Massachusetts
Worker's Compensation
Claim Kit

AmTrust North America
An AmTrust Financial Company

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Workers' Compensation Claim Reporting Information

AmTrust INSURANCE

24/7 Toll Free Claim Reporting for All States

(888)239-3909

WorkersCompClaimReport@AmTrustgroup.com

www.amtrustfinancial.com

Information Required for All Claims Reported

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

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

How do I help my injured worker find a doctor?

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

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

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

Timely Reporting

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

We're Here To Help

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

Relax And Stay Positive

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

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

AmTrust INSURANCE

MKT6310 06/23

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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 "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.

Notice to Employees Poster

- All Employers must: Fill out the Notice to Employees
- Post in a visible location utilized and accessible to all employees. If no such location exists, the poster must be distributed to employees electronically or by mailing a copy.
- The Poster must be updated, reposted and redistributed whenever any of the information changes.

To complete the form, please enter the following information in the spaces provided:

- Employer HR/Workers' Compensation Contact
- Phone Number
- Insurance Carrier
- Employer name
- Employer address
- Name, address and phone number of a local hospital to provide emergency medical treatment

For your convenience, AmTrusts' contact information has been completed on the poster.

(Annotated Laws of Massachusetts 152 § 21 and § 22)

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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NOTICE TO EMPLOYEES

THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS

IF YOU ARE INJURED ON THE JOB:

- **Immediately notify your employer that you have been injured.**

Employer HR/Workers' Compensation Contact Phone Number

- **Tell the medical provider that you have been injured at work and give the information below:**

Insurance Carrier	Address	Phone Number
C/O AmTrust North America	PO Box 89404 Cleveland, OH 44101	888-239-3909

Employer	Address

- **If the employer fails to report the injury to the insurer, the employee may file an Employee's Claim (Form 110).**
- **Additional information regarding your rights and eligibility for benefits pursuant the Workers' Compensation law may be obtained by contacting the Department of Industrial Accidents at 617.727.4900 or visiting www.mass.gov/dia.**

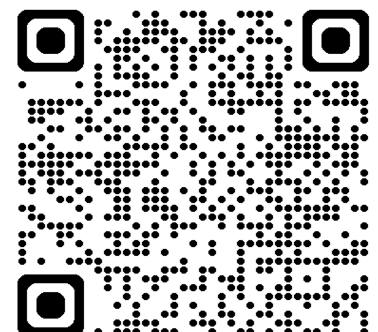
IF MEDICAL TREATMENT IS NEEDED:

Injured workers may select their own medical provider. Medical treatment costs that are reasonable, necessary, and related to the work injury will be paid by the above-named insurer.

If medical facility information is provided below, the above-named insurer has a preferred provider arrangement and the insurer has arranged for your initial treatment at:

Medical Facility: Address:

Phone Number:



EMPLOYER: THIS NOTICE MUST BE FILLED OUT AND POSTED WHERE EMPLOYEES CAN READ IT PURSUANT M.G.L. C. 152, SECTIONS 21, 22, 30, AND 75B (2). EMPLOYERS MAY NOT RETALIATE, DISCRIMINATE (IN ACCORDANCE WITH ANY APPLICABLE STATE OR FEDERAL LAWS WHICH INCLUDES IMMIGRATION STATUS), OR PROVIDE FALSE INFORMATION ABOUT THE WORKERS' COMPENSATION PROCESS TO THEIR EMPLOYEES. THIS NOTICE MUST BE UPDATED, POSTED AND REDISTRIBUTED WHEN THERE ARE CHANGES TO THE INFORMATION.

REVISED JUNE 2024

AVISO PARA EMPLEADOS

COMMONWEALTH DE MASSACHUSETTS
DEPARTAMENTO DE ACCIDENTES INDUSTRIALES

SI USTED TIENE UN ACCIDENTE EN EL TRABAJO:

- **Avise inmediatamente a su empleador que tuvo un accidente.**

Contacto de RH del Empleador/Indemnización por Accidente Laboral: ____________________

Número de Teléfono: ____________________

- **Avise al proveedor médico que usted tuvo un accidente en el trabajo y proporcione la siguiente información:**

Compañía de Seguros: C/O AmTrust North America

Dirección: PO Box 89404
Cleveland, OH 44101

Número de Teléfono: 888-239-3909

Empleador: ____________________

Dirección: ____________________

- **Si el empleador no informa el accidente a la compañía de seguros, el trabajador puede presentar un Reclamo del Empleado (Form. 110).**

- **Puede contactar al Departamento de Accidentes Industriales a través del 617.727.4900 o www.mass.gov/dia para obtener información adicional sobre sus derechos y elegibilidad para los beneficios según la ley de Indemnización por Accidentes de Trabajo.**

SI SE REQUIERE TRATAMIENTO MÉDICO:

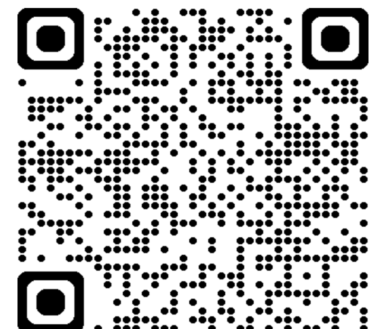
Los trabajadores que resulten lesionados pueden elegir sus propios proveedores médicos. Los costos por tratamientos médicos que sean razonables, necesarios y relativos al accidente laboral serán pagados por la compañía aseguradora que se menciona anteriormente.

Si se incluye información de una institución médica a continuación, significa que la compañía aseguradora mencionada tiene un acuerdo con un proveedor de preferencia para que su tratamiento inicial se realice en:

Institución Médica: ____________________

Dirección: ____________________

Número de Teléfono: ____________________



EMPLEADOR: ESTE AVISO DEBE COMPLETARSE Y PUBLICARSE EN UN LUGAR EN EL QUE LOS EMPLEADOS PUEDAN LEERLO, TAL COMO SE ESTABLECE EN M.G.L. C. 152, SECCIONES 21, 22, 30 Y 75B (2). LOS EMPLEADORES NO PODRÁN TOMAR REPRESALIAS, DISCRIMINAR (SEGÚN LO ESTABLECIDO PARA CUALQUIERA DE LAS LEYES ESTATALES O FEDERALES APLICABLES, INCLUYENDO LA CONDICIÓN MIGRATORIA), NI BRINDAR INFORMACIÓN FALSA SOBRE EL PROCESO DE INDEMNIZACION POR ACCIDENTE LABORAL A SUS EMPLEADOS. ESTE AVISO DEBE ACTUALIZARSE, PUBLICARSE Y DISTRIBUIRSE CADA VEZ QUE SE PRODUZCAN CAMBIOS EN LA INFORMACIÓN.

