



AmTrust North America
An AmTrust Financial Company

Alabama Worker's Compensation Claim Kit



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AmTrust North America
An AmTrust Financial Company

EASY ONLINE CLAIMS REPORTING INSTRUCTIONS

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

First Time Portal Access:

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

Reporting of New Injuries:

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

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



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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 **“Save as Draft”** and you may return to it later by going back into the **“First Reports”** screen and clicking on **“InProgress”**

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

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY
OR OCCUPATIONAL DISEASE

CLAIM REFERENCE					
1. Insured Report Number	2. Filing Office Claim Number	3. OSHA Log Case Number			
EMPLOYER					
4. Employer Business Name			ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS		
5. Physical Address 1			10. Mailing Address 1		
6. Physical Address 2			11. Mailing Address 2		
7. City	8. State	9. Zip	12. City	13. State	14. Zip
15. Federal ID Number		16. U.C. Account Number		17. NAICS	
INSURER / FILING OFFICE					
18. Insurer Name			21. Filing Office Name		
19. Insurer Federal ID Number			22. Mailing Address 1 P.O. BOX 94405		
20. Type Insurer Ins Co <input type="checkbox"/> Self-Insurer <input type="checkbox"/> Group Fund <input type="checkbox"/>			23. Mailing Address 2 or Telephone Number 888-239-3909		
			24. City CLEVELAND 25. State OH 26. Zip 44101		
			27. Filing Office Federal ID Number		
EMPLOYEE / WAGES					
28. First Name			32. Employee ID Number		
29. Middle Name			33. Type Employee ID Number		
30. Last Name			SSN <input type="checkbox"/> Passport Number <input type="checkbox"/> Green Card <input type="checkbox"/>		
31. Last Name Suffix (ie. Jr., Sr., III)			Employment Visa <input type="checkbox"/> Assigned by Jurisdiction <input type="checkbox"/>		
34. Mailing Address 1			40. Gender Male <input type="checkbox"/> Female <input type="checkbox"/>		41. Date of Birth
35. Mailing Address 2			39. Phone		42. Nbr of Dependents
36. City			37. State		38. Zip
43. Marital Status Unmarried (Single or Divorced or Widowed) <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/>					44. Date Hired
45. Occupation Description				46. Number of Days Worked Per Week	
47. Wages \$			49. Received Full Pay For Day of Injury? Yes <input type="checkbox"/> No <input type="checkbox"/>		
48. Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/>			50. Did Salary Continue? Yes <input type="checkbox"/> No <input type="checkbox"/>		
INJURY / TREATMENT					
51. Date of Injury	52. Time of Injury a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> unk <input type="checkbox"/>		53. Time Employee Began Work a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		54. Date Disability Began
55. Date of Death					
PLACE OF ACCIDENT, INJURY, OR EXPOSURE			61. Injury Occurred on Employer's Premises? Yes <input type="checkbox"/> No <input type="checkbox"/>		
56. Site Address			62. Date Employer Notified		
57. City			58. State		59. Zip
60. County					
63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)					
PROVIDE DESCRIPTION CODES to identify Nature of Injury, Part of Body that was affected, and Cause of Injury. (FOR COMPLETE LIST OF CODES, GO TO HTTP:// LABOR.ALABAMA.GOV/WC					
64. Nature of Injury Code		65. Part of Body Code		66. Cause of Injury Code	
67. Initial Treatment		No Medical Treatment <input type="checkbox"/>		68. Name of Treatment Facility	
First Aid By Employer <input type="checkbox"/>		Minor Clinic / Hospital <input type="checkbox"/>		69. Address	
Emergency Room <input type="checkbox"/>		Hospitalized Overnight <input type="checkbox"/>		70. City	
Hospitalized > 24 Hours <input type="checkbox"/>		Outpatient Treatment <input type="checkbox"/>		71. State	
73. Name of Physician or Other Health Care Professional			74. Has Injured Returned to Work Yes <input type="checkbox"/> No <input type="checkbox"/>		75. Date
					76. Time a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>
OTHER					
77. Date Prepared	78. Preparer's First Name		79. Last Name		80. Title
					81. Preparer's Telephone Number

