AmTrust North America

An AmTrust Financial Company

South Carolina
Worker's Compensation
Claim Kit

AmTrust North America
An AmTrust Financial Company

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AmTrust INSURANCE

Workers' Compensation Claim Reporting Information

24/7 Toll Free Claim Reporting for All States

(888)239-3909

WorkersCompClaimReport@AmTrustgroup.com

www.amtrustfinancial.com

Information Required for All Claims Reported

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

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

How do I help my injured worker find a doctor?

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

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

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

Timely Reporting

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

We're Here To Help

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

Relax And Stay Positive

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

877.528.7878 I www.amtrustfinancial.com

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

AmTrust INSURANCE

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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.

South Carolina 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 Compliance Poster**
- **Anti-Fraud Notice (English and Spanish)**

The following forms need to be printed and reviewed with current staff and new employees at the time of hire:

- **First Report of Injury - Form 12A.** Upon receiving notification of a work-related injury, promptly complete this form and submit it to AmTrust. Report the Injury: Injured workers should notify their employers of the injury as soon as possible, ideally within 24 hours. South Carolina law requires workers to report the incident within 90 days of the accident, though exceptions may apply in certain circumstances. In the case of fatalities, reporting must occur within 24 hours. This form is required for notifying AmTrust of any work-related injury or illness experienced by an employee, no matter the severity.

- **Optum First Fill Form.** Use of this form will enable quick authorization for your employee's initial medication and ensure that the initial prescription is provided at no cost to the injured employee. Immediately upon receiving notice of injury, fill in the information on this form and give this form to the employee.Your employee will need to provide this completed form along with the prescription for their work-related injury or occupational disease to the pharmacist.

- **Statement of Wages/Salary.** This form enables us to calculate the correct compensation that may be owed to an injured employee. Please complete this form and submit to AmTrust within five days after your knowledge of any accident that has caused your employee to be disabled for more than seven scheduled work calendar days

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

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

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

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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February 20, 2014

South Carolina Workers' Compensation

Workers' Compensation Compliance Poster

We are operating under and subject to the South Carolina Workers' Compensation Act

In case of accidental injury or death to an employee, the injured employee, or someone acting in his or her behalf, must give immediate notice to the employer or general authorized agent. Failure to give such immediate notice may be the cause of serious delay in the payment of compensation to the injured employee or his or her dependents and may result in failure to receive any compensation benefits under the law.

Workers' Compensation:

1. Pays 100% of your medical bills and some other expenses.
2. Compensates you for 66 2/3% of your salary, limited to the maximum wage set by law, if you are unable to work for more than seven (7) calendar days.

If you are injured on the job, you should:

1. Notify your employer at once. You cannot receive benefits unless your employer knows you are injured.
2. Tell the doctor your employer sends you to that you are covered by workers' compensation.
3. Notify the Workers' Compensation Provider listed on this poster or the South Carolina Workers' Compensation Commission at 803.737.5700 if you experience undue delays or problems with your claim.

South Carolina
Workers' Compensation Commission
P.O. Box 1715, 1333 Main Street, Suite 500
Columbia, S.C. 29202-1715
803-737-5700
www.wcc.sc.gov

Workers' Compensation Provider Name

Mailing Address

Claims Telephone Number

WORKERS' COMPENSATION FRAUD.
YEAH, IT'S A BIG DEAL $$$$$.

Workers' Compensation fraud amounts to an estimated $7.2 billion per year across the United States!

STILL NOT CONVINCED?

Think about this ... when somebody commits the crime of Workers' Compensation fraud:

YOU work harder because of it.

YOUR COMPANY pays more for insurance because of it.

It harms the reputation of HONEST WORKERS and the reputation of your company.

IT AFFECTS US ALL.

REPORT WORKERS' COMPENSATION FRAUD.
EVERY TIME.

To report Workers' Comp Fraud, send an email to SIU@AmTrustGroup.com or please call 855.716.2529. You can remain anonymous if desired.

AmTrust

FRAUDE AL SEGURO DE COMPENSACIÓN DE TRABAJADORES.

SÍ, ES UNA GRAN COSA $$$$.

¡Fraude al seguro de Compensación De Trabajadores resulta en un estimado más de $7 mil millones cada año en todos los Estados Unidos!

¿TODAVÍA NO ESTÁ CONVENCIDO?

Piense de esto... cuando alguien comete el crimen de fraude al seguro de compensación de trabajadores:

Usted trabaja más.

Su compañía paga más de seguro.

Daña la reputación de trabajadores honestos y la reputación de su compañía.