REVISADO EN JUNIO DE 2024

إشعار إلى الموظفين

كومنولث ولاية ماساتشوستس
إدارة الحوادث الصناعية

إذا تعرضت للإصابة في العمل:

- **أخبر جهة العمل على الفور أنك قد أُصِبت.**

طرف الاتصال بإدارة الموارد البشرية/ إدارة شؤون تعويضات العمال التابعة لجهة العمل | رقم الهاتف

- **أخبر مقدم الخدمة الطبية أنك قد أُصِبت في العمل وقدم المعلومات أدناه:**

اسم شركة التأمين	العنوان	رقم الهاتف
C/O AmTrust North America	PO Box 89404 Cleveland, OH 44101	888-239-3909

جهة العمل | العنوان

- **إذا فشلت جهة العمل في الإبلاغ عن الإصابة إلى شركة التأمين، يمكن للموظف تقديم مطالبة الموظف (النموذج 110).**
- **يمكن الحصول على معلومات إضافية حول حقوقك وأهليتك للحصول على الإعانات وفقاً لقانون تعويض العمال عن طريق الاتصال بإدارة الحوادث الصناعية على رقم الهاتف 617.727.4900 أو زيارة الرابط www.mass.gov/dia.**

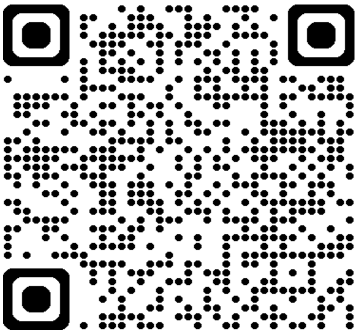
إذا كانت هناك حاجة إلى العلاج الطبي:

يمكن للعمال المصابين اختيار مقدم الرعاية الطبية الخاص بهم. سيتم دفع تكاليف العلاج الطبي المعقولة والضرورية والمتعلقة بإصابة العمل من قبل شركة التأمين المذكورة أعلاه.

إذا تم تقديم معلومات المنشأة الطبية أدناه، فإن شركة التأمين المذكورة أعلاه لديها ترتيب مقدم خدمة مفضّل وقد قامت شركة التأمين بترتيب علاجك الأولي في:

المنشأة الطبية: | العنوان:

رقم الهاتف:



جهة العمل: يجب ملء هذا الإشعار ونشره حيث يمكن للموظفين قراءته وفقاً للقانون العام لولاية ماساتشوستس (M.G.L.C. 152، الأقسام 21، و22، و30، و(2) 75B). لا يجوز لجهات العمل الانتقام أو التمييز (وفقاً لأي قوانين تابعة للولاية أو قوانين اتحادية معمول بها بما في ذلك وضع الهجرة) أو تقديم معلومات خاطئة عن عملية تعويض العمال لموظفيهم. يجب تحديث هذا الإشعار ونشره وإعادة توزيعه عند حدوث تغييرات على المعلومات.

روجع في يونيو/ حزيران 2024

AVISO PA FUNCIONÁRIUS

DEPARTAMENTU DI ACIDENTIS INDUSTRIAL DI COMMONWEALTH DI MASSACHUSETTS

SI BU SUFRI UM ACIDENTI DI TRABADJU:

- **Notifica imediatamenti bu empregador ma bu sufri um acidenti.**

Contactu di RH/Compensazon di Trabadjadores di Empregador ____________________

Número de telefoni ____________________

- **Informa provedor médico ma bu sufri um acidenti di trabadju e das kes informazons abaixu:**

Nomi de seguru	Direson	Número de telefoni
C/O AmTrust North America	PO Box 89404 Cleveland, OH 44101	888-239-3909

Empregador	Direson

- **Si empregador ka comunica acidenti pa seguradora, funcionáriu pode presenta um Reclamason di Funcionáriu (Formulário 110).**
- **Informazons adicionais sobre bus direitus e elegibilidade pa benefícius di acordo ku lei de Indenizason di Trabadjadores podi ser obtidu ntrandu em contatu ku Departamentu di Acidenti Industrial pa telefoni 617.727.4900 ou pa site www.mass.gov/dia.**

SI TRATAMENTU MÉDICO FOR NECESSARIU:

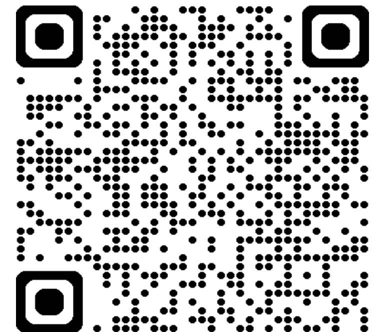
Trabadjadores acidentadus podi scodji se própriu provedor médico. Custus di tratamentu médico ki for razoável, necessariu e relacionadus a acidenti di trabadju ta ser pagus pa seguradora mencionadu diriba.

Si informazons sobri estabelecimentu médico for fornecidus abaixu, seguradora mencionadu diriba tem um acordu di provedor preferencial e seguradora providencia si tratamentu inicial na:

Instalazons médicus: ____________________

Direson: ____________________

Número de telefoni: ____________________



EMPREGADOR: ES AVISU DEVI SER PREENCHIDU E AFIXADU NA UM LOCAL UNDI FUNCIONÁRIUS PODI LÊL, DI ACORDU KU M.G.L. C. 152, SEKSONS 21, 22, 30 i 75B (2). EMPREGADORES KA PODI RITALIA, DISCRIMINA (DI ACORDU KU KUALKUER LEI ESTADUAL OU FEDERAL APLICÁVEL, KI TA INCLUI STATUS DI IMIGRASON) OU FORNICE INFORMASONS FALSUS SOBRI PROCESSU DI INDENIZASON DI TRABADJADORIS A SES FUNCIONÁRIUS. ES AVISU DEVI SER ATUALIZADU, PUBLICADU E REDISTRIBUÍDU HORAS KI OUVER ALTERASONS NAS INFORMASONS.

REVISED JUNE 2024

员工的通知

马萨诸塞州工业事故部门

如果你在工作中受伤:

- **立即通知您的雇主您受伤了.**

雇主人力资源部/工伤赔偿联系 ____________________ 电话 ____________________

- **告诉医务人员您在工作中受伤,并提供以下信息:**

保险公司	地址	电话
C/O AmTrust North America	PO Box 89404 Cleveland, OH 44101	888-239-3909

雇主 ____________________ 地址 ____________________

- **如果雇主未能向保险公司报告受伤情况,员工可以提交员工索赔（表格 110）.**
- **附加信息关于您的权利和享受福利的资格根据工人赔偿法, 您可以致电 617.727.4900 联系工业事故部或游览 www.mass.gov/dia.**

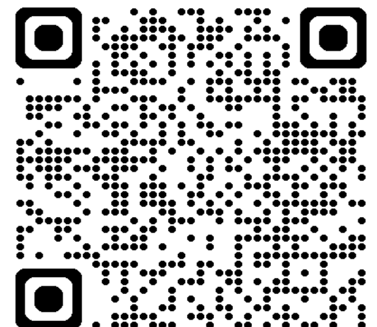
如果需要治疗:

受伤的工人可自行选择医疗机构. 合理的费用, 必要的治疗, 和上述的保险公司将支付与工伤相关的医疗费用.

如果下面提供了医疗机构信息, 上述保险公司有优先医疗权安排治疗 服务,并且保险公司已安排您在:

医疗机构: ____________________ 地址: ____________________

电话: ____________________



雇主：根据 M.G.L. C. 152 第 21、22、30 和 75B (2) 条，必须填写本通知并将其张贴在员工可以阅读的地方。雇主不得报复、歧视（根据任何适用的州或联邦法律，包括移民身份）或向其员工提供有关工人赔偿流程的虚假信息。当信息发生变化时，必须更新、张贴和重新分发本通知.

