para medir la efectividad de programas de WCD, actividades para prevención de lesiones, y para proveerlo a agencias federales en el programa de Medicare para su uso como está requerido por la ley federal. Las siguientes leyes autorizan a WCD a obtener su número de seguro social: the Privacy Act of 1974, 5 USC § 552a, Section (7)(a)(2)(B); Oregon Revised Statutes chapter 656; and Oregon Administrative Rules chapter 436 (Workers' Compensation Board Administrative Order No. 4-1967).

440-3283s (6/24 tr 6/24/DCBS/WCD/WEB)

Notice to Worker

Oregon law requires your employer's insurer to provide this information. [Oregon Revised Statute (ORS) 656.262(6)]

The notice of acceptance must tell you what medical conditions are accepted and whether your claim is disabling or nondisabling.

Nondisabling claims – reclassification review
Generally, if your claim has been classified as nondisabling, that means the insurer concluded no disability payments are due and all of the following are true:

- You were able to return to work at full wages on or before the fourth calendar day after leaving work or losing wages as a result of your injury.
- You did not lose time or wages from work as a result of your injury on or after that fourth calendar day.
- It appears you will not have any permanent disability as a result of your injury.

If you think the insurer made a mistake in classifying your claim as nondisabling, you have the right to object to that decision by requesting reclassification under ORS 656.277. You need to contact the insurer and request reclassification within one year of the date the insurer accepted your claim. The insurer must complete its review and send you its decision within 14 days of receiving your request. If the insurer's decision is that your claim is correctly classified as nondisabling and you still disagree, you have the right to request – within 60 days of the date of the insurer's notice – that the Workers' Compensation Division review your claim to determine if the nondisabling classification is correct. If the insurer does not respond to your request for reclassification within 14 days of receiving your request, you may ask the division to review the classification of your claim.

Nondisabling claims – aggravation (worsening) of injury-caused conditions
If your claim is nondisabling, you may be entitled to benefits for an aggravation if your injury-related condition worsens. Ask your doctor for Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claims," and check the box "Report of aggravation of original injury." Complete and sign your section of the form and give it to your doctor. Your doctor will complete the remainder of the form and send it to the insurer. If your injury remains nondisabling for at least one year after the date your claim was accepted, your aggravation rights will expire five years after the date of your injury.

After your aggravation rights expire, you are entitled to limited benefits.

Employment reinstatement rights and responsibilities under ORS chapter 659A
In most cases, ORS 659A.043 requires an employer with more than 20 employees to reinstate a permanent worker when the worker's attending physician or authorized nurse practitioner has approved the worker's return to regular work or other suitable work. For purposes of reinstatement rights, your attending physician is the doctor or physician assistant who is primarily responsible for the treatment of your injury, as described in ORS 656.005(12). If your employer at the time of your injury (employer at injury) is required to reinstate workers, your employer at injury must return you to the job you were doing at the time of your injury upon your request to be reinstated, unless that job no longer exists, that job is unavailable, or your work-related disabilities prevent you from doing your former duties. A job is "available" even if filled by a replacement worker during your absence. If your job is not available, your employer must return you to any other existing position that is vacant and suitable.

A certificate from your attending physician or authorized nurse practitioner stating that you can return to your regular job or other suitable job is enough evidence that you are able to do the job. However, your reinstatement rights may be limited by seniority rights and other employment restrictions contained in a valid collective bargaining agreement between your employer and an employee representative.

Within five days after your attending physician or authorized nurse practitioner notifies the insurer that you are released to return to work, the insurer must inform you about the opportunity to request work with your employer-at-injury.

You will lose your right to be reinstated to your regular job if any of the following are true:

- Your attending physician, or a medical arbiter determines that you are medically stationary, but not physically able to return to your regular job.
- You are eligible for and participate in vocational assistance under ORS 656.340.
- You accept a suitable job with another employer after becoming medically stationary.
- You refuse a bona fide offer from your employer of suitable light duty or modified employment before you become medically stationary.
- You did not request reinstatement within seven days of receiving certified mail from the insurer notifying you that your attending physician or authorized nurse practitioner approved you to return to your regular work or other suitable work.
- Three years have passed since your date of injury.
- You are fired for valid reasons not connected with the injury and for which others are or would be discharged.
- You clearly abandoned employment with the employer.

