DISTRICT OF COLUMBIA COMPENSATION INSURANCE PROGRAM
IMPORTANT NOTICE

POLICY HOLDERS NOTICE OF LOSS CONTROL SERVICES

In compliance with the District of Columbia Workers' Compensation Insurance plan, we provide for our policyholders a broad range of Loss Control Services. When requested, our Loss Control Department is prepared to provide, at no additional charge, the following services:

1. Consultative services pertaining to the safety performance of your business and operations.

2. An appraisal of the various mechanical hazards, material handling methods, chemical and ergonomic exposures that may exist at your business.

3. Advice and assistance in the recognition, evaluation and control of occupational safety and health hazards.

4. Advice and assistance in coordinating and implementing employee safety and health programs.

5. Recommendations for corrective actions to address workplace hazards identified in conjunction with other services provided.

6. Assistance in developing a comprehensive safety and health program for your business, including the following elements:

- Safety Policy
- Safety Rules
- Safety Inspections, both Regular and Periodic
- Preventative Maintenance Programs
- Safety and Health Training Programs
- First Aid Programs
- Accident Investigation Programs
- Recordkeeping

(Note: Our representatives are ethically and legally required to submit recommendations for discrepancies and deficiencies discovered in the course of their consultations with you. Mandatory compliance may be required.)

Contact Us

If you wish to have the Loss Control Department provide any of these services for your business:

Telephone: (678)258-8151

Toll-Free: 1-888-239-3909
(please ask for the Loss Control Department)

e-mail: ARlosscontrol@amtrustgroup.com

Or detach the coupon below and mail to:
AmTrust North America
Attn. Gina Forstman
P.O. Box 5446
Cleveland, OH 44101-4406

☐ Yes, we are interested in Loss Control Assistance.

Company Name:_____ **Policy Number:**_____

Address:_____

_____

Telephone Number:_____ **Person to Contact:**_____

Position/Title:_____

Workers' Compensation Quick Reference Guide

Carrier: Technology Insurance Company

Claim Administrator: Amtrust North America
P.O. Box 5446
Cleveland, OH 44101-4406
678-258-8000 Fax - 678-258-8399
Toll Free: 888-239-3909

CONTACTS

Claims Analyst:	Patricia Stiebritz	888-239-3909 x 463051
Policy Svcs/Loss Control:	Gina Forstman	(678) 258-8105
Customer Service:		877-882-1305

YOUR DUTIES UNDER THE WCIP

1. Pay all premiums promptly and timely
2. Advise us or your agent of any material change in your corporate entity, location of business or a change in the nature of your business.
3. All claims must be reported timely.
4. Payroll and overtime records must be available at all times.
5. Allow reasonable access to your workplace for safety inspections during business hours.
6. Loss Control recommendations must be complied within specified time frames.

Lack of cooperation in any of these areas could result in cancellation.

YOUR RESPONSIBILITIES BEFORE & AFTER AN INJURY

1. **Report all injuries immediately on the proper State Board forms.**

2. Emergency Situations:
   In case of emergency send the injured employee to the closest emergency facility.

3. Assist injured employees in getting appropriate medical care.

Technology Insurance Company

Claim Reporting
For Workers' Compensation Claims

Please note the following numbers & instructions

By Phone – 1-866-272-9267

By Fax – 1-775-908-3724

or

1-877-669-9140

By E-mail – AmTrustclaims@qrm-inc.com

When a work injury is reported to you, simply fax or mail the claim report to us by one of the means stated above. The state law **requires the employer to timely and fully complete the State specific First Report of Injury form**. You must have the following information available when you complete the claim form.

1. Name of employer (name as it appears on the policy is preferred).
2. Policy Number, if known.
3. Injured employee's: Name, address, phone #, Social Security #, Date of Hire and Date of Birth.
4. Date & Time and Place of Incident.
5. Description of the incident.
6. Nature of injury.
7. Name & phone # for initial medical provider, if known.
8. Wage information.

District of Columbia Government
Office of Worker's Compensation
P.O. Box 56098
Washington, DC 20011
(202) 671-1000

Warning: *It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.*

Date of This Report

Employee Social Security No.

Employer Identification No.

Insurer No.

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

Employee Name and Address:	Employer Name and Address:	Insurer Name and Address:
		P.O. BOX 94405 CLEVELAND, OH 44101

IMPORTANT: Every employer shall file this report as soon as possible after knowledge of an occupational injury or disease to one of his/her's employees, but no later than ten days thereafter. Failure to file this form shall be subject to civil penalty not to exceed $1,000.

