AmTrust North America
An AmTrust Financial Company

Utah
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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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.

AmTrust North America
An AmTrust Financial Company

Helpful Hints:

- "**Time Employee Began Work**" and "**Time of Occurrence**" must be entered in military time
- Enter the hours in the first box and the minutes in the second box
- All dates must be entered as two-digit day, two-digit month and four-digit year, i.e.: XX/XX/XXXX
- For PEOs, in the "**Location Address**" box, please include the PEO client name and address of the applicable PEO client location. If there is a location code/number, specify in the "**Location #**" box
- If during the entry of a claim you must exit the application, first click on "S**ave as Draft**" and you may return to it later by going back into the "**First Reports"** screen and clicking on "**In Progress**"

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

Thank you for your attention to this matter.

Sincerely,

AmTrust North
America Claims
Department

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

Form 122E

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

Rev 10/2019

TO BE COMPLETED BY EMPLOYER WITH ORIGINAL SENT TO INSURANCE CARRIER AND COPY SENT TO INJURED WORKER

INJURED WORKER INFORMATION:

Name:	Phone:
Address:	City: State: Zip:
Social Security Number:	Date of Birth:
Marital Status:	Sex: Male ☐ Female ☐ Unknown ☐
Occupation / Job Title:	Date Hired:
Employment Status:	Number of Dependents:
Wage: Wage Period:	Daily ☐ Weekly ☐ Monthly ☐
Full Pay for Day of Injury: Yes ☐ No ☐	Number of Days Worked per Week:

EMPLOYER INFORMATION:

Business Name:	Phone:
Employer Contact:	Phone:
Mailing Address:	City: State: Zip:
Employment Address:	City: State: Zip:
Employer FEIN:	

INSURANCE INFORMATION:

Carrier:	Phone: 888-239-3909
Carrier Address: P.O. BOX 89453	City: CLEVELAND State: OH Zip: 44101
Policy / Self-Insured Number:	Policy Period:

OCCURRENCE/TREATMENT:

Date of Injury / Disease:	Time of Injury:	Date Employer Notified:
Nature:	Body Part:	Cause:
Last Day Worked:	Date Disability Began:	Date Returned to Work:
Fatality: Yes ☐ No ☐	Date of Death:	Date Administrator Notified:

Address of Occurrence: City: State: Zip:

Premises: Employer's ☐ Other ☐ Description:

Accident Description:

Provider Injured Worker Received Care From:

Provider Address : City: State: Zip:

Treating Physician: Phone:

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

Witnesses: Yes ☐ No ☐ If yes list their names and phone number:

For your protection, it is required by Utah Law to give notice that workers' compensation fraud is a crime. See next page for full fraud statement.

UTAH LABOR COMMISSION
Industrial Accidents Division

160 East 300 South 3rd Floor P.O. Box 146610 Salt Lake City, Utah 84114-6610
Office: (801)-530-6800 Fax: (801)-530-6804 Toll Free: (800)-530-5090 www.laborcommission.utah.gov

Form 122E

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

Rev 10/2019

INSTRUCTIONS TO THE EMPLOYER

PLEASE NOTE:

The filing of this form does not admit liability or fault. However, failure to file this report with the insurance carrier and provide a copy to the injured worker can result in a citation and civil penalty for each violation as per §34A-2-407(8), U.C.A.

The insurance carrier is to receive the original of this form. The injured worker shall then receive a copy along with their rights and obligations of the Utah's Workers' Compensation Act (Form 100). The employer should keep a copy for their records. The Labor Commission, Division of Industrial Accidents, will receive an electronic copy from the insurance carrier. The electronic copy of this form is private information and only released to parties of the claim.

In order to dispute the validity of the injured worker's claim, contact the insurance carrier or claim administrator for more information.

All fields on this form are required. Please complete this form entirely and do not leave any blank fields. This form will be returned and additional information will be requested if it is not properly completed. If you, the employer, need assistance to complete the form contact your workers' compensation insurance carrier or claims administrator.

