AmTrust North America
An AmTrust Financial Company

Indiana
Worker's Compensation
Claim Kit

(p) 888.239.3909 • (f) 678.258.8399 • www.amtrustfinancial.com

AmTrust North America
An AmTrust Financial Company

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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

800 Superior Avenue E • 21st Floor • Cleveland, OH 44114
(p) 866.203.3037 • (f) 800.487.9654 • www.amtrustnorthamerica.com

Reset Form

INDIANA WORKER'S COMPENSATION FIRST REPORT OF EMPLOYEE INJURY, ILLNESS

State Form 34401 (R10 / 1-02)

FOR WORKER'S COMPENSATION BOARD USE ONLY		
Jurisdiction	Jurisdiction claim number	Process date

Please return completed form electronically by an approved EDI process.

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

EMPLOYEE INFORMATION

Social Security number	Date of birth	Sex ☐ Male ☐ Female ☐ Unknown	Occupation / Job title	NCCI class code

Name (*last, first, middle*)	Marital status	Date hired	State of hire	Employee status
	☐ Unmarried ☐ Married ☐ Separated ☐ Unknown			

Address (*number and street, city, state, ZIP code)*	Hrs / Day	Days / Wk	Avg Wg / Wk	☐ Paid Day of Injury ☐ Salary Continued

Telephone number (include area	Number of dependents	Wage $	Per ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year ☐ Other

EMPLOYER INFORMATION

Name of employer	Employer ID#	SIC code	Insured report number

Address of employer (*number and street, city, state, ZIP code*)	Location number	Employer's location address (*if different)*
	Telephone number	
	Carrier / Administrator claim number	OSHA log number / Report purpose code

Actual location of accident / exposure (*if not on employer's premises*)

CARRIER / CLAIMS ADMINISTRATOR INFORMATION

Name of claims administrator	Carrier federal ID number	Check if appropriate ☐ Self Insurance

Address of claims administrator (*number and street, city, state, ZIP code*)	☐ Insurance Carrier ☐ Third Party Admin.	Policy / Self-insured number
P.O. BOX 89453,CLEVELAND, OH 44101		
Telephone number: 888-239-3909		Policy period From To

Name of agent	Code number

OCCURRENCE / TREATMENT INFORMATION

Date of Inj./ Exp.	Time of occurrence ☐ AM ☐ PM ☐ Cannot be determined	Date employer notified	Type of injury / exposure	Type code

Last work date	Time workday began	Date disability began	Part of body	Part code

RTW date	Date of death	Injury / Exposure occurred on employer's premises? ☐ Yes ☐ No	Name of contact	Telephone number

Department or location where accident / exposure occurred	All equipment, materials, or chemicals involved in accident

Specific activity engaged in during accident / exposure	Work process employee engaged in during accident / exposure

How injury / exposure occurred. Describe the sequence of events and include any relevant objects or substances.

Cause of injury code

Name of physician / health care provider

Hospital or offsite treatment (*name and address*)

INITIAL TREATMENT
- ☐ No Medical Treatment
- ☐ Minor: By Employer
- ☐ Minor: Clinic / Hospital
- ☐ Emergency Care
- ☐ Hospitalized > 24 Hours
- ☐ Future Major Medical / Lost Time Anticipated

Name of witness	Telephone number	Date administrator notified

Date prepared	Name of preparer	Title	Telephone number

An employer's failure to report an occupational injury or illness may result in a $50 fine (IC 22-3-4-13).

INSTRUCTIONS

General Instructions:

1. Please enter information into all of the areas of the First Report form, except the boxes at the top right corner of the form which is for office use only.

2. Enter all dates in MM/DD/YY format.

3. Please return completed form electronically by an approved EDI process.

4. For answers to questions, please call (317) 232-3808.

Definitions:

AGENT NAME AND 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.

ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR EXPOSURE OCCURRED: List anything the employee was using, applying, handling or operating when the injury or exposure occurred. If the injury involves a fall, indicate any surfaces and / or objects the claimant fell on and where they fell from. Enter "NA" if no equipment, materials or chemicals were being used (*e.g. Acetylene cutting torch, metal plate, etc.*).

AVG WG/WK: Claimant's average weekly wage, calculated by totaling the latest 52 weeks of wages (*including overtime, tips, etc.*) and dividing by 52.

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

CONTACT NAME / TELEPHONE NUMBER: Enter the name of the individual at the employer's premises to be contacted for additional information (*i.e. Supervisor, HR Person, Nurse, etc.*)

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

DEPARTMENT OR LOCATION WHERE ACCIDENT OR EXPOSURE OCCURRED: If the accident or exposure did not occur on the employer's premises, enter address or location. Be specific (*e.g. Maintenance, Client's Office, Cafeteria, etc.*).