Date and time of Injury _____am/pm? Day of the week?_____
Normal starting time _____am/pm? If employee back to work, give date and time _____am/pm?
At what wage? _____ If fatal, give date of death _____(file supplement report)
Date of disability began? _____ am/pm? Was the injured pain in full for this day? _____
Was the injured given Form No. 7 DCWC? _____ Foreman_____
When did you or the foreman first learn of the injury? _____
Male _____ Female _____ DOB _____ Employee's Telephone No. _____
Occupation when injured? _____ Was this his/her regular occupation?_____
(Department or branch regularly employed) _____
Was the injured hired in DC? _____ How long employed by you? _____
Piece or time worker? _____ Hourly wage? _____ Hours worked/day _____
Daily wages _____ Days worked per week _____ Average weekly earnings_____
If board and lodging were furnished or gratuities reported in addition to wages, give estimated value per day, week or month:_____
Employer's principal business function in DC _____
Employer's Telephone No. _____ Insurance Policy No. _____
Location of plant or place where accident occurred: _____
On employer's premises? _____
Describe fully the events which resulted in injury or disease, what the employee was doing when injured and type of injury including parts of the body affected: _____

Name of Witnesses _____
Nature and location of injury (Describe fully): _____

Attending Physician and Address (If Hospital Involved – Indicate):

Name (Please Print or Type)

Name of Person Completing Form

Signature

Official Position

OPTUM®

AmTrust North America
An AmTrust Financial Company

Optum
PO Box 152539
Tampa, FL 33684-2539

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

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

Injured Employee:

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

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

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

Questions? Need Help?

1-866-599-5426

OPTUM®

AmTrust North America
An AmTrust Financial Company

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
CARRIER/TPA

EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER

DATE OF INJURY (YYMMDD)

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

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

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

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

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

Employer:

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

tmesys®

IMP14-1614-109-FFWG

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

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

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

Empleado lesionado:

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

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

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

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
PORTADORA — EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

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

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

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

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

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

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

Empleador:

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

tmesys®

IMP14-1614-109-FFWG

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

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

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

Some Return-to Work Benefits Include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

YOUR BUSINESS AND UNINSURED SUBCONTRACTORS

Many otherwise knowledgeable business owners utilize uninsured subcontractors for various services; unaware of the risks they are incurring for their businesses. An uninsured subcontractor is typically a business that does not provide workers compensation insurance for its employees. This may be because the business is a “one-man shop”, and believes he wants to personally assume the risk of financial loss in the event of injury; in other cases it may be ignorance of the law; or an effort to avoid the cost of workers’ compensation insurance. Uninsured subcontractors often appear as construction tradespeople, service firms (especially small operators), and others.

In truth, there are no uninsured subcontractors. When an “uninsured subcontractor” employee, (including a one-man business) is injured while working on your behalf, the courts have repeatedly held that it is in the public interest that you, the beneficiary of the sub’s work, provide workers’ compensation coverage for these “uninsured employees.” You cannot opt out of this duty. No one can sign a document of any kind and relieve you of this responsibility. You are carrying these employees on your workers’ compensation policy whether you want to or not, whether you even realize it or not. Because of this “involuntary coverage”, when an insurance company auditor finds payment to uninsured subcontractors, he will treat this payment as your payroll, and you will receive a bill for additional premium. With high-hazard occupations, such as steel erectors, roofers, and others, you may be shocked to find that one or two uninsured subs have more than doubled your workers compensation premium!

Some businesses, aware of this problem, use “hold-backs”, “retainages” or “backcharges” of a set percentage of job cost, often 10% or 15% to try and offset the additional premiums they know they’ll have to pay for using uninsured subcontractors. The problem with this is that each of the trades carries different rates, according to the relative hazard of the trade. Rates are expressed in dollars per hundred dollars of payroll, so there’s an easy-to-see correlation in percentages. Rates not only vary by trade, but they can fluctuate from state-tostate,

they can vary according to the rate filings of different companies, and they go up and down according to actuarial loss experience. Trying to obtain and keep up with this many rates is a time-consuming and unproductive task, well beyond the capabilities of most businesses.

You’re probably aware that safety pays, and you make certain efforts to be sure your direct employees do not take unnecessary risks, do not work with unnecessarily dangerous or broken tools and equipment, and are protected from toxic materials. But a subcontractor might not take these precautions. And if his carelessness leads to employee injury, your claim history will be damaged.

RECOMMENDATIONS—

1.) Avoid using any uninsured subs, but especially high-hazard occupations such as roofing, carpenters, and painters. It is false economy to use uninsured businessmen who seem to offer lower costs. They may be operating outside the law, and in fact, are transferring the costs of their risk, and potential economic devastation, to you.
2.) Obtain current certificates of workers compensation (and other applicable coverage) from the sub's insurance agent or insurance carrier. Implement a hard and fast rule—"No insurance certificate—no check on Friday".
3.) You can easily keep copies of all certificates in a notebook, and check the expiration dates before giving work to a particular subcontractor. Copies of all certificates should be retained.