Rule R612-200-1(A)(2) Except for injuries treated only by first aid, an employer shall report each employee work injury within 7 days after receiving initial notice of the injury, as follows:

a. An employer that has obtained workers' compensation insurance shall report the injury to its insurance carrier.

b. An employer that has received Division authorization to self-insure shall report the injury to its claims administrator.

c. An employer that has failed to obtain worker's compensation coverage shall report the injury by contacting the Division directly.

3. An employer has notice of a work injury upon the earliest of:

a. Observation of the injury;

b. Verbal or written notice of the injury from any source; or

c. Receipt of any other information sufficient to warrant further inquiry by the employer.

FRAUD WARNING:

Any person who knowingly presents false or fraudulent underwriting information, files, claim for disability compensation, medical benefits, health care fees, or other professional services are of guilty of a crime and may be subject to fines and confinement in state prison.

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Industrial Accidents Division

160 East 300 South 3rd Floor P.O. Box 146610 Salt Lake City, Utah 84114-6610
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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!

Form 100

INJURED WORKERS' RIGHTS AND RESPONSIBILITES

Rev 10/2019

THIS FORM IS TO BE PROVIDED TO THE INJURED WORKER WITH THE INITIAL REPORT OF INJURY

RIGHTS

Medical Expenses: You are entitled to have all reasonable medical expenses paid that are as a result of a work–related injury or illness. You may also be eligible for reimbursement for travel to and from approved medical care.

Compensation Benefits: You may be entitled to 66-2/3% of your wages up to 100% of the state average weekly wage if the claim is found to be compensable and a physician states you are totally unable to work. No compensation benefits are to be paid in the first three (3) days unless the disability prevents you from working for more than a total of fourteen (14) days. If your work injury or illness prevents you from earning your full wage while you are recovering and working with restrictions, you may be entitled to partial compensation. If you have sustained a permanent impairment due to an industrial injury or disease, you are entitled to disability compensation based on an impairment rating as determined by a physician. If you are permanently and totally disabled from working due to an industrial injury, you may need to apply for a hearing at the Labor Commission to determine if benefits are due.

Dependent Benefits: In the case of death of an employee resulting from a work-related injury, workers' compensation shall pay some funeral and burial expenses. In addition, the deceased worker's spouse, dependent children, and other dependents may be entitled to monthly payments.

Reemployment Assistance: You may be eligible for reemployment assistance if you are unable to return to work due to an industrial injury. Contact the insurance adjuster or the Utah State Office of Rehabilitation for further information at (801)-887-9500 or www.usor.utah.gov.

RESPONSIBILITIES:

Employer's Physician: If your employer has a company physician or designated clinic for industrial accidents, you must see the company physician first or you may be obligated to pay for the difference in medical costs. After you have been seen by your employer's physician, you have the right to change the treating physician once throughout the duration of your claim.

Medical Records: You shall comply with rules adopted by the Labor Commission regarding disclosure of your medical records which are relevant to the industrial accident or illness claim, otherwise benefits could be denied.

Cooperation: Promptly provide information requested by the insurance adjuster and cooperate with the investigation of your claim. If a claim is denied and you disagree with the denial reason, you may file an application for hearing and an Administrative Law Judge will issue a decision on your claim.

Medical Cooperation: You must cooperate with your employer or the insurance adjuster by following prescribed medical treatments / evaluations / visits as to return to work as quickly as possible.

Concerns: Contact the insurance adjuster if problems arise concerning your industrial accident claim regarding medical treatment, payment of medical bills, compensation benefits, or work restrictions. If you have any additional questions regarding your rights and responsibilities throughout the duration of the claim process, feel free to contact the Utah Labor Commission, Division of Industrial Accidents.

The employer must provide a copy of this form to the injured worker with form 122E Employer's First Report of Injury. Additionally, the carrier/self-insured employer must provide a copy of this form to the injured worker with the initial injury report processed for the claim (Form 122C, 089, or 441).