NATURE OF INJURY	PART OF BODY	CAUSE OF INJURY
01. No Physical Injury	10. Multiple Head Injury	01. Chemicals
02. Amputation	11. Skull	02. Hot Objects or Substances
03. Angina Pectoris	12. Brain	03. Temperature Extremes
04. Burn	13. Ear(s)	04. Fire or Flame
07. Concussion	14. Eye(s)	05. Steam or Hot Fluids
10. Contusion	15. Nose	06. Dust, Gases, Fumes or Vapors
13. Crushing	16. Teeth	07. Welding Operation
16. Dislocation	17. Mouth	08. Radiation
19. Electric Shock	18. Soft Tissue	09. Contact With, NOC.
22. Enucleation	19. Facial Bones	10. Machine or Machinery
25. Foreign Body	20. Multiple Neck Injury	11. Cold Objects or Substances
28. Fracture	21. Vertebrae	12. Object Handled
30. Freezing	22. Disc	13. Caught In, Under or Between, NOC.
31. Hearing Loss or Impairment	23. Spinal Cord	14. Abnormal Air Pressure
32. Heat Prostration	24. Larynx	15. Broken Glass
34. Hernia	25. Soft Tissue	16. Hand Tool, Utensil; Not Powered
36. Infection	26. Trachea	17. Object Being Lifted or Handled
37. Inflammation	30. Multiple Upper Extremities	18. Powered Hand Tool, Appliance
40. Laceration	31. Upper Arm	19. Caught, Puncture, Scrape, NOC.
41. Myocardial Infarction	32. Elbow	20. Collapsing Materials (Slides of Earth) Either Man Made or Natural
42. Poisoning - General	33. Lower Arm	25. From Different Level (Elevation) Off Wall, Catwalk, Bridge, Etc.
43. Puncture	34. Wrist	26. From Ladder or Scaffolding
46. Rupture	35. Hand	27. From Liquid or Grease Spills
47. Severance	36. Finger(s)	28. Into Openings Shafts, Excavations, Floor Openings, Etc.
49. Sprain or Tear	38. Shoulder(s)	29. On Same Level
52. Strain or Tear	39. Wrist (s) & Hand(s)	30. Slipped, Do Not Fall
53. Syncope	40. Multiple Trunk	31. Fall, Slip or Trip, NOC.
54. Asphyxiation	41. Upper Back Area	32. On Ice or Snow
55. Vascular	42. Lower Back Area	33. On Stairs
58. Vision Loss	43. Disc	40. Crash of Water Vehicle
59. All Other Specific Injuries, NOC	44. Chest	41. Crash of Rail Vehicle
60. Dust Disease, NOC	45. Sacrum and Coccyx	45. Collision or Sideswipe With Another Vehicle
61. Asbestosis	46. Pelvis	46. Collision with a Fixed Object Standing Vehicle or Stationary Object
62. Black Lung	47. Spinal Cord	47. Crash of Airplane
63. Byssinosis	48. Internal Organs	48. Vehicle Upset Overturned or Jackknifed
64. Silicosis	49. Heart	50. Motor Vehicle, NOC.
65. Respiratory Disorders	50. Multiple Lower Extremities	52. Continual Noise
66. Poisoning - Chemical, (Other Than Metals)	51. Hip	53. Twisting
67. Poisoning - Metal	52. Upper Leg	54. Jumping
68. Dermatitis	53. Knee	55. Holding or Carrying
69. Mental Disorder	54. Lower Leg	56. Lifting
70. Radiation	55. Ankle	57. Pushing or Pulling
71. All Other Occupational Disease Injury, NOC	56. Foot	58. Reaching
72. Loss of Hearing	57. Toes	59. Using Tool or Machinery
73. Contagious Disease	58. Big Toes	60. Strain or Injury By, NOC.
74. Cancer	60. Lungs	61. Welding or Throwing
75. AIDS	61. Abdomen Including Groin	65. Moving Part of Machine
76. VDT - Related Diseases	62. Buttocks	66. Object Being Lifted or Handled
77. Mental Stress	63. Lumbar & or Sacral Vertebrae	67. Sanding, Scraping, Cleaning Operation
78. Carpal Tunnel Syndrome	64. Artificial Appliance	68. Stationary Object
79. Hepatitis C	65. Insufficient Info to Properly Identify	69. Stepping on Sharp Object
80. All Other Cumulative Injury, NOC	66. No Physical Injury	70. Striking Against or Stepping On, NOC.
90. Multiple Physical Injuries Only	90. Multiple Body Parts	74. Fellow Worker; Patient
91. Multiple Injuries Including Both Physical & Psychological	91. Body Systems and Multiple Body	75. Falling or Flying Object
	99. Whole Body	76. Hand Tool or Machine in Use
		77. Motor Vehicle
		78. Moving Parts of Machine
		79. Object Being Lifted or Handled
		80. Object Handled By Others
		81. Struck or Injured, NOC.
		82. Absorption, Ingestion or Inhalation, NOC
		84. Electrical Current
		85. Animal or Insect
		86. Explosion or Flare Back
		87. Foreign Matter (Body) in Eye(s)
		88. Natural Disasters
		89. Person in Act of a Crime
		90. Other Than Physical Cause of Injury
		91. Mold
		94. Repetitive Motion Callous, Blister, Etc.
		95. Rubbed or Abraded, NOC.
		96. Terrorism
		97. Repetitive Motion Carpel Tunnel Syndrome
		98. Cumulative, NOC
		99. Other - Miscellaneous, NOC