REVISED JUNE 2024

AVI POU TOUT ANPLWAYE

THE COMMONWEALTH OF MASSACHUSETTS
DEPATMAN AKSIDAN ENDISTRYÈL (DIA)

SI OU VIKTIM YON AKSIDAN PANDAN OU NAN TRAVAY OU :

- **Fè anplwayè w konnen touswit ke ou sot viktim yon aksidan.**

Reponsab Resous Imèn (HR) Anplwayè a/Kontak Konpansasyon Travayè ____________________ Nimewo Telefòn ____________________

- **Di pèsonèl medikal kap ba w swen a ke se pandan ou te nan travay ke ou te fè yon aksidan ki andomaje w; epi tou, ba l enfòmasyon ki anba yo:**

Konpayi Asirans	Adrès	Nimewo Telefòn
C/O AmTrust North America	PO Box 89404, Cleveland, OH 44101	888-239-3909

Anplwayè	Adrès

- **Si anplwayè a pa rapòte aksidan an oswa andomajman an bay konpayi asirans la, travayè a ta dwe ranpli yon Fòm Reklamasyon Anplwaye (Fòm 110).**
- **Ou ka jwenn plis enfòmasyon konsènan dwa w ak kondisyon ki nesesè pou kalifye pou benefis an akò ak lwa sou Konpansasyon Travayè, si w kontakte Depatman Aksidan Endistriyèl la (DIA) nan nimewo 617.727.4900 oswa si w vizite sit entènèt www.mass.gov/dia la.**

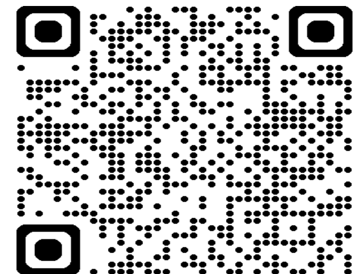
SI YON TRETMAN MEDIKAL NESESÈ:

Travayè ki viktim yon aksidan ka chwazi pwòp founisè sèvis medikal yo. Depi depans pou trètman medikal la rezonab, li nesesè, epi li gen rapò ak aksidan moun nan te sibi nan travay la, konpayi asirans li te deklare anwo nan fòm la ap peye pou yo.

Si nan etablisman sante ki liste anba a, konpayi asirans ou te deklare nan fòm la gen yon aranjman ki pi favorab ak youn ladan yo, konpayi asirans la gen pou notifye w ke li deja fè aranjman pou kòmanse tretman ou a nan etablisman sa a:

Etablisman Medikal: ____________________ Adrès: ____________________

Nimewo Telefòn: ____________________



ENFÒMASYON MIZAJOU AN JEN 2024

ANPLWAYÈ: AN KONFÒMITE AK SEKSYON 21, 22, 30, AK 75B (2) NAN M.G.L. C. 152 AVI SA A FÈT POU RANPLI EPI AFICHE KOTE TOUT TRAVAYÈ YO KA WÈ L. ANPLWAYÈ YO PA GEN DWA PRAN VANJANS SOU TRAVAYÈ YO, DISKRIMINE KONT YO (SOU BAZ ANKENN LWA ETA A, OSWA LWA FEDERAL KI GEN POU WÈ AK KESYON SITIYASION IMIGRASYON), NI TOU BAYO MOVE ENFÒMASYON SOU PWOSESIS KONPANSASYON POU TRAVAYÈ. ANPLWAYÈ YO DWE FÈ MIZAJOU AVI SA A, AFICHE L EPI REDISTRIBYE L CHAK FWA GEN CHANJMAN NAN ENFÒMASYON AN.

ការជូនដំណឹងដល់និយោជិត

នាយកដ្ឋានឧស្សាហកម្មឧប្បត្តិហេតុនៃរដ្ឋ MASSACHUSETTS

ប្រសិនបើអ្នករងរបួសនៅកន្លែងធ្វើការៈ

- ជូនដំណឹងដល់និយោជករបស់អ្នកភ្លាមៗថាអ្នកបានរងរបួស។

លេខទូរស័ព្ទទំនាក់ទំនង

និយោជកប្រភពមនុស្ស (HR)/ ប្រាក់សំណងរបស់កម្មករ

- ប្រាប់អ្នកផ្តល់សេវាវេជ្ជសាស្ត្រ ថាអ្នកត្រូវបានរងរបួសនៅកន្លែងធ្វើការ និងផ្តល់ព័ត៌មានខាងក្រោមៈ

ឈ្មោះ	អាសយដ្ឋាន	លេខទូរស័ព្ទអ្នកធានារ៉ាប់រង
C/O AmTrust North America	PO Box 89404 Cleveland, OH 44101	888-239-3909

អាសយដ្ឋាន

និយោជក

- ប្រសិនបើនិយោជកមិនបានរាយការណ៍អំពីការរងរបួសទៅអ្នកធានា និយោជិតដាក់ការប្តឹងទាមទាររបស់និយោជិត (ទម្រង់ 101)។
- ព័ត៌មានបន្ថែមទាក់ទងនឹងសិទ្ធិ និងសិទ្ធិទទួលបានអត្ថប្រយោជន៍របស់អ្នកដោយយោងតាមច្បាប់ ស្តីពីសំណងរបស់កម្មករអាចទទួលបានដោយទាក់ទងនាយកដ្ឋានគ្រោះថ្នាក់ឧស្សាហកម្មតាមរយៈលេខ 617.727.4900 ឬចូលទៅកាន់ www.mass.gov/dia.

បើការព្យាបាលខាងវេជ្ជសាស្ត្រគឺត្រូវការចាំបាច់ៈ

កម្មកររងរបួសអាចជ្រើសរើសអ្នកផ្តល់សេវាវេជ្ជសាស្ត្ររបស់ខ្លួនផ្ទាល់។ ថ្លៃព្យាបាលដែលសមហេតុ ផលចាំបាច់ និងទាក់ទងនឹងរបួសការងារ នឹងត្រូវបង់ដោយក្រុមហ៊ុនធានារ៉ាប់រងដែលមានឈ្មោះខាងលើ។

ប្រសិនបើព័ត៌មានអំពីមណ្ឌលសុខភាពត្រូវបានផ្តល់ជូនខាងក្រោម អ្នកធានាដែលមាន ឈ្មោះខាងលើមានការរៀបចំអ្នកផ្តល់សេវា ដែលពេញចិត្ត ហើយក្រុមហ៊ុនធានារ៉ាប់រងបាន រៀបចំសម្រាប់ការព្យាបាលដំបូងរបស់អ្នកនៅៈ

ស្ថាប័នវេជ្ជសាស្ត្រៈ

អាសយដ្ឋានៈ

លេខទូរស័ព្ទៈ

និយោជកៈ សេចក្តីជូនដំណឹងត្រូវតែបានបំពេញ និងដាក់តាំងនៅទីកន្លែងដែលនិយោជិតទាំងឡាយអាចអានវា អនុលោម M.G.L. C. 152, SECTIONS 21, 22, 30, AND 75B (2). និយោជកមិនអាចសងសឹក រើសអើង (ស្របតាមរដ្ឋដែលអាចអនុវត្តបាន ឬច្បាប់សហព័ន្ធដែលរួមបញ្ចូលស្ថានភាពអន្តោប្រវេសន៍) ឬផ្តល់ព័ត៌មានមិនពិតអំពីសំណងរបស់កម្មករនិយោជិត។ សេចក្តីជូនដំណឹងនេះត្រូវតែមានបច្ចុប្បន្នភាពដាក់តាំង នឹងចែករំលែកម្តងហើយម្តងទៀត នៅពេលមានការផ្លាស់ប្តូរចំពោះព័ត៌មាន។