FRAUD WARNING

Any person who knowingly presents false or fraudulent underwriting information, files, claim for disability compensation, medical benefits, health care fees, or other professional services are of guilty of a crime and may be subject to fines and confinement in state prison.

UTAH LABOR COMMISSION
Industrial Accidents Division

160 East 300 South 3rd Floor P.O. Box 146610 Salt Lake City, Utah 84114-6610
Office: (801)-530-6800 Fax: (801)-530-6804 Toll Free: (800)-530-5090 www.laborcommission.utah.gov

Form 100

INJURED WORKERS' RIGHTS AND RESPONSIBILITES

Rev 10/2019

ESTE FORMULARIO DEBE SER PROPORCIONADO AL TRABAJADOR LESIONADO CON EL INFORME INICIAL DE LESIÓN

DERECHOS:

Gastos Médicos: Usted tiene derecho a que se paguen todos los gastos médicos razonables que sean como resultado de una lesión o enfermedad relacionada con el trabajo. También puede ser elegible para el reembolso por el viaje hacia y desde proveedores médicos aprobados.

Beneficios De La Compensación: Usted puede tener derecho a 66-2/3% de su salario hasta el 100% del salario promedio semanal del estado si el reclamo se determina que es compensable y un médico declara que usted es totalmente incapaz de trabajar. No se pagan beneficios de compensación en los primeros tres días a menos que la discapacidad le impida trabajar más de un total de 14 días. Si su lesión laboral o enfermedad le impide ganar su salario completo mientras se está recuperando y trabajando con restricciones, puede tener derecho a una compensación parcial. Si usted ha sufrido una incapacidad permanente debido a una lesión o enfermedad industrial, tiene derecho a una compensación de incapacidad que es basada en una calificación de incapacidad que es determinada por un médico. Si está permanentemente y totalmente incapacitado de trabajar debido a una lesión o enfermedad laboral, tiene que solicitar una audiencia en la Comisión Laboral para determinar si los beneficios son debidos.

Beneficios Para Dependientes: En caso de muerte de un empleado como resultado de una lesión relacionada con el trabajo, la compensación para los trabajadores pagará algunos gastos funerarios y del entierro. Además, el esposo/la esposa, los hijos a cargo, y otros dependientes del trabajador fallecido pueden tener derecho a pagos mensuales.

Asistencia De Reemplazo: Usted puede ser elegible para recibir asistencia de reempleo si no puede regresar al trabajo debido a una lesión laboral. Para obtener más información, comuníquese con el ajustador de seguros o con la Oficina de Rehabilitación del Estado de Utah al 801-887-9500 o www.usor.utah.gov.

RESPONSABILIDADES:

Médico Del Empleador: Si su empleador tiene un médico de la compañía o una clínica designada para accidentes industriales, es necesario ver al médico de la compañía primero o puede estar obligado a pagar por la diferencia en los gastos médicos. Después de haber sido visto por el médico del empleador, tiene el derecho de cambiar al médico tratante una vez durante la duración de su reclamo.

Registros Médicos: Usted deberá cumplir con las reglas adoptadas por la Comisión Laboral con respecto al descargo de sus registros médicos que sean relevantes al reclamo de accidente o enfermedad industrial, si no los beneficios podrían ser negados.

Cooperación: Proporcione rápidamente la información solicitada del ajustador de seguros y coopere con la investigación de su reclamo. Si se niega su reclamo y no está de acuerdo con la razón de denegación, puede presentar una solicitud de audiencia y un Juez de Derecho Administrativo hará una decisión sobre su reclamo.

Cooperación Médica: Usted debe cooperar con su empleador o con el ajustador de seguros en seguir los tratamientos, evaluaciones, y visitas médicas para regresar al trabajo lo más rápido posible.