EMPLOYEE STATUS: Indicate the employee's work status from the following choices: Full-time, Part-time, Apprentice Full-time, Apprentice Part-time, Volunteer, Seasonal Worker, Piece Worker, On-Strike, Disabled, Retired, Not Employed or Unknown (you may also abbreviate the above as: (*FT, PT, AFT, APT, VO, SW, PW, OS, DI, RE, NE, or UK*).

HOW INJURY / ILLNESS OCCURRED: Describe the sequence of events leading to the injury or exposure (*e.g. Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, he brushed against the hot metal; Worker stepped to the edge of the scaffolding, lost balance and fell six feet to the concrete floor. The worker's right wrist was broken in the fall*).

NCCI CLASS CODE: A four-digit code classifying the occupation of the claimant.

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

PART OF BODY AFFECTED: Indicate the part of body affected by the injury / illness (*e.g. Right forearm, Low Back, etc.*)

REPORT PURPOSE CODE: 00 = Original First Report of Injury; 02 = Updated or Amended First Report.

RTW DATE (*Return to Work Date)***:** Enter the date following the most recent disability period on which the employee returned to work.

SIC CODE: This is the code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

SPECIFIC ACTIVITY EMPLOYEE ENGAGED IN DURING ACCIDENT / EXPOSURE: Describe the specific activity the employee was engaged in during the accident or exposure (*e.g. Cutting metal plate for flooring, sanding ceiling woodwork in preparation for painting*).

TYPE OF INJURY / ILLNESS: Briefly describe the nature of the injury or illness (*e.g. Contusion, Laceration, Fracture, etc.*)

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN DURING ACCIDENT / EXPOSURE: Enter "NA" if employee was not engaged in a work process, such as if walking down the hallway (*e.g. Building maintenance*).

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 Americ
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!

WORKER'S COMPENSATION NOTICE

Your employer is required to provide for payment of benefits under the Worker's Compensation Act of the State of Indiana.

Any employee who is injured while at work should report the injury immediately to their supervisor, employer, or designated representative.

The worker's compensation insurance carrier or the administrator for

_____ is: _____
(name of company) (name of insurance carrier or administrator)

AmTrust Insurance Company
(name of carrier/administrator)

P.O BOX 89453
(mailing address)

CLEVELAND, OH 44101
(city, state, zip)

888-239-3909
(telephone number)

_____
(contact person)

For more information about rights or procedures under the Indiana Worker's Compensation system, call or write:

Worker's Compensation Board of Indiana
Ombudsman Division
402 W. Washington St., Rm W196
Indianapolis, IN 46204
(317) 232-3808
1-800-824-2667

NOTICIA DE COMPENSACION PARA TRABAJADORES

A su empleador le es requerido proveer pagos de beneficios bajo el Acta de Compensación para Trabajadores del Estado de Indiana.

Cualquier empleado que sea lesionado mientras esté trabajando debe reportar el accidente laboral inmediatamente a su supervisor, empleador o representante designado.

La compañía de seguro de compensación del trabajador o el administrador de la compañía _____ es:
(nombre de la compañía)

_____
(nombre de la compañía de seguro/administrador)

AmTrust Insurance Company
(dirección)

_____P.O. BOX 89453, CLEVELAND, OH 44101_____ _____
(ciudad, estado, código postal)

___888-239-3909_____
(número de teléfono)

_____
(persona de contacto)

Para más información acerca de sus derechos o los procedimientos bajo el sistema de compensación para trabajadores de Indiana, llame o escriba a:

Worker's Compensation Board of Indiana
Ombudsman Division
402 W. Washington St., Rm W196
Indianapolis, IN 46204
(317) 232-3808
1-800-824-2667

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					

Summary of Benefits Paid

State Form TBD (R1 /)

INDIANA WORKER'S COMPENSATION BOARD
402 West Washington Street, Room W196
Indianapolis, IN 46204
Telephone: (317) 233-3009
www.in.gov/wcb

Date of Injury (month, day, year)	Jurisdiction Claim Number

CLAIM INFORMATION

Name of Injured Worker	Name of Employer
Address (number and street, city, state, and ZIP code)	Address (number and street, city, state, and ZIP code)
Telephone Number	Name of Claim Administrator
E-mail Address	Administrator Claim Number

CLAIMS ADJUSTER INFORMATION

Name of Claims Adjuster	Telephone Number
Address (number and street, city, state, and ZIP code)	
E-mail Address	

ACCIDENT INFORMATION

Nature of Injury		
Date Returned to Work (if available)	Date of Maximum Medical Improvement (if available)	Average Weekly Wage
Last Check Date		TTD Rate

INDEMNITY BENEFITS

Disability Type: TTD,TPD,PTD	Total Paid	$/Wk Rate	# of Weeks	# of Days	Benefit Start Date	Benefit End Date

A new period of disability must be reported each time the TTD Rate changes; or Type of Disability changes.