បានកែសម្រួលខែមិថុនា 2024

NOTIFICAÇÃO AOS EMPREGADOS

Estado de Massachusetts

Departamento de Acidentes Industriais

SE VOCÊ SE FERIR NO TRABALHO:

- **Notifique imediatamente seu empregador de que se feriu.**

Contato do Departamento de RH/Indenização Trabalhista do Empregador | Telefone

- **Diga ao seu provedor de serviços médicos que se feriu no trabalho e dê a ele as seguintes informações:**

Seguradora	Endereço	Telefone
C/O AmTrust North America	PO Box 89404 Cleveland, OH 44101	888-239-3909

Endereço do empregador

- **Se o empregador não informar o ferimento à seguradora, o empregado pode fazer um Requerimento do Empregado (Formulário 110).**
- **Para obter mais informações a respeito de seus direitos e sua elegibilidade de acordo com a Lei de Indenização Trabalhista (Workers' Compensation Law), contate o Departamento de Acidentes Industriais pelo telefone 617.727.4900 ou acesse www.mass.gov/dia.**

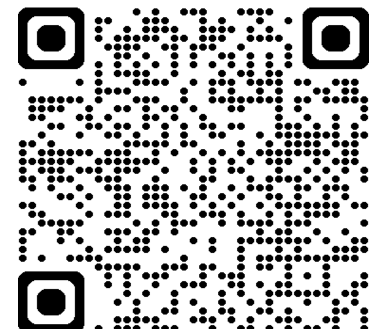
SE FOR NECESSÁRIO TRATAMENTO MÉDICO:

Os empregados feridos podem selecionar seus próprios provedores de serviços médicos. Custos razoáveis e necessários do tratamento médico, e que estejam relacionados à lesão serão pagos pela seguradora indicada acima.

Se informações sobre a instalação médica estão fornecidas abaixo, a seguradora indicada acima tem um acordo de provedores preferenciais e a seguradora tem um acordo para seu tratamento inicial em:

Instalação médica: | Endereço:

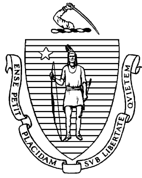
Telefone:



EMPREGADOR: ESTA NOTIFICAÇÃO DEVE SER PREENCHIDA E AFIXADA EM UM LOCAL ONDE OS EMPREGADOS POSSAM LÊ-LA, DE ACORDO COM AS M.G.L. (LEIS GERAIS DE MASSACHUSSETS) C. 152, SEÇÕES 21, 22, 30 E 75B (2). OS EMPREGADORES NÃO PODEM RETALIAR, DISCRIMINAR (DE ACORDO COM AS LEIS ESTADUAIS OU FEDERAIS APLICÁVEIS, INCLUINDO A SITUAÇÃO IMIGRATÓRIA), OU FORNECER INFORMAÇÕES FALSAS SOBRE O PROCESSO DE INDENIZAÇÃO TRABALHISTA A SEUS EMPREGADOS. ESTA NOTIFICAÇÃO DEVE SER ATUALIZADA, AFIXADA E REDISTRIBUÍDA QUANDO HOUVER MUDANÇAS NAS INFORMAÇÕES.

REVISADA EM JUNHO DE 2024

FORM 101



The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 101
1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.mass.gov/dia

DIA USE ONLY

Print Form

EMPLOYER'S FIRST REPORT OF INJURY OR FATALITY

THIS FORM MUST BE FILED BY THE *EMPLOYER* IN THE EVENT OF AN INJURY THAT RESULTS IN DEATH OR FIVE OR MORE CALENDAR DAYS OF TOTAL OR PARTIAL INCAPACITY FROM EARNING WAGES.

***INSTRUCTIONS AND CODES ON THE REVERSE SIDE* - Please Print Legibly or Type - Unreadable forms will be returned.**

EMPLOYEE

1. Employee's Name (Last, First, MI):	2. Home Telephone Number:	3. Social Security Number*:	4. Sex: ☐ M ☐ F
5. Home Address (No., Street, City, State & Zip Code):	5a. Native Language Code: ______ Other:______________	6. Marital Status: ☐ M ☐ S	7. No. of Dependents:
8. Date of Hire (mm/dd/yyyy):	9. Date of Birth (mm/dd/yyyy):	10. Average Weekly Wage: $ ☐ Estimated ☐ Actual	

EMPLOYER

11. Employer's Name:	12. Federal Tax I.D. Number:
13. Employer's Address (No., Street, City, State & Zip Code):	14. Employer's Telephone Number:
	15. Industry Code (See Reverse Side):
16. Workers' Compensation Insurance Carrier and Tel. No. (NOT LOCAL AGENT/ADMINISTRATOR):	17. W.C. Policy Number:
18. Self-Insured? ☐ Yes ☐ No If Yes, Self-Insurer Number:	19. Business Type : ☐ Service ☐ Wholesale ☐ Mfg. ☐ Retail ☐ Other ______________________

INJURY INFORMATION

20. DATE OF INJURY (mm/dd/yyyy):	**20a. Insurer's Case/Claim File No.:**	
21. Was Employee Injured on Employer's Premises? ☐ Yes ☐ No	22. Location of Injury if not on Employer's Premises:	
23. FIRST day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):	**24. FIFTH day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):**	
25. If Employee has Died, Date of Death (mm/dd/yyyy):	26. Source of Injury (Chemicals, Machinery, etc.):	
27. Briefly Describe How Injury/Exposure Occurred and Body Part(s) involved:		
28. Person to Whom Injury was Reported (list position):	29. Date Reported (mm/dd/yyyy):	30. Date Reported as work related (mm/dd/yyyy):
31. Injury Code(s) / Body Part Code(s) a. to body part a. b. to body part b. c. to body part c.	32. Witness(es) to Injury - Give Full Name(s), if none state as such:	
33. Has Employee Returned to Work? ☐ Yes ☐ No	34. Date Employee Returned to Work(mm/dd/yyyy):	
35. Employee's Regular Occupation:	36. Has Employee Returned to Regular Occupation: ☐ Yes ☐ No	

PREPARER

37. PREPARER'S Name (SEE INSTRUCTIONS ON REVERSE SIDE):	38. PREPARER'S Title:	
39. PREPARER'S Signature (SEE INSTRUCTIONS ON REVERSE SIDE):	40. Date Prepared (mm/dd/yyyy):	40a. PREPARER'S e-mail address:

*Disclosure of Social Security Number is Voluntary. It will aid in the processing of your report.

THIS FORM DOES NOT CONSTITUTE AN EMPLOYEE'S CLAIM FOR BENEFITS UNDER WORKERS' COMPENSATION.