Preocupaciones: Póngase en contacto con el ajustador de seguros si tiene problemas acerca de su reclamo de accidente industrial con respecto al tratamiento médico, pago de facturas médicas, beneficios de compensación o restricciones de trabajo. Si tiene preguntas adicionales sobre sus derechos y responsabilidades durante el proceso de reclamo, debe comunicarse con la Comisión Laboral de Utah, División de Accidentes Industriales

El empleador debe roporcionar una copia de esta forma al trabajador lesionado junto con la forma 122E (primer reporte de accidente del empleador) adicionalmente la compania de seguros o compania auto asegurada debe proporcionar una copia de esta forma al trabajador lesionado junto con el primer reporte de accidente. (forma 122 c, 089, or 441).

ADVERTENCIA DE FRAUDE

Cualquier persona que a sabiendas presente informacion falsa o fraudulenta a la compania de seguros, aplique por un reclamo por incapacidad, beneficios medicos, honorarios de atencion medica u otros servicios profesionales, es culpable de de un crimen y esta sujeto a multas o encarcelamiento en una prision estatal.

UTAH LABOR COMMISSION
Industrial Accidents Division

160 East 300 South 3rd Floor P.O. Box 146610 Salt Lake City, Utah 84114-6610
Office: (801)-530-6800 Fax: (801)-530-6804 Toll Free: (800)-530-5090 www.laborcommission.utah.gov

WORKERS' COMPENSATION NOTICE

Employer: _____

has complied with the provisions of the Workers' Compensation Act (§34A-2-101, Utah Code Annotated), the Utah Occupational Disease Act (§34A-3-101, Utah Code Annotated), and the rules of the Labor Commission by insuring the liability to pay the compensation and other benefits provided by said Acts through:

Insurance Company: _____

Policy Number: _____

Address for the above insurance company: P.O. BOX 89453, CLEVELAND, OH 44101

Telephone number: 888-239-3909

☐ Check here if the employer has been authorized by the Division of Industrial Accidents to self-insure and directly pay workers' compensation benefits.

WORKERS' COMPENSATION

Workers' Compensation is insurance which pays medical expenses and helps offset lost wages for employees with work-related injuries or illnesses. If you have an on-the-job injury or occupational disease, it may pay for: hospital and medical bills, time lost from work, permanent loss of body function, prosthetic devices, and burial and dependent benefits in case of death.

HOW TO REPORT AN ACCIDENT

1. Report the injury, no matter how slight, immediately to your supervisor. You may lose your rights if your injury is not reported within 180 days of the injury or work-related illness.
2. Ask your employer where you should go for treatment. If your employer has a first-aid room or company designated doctor, go there promptly for treatment. If not, go to a doctor of your choice.
3. Tell the doctor HOW, WHEN and WHERE the accident happened. The doctor will fill out a physician's initial report form. A copy of the report is given to you and copies of the report are sent to the insurance company and the Labor Commission within seven (7) days of your doctor visit.
4. Your employer shall fill out the employer's first report of injury form. A copy of this report is sent to the insurance company within seven (7) days of the accident. The insurance company will report the injury to the Labor Commission.

HOW TO START COMPENSATION

1. Ask your employer which insurance company pays workers' compensation benefits for the company.
2. Ask your employer to report the accident to the insurance company and give you the claim number.
3. Call the insurance company and ask them to start your workers' compensation benefits. The insurance company will require the employer's report, the physician's report, and may ask you to fill out a request for compensation. Cooperate with the adjuster's investigation of the injury.
4. Ask your doctor to send medical reports to the insurance company, including the work status statement.

REHABILITATION

If you cannot return to work, you may be eligible for a rehabilitation program. Contact the insurance company listed above or the Utah State Office of Rehabilitation.

FRAUD STATEMENT: "Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison."

STATE OF UTAH - LABOR COMMISSION

160 EAST 300 SOUTH – 3rd FLOOR, PO BOX 146610

SALT LAKE CITY, UT 84114-6610

Phone: (801) 530-6800 • Toll Free: (800)530-5090 • Email: IACCD@utah.gov

If you want copy of an *Employee's Guide to Workers' Compensation* booklet or have questions, contact the Labor Commission or go to the webpage at www.laborcommission.utah.gov.

