AmTrust North America
An AmTrust Financial Company

Pennsylvania
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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AmTrust INSURANCE

Workers' Compensation Claim Reporting Information

24/7 Toll Free Claim Reporting for All States

(888)239-3909

WorkersCompClaimReport@AmTrustgroup.com

www.amtrustfinancial.com

Information Required for All Claims Reported

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

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

How do I help my injured worker find a doctor?

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

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

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

Timely Reporting

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

We're Here To Help

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

Relax And Stay Positive

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

877.528.7878 I www.amtrustfinancial.com

AmTrust INSURANCE

MKT6310 06/23

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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 https://amtrustfinancial.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 https://amtrustfinancial.com/ and log in

Reporting of New Injuries:

1. Go to https://amtrustfinancial.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.

Workers Compensation Posting Requirements

Thank you for placing your Workers' Compensation Coverage with AmTrust.

Pennsylvania Required Posting Notices

Post at place of employment, in a sufficient number of places on the premises to assure that the notice will reasonably be seen by all employees at all business locations and work sites (Break Room, Lunch Room or Time Clock) Employees that may not reasonably be expected to see a posted notice must receive notice of the posting in writing.

- **Workers' Compensation Insurance Notice (Form LIBC-500)**
- **PA Worker and Community Right To Know Act (Form LIBC-262) English & Spanish**

The following document must be signed by the employee at the time of hire, whenever changes are made to this document and/or when an on-the-job injury or occupational disease occurs:

- Notification of Rights and Duties

Please complete and submit the following forms to AmTrust when a work-related injury occurs:

- **Form LIBC-344 First Report of Injury (FROI).** As soon as you have been notified of a work-related injury, please fill out this form and submit to AmTrust. This form must be submitted within 10 days from notice of an accident. Fatalities must be reported within 24 hours. You must use this form to notify AmTrust of every work-related injury or disease by an employee, regardless of severity.
- **Form LIBC-494C Wage Statement.** This form enables us to calculate the correct compensation that may be owed to an injured employee. Please complete this form and submit to AmTrust within five days after your knowledge of any accident that has caused your employee to be disabled for more than the PA seven day waiting period. If an employee is out of work beyond seven scheduled work calendar days, the employee may be entitled to indemnity benefits.
- **Optum First Fill Form.** Use of this form will enable quick authorization for your employee's initial medication and ensure that the initial prescription is provided at no cost to the injured employee. Immediately upon receiving notice of injury, fill in the information on this form and give this form to the employee.Your employee will need to provide this completed form along with the prescription for their work-related injury or occupational disease to the pharmacist.

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.

59 Maiden Lane, New York, NY 10038 I 877.528.7878 I www.amtrustfinancial.com

AmTrust FINANCIAL

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DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

REMEMBER: IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR INJURY

The name, address and telephone number of your employer's workers' compensation insurance company, third-party administrator (TPA), or person handling workers' compensation claims for your company, are shown below.

Employer Name: _____ **Date Posted:** _____

IF INSURED:
(Complete all applicable spaces)

Name of Insurance Company: _____

Address: PO Box 89404
Cleveland, OH 44101

Telephone Number: 888-239-3909

Insurer Code: _____

IF SOMEONE OTHER THAN INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator):
AmTrust North America

Address: PO Box 89404
Cleveland, OH 44101

Telephone Number: 888-239-3909

IF SELF-INSURED
(Complete all applicable spaces)

Name of person handling claims at the self-insured: _____

Address: _____

Telephone Number: _____

Insurer Code: _____

IF SOMEONE OTHER THAN SELF-INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator): _____

Address: _____

Telephone Number: _____

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services	Claims Information Services	Hearing Impaired	Email
717.772.3702	toll-free inside PA: 800.482.2383 local & outside PA: 717.772.4447	PA Relay 7-1-1	ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

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DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

RECUERDE: ES IMPORTANTE INFORMARLE A SU EMPLEADOR SOBRE SU LESIÓN

El nombre, la dirección y el número de teléfono de la compañía de seguros de compensación para trabajadores de su empleador, el administrador externo (TPA) o la persona que maneja las reclamaciones de compensación para trabajadores de su empresa se muestran a continuación.