EMPLOYER'S FIRST REPORT OF INJURY OR FATALITY

FILING INSTRUCTIONS

1. WHEN TO FILE: File this form within 7 calendar days, not including Sundays and legal holidays, of receipt of notice of any injury alleged to have arisen out of and in the course of employment, which totally or partially incapacitates an employee for a period of 5 or more calendar days from earning wages. This form is not an admission of liability, but must be filed even though the Employer may believe that the Employee is not injured, or that the Employee is not entitled to benefits under M.G.L. Chapter 152.
2. WHERE TO FILE: This form should be mailed to the Department of Industrial Accidents at the address shown on the front of the form. Copies must also be provided to the Employee and to the Employer's Workers' Compensation insurer.
3. PENALTIES: Failure to report injuries on this form may result in a fine of $100.00 in accordance with M.G.L. Chapter 152, Section 6.
4. EMPLOYER'S NAME & SIGNATURE IN BOXES 37 & 39: This form must be filed by the employer or an authorized agent/representative of the employer.

NATIVE LANGUAGE CODES

1 – English / 2 – Portuguese / 3 – Haitian Creole / 4 – Spanish / 5 – Chinese / 6 – Vietnamese / 7 – Cape Verdean / 9 – Other

INDUSTRY CODES

Agriculture, Forestry and Fishing
01 Agriculture Production - Crops
02 Agriculture Production - Livestock
07 Agricultural Services
08 Forestry
09 Fishing, Hunting and Trapping

Mining
10 Metal Mining
12 Coal Mining
13 Oil and Natural Gas
14 Nonmetallic Minerals, Except Fuels

Construction
15 General Building Contractors
16 Heavy Construction, Ex. Building
17 Special Trade Contractors

Manufacturing
20 Food and Kindred Products
21 Tobacco Products
22 Textile Mill Products
23 Apparel and Other Textile Products
24 Lumber and Wood Products
25 Furniture and Fixtures
26 Paper and Allied Products
27 Printing and Publishing
28 Chemicals and Allied Products
29 Petroleum and Coal Products
30 Rubber and Misc. Plastic Products
31 Leather and Leather Products
32 Stone, Clay and Glass Products
33 Primary Metal Industries
34 Fabricated Metal Products
35 Industrial Machinery and Equipment
36 Electronic and Other Electrical Equipment
37 Transportation Equipment
38 Instruments and Related Products
39 Miscellaneous Manufacturing Industries

Transportation and Public Utilities
40 Railroad Transportation
41 Local and Interurban Passenger Transit
42 Trucking and Warehousing
43 U.S. Postal Service
44 Water Transportation
45 Transportation by Air
46 Pipelines, Except Natural Gas
47 Transportation Services
48 Communications
49 Electric, Gas and Sanitary Services

Wholesale Trade
50 Wholesale Trade - Durable Goods
51 Wholesale Trade - Non-durable Goods

Retail Trade
52 Building Materials and Garden Supplies
53 General Merchandizing
54 Food Stores
55 Automotive Dealers and Service Stations
56 Apparel and Accessory Stores
57 Furniture and Home Furnishing Stores
58 Eating and Drinking Establishments
59 Miscellaneous Retail

Finance, Insurance and Real Estate
60 Depository Institutions
61 Non-depository Institutions
62 Security and Commodity Brokers
63 Insurance Carriers
64 Insurance Agents, Brokers and Service
65 Real Estate
67 Holding and Other Investment Officers

Services
70 Hotels and Other Lodging Places
72 Personal Services
73 Business Services
75 Auto Repair Services and Parking
76 Miscellaneous Repair Services
78 Motion Pictures
79 Amusements and Recreation Services
80 Health Services
81 Legal Services
82 Educational Services
83 Social Services
84 Museums, Botanical, Zoological Gardens
86 Membership Organizations
87 Engineering and Management Services
88 Private Households
89 Services, NEC

Public Administration
91 Executive, Legislative and Garden
92 Justice, Public Order, and Safety
93 Finance, Taxation, and Monetary Benefits
94 Administration of Human Services
95 Environmental Quality and Housing
96 Administration of Economic Program
97 National Security and International Affairs

Non-classifiable Establishments
99 Non-classifiable Establishments

NATURE OF INJURY OR ILLNESS CODES

100 Amputation or Enucleation
110 Asphyxia or Strangulation Etc.
120 Burns (Heat)
130 Burns (Chemical)
140 Concussion
160 Contusion, Crushing, Bruise
170 Cut, Laceration, Puncture
190 Dislocation
200 Electric Shock, Electrocution
210 Fracture
250 Hernia, Rupture
300 Scratches, Abrasions
310 Sprains, Strains
400 Multiple Injuries
900 No Injury
950 Damage to Prosthetic Devices
995 No Other Injury, NEC**
999 Non-classifiable

Infective or Parasitic Disease
150 Infective or Parasitic Disease, UNS*
151 Amebiasis
152 Anthrax
153 Brucellosis
154 Conjunctivitis and Opthalmia
156 Tetanus
157 Tuberculosis
159 Other Infective or Parasitic Diseases

Dermatitis
180 Dermatitis, UNS*
183 Primary Infections of the Skin
184 Other Skin Conditions
185 Dermatitis, Allergenic or Contact
189 Skin Condition, NEC**

Poisoning Systemic
270 Poisoning, Systemic, UNS*
271 Due to Toxic Materials other than Lead
272 Diseases of the Blood and Blood Forming Organs
273 Upper Respiratory Conditions
274 Influenza, Pneumonia, Etc.
276 Other Diseases of the Gastro-Intestinal Tract
278 Effects of Lead
279 Other Toxic Effects of One System Only

Respiratory Systems, Conditions of
570 Respiratory Systems, Conditions of
571 Upper Respiratory
572 Asthma, Influenza, Pneumonia

Pneumoconiosis
280 Pneumoconiosis
281 Aluminosis
282 Anthracosis
283 Asbestosis
284 Byssinosis
285 Siderosis
286 Silicosis
287 Other Pneumoconioses
289 Pneumoconiosis and Tuberculosis

Nervous System, Conditions of
560 Nervous System, Conditions of - NEC**
561 Diseases of the Central Nervous System
562 Diseases of the Nerves and Peripheral Ganglia

Neoplasm Tumor
550 Neoplasm Tumor, UNS*
551 Malignant
552 Benign

Radiation Effects
290 Radiation Effects, UNS*
291 Non-Ionizing Radiation
292 Microwaves
293 Ionizing Radiation - X-Ray
294 Ionizing Radiation - Isotopes
295 Welder's Flash

Other
265 Carpal Tunnel Syndrome
510 Cardiovascular and Other Conditions of the Circulatory System
520 Complications Peculiar to Medical Care
500 Effects of Changes in Atmospheric Pressure
240 Effects of Environmental Heat
220 Effects of Exposure to Low Temperature
530 Eye, other Diseases of the Eye
230 Hearing Loss or Impairment
991 Heart Condition ,Excludes Heart Attack
320 Hemorrhoids
330 Hepatitis, Serum and Infective
275 Hepatitis, Toxic
260 Inflammation of Joints, Etc.
540 Mental Disorders
900 No Illness
999 Non-classifiable
990 Occupational Disease, NEC**
580 Symptoms and Ill-defined Conditions

BODY PART AFFECTED CODES

Head
100 Head, UNS*
110 Brain
120 Ear(s), UNS*
121 Ear(s), External
124 Ear(s), Internal
130 Eye(s), UNS*
140 Face, UNS*
141 Jaw, Chin
144 Mouth and Throat (vocal chords, larynx)
146 Nose
148 Face, Multiple Parts
149 Face, NEC**
150 Scalp
160 Skull
198 Head Multiple
200 Neck & Cervical Vertebrae