Note: This notice must be posted and kept continuously in public and conspicuous places in the office, shop or place of business of the employer as per §34A-2-204 and §34A-2-104.5, Utah Code Annotated.

Revised May 2017

AVISO DE COMPENSACIÓN PARA LOS TRABAJADORES

La Empresa: _____

Ha cumplido con las disposiciones de la Ley de Compensación para los Trabajadores (§34A-2-101, Código de Utah Anatado), la Ley de Enfermedades Ocupacionales de Utah (§34A-3-101, Código de Utah Anatado), y las reglas de la Comisión Laboral por asegurando la obligación de pagar compensactión y otros beneficios preveidos por las Leyes y teniendo cobertura con:

Compañía de Seguros: _____

Numero de Póliza: _____

Dirección de la compañía de seguros: P.O. BOX 89453, CLEVELAND, OH 44101

Numero de teléfono: 888-239-3909

☐ Marque aquí si la División de Accidentes Industriales ha autorizado el empleador a tener el auto-seguro y pagar los beneficios de compensación directamente al trabajador.

COMPENSACIÓN PARA LOS TRABAJADORES

Compensación para los trabajadores es un seguro que paga los gastos médicos y ayuda a compensar los salarios perdidos de los empleados con lesiones o enfermedades relacionadas con el trabajo. Si usted tiene una lesión en el trabajo o una enfermedad occupasional, puede pagar: facturas hospitalarias y médicas, pérdida de tiempo del trabajo, pérdida permanente de la función corporal, dispositivos protésicos y servicios funerarios y beneficios para dependientes en caso de muerte.

COMO REPORTAR UN ACCIDENTE

1. Informe inmediatamente a su supervisor de la lesión. Usted puede perder sus derechos si no reporte su lesión o enfermedad relacionada con el trabajo dentro de 180 días.
2. Pregunte a su empleador dónde debe ir para recibir tratamiento. Si su empleador tiene un clínico designado, vaya allí de inmediato para recibir tratamiento. Si no tiene un clínico designado, vaya a un médico de su elección.
3. Informe al doctor CÓMO, CUÁNDO y DÓNDE ocurrió el accidente. El médico llenará el formulario de informe inicial del médico. Usted debe recibir una copia del informe y copias se envían a la compañía de seguros y a la Comisión Laboral dentro de siete (7) días de su visita al médico.
4. Su empleador llenará el formulario de informe inicial del empleador. Usted debe recibir una copia del informe y una copia se envía a la compañía de seguros dentro de siete (7) días. La compañía de seguros es responsable a reportar a la Comisión Laboral.

COMO EMPEZAR COMPENSACIÓN

1. Pregunte a su empleador qué compañía de seguros pagará los beneficios de compensación para los trabajadores.
2. Pídale a su empleador que reporte el accidente a la compañía de seguros y que le dé el número de reclamo.
3. Llame a la compañía de seguros y pídales que inicien sus beneficios de compensación para trabajadores. La compañía de seguros requerirá el informe del empleador, el informe del médico, y puede pedirle a usted que llene una solicitud de compensación. Cooperar con la investigación del ajustador sobre la lesión.
4. Pídale a su médico que envíe informes médicos a la compañía de seguros, incluyendo la declaración de estado de trabajo.

REHABILITACIÓN

Si no puede regresar al trabajo, puede ser elegible para un programa de rehabilitación. Póngase en contacto con la compañía de seguros mencionada anteriormente o con la Oficina de Rehabilitación del Estado de Utah.

DECLARACIÓN DE FRAUDE: "Cualquier persona que a sabiendas presente información falsa o fraudulenta de suscripción de seguros, archivos o causas para presentar una reclamo falso o fraudulento por compensación de incapacidad o beneficios médicos, o presente un informe o facturación falsa o fraudulenta por gastos médicos u otros servicios profesionales es culpable de un crimen y pueden ser sujetos a multas y confinamiento en una prisión estatal."