Nombre del empleador: _____ **Fecha de publicación:** _____

SI ESTA ASEGURADO/A:
(Complete todos espacios que apliquen)

Nombre de la compañía de seguro: _____

Dirección: PO Box 89404
Cleveland, OH 44101

Número de teléfono: 888-239-3909

Código del asegurador: _____

SI ALGUIEN QUE NO SEA LA ASEGURADORA ESTÁ MANEJANDO LOS RECLAMOS:
(Complete todos los espacios que apliquen)

Nombre del TPA (Administrador de reclamos): AmTrust North America

Dirección: PO Box 89404
Cleveland, OH 44101

Número de teléfono: 888-239-3909

SI ESTA AUTO-ASEGURADO
(Complete todos los espacios que apliquen)

Nombre de la persona que está manejando los reclamos en el autoseguro: _____

Dirección: _____

Número de teléfono: _____

Código del asegurador: _____

SI ALGUIEN QUE NO SEA EL AUTO-ASEGURADOR ESTA MANEJANDO LOS RECLAMOS:
(Complete todos los espacios que apliquen)

Nombre del TPA (Administrador de reclamos): _____

Dirección: _____

Número de teléfono: _____

Cualquier individuo que presente información errónea o incompleta a sabiendas y con la intención de defraudar, infringe la Sección 1102 de la Ley de Compensación para Trabajadores de Pensilvania, 77 P.S. §1039.2, y también puede estar sujeto a sanciones penales y civiles según 18 Pa. C.S.A. §4117 (relacionado con el fraude de seguros).

Servicios de información para empleadores
717.772.3702

Servicios de información de reclamaciones
Número gratuito dentro PA: 800.482.2383
Local & fuera de PA: 717.772.4447

Personas con discapacidad auditive
PA Relay 7-1-1

Correo electrónico
ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

INFORMATION NECESSARY TO FILL OUT POSTING NOTICE- FORM LIBC-500

IF INSURED Section

NAME OF INSURANCE COMPANY: (pick one)

Technology Insurance Company, Inc. (TWC)

Wesco Insurance Company, Inc. (WWC)

First Nonprofit Insurance Company, Inc. (FWC)

Security National Insurance Company, Inc. (SWC)

AmTrust Insurance Company Inc. (KWC) Milford

Casualty Insurance Company, Inc. (MWC) Sequoia

Insurance Company, Inc. (QWC)

ARI Insurance Company, Inc. (PWC)

TPA ADDRESS:

AmTrust North America

P.O. Box 89404

Cleveland, Ohio 44101

TELEPHONE NUMBER:

888-239-3909

INSURER CODE: (pick one)

Technology Insurance Company, Inc. (TWC)	2316
Wesco Insurance Company, Inc. (WWC)	2368
First Nonprofit Insurance Company, Inc. (FWC)	2289
Security National Insurance Company, Inc. (SWC)	2412
AmTrust Insurance Company Inc. (KWC) Milford	2413
Casualty Insurance Company, Inc. (MWC) Sequoia	2425
Insurance Company, Inc. (QWC)	2599
ARI Insurance Company. Inc. (PWC)	2104

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

EMPLOYEE WORKPLACE NOTICE
PUBLIC SECTOR
Pennsylvania Worker and Community Right To Know Act

The Pennsylvania Worker and Community Right to Know Act requires that information about hazardous substances in the workplace and in the environment is available to public sector employees and employees of private sector workplaces not covered by the Federal Occupational Safety and Health Administration (OSHA) Hazard Communication Standard and to all persons living or working in the state. Employee rights listed below are further defined in the Worker and Community Right to Know Act (P.L. 734, No. 159) and Regulations. For additional information, contact the Department of Labor & Industry, Bureau of Workers' Compensation, Health & Safety Division, 651 Boas Street, Harrisburg, PA 17121, or by phone (717) 772-1635, or by email at RA-LI-BWC-SAFETY@pa.gov.