Reinstatement rights do not apply if any of the following are true:

- You were hired on a temporary basis as a replacement for an injured worker.
- You are a seasonal worker employed to perform less than six months' work in a calendar year.
- Your job at injury resulted from a referral to short-term employment from a hiring hall operating under a collective bargaining agreement.
- Your employer has 20 or fewer workers at the time of your injury **and** at the time of your demand for reinstatement.

If you have questions or complaints related to your reinstatement rights, contact the Oregon Bureau of Labor and Industries (BOLI). Contact information for BOLI is located at the end of this notice.

Re-employment assistance under ORS 656.622

The division has a re-employment assistance program: **The Employer-at-Injury Program provides Oregon's qualified injured workers help with staying on the job or getting back to work. Because of your injury, your employer may be eligible for assistance to return you to transitional work through this program while your claim is open. Your employer may contact [insurer name and phone number].**

Reimbursement for your injury-related expenses, OAR 436-009-0025

The insurer will reimburse you for claim-related expenses, such as prescriptions, transportation, meals, and lodging necessary to attend medical appointments, with some limitations and up to a maximum amount. You must request reimbursement in writing and include copies of receipts or other supporting

documentation as required by the insurer. The insurer must receive your request for reimbursement within two years of the date you paid for the expense or within two years of the date your claim is determined compensable, whichever is later. Form 3921 “Request for Reimbursement of Expenses” is available at wcd.oregon.gov or the insurer may provide a form for requesting reimbursement.

Omitted medical conditions or incorrect notices of acceptance

If you think a medical condition was not included in the notice of acceptance, or the notice is incomplete or incorrect, you must notify the insurer in writing. Explain why you think the notice of acceptance is wrong. You may notify the insurer using Form 827 – see under “New medical condition” below.

New medical condition

If you develop a new medical condition that you believe should be accepted under your claim after your claim has been accepted, you must write to the insurer, identify the condition as being a “new medical condition,” and request formal written acceptance of the condition. You may notify the insurer using Form 827 – see below.

- Requesting new or omitted medical conditions using Form 827, “Worker’s and Health Care Provider’s Report for Workers’ Compensation Claim”: Ask your health care provider for Form 827, complete your section of the form, check the box “Request for acceptance of a new or omitted medical condition on an existing claim,” indicate what condition you believe should be accepted, sign the form, and return the form to your doctor so it can be forwarded to the insurer.

Expedited claim service, ORS 656.291

If you disagree with actions taken in your claim, and your claim qualifies, you may be entitled to an expedited hearing by the Hearings Division of the Workers’ Compensation Board within 30 days of your request for hearing if any of the following is true:

- The dispute does not involve the compensability of or responsibility for your claim, and the total amount in dispute (not including any penalties and attorney fees) is $1,000 or less.
- The only issue in the dispute is the entitlement to penalties or related attorney fees.
- The dispute arose because your claim was denied under ORS 656.262(15) due to the insurer’s belief that you did not cooperate with its investigation.

If you have questions about your claim, contact your employer or insurer. If you have additional questions, contact one or more of the following:

Oregon Department of Consumer and Business Services

Workers’ Compensation Division, 350 Winter St. NE, P.O. Box 14480, Salem, OR 97309-0405
503-947-7585, or toll-free, 800-452-0288

Ombuds Office for Oregon Workers, 350 Winter St. NE, P.O. Box 14480, Salem, OR 97309-0405
503-378-3351, or toll-free, 800-927-1271

Oregon Bureau of Labor & Industries

Phone: 971-673-0761, email: BOLI_help@boli.oregon.gov, website: oregon.gov/boli

Aviso al Trabajador

La ley de compensación para trabajadores de Oregon requiere que la aseguradora de su empleador le provea esta información. [Estatuto Revisado de Oregon (ORS) 656.262(6)]

El aviso de aceptación debe decirle cuales son las condiciones médicas aceptadas y si su reclamación es incapacitante o no incapacitante.