ESTADO DE UTAH - COMISIÓN LABORAL
160 EAST 300 SOUTH - 3º PISO, PO BOX 146610
SALT LAKE CITY, UT 84114-6610
Teléfono: (801)530-6800 • Línea gratuita: (800)530-5090 • Correo electrónico: IACCD@utah.gov

Si desea una copia del folleto de *la Guía Sobre el Seguro de Compensación Para los Trabajadores* o tiene preguntas, comuníquese con la Comisión Laboral o visite la página web en www.laborcommission.utah.gov.

Nota: Este aviso debe ser publicado y mantenido continuamente en lugares públicos y visibles en la oficina, tienda o lugar de negocios del empleador según §34A-2-204 y §34A-2-104.5, Código de Utah Anatado.

Workplace Safety and Health in the State of Utah

THIS NOTICE MUST BE POSTED IN THE WORKPLACE

The Utah Occupational Safety and Health Act of 1973 requires Utah employers to provide a safe and healthful workplace, free from recognized hazards that are likely to cause death or serious physical harm to employees. The Utah Occupational Safety and Health Division (UOSH) of the Utah Labor Commission, has the primary responsibility for administering the Utah Occupational Safety and Health Act.

NOTICE TO EMPLOYEES

You have **the obligation to comply** with all workplace safety and health rules established by your employer.

You have the right **to notify your employer or UOSH about workplace hazards**. You may ask to keep your name confidential.

You have the right **to request a UOSH inspection** if you believe that there are unsafe or unhealthful conditions in your workplace.

You can **file a complaint with UOSH** if you feel that your employer has retaliated against you for making safety or health complaints, or for exercising your rights under the Utah Occupational Safety and Health Act. Such whistleblower complaints must be filed within 30 days.

You have a right to **see all UOSH citations issued to your employer**. Your employer must post the citations at or near the place of the alleged violation. You may request an informal review of the abatement period granted to the employer.

You have the right to **know your employer is obligated to correct workplace hazards** by the date indicated on the citation and must certify that these hazards have been reduced or eliminated.

You have the right to **copies of your medical records** or records of your exposure to toxic and harmful substances or conditions.

NOTICE TO EMPLOYERS

UTAH EMPLOYERS ARE REQUIRED TO PROVIDE EMPLOYEES A SAFE AND HEALTHFUL WORKPLACE

REPORTING REQUIREMENTS
Employers are required to notify UOSH at (801) 530-6901 **within 8 hours of occurrence of all fatalities, disabling, significant, and serious injuries or illnesses to workers.** You can call in your report 24 hours a day, 7 days a week. Tools, equipment, materials, or other evidence that might pertain to the cause of such accidents shall not be removed or destroyed until authorized by UOSH. You are also required to investigate all incidents of worker injuries and occupational illnesses.

REPORTING GUIDANCE
"Disabling and serious" includes, but is not limited to any injury or illness resulting in immediate admittance to the hospital, permanent or temporary impairment where part of the body is made functionally useless or is substantially reduced in efficiency and which would require treatment by a medical doctor, such as amputation, fracture, deep cuts, severe burns, electric shock, sight impairment, loss of consciousness, and concussions; illnesses that could shorten life or significantly reduce physical or mental efficiency inhibiting the normal function of a part of the body, such as cancer, silicosis, asbestosis, hearing impairment and visual impairment.

INSPECTIONS, CITATIONS, ASSESSED PENALTIES
UOSH may enter at reasonable times without delay any work place under its jurisdiction to conduct an inspection, investigation, or interview a reasonable number of employees to determine compliance with the Utah Act, rules and standards. Citations may be issued if an employer is in violation of any of those rules or standards. A serious violation may be assessed a proposed penalty of up to $7,000. Willful or Repeated violations may be assessed a proposed penalty up to $70,000. Failure to correct or abate a violation may result in additional penalties not to exceed $7,000 for each day each violation is not corrected.