If asterisk (*) is present in Benefit Start Date and Benefit End Date Header, it indicates non-consecutive periods of payment reported via use of State Form 54217 Notice of Suspension of Compensation and/or Benefits.

Data displayed on form is taken only from electronic filing of SROI SX. This EDI transaction populates both the 38911 and the Benefits Summary. Numbers are not verified by WCB.

Termination of Benefits/Request for IME

State Form 38911 (R8 / 1-14)

INDIANA WORKER'S COMPENSATION BOARD
402 West Washington Street, Room W196
Indianapolis, IN 46204
Telephone: (317) 232-3808
www.in.gov/wcb

Date of Injury (month, day, year)	Jurisdiction Claim Number

CLAIM INFORMATION

Name of Injured Worker	Name of Employer
Address (number and street, city, state, and ZIP code)	Address (number and street, city, state, and ZIP code)
Telephone Number	Name of Claim Administrator
E-mail Address	Administrator Claim Number

CLAIMS ADJUSTER INFORMATION

Name of Claims Adjuster	Telephone Number
Address (number and street, city, state, and ZIP code)	
E-mail Address	

BENEFIT TERMINATION *(check all that apply)*

* If termination is NOT due to one of the 5 reasons enumerated in IC 22-3-3-7 (d), 4 additional days of TTD are owed. In accordance with IC-22-3-3-7(d), TTD/TPD benefits have been/will be terminated due to the following:

S1	☐ The injured worker has returned to any employment*; **OR** has been released by the treating physician to return to work;
S2	☐ The injured worker has refused to undergo a medical examination under Section 6 (IC 22-3-3-6)*;
S3	☐ The injured worker has refused to accept suitable employment under Section 11 (IC 22-3-3-11)*;
S4	☐ The injured worker has died*;
S5/S6	☐ The injured worker is unable or unavailable to work for reason unrelated to the compensable injury*;
S7	☐ The injured worker has received five hundred (500) weeks of TTD/TPD benefits or has been paid the maximum compensation allowed under IC 22-3-3-22*;
S8	☐ The injured worker has changed jurisdiction to a state other than Indiana;

Explanation:

DISPUTE OF BENEFIT TERMINATION AND/OR REQUEST FOR AN INDEPENDENT MEDICAL EXAMINATION (IME)

If the injured worker disagrees with proposed benefit termination, the injured worker must complete, sign and send a copy of this notice to the **Worker's Compensation Board** and **the employer** within **seven (7) days** of receipt. Preferably, this notice may be filed via the **Dispute Termination of Benefits** link on the Board's website. **PLEASE DO NOT MAIL THIS FORM TO THE BOARD UNLESS THE INJURED WORKER HAS NO ACCESS TO THE INTERNET.**

Please check all that apply:

☐ Employee disagrees with the termination of benefits ☐ Employee requires further medical care

☐ Employee believes an independent medical examination (IME) may be helpful to resolve this dispute

Reason for Objection

Signature of Employee	Date Received (month, day, year)
Printed Name	By (check one): ☐ US Mail ☐ Electronic Service

CERTIFICATION OF SERVICE

Employer must sign below to certify service.

I certify that this information is true and that a copy of the relevant medical documentation is attached.

Signature of Employer	Date of Service (month, day, year)
Printed Name	By (check one): ☐ US Mail ☐ Electronic Service

Notice of Denial of Benefits

State Form 53914 (R3 /)

** Please see reverse side for Instructions **

INDIANA WORKER'S COMPENSATION BOARD
402 West Washington Street, Room W196
Indianapolis, IN 46204
Telephone: (317) 232-3808
www.in.gov/wcb

Date of Injury *(month, day, year)*	Jurisdiction Claim Number

CLAIM INFORMATION

Name of Injured Worker	Name of Employer
Address *(number and street, city, state, and ZIP code)*	Address *(number and street, city, state, and ZIP code)*
Telephone Number	Name of Claim Administrator
E-mail Address	Administrator Claim Number

CLAIMS ADJUSTER INFORMATION

Name of Claims Adjuster	Telephone Number
Address *(number and street, city, state, and ZIP code)*	
E-mail Address	

NOTICE OF DENIAL

☐ Full Denial Full Denial Effective Date:	☐ Partial Denial Partial Denial Effective Date:
Reason(s) For Denial:	Reason(s) For Denial:

Explanation:

NOTICE TO EMPLOYEES

By filing this form, your employer or its insurance carrier has indicated to the Indiana Worker's Compensation Board that it has cause to deny worker's compensation benefits for your reported injury. You may or may not agree with this denial of benefits.