INSTRUCTIONS FOR FILING WC FIRST REPORT OF INJURY

Employers should send a completed legible form to the insurance carrier or, if self-insured, to the designated office handling their workers' compensation claims. The insurance carrier or designated office should forward this First Report on to the Workers' Compensation Division, Department of Labor, Montgomery, Alabama 36131 within fifteen (15) days from the date of injury or date of notification to the employer for all injuries for which compensation is claimed or paid. This includes deaths, permanent disabilities or temporary disabilities exceeding three (3) days).

Block 1. A number assigned by the insured to identify a specific claim

Block 2. An identifier for a specific claim within a claim administrator's claims processing system.

Block 3. Case number from log maintained for OSHA

Block 4 - Block 14. Self Explanatory

Block 15. Employer Federal ID number

Block 16. Employer Unemployment Compensation Account Number

Block 17. NAICS Industry Codes http://dir.alabama.gov/docs/forms/wc_naics.pdf

Block 18. Carrier's name

Block 19. Carrier's FEIN

Block 20. A code representing the kind of entity providing financial responsibility for the claim, exp: (I) Insurance Carrier (S) Self Insurer (G) Guarantee Fund/Group

Block 21 through Block 63. Self Explanatory

Block 64. Nature of Injury Codes http://dir.alabama.gov/docs/forms/wcio_nature_table.pdf

Block 65. Part of Body Codes http://dir.alabama.gov/docs/forms/wcio_part_table.pdf

Block 66. Cause of Injury Codes http://dir.alabama.gov/docs/forms/wcio_cause_table.pdf

Block 67 through Block 81. Self Explanatory



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

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	or	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.

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



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

	<u>NDC</u>	or	<u>Envoy</u>
RxBIN	004261		002538
RxPCN	CAL		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.

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

STATE OF ALABAMA WORKERS' COMPENSATION INFORMATION



If you are injured on the job, or contract an occupational disease, notify your employer immediately.

Your employer will advise you of the physician to see for authorized medical treatment.

WORKERS' COMP INSURANCE
CARRIER _____

TELEPHONE NUMBER 888-239-3909

**ASSISTANCE IS AVAILABLE UNDER THE ALABAMA WORKERS'
COMPENSATION LAW INCLUDING MEDIATION SERVICE.**

FOR INFORMATION CALL:

1-800-528-5166

Department of Labor

Workers' Compensation Division

649 Monroe Street

Montgomery, AL 36131

**CODE OF ALABAMA, 1975, § 25-5-290(d), REQUIRES THAT THIS NOTICE
BE POSTED**

IN ONE OR MORE CONSPICUOUS PLACES IN YOUR BUSINESS.