CONTESTS, APPEALS, INFORMAL REVIEW
The Utah Labor Commission will provide an adjudicative formal hearing with its Division of Adjudication, when an employer files a written notice of contest within 30 days of receipt of the citation. Upon expiration of that 30 day period, the citation and proposed penalties are final and not subject to review by any court or agency. Employers may also request an informal review of any citation, proposed penalty or abatement period. Informal reviews do not extend the 30 days in which an employer must file a written notice of contest for a formal hearing.

To report a workplace fatality or injury, file a workplace safety complaint, or for assistance please call (801) 530-6901 or (800) 530-5090. To file a safety complaint online or obtain more information about UOSH programs please visit our website www.laborcommission.utah.gov. To obtain more information about safety and health in the workplace, please contact the Consultation Program at (801) 530-6855

State of Utah Labor Commission
Utah Occupational Safety and Health
160 East 300 South, Third Floor
PO Box 146650
Salt Lake City, Utah 84114-6650
(801) 530-6901
Fax (801) 530-7606
Toll-Free 1-800-530-5090
www.laborcommission.utah.gov

UTAH OCCUPATIONAL SAFETY & HEALTH DIVISION
LABOR COMMISSION
STATE OF UTAH
UOSH

Reporting Injuries (801) 530-6901
Compliance Program (801) 530-6901
Consultation Program (801) 530-6855

"Working together we can make the beautiful State of Utah a safer place to work, elevating our safety and health culture to a higher level of excellence"

Rev. 05.27.16

Seguridad y Salud Ocupacional en el Estado de Utah

ESTA NOTIFICATION DEBE SER PUBLICADA EN EL LUGAR DE TRABAJO

El Acta de Ley de Seguridad y Salud Ocupacional de Utah de 1973 requiere que los empleadores en el estado de Utah proporcionen un lugar de trabajo seguro y saludable, libre de riesgos reconocidos que puedan causar la muerte o daño físico serio a los empleados. La División de Seguridad y Salud Ocupacional (UOSH), tiene la responsabilidad primaria de administrar esta Acta de ley.

NOTIFICACION A LOS EMPLEADOS

Usted tiene **la obligación de cumplir** con todas las normas de seguridad y salud laboral establecidas por su empleador.

Usted tiene el derecho **de notificar a su empleador o a UOSH sobre peligros en el trabajo.** Usted puede pedir que UOSH mantenga su nombre confidencial.

Usted tiene el derecho **de solicitar una inspección de UOSH** si existen condiciones peligrosas o insalubres en su lugar de trabajo.

Usted puede **someter una queja a UOSH** si cree que su empleador ha tomado represalias en su contra por someter quejas de seguridad y salud en su trabajo, o por ejercer sus derechos bajo el Acta de ley de Utah OSHA. Tales quejas de represalias a denunciantes deben ser presentadas dentro de los primeros 30 días de haber ocurrido la represalia.

Usted tiene el derecho de **ver todas las citaciones que UOSH haya enviado a su empleador.** Su empleador debe colocar las citaciones en o cerca del lugar de la supuesta violación. Usted también puede solicitar una revisión del periodo de tiempo otorgado al empleador para completar la corrección de las violaciones.

Usted tiene el derecho **de saber que su empleador tiene la obligación de corregir los peligros en el lugar de trabajo** en la fecha indicada en la citación y que debe certificar que dichos peligros se hayan reducido o eliminado.

Usted tiene el derecho de recibir **copias de sus registros medico** de su exposición a sustancias o condiciones toxicas y peligrosas.