Employee Workplace Notice:
Public sector employers (including state and local government agencies and public schools and public universities) and private sector employers not covered by the OSHA Hazard Communication Standard must post this notice informing employees of their rights under the law. This notice must be posted prominently in the workplace at a location where employee notices are normally posted.

Training:
Public sector employers and private sector employers not covered by the OSHA Hazard Communication Standard must provide an annual education and training program to employees exposed to hazardous substances. The training program may be presented either in written form or in training sessions.

Hazardous Substance Survey Form:
The Hazardous Substance Survey Form (HSSF) provides an inventory of the hazardous substances found in the workplace during the prior calendar year. All employers must complete a workplace HSSF annually. Public sector employers and private sector employers not covered by OSHA must post the HSSF prominently in the workplace and must provide a copy to any employee upon request.

Work Area List:
The Work Area List names the hazardous substances used or produced in a specific work area in the workplace. Public sector employers and private sector employers not covered by the OSHA Hazard Communication Standard must update a Work Area List at least annually, must provide a copy to any employee of the work area upon request, and must offer a copy to any employee newly assigned to that work area.

Safety Data Sheet:
The Safety Data Sheet (SDS) provides detailed information about a hazardous substance. In public sector workplaces and private sector workplaces not covered by the OSHA Hazard Communication Standard, an SDS must be accessible in the work area where the hazardous substance it describes is used. SDSs must be readily available to employees without the intervention or permission of management or supervisors, and any employee may obtain and examine an SDS for any hazardous substance in the workplace. If an employee's request to obtain a copy of an SDS is made to the employer in writing and, after five working days from the date the request is made, the employer fails to furnish the employee with an SDS in the employer's possession or fails to provide the employee with proof of the employer's effort to obtain the requested SDS from the manufacturer, importer, supplier or distributor and from the Department of Labor & Industry, the requesting employee may refuse to work with the substance.

Environmental Hazard Survey Form:
The Environmental Hazard Survey Form (EHSF) provides information about any environmental hazards emitted, discharged or disposed of from the workplace. All employers are required to complete an EHSF when and if requested to do so by the Department of Labor & Industry. If an EHSF has been completed by a public sector employer or a private sector employer not covered by the OSHA Hazard Communication Standard, a copy must be provided to any employee upon request.

Labeling:
All containers and ports of pipelines of hazardous and non-hazardous substances in public sector workplaces and private sector workplaces not covered by the OSHA Hazard Communication Standard must be properly labeled. Employers must ensure that each label, sign, placard or other operating instruction is prominently affixed and displayed on the container or port of a pipeline system so that employees can easily identify the contents.

Health and Exposure Records:
Public sector employers and private sector employers not covered by the OSHA Hazard Communication Standard must maintain and allow employee access to records of employee chemical exposure to the extent required by OSHA (under 29 CFR 1910.1200) or by the Mine Safety Health Administration (under 30 CFR 70.210 and 71.210).

Non-discrimination:
If a public sector employee or an employee of a private sector workplace not covered by the OSHA Hazard Communication Standard believes that he or she has been discharged, disciplined or discriminated against by an employer for exercising his or her rights granted under the Pennsylvania Worker and Community Right to Know Act, that employee has 180 days from the date of the alleged violation to file a written complaint with the Department of Labor & Industry, Bureau of Workers' Compensation.