YOUR INSURANCE AUDIT –

At the end of your policy period, we will conduct an audit. In addition to tax documents, the auditor will ask for documentation of all wages paid to both employees and subcontractors. The auditor will also ask to see the certificates of insurance for each insured subcontractor. If you have a valid certificate that covers the time period that your sub was paid, this payment will not be charged to your work comp policy.

The auditor will ask for the first and last date that each sub was paid during your policy period. We are looking for the time range that each subcontractor was paid, so that we can ensure that this subcontractor had his own coverage during the time he worked for you.

If you take time throughout the year to request certificates and organize them, you will find it very beneficial at the time of audit.

Department of Employment Services

LABOR STANDARDS BUREAU

DEPARTMENT OF EMPLOYMENT SERVICES

OFFICE OF WORKERS' COMPENSATION

4058 MINNESOTA AVENUE, N.E. • WASHINGTON, DC 20019 • (202) 671-1000 • (202) 671-1929 (Fax)

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE OF COMPLIANCE

TO EMPLOYEES

1. You are required by law to report promptly to your employer and the Office of Workers' Compensation an occupational injury or disease, even if you deem it to be minor. Form No. 7 DCWC, Notice of Accidental Injury or Occupational Disease, to be obtained from the employer or the Office of Workers' Compensation, must be used for that purpose. After you have completed and signed the form, mail it to the Office of Workers' Compensation at the above address, and to your employer.
2. You are entitled, if required, to the services of a physician or hospital of your choice and lost wages. Call (202) 671-1000 or visit http://does.dc.gov for information.
3. You may not sue your employer as a result of a work-related injury or disease by reason of your exclusive remedy under the Workers' Compensation Law.
4. In order to preserve your right to benefits under the DC Workers' Compensation Law, you must file a written claim on Form No. 7A DCWC, Employee's Claim Application, within one (1) year after your injury, or within one (1) year after the last payment of benefits.
5. If you need information regarding your rights and obligations prescribed by law, you may call your employer first. If you require further information, you may call the Office of Workers' Compensation at (202) 671-1000 or visit http://does.dc.gov
6. The law gives you the right to legal representation if you so choose.

TO EMPLOYERS

1. You are required to have Workers' Compensation insurance coverage if you have one (1) or more employees.
2. You are required to display this poster at each worksite so that it will be of the greatest possible benefit to your employees.
3. You must file an Employer's First Report of Injury or Occupational Disease, Form No. 8 DCWC, with the Office of Workers' Compensation, send a copy to the nearest claim office of your insurer, for all occupational injuries or disease, as soon as possible, but no later than ten (10) working days after the date of knowledge thereof.
4. Your employee must file Form No. 7 DCWC, Employee's Notice of Accidental Injury or Occupational Disease. Please provide your employee with Form No. 7 DCWC and direct them to complete it and return it to you and the Office of Workers' Compensation. Once you have received notice from the employee, you are required to send the employee a notice of his/her rights and obligations by certified mail, return receipt requested.
5. You are required to report to the Office of Workers' Compensation, and your insurer, any disability of more than three (3) days which was not previously reported, as soon as possible, but no later than ten (10) working days after the date of knowledge thereof.
6. You are required to furnish, or cause to be furnished, reasonable medical and hospital services, other remedial care or vocational rehabilitation, and various types of disability compensation, to an injured or disabled employee.
7. You are required to obtain from the insurer identified below a supply of all required Workers' Compensation Forms, or you may download the forms and notice mentioned above at our website http://does.dc.gov.

NOTICE: Violation of the various provisions of the Workers' Compensation law provides for civil penalties.

The undersigned employer hereby gives notice of compliance with all provisions of the Workers' Compensation Law and Administrative Regulations.

NAME OF INSURANCE COMPANY Technology Insurance Company

Address: P.O BOX 5446 CLEVELAND, OH 44101

Phone: _____

NAME OF EMPLOYER

Address _____ Phone: _____

Employer Representative:_____

_____

Employer ID Number (if number unknown, employer to request from IRS)

THIS NOTICE IS TO BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE(S) OF BUSINESS

FORM NO. 1 DCWC
Revised March, 2017

Departamento de Servicios de Empleo

OFICINA DE ESTÁNDARES LABORALES

DEPARTMENT OF EMPLOYMENT SERVICES

OFICINA DE COMPENSACIÓN DE TRABAJADORES

4058 MINNESOTA AVENUE, N.E. • WASHINGTON, DC 20019 • (202) 671-1000 • (202) 671-1929 (Fax)

ADVERTENCIA: Es un delito proporcionar información falsa o engañosa a un asegurador con el propósito de defraudar al asegurador o a cualquier otra persona. Las penas incluyen prisión y/o multas. Además, un asegurador puede negar beneficios de compensación si la información falsa materialmente relacionada con una reclamación fue proporcionada por el solicitante.