Reclamaciones no incapacitantes – revisión de reclasificación
Generalmente si su reclamación ha sido clasificada como "lesión no incapacitante" significa que la aseguradora concluyó que no habrá pagos por incapacidad y que sucedió lo siguiente:

- Usted pudo regresar a trabajar y recibir la totalidad de su sueldo en/o antes del cuarto día calendario después de haber dejado de trabajar o de no haber ganado sueldo como resultado de la lesión.
- Usted no perdió tiempo de trabajo o sueldo como resultado de la lesión el cuarto día calendario o después del cuarto día.
- Parece que usted no tendrá algún tipo de incapacidad permanente como resultado de la lesión.

Si piensa que la aseguradora cometió un error clasificando su reclamación como no incapacitante, usted tiene derecho a objetar esa decisión solicitando una reclasificación conforme a ORS 656.277. Usted necesita ponerse en contacto con la aseguradora y pedir una reclasificación antes de que pase un año a partir de la fecha en que la aseguradora aceptó su reclamación. La aseguradora tiene que hacer la revisión y enviarle la decisión dentro de 14 días de recibir su solicitud. Si la decisión de la aseguradora es que su reclamación está correctamente clasificada como no incapacitante y usted aún no está de acuerdo, antes de que pasen 60 días a partir de la fecha del aviso de la aseguradora usted tiene derecho a solicitar que la División de Compensación para Trabajadores revise su reclamación para determinar si la clasificación de no incapacitante es correcta. Si la aseguradora no responde a su solicitud para reclasificación dentro de 14 días de haber recibido su solicitud, usted puede pedir a la división que revise la clasificación de su reclamación.

Reclamaciones no incapacitantes – agravación (empeoramiento) de las condiciones causadas por una lesión
Si su reclamación no es incapacitante, usted puede tener derecho a recibir beneficios si las condiciones causadas por la lesión empeoran. Pídale a su doctor el formulario 827, "Informe del Trabajador y el Proveedor Médico para Reclamaciones de Compensación para Trabajadores" ("Worker's and Health Care Provider's Report for Workers' Compensation Claims") y marque la opción "Agravación de la lesión original" ("Report of agravación of original injury"). Complete y firme la sección del formulario que a usted le corresponde y entrégueselo al doctor. Su doctor llenará el resto del formulario y lo enviará a la aseguradora. Si su lesión continúa siendo no incapacitante por lo menos por un año a partir de la fecha en que su reclamación fue aceptada, sus derechos de agravación vencerán cinco años después de la fecha de la lesión.

Después de que sus derechos de agravación expiran usted tiene derecho a beneficios limitados.

Derechos de reinstalación y responsabilidades conforme a ORS capítulo 659A

En la mayoría de los casos, ORS capítulo 659A.043 requiere que un empleador con más de 20 empleados reinstale a un trabajador permanente una vez que el doctor o enfermera(o) practicante autorizada(o) haya aprobado que el trabajador regrese a su trabajo regular o a otro trabajo apropiado. Para propósito de derechos de reinstalación su médico tratante es el doctor o asistente médico que es primariamente responsable por el tratamiento de su lesión, como está descrito en ORS 656.005(12). Si su empleador al momento de su lesión (empleador al momento de la lesión) está requerido a reinstalar trabajadores lesionados, su empleador debe regresarlo al trabajo que estuvo haciendo al momento de la lesión cuando usted pida regresar, a menos que ese trabajo ya no exista, no esté disponible, o su lesión en el trabajo no le permita realizar su trabajo previo. El trabajo se considera "disponible" aunque otro trabajador lo reemplace durante su ausencia. Si su trabajo no está disponible su empleador debe retornarle a cualquier otra posición existente que esté vacante y sea apropiada. Un certificado por parte de su doctor o enfermera(o) practicante autorizada(o) indicando que usted puede hacer su trabajo regular u otro trabajo apropiado es prueba suficiente de que usted puede realizar el trabajo. No obstante, sus derechos de reinstalación pueden estar limitados por derechos de antigüedad y otras restricciones de empleo descritas en un acuerdo de negociación colectiva válido entre el empleador y un representante del empleado.