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

LA LEY DEL DERECHO A SABER DEL TRABAJADOR Y COMUNIDAD DE PENNSYLVANIA

AVISO PARA SER COLOCADO EN EL CENTRO DE TRABAJO SECTOR PÚBLICO

La Ley del Derecho a Saber del Trabajador y la Comunidad de Pennsylvania obliga a que la información sobre sustancias peligrosas en el centro de trabajo y en el medio ambiente esté disponible para los empleados del sector público y los del sector privado que no están cubiertos bajo los Estándares de OSHA (Administración Federal de Seguridad Ocupacional y Salud, por sus siglas en inglés) y para todos aquellos viviendo o trabajando en el Estado. Los derechos de los trabajadores mencionados abajo están aún más definidos en la Ley del Derecho a Saber del Trabajador y Comunidad (L. P. 734, nro. 159) y en la regulaciones relacionadas. Para mayor información contacte con el Compensación al trabajador y el trabajador lesionado» es publicado por el Depto. de Labor e Industria, Buró de Compensación al Trabajador Lesionado, 651 Boas Street, 8th Floor, Harrisburg, PA 17121-0750; Servicios al empleador (717) 772-1635; email **RA-LI-BWC-SAFETY@pa.gov**.

Aviso en el centro de trabajo:

Los empleadores del sector público (incluidas las agencias gubernamentales locales y estatales y las escuelas y universidades públicas) y los empleadores del sector público que no están cubiertos por los Estándares de Comunicación de Peligros de OSHA deberán exhibir este aviso para informarles a los trabajadores de sus derechos bajo la ley en un lugar visible en el centro de trabajo donde los avisos son generalmente puestos.

Capacitación:

Los empleadores de los sectores público y privado que no están cubiertos por los Estándares de Comunicación de Peligros de OSHA deberán proveer un programa anual de instrucción y capacitación a los empleados expuestos a sustancias peligrosas. El programa de capacitación podría ser por escrito o en sesiones de instrucción.

Hoja de datos sobre sustancias peligrosas:

El Formulario de informe de sustancias peligrosas (HSSF, en inglés) provee una lista de las sustancias peligrosas en existencia en el centro de trabajo en el año anterior. Todo empleador deberá llenar un HSSF anualmente. Los empleadores de los sectores público y privado que no están cubiertos por OSHA deberán exhibir el HSSF visiblemente en el centro de trabajo y proveer una copia de éste al empleado que lo pida.

Lista en el centro de trabajo:

Esta lista menciona las sustancias peligrosas usadas o producidas en un área específica en el centro de trabajo. Los empleadores del sector público o privado que no están cubiertos por los Estándares de Comunicación de Peligros de OSHA deberán actualizar una lista del área de trabajo como mínimo anualmente, deberán proveerle una copia de ésta al empleado de esa área que la solicite, y ofrecérsela a todo nuevo empleado asignado a esa área de trabajo.

Hoja de datos de sustancias peligrosas:

La Hoja de información de seguridad de los materiales (MSDS) provee información detallada sobre una sustancia peligrosa. En los centros de trabajo de los sectores públicos y privados que no están cubiertos por los Estándares de Comunicación de Peligros de OSHA, un MSDS deberá estar accesible en el área de trabajo donde la sustancia peligrosa nombrada esté localizada. El MSDS deberá estar disponible para ser visto por los empleados sin la intervención o permiso del supervisor o gerente, y cualquier trabajador puede obtener y examinar un MSDS en cuanto a sustancias peligrosas localizadas en el centro de empleo. Si el pedido del trabajador de obtener una copia del MSDS es por escrito y después de cinco días laborales desde la fecha del pedido, el empleador no ha presentado el MSDS al trabajador o no le presenta al trabajador una prueba de que ha tratado de obtener dicho MSDS del fabricante, importador, abastecedor o distribuidor y del Departmento de Labor e Industria, el trabajador pidiente puede rehusar a trabajar con dicha sustancia.