NOS AFECTA A TODOS.

REPORTE EL FRAUDE DEL SEGURO DE COMPENSACIÓN DE TRABAJADORES. CADA VEZ.

Para reportar Fraude al seguro de compensación de trabajadores, por favor llame a 855.716.2529 o envié un correo electrónico a SIU@AmTrustGroup.com. Usted puede permanecer anónimo si prefiere.

AmTrust

S.C. WORKERS' COMPENSATION COMMISSION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

CARRIER/ADMINISTRATOR CLAIM NUMBER | OSHA LOG NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION #

INDUSTRY CODE | EMPLOYER FEIN | PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)

POLICY PERIOD

TO

CHECK IF APPROPRIATE

☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN | POLICY/SELF-INSURED NUMBER | ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | DATE HIRED | STATE OF HIRE

ADDRESS (INCL ZIP)

SEX

☐ Male
☐ Female
☐ Unknown

MARITAL STATUS

☐ Unmarried/Single/Divorced
☐ Married
☐ Separated
☐ Unknow

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

NCCI CLASS CODE

PHONE | # OF DEPENDENTS

RATE PER: ☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER:

DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

(☐) CANNOT BE DETERMINED

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER | TYPE OF INJURY/ILLNESS | PART OF BODY AFFECTED

DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES?

☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE | PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

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

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

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

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

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK | IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)

INITIAL TREATMENT

0 ☐ No Medical Treatment
1 ☐ MINOR: BY EMPLOYER
2 ☐ MINOR CLINIC/HOSP
3 ☐ EMERGENCY CARE
4 ☐ HOSPITALIZED > 24 HOURS
5 ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

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

SEE INSTRUCTIONS FOR IMPORTANT INFORMATION

REPRINTED WITH PERMISSION OF IAIABC

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5722

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:
Enter all dates in MM/DD/YYYY format.

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

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

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

AGENT NAME & CODE NUMBER:
Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:
This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:
Indicate the employee's work status. The valid choices are:
Full-Time On Strike Unknown Volunteer
Part-Time Disabled Apprenticeship Full-Time Seasonal
Not Employed Retired Apprenticeship Part-Time Piece Worker

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

CONTACT NAME/PHONE NUMBER:
Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:
Briefly describe the nature of the injury or illness, (e.g. Lacerations to the forearm).

PART OF BODY AFFECTED:
Indicate the part of body affected by the injury/illness, (e.g. Right forearm, lower back).

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

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

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5722

EMPLOYER'S INSTRUCTIONS – cont'd

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

(e.g. Acetylene cutting torch, metal plate)

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

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

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

(e.g. Cutting metal plate for flooring)

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

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

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

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

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

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

DATE RETURN(ED) TO WORK:

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

Optum
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:

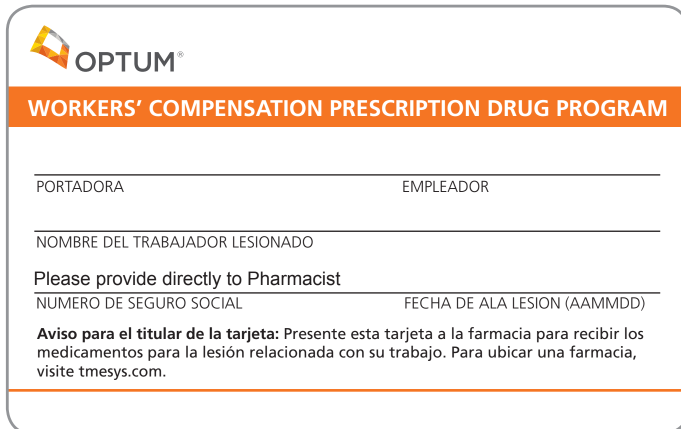
Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

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®

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					

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723

WCC File #: ____________
Carrier File #: ____________
Carrier Code #: ____________
Employer FEIN #: ____________

Claimant's Name: ____________ Employer's Name: ____________
Address: ____________ Address: ____________
City: ____________ State: ____ Zip: ______ City: ____________ State: ____ Zip: ______
Home Phone: ____________ Work Phone: ____________ Insurance Carrier: ____________
Preparer's Name: ____________ Preparer's Phone #: ____________

Date of Injury: ____________
month day year

A. Total Wages Paid

1. Check Applicable Method:
   - ☐ Report of earnings of injured employee based on four completed quarters.
   - ☐ Report of earnings of injured employee who did not complete four quarters based on actual time worked.
   - ☐ Report of earnings of similar employee. Injured employee did not work sufficient time before alleged injury. Hire date: ____________
   - ☐ Report of earnings of injured employee based on alternative method because Form 20 results in a compensation rate that is not fair and just (attach documentation to show how average weekly wage and compensation rate were calculated).