UPPER EXTREMITIES
300 Upper Extremities, NEC**
310 Arm(s), UNS*
311 Upper Arm
313 Elbow(s)
315 Forearm(s)
318 Arm(s), Multiple
319 Arm(s), NEC**
320 Wrist(s)
330 Hand(s), Not Wrists or Fingers
340 Finger(s)
398 Upper Extremities, Multiple
400 Trunk, UNS*
410 Abdomen, Internal Organs, Inguinal Hernia
420 Back
430 Chest, Ribs, Breastbone, Internal Organs
440 Hip(s)..,Pelvis, Organs and Buttocks
450 Shoulder(s)
498 Trunk, Multiple

LOWER EXTREMITIES
500 Lower Extremities
510 Leg(s), UNS*
513 Knee(s)
515 Lower Leg(s)
518 Leg(s), Multiple
519 Leg(s), NEC**
520 Ankle(s)
530 Foot or Feet, Not Ankle
540 Toe(s)
598 Lower Extremities, Multiple
700 MULTIPLE PARTS
Applies when more than one major body part as been effected such as an arm and a leg
999 NON-CLASSIFIABLE - Insufficient information to identify part of body effected. Includes damage to prosthetic devises.

***UNS - UNSPECIFIED** ****NEC - NOT ELSEWHERE CLASSIFIED**

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®

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

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

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

Empleado lesionado:

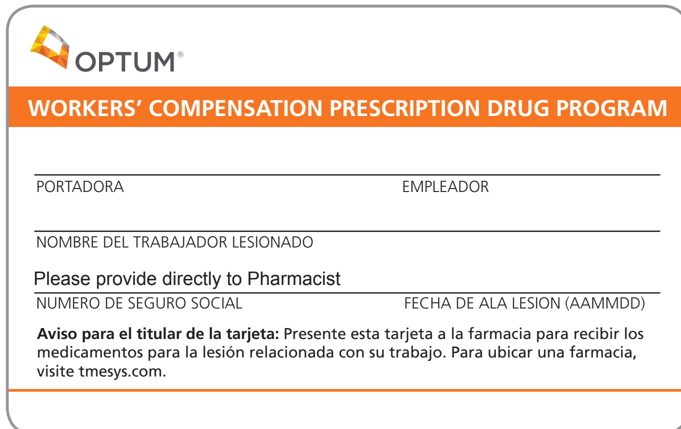
Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

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

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

¿Tiene alguna pregunta? ¿Necesita ayuda?

1-866-599-5426



OPTUM®

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

PORTADORA ____________ EMPLEADOR ____________

NOMBRE DEL TRABAJADOR LESIONADO ____________

Please provide directly to Pharmacist

NUMERO DE SEGURO SOCIAL ____________ FECHA DE ALA LESION (AAMMDD) ____________

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

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

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

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

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

Empleador:

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

The following entities comprise the Optum Workers Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers Compensation Medical Services, collectively and individually referred as "Optum."

tmesys®

IMP14-1614-109-FFWG

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!

FORM 127

The Commonwealth of Massachusetts
Department of Industrial Accidents

Lafayette City Center, 2 Avenue de Lafayette, Boston, MA 02111-1750
Info. Line (800) 323-3249 Inside Mass. / (857) 321-7470 Outside Mass.
www.mass.gov/dia

DIA USE ONLY

AVERAGE WEEKLY WAGE COMPUTATION SCHEDULE

Print or Type

1. Employer's Name and Address:		2. Insurer's Case File #:
		3. DIA Board # (if known):
4. Employee's Name and Address:		5. # of dependent children:
		6. # of other dependents:
7. Date of Injury (mm/dd/yyyy):	8. Date of Disability (mm/dd/yyyy):	9. Date of Employment (mm/dd/yyyy):

10. Has employee been certified by U.S. Veterans Administration for any type of disability? ☐ Yes ☐ No

Indicate only those wages earned by the injured worker during the 52 week period immediately preceding the accident. If the injured employee has worked for less than 52 weeks, report wages from the time worked and, for the remaining weeks on this schedule, substitute wages of a fellow employee in the same class of employment who has worked for one year or more.

11. Week No.	Year: Week Ending Month	Day	Gross Amount Before Taxes	Week No.	Year: Week Ending Month	Day	Gross Amount Before Taxes	Week No.	Year: Week Ending Month	Day	Gross Amount Before Taxes
1				19				37			
2				20				38			
3				21				39			
4				22				40			
5				23				41			
6				24				42			
7				25				43			
8				26				44			
9				27				45			
10				28				46			
11				29				47			
12				30				48			
13				31				49			
14				32				50			
15				33				51			
16				34				52			
17				35				**Total:**			
18				36							

12. Was room furnished to the employee? ☐ Yes ☐ No	13. If tips or other benefits were earned, describe and state value per week:

THIS IS A TRUE COPY OF THE PAYROLL RECORD OF THE ABOVE NAMED EMPLOYEE OR FELLOW EMPLOYEE IN THE SAME CLASS OF EMPLOYEMENT

14. Name of Fellow Employee (if applicable):	15. Employer/Preparer Signature:	16. Date Signed (mm/dd/yyyy):

Make any comments on the reverse side of this form or on a separate sheet.

Reproduce as needed.

Comments:

FORM 19

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 19
Lafayette City Center, 2 Avenue de Lafayette, Boston, MA 02111-1750
Info. Line: (800) 323-3249 (Inside Mass.) / (857) 321-7470 (Outside Mass.)
www.mass.gov/dia

DIA Board #
(if known)

SECTION 19 AGREEMENT

1. Employee's Name (Last, First, MI) and Address (No., Street, City, State, Zip):	2. Social Security Number*:
3 Employer/Address (No., Street, City, State, Zip):	
4. Insurer/Address (No., Street, City, State, Zip):	5. Date of Injury (mm/dd/yyyy):

Now come the parties in the above-referenced action and agree to the following on a:

Without Prejudice | With Prejudice
Without Liability | With Liability

Does this agreement close out the current litigation? Yes No Not Applicable
If the answer is no, what issues remain in dispute?

____

____

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This agreement does not forfeit the parties' rights to raise any other claims or defenses.

6. Employee/Claimant Signature:	**7. Date (mm/dd/yyyy):**
8. Employee Counsel Signature:	**9. Date (mm/dd/yyyy):**
10. Insurer Counsel/Claims Rep. Signature:	**11. Date (mm/dd/yyyy):**

APPROVAL FOR THE DEPARTMENT BY:

NAME: ______________________ TITLE: ______________________ DATE: ____________

***Disclosure of Social Security Number is Voluntary. It will aid in the processing of your claim.**

SECTION 19 AGREEMENT FILING INSTRUCTIONS

PENALTIES UNDER M.G.L.c. 152 § 8(1) SHALL RESULT IF PAYMENT, PURSUANT TO THIS AGREEMENT, IS NOT MADE WITHIN 14 DAYS OF THE INSURER'S RECEIPT OF THE APPROVED DOCUMENT. THE ORIGINAL FORM MUST BE FILED WITH THE DEPARTMENT AND WILL NOT BE RETURNED TO THE PARTIES.