Hoja de datos sobre peligros en el medio ambiente:

El Formulario de informe de peligros en el medio ambiente (EHSF, en inglés) le informa sobre peligros en el medio ambiente emitidos, descargados o desechados del centro de trabajo. Todos los empleadores están obligados a llenar el EHSF si la orden viene del Departamento de Labor e Industria. Si el EHSF ha sido llenado por un empleador del sector público o privado que no está cubierto por los Estándares de Comunicación de Peligros de OSHA, una copia deberá ser proveída al empleado que lo solicite.

Etiquetas o rótulos:

Todos los envases y entradas/salidas de tuberías de elementos peligrosos y no peligrosos localizados en los centros de trabajo de los sectores públicos y privados que no están cubiertos por los Estándares de Comunicación de Peligros de OSHA deberán estar debidamente etiquetados. Los empleadores deberán asegurar de que toda señal, rótulo, etiqueta u otras instrucciones se exhiban visiblemente en el envase o entrada/salida de la tubería para que los empleados puedan fácilmente identificar los elementos contenidos.

Récords médicos y de exposición:

Los empleadores del sector público o privado que no están cubiertos por los Estándares de Comunicación de Peligros de OSHA deberán mantener y permitir a los empleados acceso a récords de exposición de los empleados a sustancias tal cómo es requerido por OSHA (bajo el 29 CFR 1910.1200) o por la Administración de la Protección de la Salud en las Minas (bajo 30 CFR 70.210 y 71.210).

No discriminación:

Si un empleado del sector público o el centro de trabajo de un empleado del sector privado no cubierto por los Estándares de Comunicación de Peligros de OSHA piensa que ha sido despedido, sancionado o discriminado por un empleador al haber hecho uso de sus derechos de acuerdo a la Ley del Derecho a Saber del Trabajador y la Comunidad de Pennsylvania, dicho empleado tiene hasta 180 días–desde la fecha de la alegada acción-para presentar una queja por escrito ante el Departmento de Labor e Industria, Buró de Compensación al Trabajador Lesionado.

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

NOTIFICATION TO EMPLOYEES OF THEIR RIGHTS AND DUTIES UNDER SECTION 306 (f.1)(1)(i) OF THE PA. WORKERS' COMPENSATION ACT

The Pennsylvania Workers' Compensation Act requires that employees be given written notification of their rights and duties under Sec. 306 (f.1)(1)(i) of the Act if a list of designated health care providers is established by the employer. Below are your rights and duties under Sec. 306 (f.1)(1)(i) and an acknowledgment signature line. This acknowledgment, signed by you, is to be returned to your employer.

A brief summary: You have the right to seek emergency medical treatment from any provider; for post-emergency and other injuries, you must obtain treatment for work-related injuries and illnesses from a designated health care provider for 90 days. The penalty for not using a designated health care provider is that your employer is not liable for the medical bills incurred.

As an employee of the Commonwealth working at a location where a list of designated health care providers has been established and posted, you have:

- The duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.
- The right to seek emergency medical treatment from any provider, but subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period.
- The right to have all reasonable medical supplies and treatment related to the injury paid for by your employer as long as treatment is obtained from a designated provider during the 90-day period.
- The right, during this 90-day period, to switch from one designated health care provider to another designated provider.
- The right to seek treatment from a provider if you are referred to that provider by a designated provider.
- The right to an additional opinion from a provider of your choice when invasive surgery is prescribed by the designated provider.
- The right to seek treatment or medical consultation from a non designated provider during the 90-day period, but the services shall be **at your expense** for the applicable 90 days.
- The right to seek treatment from any health care provider after the 90-day period has ended.
- The duty to **notify your employer of treatment by a non designated provider (after the 90 day period) within 5 days of the first visit to that provider.** The employer may not be required to pay for treatment rendered by a non designated provider prior to receiving this notification.

I acknowledge that I have been informed of my rights and duties
under Sec. 306 (f.1)(1)(i) and that I understand them
to the extent that they are explained above.