Dentro de los cinco días posteriores a que su doctor o enfermera(o) practicante autorizada(o) notifique a la aseguradora que usted ha sido dado de alta y que puede regresar a trabajar, la aseguradora debe informarle sobre la oportunidad de solicitar trabajo con el empleador donde se lastimó.

Usted perderá su derecho de reinstalación a su trabajo regular si algo de lo siguiente sucede:

- Su doctor, enfermera(o) practicante, o un árbitro médico determina que usted está médicamente estacionario pero que no puede físicamente regresar a su trabajo regular.
- Usted reúne los requisitos y participa en un programa de asistencia vocacional conforme a ORS 656.340.
- Usted acepta un trabajo apropiado con otro empleador después de estar médicamente estacionario.
- Usted rechaza un ofrecimiento de buena fe de parte de su empleador para trabajo liviano o modificado antes de estar médicamente estacionario.
- Usted falla en solicitar la reinstalación dentro de los siete días a partir de la fecha en que recibió la carta certificada de la aseguradora informándole de la aprobación de su doctor o enfermera(o) practicante autorizada(o) para que regrese a trabajar en su trabajo regular u otro trabajo apropiado.
- Han pasado tres años desde la fecha de la lesión.
- Lo despiden por razones válidas no relacionadas con la lesión y por las cuales otros son o serían despedidos.
- Es claro que usted abandonó el trabajo con el empleador.

Los derechos de reinstalación no son aplicables si algo de lo siguiente sucede:

- Lo contrataron de manera temporal para reemplazar a un trabajador lesionado.
- Usted es un trabajador temporal empleado para trabajar menos de seis meses en un año calendario.
- Su trabajo al momento de la lesión resultó de una recomendación de empleo a corto plazo por parte de una oficina de empleo de un sindicato operando bajo un acuerdo de negociación colectiva.
- Su empleador tiene 20 o menos trabajadores al momento de su lesión **y** al momento de su solicitud de reinstalación.)

Si tiene preguntas o quejas con respecto a sus derechos de reinstalación, comuníquese con la oficina local del Departamento de Labor e Industrias de Oregon (Oregon Bureau of Labor and Industries - BOLI). La información para ponerse en contacto se encuentra al final de esta notificación.

Asistencia de re-empleo conforme a ORS 656.622
La división tiene un programa de asistencia para reempleo: **El Programa del Empleador Donde se Lesionó provee ayuda a los trabajadores lesionados de Oregon que reúnen los requisitos para permanecer o regresar al trabajo. Debido a su lesión, es posible que su empleador sea elegible para recibir asistencia para que usted regrese a un trabajo transicional por medio de este programa mientras su reclamación se encuentra abierta. Su empleador puede comunicarse con [nombre de la aseguradora y número de teléfono].**

Reembolso por gastos relacionados con su lesión de acuerdo a OAR 436-009-0025
La aseguradora le reembolsará por pagos que sean relacionados con los gastos de reclamación que usted haya realizado tales como medicamentos, transporte, comidas y alojamiento que sean necesarios para atender a citas médicas, con algunas limitaciones hasta cierta cantidad. Usted debe solicitar su reembolso por escrito e incluir copias de los recibos u otro tipo de documentos de respaldo que la aseguradora requiera. La aseguradora debe recibir su pedido para reembolso antes de que pasen dos años ya sea a partir de la fecha en la que usted pagó por el gasto, o de la fecha en que se determinó que su reclamación es compensable, la fecha que suceda más tarde. El formulario 3921 "Solicitud para Reembolso de Gastos" en wcd.oregon.gov o la aseguradora también puede proveerle el formulario para solicitar reembolso.

Condiciones médicas omitidas o avisos de aceptación incorrectos
Si piensa que una condición médica no fue parte del aviso de aceptación, o si el aviso es incompleto o incorrecto, usted debe notificar por escrito a la aseguradora. Explique por qué cree que el aviso de aceptación es incorrecto. Puede notificar a la aseguradora usando el Formulario 827, encuentre la información a continuación "Nueva Condición Médica".