Use Additional Space If Necessary

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FORM 153

The Commonwealth of Massachusetts

Department of Industrial Accidents
Office of Investigations - Dept. 153
Lafayette City Center, 2 Avenue de Lafayette, Boston, MA 02111-1750
http://www.mass.gov/dia

DIA Use Only

AFFIDAVIT OF EXEMPTION FOR CERTAIN CORPORATE OFFICERS OR DIRECTORS

Invest. / SWO ID #: ____________

Chapter 169 of the Acts of 2002 amended M.G.L. c. 152, §1(4) by adding the following paragraph:

"This chapter shall be elective for an officer or director of a corporation who owns at least 25 percent of the issued and outstanding stock of the corporation. Notwithstanding section 46, these provisions shall apply only if the corporate officer provides the commissioner of industrial accidents with a written waiver of his rights under this chapter. Said commissioner shall promulgate regulations to carry out the purpose of this paragraph. Violations of this paragraph shall subject the corporation to the penalties set forth in section 25C."

Pursuant to M.G.L. c. 152, §1(4) as amended, I/We the undersigned officers of:

____

Name of Corporation

____

Address of Corporation

______________________	______________________	______________________
Contact Name	***Phone***	***Email***

each holding at least 25% of the issued and outstanding stock in said corporation, do hereby invoke the right to be exempt from the provisions of M.G.L. c. 152, §25A and therefore are not required to carry a workers' compensation policy covering the undersigned corporate officer(s) or director(s). I/We the undersigned do also waive any and all rights to make claims for benefits as defined in M.G.L. c. 152 for any injuries that may be sustained while in the employ of the above-named corporation.

Further, I/we the undersigned do understand that, should the above-named corporation hire or have in its employ any employee(s) in addition to the undersigned corporate officer(s) or director(s), said corporation is required to obtain workers' compensation coverage for the employee(s) as prescribed by M.G.L. c. 152, §25A.

I/We the undersigned have read and understand the statements and obligations as delineated above and I/we have checked the appropriate box below my/our name(s) indicating my/our desire to be exempt or not to be exempt from the provisions of M.G.L. c. 152.

Signed under the pains and penalties of perjury:

______________________		______________________	______________________
Signature ☐ I wish to exercise my right of exemption	*or*	***Print Name & Title*** ☐ I wish ***NOT*** to exercise my rights of exemption	***Date (MM/DD/YYYY)***
______________________		______________________	______________________
Signature ☐ I wish to exercise my right of exemption	*or*	***Print Name & Title*** ☐ I wish ***NOT*** to exercise my rights of exemption	***Date (MM/DD/YYYY)***
______________________		______________________	______________________
Signature ☐ I wish to exercise my right of exemption	*or*	***Print Name & Title*** ☐ I wish ***NOT*** to exercise my rights of exemption	***Date (MM/DD/YYYY)***
______________________		______________________	______________________
Signature ☐ I wish to exercise my right of exemption	*or*	***Print Name & Title*** ☐ I wish ***NOT*** to exercise my rights of exemption	***Date (MM/DD/YYYY)***

***Note: ALL ELIGIBLE CORPORATE OFFICERS MUST SIGN. THERE CAN BE NO MORE THAN 4 SIGNATURES.**

Instructions on back. ➡

PURPOSE & INSTRUCTIONS

Pursuant to M.G.L. c. 152, §1(4) workers' compensation insurance "...shall be elective for an officer or director of a corporation who owns at least 25% of the issued and outstanding stock of said corporation. Notwithstanding the provisions of section 46 of this chapter, these provisions shall apply only if said corporate officer provides the Commissioner of the Department of Industrial Accidents with a written waiver of his rights under this chapter. The Commissioner of the Department of Industrial Accidents shall promulgate regulations to carry out the purpose of this subsection. Violations of the terms of these provisions in any way shall subject said corporation to the penalties set forth under section 25C of this chapter."

Therefore, in accordance with M.G.L. c. 152, §1(4) and 452 CMR c. 8.00 et. seq.:

- **Such an exemption DOES NOT apply to employees of such a corporation who are not corporate officers. Those employees must be covered by a valid workers' compensation policy at all times.**
- **A copy of this form should be submitted to the insurance carrier on an annual basis, prior to the renewal of any existing policy, as affirmation that the statements contained herein remain in effect. If there has been ANY change in status of a corporate officer or director, a new Form 153 must be filed with the DIA and provided to the insurance carrier.**
- **Any corporation in which the corporate officers or directors own at least 25% interest in the corporation may exercise their right to exempt said corporate officers or directors from the provisions of the Massachusetts Workers' Compensation Act (M.G.L. c. 152).**
- **If the corporation named on this form employs no persons other than the eligible corporate officer(s) or director(s) who have exercised their right of exemption by signing the Form 153, said corporation may legally operate without a workers' compensation coverage. However, the corporation may not employ any person other than those corporate officers or directors who have exercised their right of exemption by signing the Form153. Should the corporation hire additional employees, workers' compensation coverage must be obtained for those employees.**
- **The completed Form 153 must be submitted to the Department of Industrial Accidents, Office of Investigations for the exemption under M.G.L. c. 152, §1(4) to be invoked.**
- **The policies and procedures surrounding the exemption of a corporate officer or director are governed by 452 CMR 8.06 et. seq.**
- **If your corporation is submitting this form in response to a notice or Stop Work Order (SWO) from the DIA Office of Investigations, please write the Investigation ID Number or Stop Work Order Number on that correspondence on the space provided in upper right-hand corner of the front of this form.**

Instructions -
All eligible corporate officers must sign the form and indicate their choice to be exempt or not to be exempt from the provisions of M.G.L. c. 152 by checking the appropriate box located under their name and signature. Complete all information on the front of the form and submit it to:

Department of Industrial Accidents
Office of Investigations - Dept. 153
Lafayette City Center
2 Avenue de Lafayette
Boston, MA 02111 - 1750

FORM 122

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 122
Lafayette City Center, 2 Avenue de Lafayette, Boston, MA 02111-1750
Info. Line (800) 323-3249 Inside Mass. / (857) 321-7470 Outside Mass.
www.mass.gov/dia

DIA USE ONLY

REQUEST FOR SECTION 37 OR 37A PROCEEDING

Check Box: ☐ §37 Claim ☐ §37A Claim

Please Print or Type **All fields are required.**

EMPLOYEE	1. Employee's Name (Last, First, MI):	2. DIA Board No. for Subsequent Injury:	3. Date of Subsequent Injury:
	4. Home Address (No. & Street, City, State, Zip Code):		
	5. Employer's Name & Address:		
INSURER	6. Name of Insurer:	7. Insurer's Federal I.D. Number:	
	8. Address of Branch Responsible for Case:	9.Policy # for Subsequent injury benefit payments:	
	10. Attorney for Insurer (Name & Address):	11. Attorney's BBO#:	

Check boxes below to identify all sections of M.G.L. c. 152 relevant to the reimbursement you seek.

Reimbursement for Payments for Subsequent Injury occurring before December 23, 1991:
_____ §30 and ___ §30A Medical Services and Reports; _____ §31 and ___ §32 Surviving Dependents Coverage; _____ §33 Burial Expenses;_____ §34 Total Incapacity and ___ §34A Permanent and Total Incapacity; _____ §35 Partial Incapacity and ___ §35A Dependent Compensation _____ §36 Specific Permanent Injuries and _____ §36A Death.