NOTIFICACIÓN DE CUMPLIMIENTO

PARA EMPLEADOS

1. Por ley, usted debe informar rápidamente a su empleador y a la Oficina de Compensación de Trabajadores una lesión o enfermedad laboral, incluso si considera que es menor. Para ese fin, deberá usar el Formulario N°. 7 DCWC, Notificación de lesión accidental o enfermedad laboral, que podrá obtener del empleador o de la Oficina de Compensación de Trabajadores. Una vez completado y firmado el formulario, envíelo por correo a la Oficina de Compensación de Trabajadores a la dirección antes mencionada y a su empleador.
2. Usted tiene derecho, si es necesario, a los servicios de un médico u hospital de su elección y a los salarios perdidos. Llame al (202) 671-1000 o visite http://does.dc.gov para obtener información.
3. Usted no debe demandar a su empleador como resultado de una lesión o enfermedad relacionada con el trabajo debido a que la Ley de Compensación de Trabajadores es su único recurso.
4. Con el fin de preservar su derecho a los beneficios en el marco de la Ley de Compensación de Trabajadores del D.C., usted debe completar una reclamación por escrito en el Formulario N°. 7A DCWC, Solicitud de reclamación del empleado, en el término de un (1) año después de su lesión, o en el término de un (1) año después del último pago de beneficios.
5. Si necesita información sobre sus derechos y obligaciones prescritas por ley, puede llamar primero a su empleador. Si necesita más información, puede llamar a la Oficina de Compensación de Trabajadores al (202) 671-1000 o visitar http://does.dc.gov
6. La ley le concede el derecho a representación legal si elige tenerla.

PARA EMPLEADORES

1. Es obligatorio tener cobertura de seguro de Compensación de trabajadores si tiene uno (1) o más empleados.
2. Debe exhibir este cartel en cada lugar de trabajo para que sea del mayor beneficio posible para sus empleados.
3. Deberá presentar un Formulario N°. 8 DCWC, Primer informe del empleador sobre lesión o enfermedad laboral, ante la Oficina de Compensación de Trabajadores, enviar una copia a la oficina de reclamaciones de su aseguradora más cercana, por cualquier lesión o enfermedad laboral, lo antes posible, pero a más tardar diez (10) días hábiles después de la fecha en que tenga conocimiento del hecho.
4. Su empleado debe presentar el Formulario N°. 7 DCWC, Notificación del empleado de lesión accidental o enfermedad laboral. Por favor provea a su empleado con el Formulario N°. 7 DCWC e indíquele que lo complete y se lo entregue a usted y a la Oficina de Compensación de Trabajadores. Una vez que haya recibido la notificación del empleado, deberá enviar al empleado una notificación de sus derechos y obligaciones por correo certificado, solicitando el acuse de recibo.
5. Deberá informar a la Oficina de Compensación de Trabajadores y a su aseguradora cualquier discapacidad de más de tres (3) días que no haya sido informada previamente, tan pronto como sea posible, pero a más tardar diez (10) días hábiles después de la fecha en que tenga conocimiento del hecho.
6. Deberá proporcionar o hacer que se proporcionen servicios médicos y hospitalarios razonables, otros cuidados curativos o rehabilitación vocacional y diversos tipos de compensación por discapacidad al empleado lesionado o discapacitado.
7. Deberá obtener de la aseguradora identificada a continuación un suministro de todos los Formularios de compensación de trabajadores requeridos, o puede descargar los formularios y la notificación mencionados anteriormente en nuestro sitio web http://does.dc.gov.

NOTIFICACIÓN: La violación de las diversas disposiciones de la ley de Compensación de Trabajadores prevé sanciones civiles.

El empleador abajo firmante notifica por la presente el cumplimiento de todas las disposiciones de la Ley de Compensación de Trabajadores y las Normas Administrativas.

NOMBRE DE LA EMPRESA ASEGURADORA Technology Insurance Company

Dirección: P.O. BOX 5446, CLEVELAND, OH 44101

Teléfono: 888-239-3909

NOMBRE DEL EMPLEADOR

Dirección: _____ Teléfono: _____

Representante del Empleador: _____

_____

Número de identificación del empleador (si el número es desconocido, el empleador debe solicitarlo al IRS)

ESTE AVISO SE PUBLICARÁ NOTORIAMENTE EN Y SOBRE LOS LUGARES DE NEGOCIO DEL EMPLEADOR

FORMULARIO N°. 1 DCWC
Revisado Marzo de 2017

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					