2. List total wages paid as reported to the Employment Security Commission on the Employer Quarterly Contribution and Age Reports during the four quarters immediately preceding the quarter in which the injury occurred. Do not include the quarter during which the injury occurred.

Quarter	Ending Date	Total Wages Paid
1st		$
2nd		$
3rd		$
4th		$

Total Paid 2. $ ____________

3. List total value of other allowances of any character made in lieu of wages during four quarters above. 3. $ ____________
4. Add lines 2 and 3. **TOTAL WAGES PAID:** 4. $ ____________
5. List total number of weeks paid to employee during the four quarters immediately preceding the quarter in which the injury occurred. 5. ____________

B. Average Weekly Wage

6. To calculate average weekly wage, divide total wages (line 4) by total weeks paid (line 5).
   AVERAGE WEEKLY WAGE: 6. $ ____________

C. Compensation Rate

7. The general rule for calculating the compensation rate is to multiply average weekly wage (line 6) by .6667. Estimate compensation rate by multiplying average weekly wage (line 6) by .6667. See part 8 below to determine the actual compensation rate. 7. $ ____________
8. The compensation rate is as follows (choose one):
   - ☐ When average weekly wage (line 6) is less than $75.00, the compensation rate is the average weekly wage. Enter average weekly wage on line 8.
   - ☐ When the estimated compensation rate (line 7) is less than $75.00 and average weekly wage (line 6) is more than $75.00, the compensation rate is $75.00. Enter $75.00 on line 8.
   - ☐ When the estimated compensation rate (line 7) is more than the maximum compensation rate for the year in which the injury occurred, enter the maximum compensation rate for the year in which the injury occurred on line 8.
   - ☐ Employee is within the exceptions listed in S.C. Code Ann. Section 42-7-65. List applicable exception here and enter appropriate compensation rate on line 8. ____________
   - ☐ The calculated compensation rate (line 7) applies. Enter amount from line 7 on line 8.

WEEKLY COMPENSATION RATE: 8. $ ____________

Employer's representative shall prepare a Form 20 and serve per R.67-211 a copy on the claimant within thirty days of beginning temporary compensation. See R.67-1603 when no temporary compensation is paid. NOTE: Average weekly wage represents average gross pay before taxes and other deductions. WHEN THE CLAIMANT DOES NOT AGREE WITH THE COMPENSATION RATE ON LINE 8, HE OR SHE SHOULD CONTACT THE EMPLOYER'S REPRESENTATIVE TO TRY TO REACH AN AGREEMENT AS TO THE COMPENSATION RATE. IF NO AGREEMENT CAN BE REACHED, THE CLAIMANT SHOULD CONTACT THE CLAIMS DEPARTMENT AT (803)737-5723.

Amended

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5700 www.wcc.sc.gov

WCC File #: ______________________
Carrier File #: ______________________
Carrier Code #: ______________________
Employer FEIN #: ______________________

Claimant's Name: ______________________ SSN: ___ - ___ - ___ Employer's Name: ______________________

Address: ______________________ Address: ______________________

City: ______________ State: ____ Zip: ______ City: ______________ State: ____ Zip: ______

Home Phone: ( ) - Work Phone: ( ) - Insurance Carrier: ______________________

Preparer's Name: Law Firm: Preparer's Phone #: ( ) -

A claim for workers' compensation benefits is made based on the following grounds:

☐Injury ☐ Illness ☐ Repetitive Trauma ☐Occupational Disease ☐Physical Brain Injury ☐Concurrent Jurisdiction

1. The claimant sustained an injury to (Part(s) of Body Injured) on (Month/Day/Year) in county, state of .
2. Body part(s) affected are:
   Briefly describe how the accident occurred.
3. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.
4. The relationship of employer and employee existed at the time of injury.
5. At the time of the injury the claimant was performing services arising out of and in the course of employment.
6. Notice of the accidental injury was given to the Employer on (Month/Day/Year) in the following manner:

☐7. Due to injury, the claimant is in need of (check one):

☐(a) medical examination and treatment for: ______________ ☐(b) additional medical examination and treatment for: ______________

☐8. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of:

☐9. Claimant at MMI: ☐ Yes ☐ No. 9a. If yes, due to the injury, the Claimant has permanent disability of the following nature and extent (check one):

☐(1) General Disability: ☐Total ☐ Partial ☐(2) Specific Disability: ☐Total ☐ Partial ☐ (3) Wage Loss

☐10. Due to the injury, the Claimant has a serious bodily disfigurement consisting of: ______________________ .