Nueva condición médica
Si desarrolla una nueva condición médica después que su reclamación ha sido aceptada, usted debe notificar a la aseguradora por escrito identificando la condición como una "nueva condición médica (new medical condition)" y solicite una aceptación formal de la condición por escrito. Usted debe notificar a la aseguradora usando el Formulario 827 – mire la nota mencionada a continuación.

- Formulario 827 – Solicite condiciones médicas nuevas u omitidas usando el Formulario 827 "Reporte para Reclamación de Compensación para Trabajares y Proveedores del Cuidado de la Salud." Pida a su proveedor médico el Formulario 827, complete la parte que a usted le corresponde en el formulario, y marque el casillero "Solicitud para aceptación de una nueva u omitida condición médica en una reclamación existente" indique la condición que usted cree que debe ser aceptada, firme el formulario y devuélvaselo a su proveedor médico para que sea remitida a la aseguradora.

Servicio de audiencia acelerada, ORS 656.291
Si no está de acuerdo con las medidas tomadas en su reclamación, y su reclamación califica, usted puede tener derecho a recibir una audiencia acelerada ante la División de Apelación de Audiencias de la Junta Directiva de Compensación para Trabajadores antes de que pasen 30 días a partir de la fecha de su solicitud para una audiencia, si es que algo de lo siguiente sucede:

- La disputa no implica la compensabilidad o responsabilidad por su reclamación, y la cantidad total en disputa (sin incluir las multas y los honorarios de abogado) es menos de $1,000 dólares.
- El único problema en la disputa es el derecho a multas o los honorarios del abogado.
- La disputa surgió porque su reclamación fue negada de acuerdo a ORS 656.262(15) ya que la aseguradora cree que usted no cooperó con la investigación de su reclamación.

Si tiene preguntas sobre su reclamación, comuníquese con su empleador o con la aseguradora. Si tiene preguntas adicionales, comuníquese con una o más de las siguientes oficinas:

Departamento de Servicios para Consumidores y Negocios de Oregon

División de Compensación para Trabajadores
350 Winter St.NE, P.O. Box 14480, Salem, OR 97309-0405
503-947-7585, o gratis en Oregon, 800-452-0288

Oficina del Ombuds para Trabajadores de Oregon
350 Winter St.NE, P.O. Box 14480, Salem, OR 97309-0405
503-378-3351, o gratis, 800-927-1271

Departamento de Labor e Industrias

Teléfono: 971-673-0761, correo electrónico: BOLI_help@boli.oregon.gov, sitio web: oregon.gov/boli

Request for Reimbursement of Expenses

Complete this form, including your workers' compensation claim number, and send it to the insurer that processes your claim. Include copies of receipts for all items except private vehicle mileage. Incomplete requests will be returned for additional information. You must request reimbursement by whichever date is later: (a) two years from the date the costs were incurred or (b) two years from the date the claim or medical condition is finally determined compensable.

Name

Claim number

Mailing address | Apt. #

☐ This is a new address

City | State | ZIP | Phone ( ) -

P.O. Box | City | State | ZIP

TRANSPORTATION

Start location	End location	Medical provider	Trip miles	Date	
					TOTAL miles

MEALS

Date	Breakfast	City	Date	Lunch	City	Date	Dinner	City	
	$			$			$		
	$			$			$		
	$			$			$		$
									TOTAL meals reimbursement

LODGING

Hotel/motel name	Location	Date	Cost	
			$	
			$	
			$	$
				TOTAL lodging reimbursement

PRESCRIPTIONS

Name of medication	Doctor	Date	Cost	
			$	
			$	
			$	
			$	$
				TOTAL prescription reimbursement

By my signature, I certify that all information I have given in this request for reimbursement is true and contains no false statements or misrepresentations.