_____ _____

Print Name Employee Signature Date

See reverse for a complete text of Section 306 (f.1)(1)(i)

If you have any questions, ask your human resources office representative or call
The Bureau of Workers' Compensation at 1-800-482-2383

PENNSYLVANIA WORKERS' COMPENSATION ACT
SECTION 306 (f.1)(1)(i)

The employer shall provide payment in accordance with this section for reasonable surgical and medical services, services rendered by physicians or other health care providers, including an additional opinion when invasive surgery may be necessary, medicines and supplies, as and when needed. Provided an employer establishes a list of at least six designated health care providers, no more than four of whom may be a coordinated care organization and no fewer than three of whom shall be physicians, the employee shall be required to visit one of the physicians or other health care providers so designated and shall continue to visit the same or another designated physician or health care provider for a period of ninety (90) days from the date of the first visit: provided, however, that the employer shall not include on the list a physician or other health care provider who is employed, owned or controlled by the employer or the employer's insurer unless employment, ownership or control is disclosed on the list. Should invasive surgery for an employee be prescribed by a physician or other health care provider so designated by the employer, the employee shall be permitted to receive an additional opinion from any health care provider of the employee's own choice. If the additional opinion differs from the opinion provided by the physician or health care provider so designated by the employer, the employee shall determine which course of treatment to follow: provided, that the second opinion provides a specific and detailed course of treatment. If the employee chooses to follow the procedures designated in the second opinion, such procedures shall be performed by one of the physicians or other health care providers so designated by the employer for a period of ninety (90) days from the date of the visit to the physician or other health care provider of the employee's own choice. Should the employee not comply with the foregoing, the employer will be relieved from liability for the payment for the services rendered during such applicable period. It shall be the duty of the employer to provide a clearly written notification of the employee's rights and duties under this section to the employee. The employer shall further ensure that the employee has been informed and that he understands these rights and duties. This duty shall be evidenced only by the employee's written acknowledgment of having been informed and having understood his rights and duties. Any failure of the employer to provide and evidence such notification shall relieve the employee from any notification duty owed, notwithstanding any provision of this act to the contrary, and the employer shall remain liable for all rendered treatment. Subsequent treatment may be provided by any health care provider of the employee's own choice. Any employee who, next following termination of the applicable period, is provided treatment from a nondesignated health care provider shall notify the employer within five (5) days of the first visit to said health care provider. Failure to so notify the employer will relieve the employer from liability for the payment for the services rendered prior to appropriate notice if such services are determined pursuant to paragraph (6) to have been unreasonable or unnecessary.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG, PA 17104-2501
(TOLL FREE) 800-482-2383
TTY (TOLL FREE) 800-362-4228

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

EMPLOYEE SOCIAL SECURITY NUMBER

DATE OF INJURY
MONTH DAY YEAR

EMPLOYEE FIRST NAME

EMPLOYEE LAST NAME

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY PHONE NUMBER

EMPLOYEE:
MALE ☐ MARRIED ☐
FEMALE ☐ SINGLE ☐

NUMBER OF DEPENDENTS

DATE OF BIRTH
MONTH DAY YEAR

OCCUPATION OR JOB TITLE

NCCI CLASS CODE (IF KNOWN)

EMPLOYMENT STATUS
FT = Full time
PT = Part-time
SL = Seasonal
VO = Volunteer
ZZ = Other

EMPLOYER

STREET ADDRESS

CITY STATE ZIP CODE

SIC CODE EMPLOYER FEIN PHONE NUMBER

COUNTY NAICS CODE

FULL PAY FOR DAY OF INJURY?
YES ☐
NO ☐

TIME EMPLOYEE BEGAN WORK
AM ☐
PM ☐

TIME OF OCCURRENCE
AM ☐
PM ☐

344 1197-1

LAST DAY WORKED
MONTH DAY YEAR

DATE DISABILITY BEGAN
MONTH DAY YEAR

DATE EMPLOYER NOTIFIED
MONTH DAY YEAR

DATE RETURNED TO WORK
MONTH DAY YEAR

DATE OF HIRE
MONTH DAY YEAR

CONTACT FIRST NAME CONTACT PHONE NUMBER

CONTACT LAST NAME

NOTICE: Report should be clearly completed, (preferably typed) and original mailed to the Bureau at the address in the upper left corner and a copy to employee and insurer.