☐ 11. At the time of the injury, the Claimant was paid weekly wages of $, and demands accounting of days worked and wages earned as provided by law.

☐ 12. Give names and addresses of all employers for whom the Claimant has worked since the date of the accident:

☐ 13. Further grounds or unusual aspects of claim:

☐ 13a. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.

☐13b. List names and addresses of all physicians or other medical specialists who have seen or treated the Claimant as a result of the accident:

☐ 13c. To the best of your knowledge, did you have any prior permanent disability?
If yes, describe:

☐ 14. ☐ I am adding a party. ______________________(name/address).
☐ I am removing a party. ______________________(name/address).
☐ Other amendment: ______________________.

☐15. **I am filing a claim. I am not requesting a hearing at this time.** Estimated time needed for hearing: ________

☐16. **I am requesting a hearing. A $50 fee is required.**

☐ **Mediation**

☐a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.
☐b. Mediation is required pursuant to Reg. 67-1802.
☐c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.
☐d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Questions regarding mediation may be submitted to **mediation@wcc.sc.gov.**

I certify I have served this document pursuant to Reg. 67-211. See attached certificate of service. I verify the contents of this form are accurate and true to the best of my knowledge.

Preparer's Signature	Title	Email	Date (m/d/yyyy)

Workers’ Compensation

If you are injured on the job, you should:

1. Notify your employer at once. You can’t receive benefits unless your employer knows you’re injured.
2. Tell the doctor your employer sends you to that you’re covered by Workers’ Comp.
3. Notify the Workers’ Comp. Provider below or the S.C. Workers’ Comp. Commission at (803) 737-5700 if you experience undue delays or problems with your claim.

Workers’ Compensation:

1. Pays 100% of your medical bills and some other expenses.
2. Compensates you for 66 2/3% of your salary, limited to the maximum wage set by law, if you are unable to work for more than seven (7) calendar days.

We are operating under and subject to the
S.C. Workers’ Compensation Act

In case of accidental injury or death to an employee, the injured employee, or someone acting in his or her behalf, must give immediate notice to the employer or general authorized agent. Failure to give such immediate notice may be the cause of serious delay in the payment of compensation to the injured employee or his or her dependents and may result in failure to receive any compensation benefits under the law.

S.C. Workers’ Compensation Commission
1333 Main Street
Columbia, S.C. 29201
(803) 737-5700
www.wcc.sc.gov

Compensación del Trabajador

Si usted se lesiona en el trabajo, usted debe:

1. Notificar a su patrón inmediatamente. Usted n puede recibir beneficios a menos que su patrón sepaque se ha lesionado.
2. Decirle al doctor al que su patrón le envíe que usted está cubierto por la Compensación del Trabajador.
3. Notificar al Proveedor de Compensación del Trabajador abajo mencionado o a la Comisión de Compensación del Trabajador de Carolina del Sur al (803) 737-5700 si usted tiene retrasos o problemas indebidos con su reclamación.

La Compensación del Trabajador:

1. Paga el 100% de sus recibos médicos y otros gastos.
2. Le compensa por el 66 2/3% de su salario, limitado al salario máximo establecido por la ley, si usted no puede trabajar por más de siete (7) días calendario.

Trabajamos conforme al Acto de Compensación del Trabajador de Carolina del Sur

En caso de lesión accidental o muerte de un empleado, el empleado lesionado, o alguien que le represente, tiene que avisar inmediatamente al patrón o agente autorizado general. El hecho de no avisar inmediatamente puede causar una demora seria en el pago de la compensación al empleado lesionado o a sus dependientes y puede resultar en el impago de los beneficios de compensación según estipula la ley.

S.C. Workers' Compensation Commission
(Comisión de Compensación de Trabajadores)
1333 Main Street
Columbia, SC 29201
(803) 737-5700
www.wcc.state.sc.us

** PLEASE NOTE **

EMPLOYERS MAY OBTAIN ***FREE OF CHARGE,*** THE SC "WORKPLACE LAWS" POSTER WHICH IS **REQUIRED** BY THE STATE AND SHOULD BE POSTED IN AN AREA ACCESSIBLE TO ALL EMPLOYEES

THE **EMPLOYER** MUST CALL ONE OF THE BELOW NUMBERS:

SC Employment Security Commission: 803-737-2400
SC Human Affairs Commission: 803-737-7800 or 800-521-0725
SC Workers Comp Commission: 803-737-5700

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!