Estado de Alabama

Información de Compensación de Trabajadores

Si se lesiona en el trabajo, o tiene una enfermedad ocupacional, notifique a su empleador inmediatamente.

If you are injured on the job, or contract an occupational disease, notify your employer immediately.



Su empleador le aconsejará a que médico tiene que consultar para tratamiento médico autorizado.

Your employer will advise you of the physician to see for authorized medical treatment.

Portador de Seguro de Compensación al Trabajador: _____
Workers' Compensation Insurance Carrier

Número de Teléfono: 888-239-3909 _____
Telephone number

La asistencia está disponible bajo la Ley de Compensación de Trabajadores de Alabama, incluyendo el servicio de mediación.

Assistance is available under the Alabama Workers' Compensation Law including mediation service.

Para más información llame al:

For information call:

1-800-528-5166

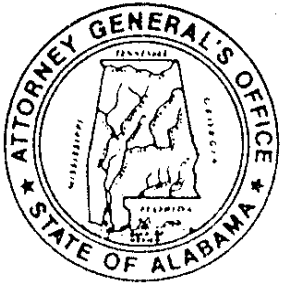
**Alabama Department of Labor
Workers' Compensation Division
649 Monroe Street
Montgomery, AL 36131**

Código de Alabama, 1975, 25-5-290(d), requiere que este aviso se publique en uno o más lugares visibles en su negocio.

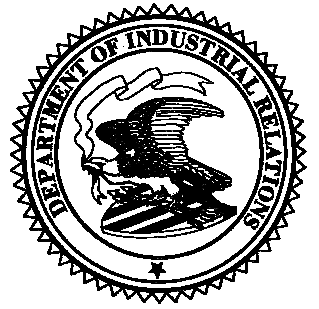
Code of Alabama, 1975, 25-5-290(d), requires that this notice be posted in one or more conspicuous places in your business.

WORKERS' COMPENSATION FRAUD

It could be a ticket to jail!



The Alabama
Attorney
General's
Office and the
Alabama
Department of
Industrial
Relations



are working
together to
find and
prosecute
Workers'
Compensation
Fraud.

Workers' Compensation Fraud is STEALING!

W A N T E D

INFORMATION LEADING TO THE DISCOVERY AND OR CONVICTION OF WORKERS' COMPENSATION FRAUD.

Making a false statement to obtain workers' compensation benefits (Ala. Criminal Code, Section 13A-11-124) is a Class C Felony under Alabama law. Class C Felonies are punishable by imprisonment for as much as 10 years and monetary fines of up to \$15,000.

FIVE TYPES OF WORKERS' COMPENSATION FRAUD

Agent ~ Employer ~ Employee ~ Medical ~ Legal

WORKERS' COMPENSATION FRAUD CAN BE:

- * Reporting an off the job accident as an on the job accident.
- * Reporting an accident that never happened.
- * Complaints of accident injury symptoms that are exaggerated or non-existent.
- * Malingering - to avoid work when injury is healed.
- * Not reporting outside income from other work-related activities while drawing workers' compensation benefits from another employer.
- * Making false or fraudulent statements for the purpose of obtaining workers' compensation benefits.

**TO REPORT WORKERS' COMPENSATION FRAUD
CALL**

1-800-923-2533 or 334-242-7345

STATEMENT OF WAGES/SALARY

IMPORTANT: PLEASE COMPLETE ALL INFORMATION REQUESTED

Employee:
Social Security Number:

Employer:
Date of Hire:

Claim Number:
Position/Job Title

EMPLOYMENT TYPE: Full Time ___ Part Time ___ Seasonal ___ Temp ___

If Temporary or Seasonal worker, last day of season or job end date _____

WAGETYPE: 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					