LIBC-344 REV 1-01

(OVER)

TYPE OF INJURY CODE

PART OF BODY AFFECTED CODE

CAUSE OF INJURY CODE (ENTER CODES, IF KNOWN)

TYPE OF INJURY OR ILLNESS

PARTS OF BODY AFFECTED

CAUSE OF INJURY

DID INJURY OR ILLNESS OCCUR ON EMPLOYER'S PREMISES?
YES ☐
NO ☐

IF OUT OF STATE, SPECIFY STATE OF INJURY

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?
YES ☐
NO ☐

WERE SAFEGUARDS OR SAFETY EQUIPMENT USED?
YES ☐
NO ☐

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

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES DIRECTLY RESPONSIBLE.

IF FATAL, GIVE DATE OF DEATH
MONTH - DAY - YEAR

INITIAL TREATMENT:
- ☐ NO MEDICAL TREATMENT
- ☐ MINOR BY EMPLOYEE
- ☐ CLINIC / HOSPITAL
- ☐ PANEL PHYSICIAN
- ☐ EMPLOYEE PHYSICIAN
- ☐ EMERGENCY CARE
- ☐ HOSPITALIZED MORE THAN 24 HOURS

PHYSICIAN/HEALTH CARE PROVIDER

FIRST NAME: LAST NAME:

STREET

CITY STATE ZIP

HOSPITAL NAME:

STREET

CITY STATE ZIP

POLICY PERIOD FROM:
MONTH - DAY - YEAR

POLICY PERIOD TO:
MONTH - DAY - YEAR

POLICY/SELF INSURED NUMBER:

WITNESS FIRST NAME

WITNESS PHONE NUMBER

WITNESS LAST NAME

PERSON COMPLETING THIS FORM:

NAME:

TITLE:

PHONE:

INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR (IF SELF-INSURED)

NAME:

STREET

CITY STATE ZIP

BUREAU CODE: FEIN:

DATE PREPARED
MONTH - DAY - YEAR

344 1197-2

Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165.

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

STATEMENT OF WAGES (FOR INJURIES OCCURRING ON OR AFTER JUNE 24, 1996)

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER

___ - ___ - ____ _____

DATE OF INJURY

__ - __ - ____
MM DD YYYY

WCAIS CLAIM NUMBER

_____

EMPLOYEE

First name _____

Last name _____

Date of birth _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____ Telephone _____

EMPLOYER

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

CONCURRENT EMPLOYMENT ONLY

Check if ☐ Primary employer OR
☐ Concurrent employer

INSURER or THIRD PARTY ADMINISTRATOR (if self-insured)

Name _____

Address _____

Address _____

City/Town _____ State ____ ZIP _____

County _____

Telephone _____ FEIN _____

Contact _____

NAIC code _____ or Insurer code _____

Insurer/TPA claim # _____

INSTRUCTIONS

The Statement of Wages must be clearly completed in accordance with the Pennsylvania Workers' Compensation Act and uploaded in accordance with the provisions of the EDI Implementation Guide when submitting certain EDI transactions. A copy must be sent to the injured employee.

The "average weekly wage" is used to determine the amount of weekly compensation wage-loss benefits payable under the Pennsylvania Workers' Compensation Act. A chart is available from the Bureau of Workers' Compensation to aid in determining the weekly compensation rate, online at www.dli.pa.gov

CONCURRENT EMPLOYMENT

If the employee had more than one employer at the time of injury, a separate Statement of Wages form must be completed for each employer. Submit these forms together. Using #8 on the Primary Employer's form **only** (employer with whom the injury occurred): show the addition of the average weekly wages from all employers, show the combined average weekly wage to the right of the equal sign and show the appropriate workers' compensation rate. Check the Primary employer box for the Primary employer and the Concurrent employer box for all other employers.