Reimbursement for Payments for Subsequent Injury occurring on or after December 23, 1991:
_____ §31 and ___ §32 Surviving Dependents Coverage; ___ §33 Burial Expenses; _____ §34A Permanent and Total Disability; _____ §36A Death; _____ §30 Medical: only for benefits due under above sections.

Reimbursable Payments made after 104th Week from the date of onset of Disability or Death.
(Please indicate Section, Dates, Weeks, Amounts and Total Payments):

1. § ____ _______ to ______ = ____ weeks $ ______ 4. § ____ _______ to ______ = ____ weeks $ ______
2. § ____ _______ to ______ = ____ weeks $ ______ 5. § ____ _______ to ______ = ____ weeks $ ______
3. § ____ _______ to ______ = ____ weeks $ ______ 6. § ____ _______ to ______ = ____ weeks $ ______

Lump Sum (with attorney fees + expenses deducted) Date: _______ Amount: $ ______________
Medical Bills for Reimbursable Services after 104 th Week Amount: $ ______________
Total Payments: $ ______________

Benefit Status

12. 104th Week From Disability (mm/dd/yyyy):	13. Is Employee still receiving compensation?: __ Yes __ No
14. Is pre-existing physical impairment due to: ☐ Previous Accident ☐ Previous Disease ☐ Congenital Condition	

Petition

15. Preparer's Name & Title (First, MI, Last):	16. Certificate of Service Attached: __ Yes __ No
17. Preparer's Signature:	18. Date Prepared (mm/dd/yyyy):

All fields are required. See Reverse for Filing Requirements. Reproduce as needed.

REQUIREMENTS TO FILE CLAIMS UNDER §§37/37A

1. After you file this claim it will be scheduled for conciliation in the Boston Office unless the parties agree in writing, at the time of the filing, that it is to be adjudicated at a specified regional office.

2. A claim requesting reimbursement under M.G.L. c. 152, §§ 37 and 37A shall be made on Form 122 and it shall be accompanied by both a certificate stating that it was served on the Office of Legal Counsel, and by a petition which sets forth and documents items which include, but are not limited to, the following:

a) Employee's job description and duties; educational, military, and employment history; and, vocational training prior to the "subsequent impairment" (i.e. compensable personal injury for which petitioner seeks M.G.L. c. 152, §§37/37A reimbursement; also known as "second injury.")

b) Evidence of employer's knowledge of employee's pre-existing physical impairment due to a previous accident, disease or congenital condition as evidenced by such documents as a job application, a pre-employment physical report, or by employer's affidavit attesting that employer knew of the impairment not later than 30 days after the date of employment, or (for injuries occurring prior to12/23/91) by medical records which existed prior to the date of the subsequent impairment.

c) Evidence that a known pre-existing physical impairment was, or was likely to be, a hindrance or obstacle to employment (i.e. medical records evidencing permanent physical restrictions, documented job modifications or accommodations which employer made on behalf of employee).

d) All medical records pertaining to the subsequent impairment including attending physician reports, insurance medical examinations, and DIA impartial physician report.

e) From the compensation claim involving the second injury, copies of all DIA documents which substantiate the reimbursement which the petitioner seeks, such as:

(1) Employee Claim Form (110)
(2) First Report of Injury
(3) Agreement(s) to Compensation
(4) Conference Orders, Hearing Decisions and Lump Sum Agreement

f) Indemnity record for all reimbursable compensation paid after the 104th week from the date of the onset of disability or death that clearly identify the claimant, the section under which compensation was paid, the dates for which payment was made, and the amount of weekly compensation.

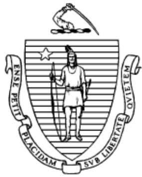
g) Medical bills paid for all related reimbursable medical treatment received by employee after the 104th week from the date of the onset of disability. (Computer printouts which clearly identify the claimant, service providers, and the dates of service constitute satisfactory documentation).

h) A description of the subsequent impairment which includes an authoritative medical statement as to how the subsequent impairment is substantially greater (by the combined effects of such impairment and subsequent personal injury) than the disability that would have resulted from the subsequent personal injury alone, or that the subsequent injury was caused by the pre-existing impairment, and, if death results from the subsequent injury, that the death would not have occurred except for such pre-existing physical impairment.

3. Any matter not resolved at conciliation shall be scheduled for conference before an administrative judge unless parties agree to an alternative method of resolution as provided in M.G.L. c. 152, §10 B.

4. All fields on this form are required. Missing information will result in rejection of the form.

FORM 123



The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 123
Lafayette City Center, 2 Avenue de Lafayette, Boston, MA 02111-1750
Info. Line (800) 323-3249 in Mass. / (857) 321-7470 Outside Mass.
www.mass.gov/dia

DIA BOARD NO. §37 or §37A Claim

Please print or type.
All fields are required.

AGREEMENT UNDER SECTION 37 or 37A

Please Note – For Injuries on or after 12/23/1991, the insurer must file their quarterly request for reimbursement within two (2) years from the date of the final approval of the Form 123. All subsequent quarterly request for reimbursements must be received by the DIA within two (2) years from the date of payment by the insurer.

EMPLOYEE	1. Employee's Name (Last, First, MI):		
	2. Home Address (No. & Street, City, State, Zip Code):		
	3. Employer's Name:		
	4. Employer's Address (No. & Street, City, State, Zip Code):		
INSURER	5. Insurance Carrier's Name:	6. Insurance Company Address:	
	7. Name, Address & Tel. # of Person Able to Verify Information:		
	8. DIA Board Number of underlying claim:	8a. If 3rd party, docket #/Court	8b. Policy No. for underlying claim

9. Paid Through (mm/dd/yyyy):	10. First Date of Disability (mm/dd/yyyy):	11. If Employee Died, Enter Date of Death:

12. Total Amount to be reimbursed under Section 37 ☐ or 37A ☐ : $____________________ (Check all that apply to this agreement) ☐ NEGOTIATED ☐ FULL & FINAL

13. Amount of Quarterly Reimbursements (if any): $________________________

14. Is employee still receiving weekly compensation benefits? Yes ☐ No ☐ If Yes, please fill out the following

TYPE OF WEEKLY COMPENSATION	**COMPENSATION AMOUNT**
a. ☐ Total Disability – Temporary (§34)	$______________________________
b. ☐ Total Disability – Permanent (§34A)	$______________________________
c. ☐ Partial Disability (§35)	$______________________________
d. ☐ Dependent Coverage (§35A)	$______________________________
e. ☐ Surviving Dependents Coverage (§31)	$______________________________
f. ☐ Other (Specify) ______________________	$______________________________

I hereby certify that the information contained herein is a true accounting of all payments made to the above named employee.

____ _____________________
Signature of Insurer's Authorized Representative Prepared Date (mm/dd/yyyy)

____
Name & title (Last, First, MI)

I hereby agree to and approve the following reimbursement to be made per the provisions of this agreement.

_________________________ _______________ _________________________
Signature for the Office of Legal Counsel Date (mm/dd/yyyy) Name & title (Last, First, MI)

I hereby agree to and authorize the following reimbursement to be made per the provisions of this agreement.

_________________________ _______________ _________________________
Signature for the Office of the Director Date (mm/dd/yyyy Name & title (Last, First, MI)

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					
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26						52					