Signature of worker | Date

TOTAL miles

$
TOTAL meals, lodging, and prescription reimbursement

Standard rates for the continental United States:

<table>
<tr><th colspan="2">Lodging and meal rates effective Oct. 1, 2022 – Sept. 30, 2023</th><th>ALL private vehicle mileage effective July 1, 2022
62.5 cents per mile</th></tr>
<tr><td>Breakfast</td><td>$14.75</td><td rowspan="4">Previous mileage rates:
01/01/22 – 58.5 cents per mile
01/01/21 – 56 cents per mile
01/01/20 – 57.5 cents per mile
01/01/19 – 58 cents per mile</td></tr>
<tr><td>Lunch</td><td>$14.75</td></tr>
<tr><td>Dinner</td><td>$29.50</td></tr>
<tr><td>Lodging</td><td>$98.00</td></tr>
<tr><td colspan="3">Lodging rates do not include taxes. Room taxes are reimbursable in addition to the lodging allowance.</td></tr>
</table>

Lodging and meal rates exceed the standard rate in the following Oregon locations:

County	Effective dates	Max. lodging rate*	Meal rate**
Clackamas	10/01/22 – 05/31/23	$115	$64
	06/01/23 – 08/31/23	$138	$64
	09/01/23 – 09/30/23	$115	$64
Clatsop	10/01/22 – 01/31/23	$121	$69
	02/01/23 – 06/30/23	$131	$69
	07/01/23 – 08/31/23	$222	$69
	09/01/23 – 09/30/23	$121	$69
Deschutes	10/01/22 – 05/31/23	$120	$64
	06/01/23 – 08/31/23	$173	$64
	09/01/23 – 09/30/23	$120	$64
Lane	10/01/22 – 09/30/23	$122	$64
Lincoln	10/01/22 – 06/30/23	$131	$69
	07/01/23 – 08/31/23	$202	$69
	09/01/23 – 09/30/23	$131	$69
Multnomah	10/01/22 – 10/31/22	$182	$74
	11/01/22 – 05/31/23	$152	$74
	06/01/23 – 09/30/23	$182	$74
Washington	10/01/22 – 09/30/23	$136	$64

***Lodging rates do not include taxes. Room taxes are reimbursable in addition to the lodging allowance.**

****For meals, the following percentages must be used: breakfast -- 25%; lunch -- 25%; dinner -- 50%**

Rates obtained from Bulletin 112. See bulletin for more information.

Solicitud para reembolso de gastos
(Request for Reimbursement of Expenses)

Complete este formulario, incluya su número de reclamo de compensación para trabajadores y envíelo a su aseguradora. Incluya copias de los recibos de todos sus gastos excepto por millaje. Si su solicitud está incompleta le será regresada para que complete la información adicional. Debe solicitar reembolso antes de la fecha que venga después: (a) dos años a partir de la fecha en que se incurrió los costos o (b) dos años a partir de la fecha en que la reclamación o condición médica es finalmente determinada compensable.

(Complete this form, including your workers' compensation claim number, and send it to the insurer that processes your claim. Include copies of receipts for all items except personal vehicle mileage. Incomplete requests will be returned for additional information. You must request reimbursement by whichever date is later: (a) two years from the date the costs were incurred or (b) two years from the date the claim or medical condition is finally determined compensable.)

Nombre (Name)

Número de reclamo (Claim number)

Dirección postal (Mailing address) # de Apto. (Apt. #)

☐ Nueva dirección (This is a new address)

Ciudad (City) Estado (State) Código postal (Zip) Teléfono (Phone) ( ) -

Casilla Postal (P.O. Box) Ciudad (City) Estado (State) Código postal (ZIP)

TRANSPORTE (TRANSPORTATION)

Lugar de comienzo (Start location)	Destino Final (End location)	Proveedor de servicios medicos (Medical provider)	Millas (Trip miles)	Fecha (Date)	
					Reembolso total por millas (**TOTAL** miles)

COMIDAS (MEALS)

Fecha (Date)	Desayuno (Breakfast)	Ciudad (City)	Fecha (Date)	Almuerzo (Lunch)	Ciudad (City)	Fecha (Date)	Cena (Dinner)	Ciudad (City)	
	$			$			$		
	$			$			$		
	$			$			$		$
									Reembolso total por comidas (**TOTAL** meals reimbursement)

HOSPEDAJE (LODGING)

Nombre del hotel/motel (Hotel/motel name)	Ciudad (Location)	Fecha (Date)	Costo (Cost)	
			$	
			$	
			$	$
				Reembolso total por hospedaje (**TOTAL** lodging reimbursement)

Continua
(Continued)

RECETAS MÉDICAS (PRESCRIPTIONS)

Nombre de la medicina (Name of medication)	**Doctor que la recetó (Doctor)**	**Fecha (Date)**	**Costo (Cost)**	
			$	
			$	
			$	
			$	**$**
				Reembolso Total por prescripciones (**TOTAL** prescription reimbursement)

Con mi firma, Yo certifico que toda la información solicitada en este reembolso es verdadera y no contiene declaraciones o representaciones falsas.