Computation: Compute the appropriate items below for the employee to determine the average weekly wage.

	Wage		Weekly Board/ Lodging		Weekly Federal Reported Gratuities		Annual Bonus, Incentive or Vacation		Average Weekly Wage
1. If wages are fixed by the week:	_____	+	_____	+	_____	+	_____	= $	_____
2. If wages are fixed by the month:	_____ x 12 ÷ 52	+	_____	+	_____	+	_____	= $	_____
3. If wages are fixed by the year:	_____ ÷ 52	+	_____	+	_____	+	_____	= $	_____

4. If paid in another manner, then complete the following for each of the last four consecutive periods of 13 calendar weeks preceding the injury.

	From	Through	Wages		Board/ Lodging		Federal Reported Gratuities		Period Weekly Wage
1st Period	_____	_____	_____	+	_____	+	_____ ÷ 13	= $	_____
2nd Period	_____	_____	_____	+	_____	+	_____ ÷ 13	= $	_____
3rd Period	_____	_____	_____	+	_____	+	_____ ÷ 13	= $	_____
4th Period	_____	_____	_____	+	_____	+	_____ ÷ 13	= $	_____
							(Sum of three highest periods)	= $	_____

Annual bonus, incentive and vacation $ _____ ÷ 52 = $ _____ (Weekly bonus, etc) Average Weekly Wage

Sum of the highest three period weekly averages = $ _____ ÷ 3 + $ _____ (Weekly bonus, etc) = $ _____

5. If the employee has not been employed by the employer for at least three consecutive periods of 13 calendar weeks in the 52 weeks preceding the injury, use #4 above and put in the wages for any completed periods(s) of 13 weeks immediately preceding the injury and average the total amounts ..... = $ _____

6. If the employee worked less than a complete period of 13 calendar weeks and does not have fixed weekly wages: hourly wage rate $ _____ x the number of hours the employee was expected to work per week under the terms of employment _____ = $ _____ + weekly board/lodging of $ _____ + weekly federal reported gratuities $ _____ + (annual bonus, incentive or vacation pay ÷ 52) $ _____ ..... = $ _____

7. For seasonal occupations, the average weekly wage is one-fiftieth of the total wages earned from all occupations during the 12 months immediately preceding the injury. Twelve months prior earnings $ _____ ÷ 50 = $ _____ + weekly board/lodging $ _____ + weekly federal reported gratuities $ _____ = $ _____

8. If the calculation in #7, or any other calculation above, does not fairly ascertain the earnings of the employee, the period of calculation is extended to give a fair calculation of their average weekly wage. Show this calculation here **OR** use the space below to show calculations for concurrent employment.

_____ = $ _____

COMPENSATION PAYABLE PER WEEK: = $ _____

_____ _____

Employer/Defendant Representative's signature | Employer/Defendant Representative's name (typed/printed)

_____

Telephone

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
PA Relay 7-1-1

Email
ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

OPTUM®

AmTrust North America
An AmTrust Financial Company

Optum
PO Box 152539
Tampa, FL 33684-2539

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

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

Injured Employee:

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

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

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

Questions? Need Help?

1-866-599-5426

OPTUM®

AmTrust North America
An AmTrust Financial Company

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
CARRIER/TPA

EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER

DATE OF INJURY (YYMMDD)

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

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

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

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

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

Employer:

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

tmesys®

IMP14-1614-109-FFWG

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

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

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

Empleado lesionado:

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

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

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

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Amtrust North America
PORTADORA — EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

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

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

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

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

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

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

Empleador:

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

tmesys®

IMP14-1614-109-FFWG

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

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

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

Some Return-to Work Benefits Include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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