If you disagree with the denial of benefits, you should discuss the reason for denial with your employer or employer's insurance carrier. If, after having this discussion, you are not satisfied that benefits were properly denied, you may contact an attorney for legal advice, or contact an ombudsman at the Indiana Worker's Compensation Board for information at (317) 233-3009. Additional information can also be found at www.in.gov/wcb.

EMPLOYER CERTIFICATION

Employer must sign below to certify service of this notice.

Signature of Employer	*Date (month, day, year)*
Printed Name	*By (check one):* ☐ US Mail ☐ Electronic Service

INSTRUCTIONS FOR FULL OR PARTIAL DENIALS

FULL DENIALS:
You may select up to five (5) different reasons listed below explaining why the claim is being denied. Please put the code(s) inside the "Full Denial" box provided followed by a denial reason narrative in the explanation field.

FULL DENIAL REASON CODES:

No Compensable Accident/Not in Course and Scope of Employment

1A - Coming and Going
1B - Horseplay
1C - Willful Intent to Injure Oneself
1D - Not Statutory Definition of Accident
1E - Deviation From Employment
1F - Recreational/Social Activity
1H - Subsequent Intervening Accident

No Causal Relationship

2A - Idiopathic Condition
2B - Pre-existing Condition
2C - Stress Non-Work Related
2D - No Medical Evidence of Injury
2E - No Injury Per Statutory Definition
2F - Accident Not Major Contributing Cause of Injury

No Coverage

3A - No Employee/Employer Relationship
3B - Independent Contractor
3C - Not Statutory Definition of Employee
3D - No Jurisdiction
3E - No Policy in Effect On Date of Accident
3F - Statute of Limitation Expired
3G - Statutory Exemptions (Sole Proprietor, Corporate Officer, etc)
3I - Employee Not Reported to PEO

Substance Use/Abuse

4A - Injury Primarily Occasioned by Intoxication or Use of Any Drug

Other (Not Elsewhere Classified)

5A - Failure To Report Accident Timely
5C - Misrepresentation

PARTIAL DENIALS:
Please select one (1) of the reasons below to help explain which aspect(s) of the claim is being denied. Please put the code inside the "Partial Denial" box provided followed by a denial reason narrative in the explanation field.

PARTIAL DENIAL REASON CODES:

A - Denying Indemnity in Whole, Not Medical
B - Denying Indemnity in Part, Not Medical
C - Denying Medical in Whole, Not Indemnity
D - Denying Medical in Part, Not Indemnity
E - Denying Indemnity in Whole, Medical in Part
F - Denying Medical in Whole, Indemnity in Part
G - Denying Both Indemnity & Medical in Part

NOTICE OF SUSPENSION OF COMPENSATION AND/OR BENEFITS

State Form 54217 (TBD)

INDIANA WORKER'S COMPENSATION BOARD
402 West Washington Street, Room W196
Indianapolis, IN 46204
Telephone: (317) 232-3808
www.in.gov/wcb

Date of Injury *(month, day, year)*	Jurisdiction Claim Number

NOTICE is hereby given that the employer intends to suspend compensation and/or benefits for a compensable injury under the Indiana Worker's Compensation Act for the reason listed below.

EMPLOYEE AND CLAIM INFORMATION

Name of Injured Worker	Name of Employer
Address *(number and street, city, state, and ZIP code)*	Address *(number and street, city, state, and ZIP code)*
Telephone Number	Name of Insurance Carrier / Third Party Administrator
E-mail Address	Administrator Claim Number

CLAIM ADJUSTER / ATTORNEY INFORMATION

Name of Adjuster / Attorney *(typed or printed)*

Address *(number and street, city, state, and ZIP code)*

Telephone Number	E-mail Address

SUSPENSION AND REINSTATEMENT INFORMATION

According to IC 22-3-3-4(c) or 22-3-3-6(a), injured workers shall not receive temporary total or partial disability payments and/or permanent partial impairment payments, reimbursement for unauthorized medical care, nor are they entitled to have a case heard, until they agree to comply with the following:

Date Suspension Initiated *(month, day, year)*

Reason compensation and/or benefits are being suspended:

- ☐ Refusal of treatment, services and supplies (IC 22-3-3-4(c)) / (IC 22-3-3-7)
- ☐ Refusal or obstruction of examination (IC 22-3-3-6(a))
- ☐ Refusal to accept suitable employment (IC 22-3-3-11)
- ☐ Refusal of Board ordered autopsy (IC 22-3-3-6(h))

Actions required to have compensation and/or benefits reinstated

Signature of Employee acknowledging receipt:	Date signed *(month, day, year)*

CERTIFICATION

Adjuster/Attorney must sign below to certify service.
I certify that this information is true and that the injured worker has been served with a copy.

Signature of Adjuster/Attorney	Date of Service (month, day, year)
Printed Name	By (check one): ☐ US Mail ☐ Electronic Service