(By my signature, I certify that all information I have given in this request for reimbursement is true and contains no false statements or misrepresentations.)

Total de millas (**TOTAL** miles)

Firma del trabajador (Signature of worker)

Fecha (Date)

$
Reembolso Total por comidas, hospedaje y prescripciones (**TOTAL** meals, lodging, and prescription reimbursement)

Estándares de tarifas en los Estados Unidos continentales:
(Standard rates for the continental United States:)

Tarifas de alojamiento y comidas en efecto desde el 1 de octubre del 2022 hasta el 30 de septiembre del 2023 (Lodging and meal rates effective Oct. 1, 2022 – Sept. 30, 2023)		**Millaje en TODOS los vehículos privados en efecto desde el Julio 1, 2022 62.5 centavos de dólar por milla** (ALL private vehicle mileage effective July 1, 2022 62.5 cents per mile)
Desayuno (Breakfast)	**$14.75**	**Tarifa de millaje previa:** (Previous mileage rates:)
Almuerzo (Lunch)	**$14.75**	**01/01/22 – 58.5 centavos por milla** (cents per mile)
Cena (Dinner)	**$29.50**	**01/01/21 – 56 centavos por milla** (cents per mile)
Alojamiento (Lodging)	**$98.00**	**01/01/20 – 57.5 centavos por milla** (cents per mile)
		01/01/19 – 58 centavos por milla (cents per mile)

Los impuestos de alojamiento son reembolsables aparte de la subvención de alojamiento. Las tarifas de alojamiento no incluyen impuestos.
(Lodging rates do not include taxes. Room taxes are reimbursable in addition to the lodging allowance.)

Las tarifas de alojamiento y comidas exceden las tarifas estándares en los siguientes condados de Oregon: (Lodging and meal rates exceed the standard rate in the following Oregon locations:)

Condado (County)	**Fechas (Effective dates)**	**Tarifas máximas de Alojamiento* (Max. lodging rate*)**	**Tarifas de comidas** (Meal rate**)**
Clackamas	10/01/22 – 05/31/23	$115	$64
	06/01/23 – 08/31/23	$138	$64
	09/01/23 – 09/30/23	$115	$64
Clatsop	10/01/22 – 01/31/23	$121	$69
	02/01/23 – 06/30/23	$131	$69
	07/01/23 – 08/31/23	$222	$69
	09/01/23 – 09/30/23	$121	$69
Deschutes	10/01/22 – 05/31/23	$120	$64
	06/01/23 – 08/31/23	$173	$64
	09/01/23 – 09/30/23	$120	$64
Lane	10/01/22 – 09/30/23	$122	$64
Lincoln	10/01/22 – 06/30/23	$131	$69
	07/01/23 – 08/31/23	$202	$69
	09/01/23 – 09/30/23	$131	$69
Multnomah	10/01/22 – 10/31/22	$182	$74
	11/01/22 – 05/31/23	$152	$74
	06/01/23 – 09/30/23	$182	$74
Washington	10/01/22 – 09/30/23	$136	$64

***Los impuestos de alojamiento son reembolsables aparte de la subvención de alojamiento. Las tarifas de alojamiento no incluyen impuestos.**
(*Lodging rates do not include taxes. Room taxes are reimbursable in addition to the lodging allowance.)

****Para comidas, debe utilizar los siguientes porcentajes: desayuno – 25%; almuerzo – 25%; cena – 50%**
(**For meals, the following percentages must be used: breakfast -- 25%; lunch -- 25%; dinner -- 50%)

Tarifas obtenidas del Boletín 112. Vea el boletín para más información.
(Rates obtained from Bulletin 112. See bulletin for more information.)

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!