NOTIFICACION A LOS EMPLEADORES

EN EL ESTADO DE UTAH SE REQUIERE QUE LOS EMPLEADORES PROPORCIONEN A LOS EMPLEADOS UN LUGAR DE TRABAJO SEGURO Y SALUDABLE

REQUERIMIENTO DE REPORTAR CASOS
Los empleadores **están requeridos a reportar a UOSH al 801-530-6901 dentro de las primeras 8 horas de la ocurrencia de muertes, incapacidad, lesiones graves, significativas o enfermedades a los trabajadores.** Los empleadores pueden llamar para someter su reporte las 24 horas del día, los 7 días de semana. Herramientas, equipos, materiales u otra evidencia que pueda estar relacionada con la causa de estos accidentes no deben ser removidos o destruidos hasta que sea autorizado por UOSH. También los empleadores están obligados a investigar todo los casos de lesiones y enfermedades ocupacionales.

GUIA PARA REPORTAR CASOS
"Incapacidad y gravedad" incluye, pero no esta limitado a cualquier lesión o enfermedad que resulta en la admisión inmediata al hospital, incapacidad permanente o temporal que hace parte del cuerpo funcionalmente inútil o que se reduce sustancialmente en eficiencia y que requieren tratamiento de un doctor en medicina, tales como amputaciones, fracturas, heridas profundas, quemadas severas, choque eléctrico, deterioro visual, perdida de conocimiento y contusiones; enfermedades que podrían acortar la vida o reducir significativamente la eficiencia física o mental inhibiendo la función normal de una parte de cuerpo, tales como el cáncer, silicosis, asbestosis, discapacidad auditiva y discapacidad visual.

INSPECCIONES, CITACIONES, PENALIDADES
UOSH puede entrar a horas razonables y sin demora a cualquier lugar de trabajo bajo su jurisdicción para llevar a cabo una inspección, investigación o para entrevistar un numero razonable de empleados para determinar el cumplimiento con el Acta de ley de Utah, las reglas y estándares. Citaciones pueden ser presentadas a empleadores que están en violación de esas reglas y estándares. Una violación grave puede ser conllevar una penalidad de hasta $7,000. Violaciones intencionales o repetidas pueden conllevar una penalidad de hasta $70,000. La falta de no corregir o eliminar una violación puede resultar en sanciones adicionales de hasta $7,000 por cada día que cada violación no es corregida.

IMPUGNAS, APELACIONES, REVISIONES
La Comisión Laboral de Utah proporcionará una audiencia formal con la División de Adjudicación, cuando el empleador somete una notificación escrita de impugna o apelación dentro de los 30 días siguientes al recibo de la citación. A la expiración de dicho plazo de 30 días, la citación y penalidades propuestas son consideradas finales y ya no están sujetas a revisión por ninguna corte o agencia. Los empleadores también pueden solicitar una revisión informal de cualquier citación, multa o periodo de corrección. Las revisiones informales no extienden el plazo de 30 días que tiene el empleador para presentar una notificación por escrito de impugna o apelación.

Para reportar a UOSH muertes o lesiones serias en el trabajo, quejas sobre seguridad en el trabajo, o para obtener asistencia por favor llame al (801) 530-6901 o al (800) 530-5090. Para someter una queja de seguridad en forma electrónica o para obtener más información sobre los programas de UOSH, como el programa de Consulta por favor visite nuestro sitio web www.laborcommission.utah.gov.

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Salt Lake City, Utah 84114-6650
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UOSH

Reportar Lesiones	***(801) 530-6901***
Cumplimiento	***(801) 530-6901***
Consultoria	***(801) 530-6855***

"Trabajando juntos podemos hacer del bello estado de Utah un lugar mas seguro para trabajar, elevando nuestra cultura de seguridad a un nivel mas alto de excelencia"

Rev. 05.27.16

STATEMENT OF WAGES/SALARY

IMPORTANT: PLEASE COMPLETE ALL INFORMATION REQUESTED

Employee: Employer: Claim Number:
Social Security Number: Date of Hire: Position/Job Title

EMPLOYMENT TYPE: Full Time____Part Time____Seasonal____Temp_____
If Temporary or Seasonal worker, last day of season or job end date _____
WAGE TYPE: Hourly____Salary____Commission____
WAGE INFORMATION:
$_____ per hour ; Monthly Wage $_____ ; Does monthly wage include commission ____Yes ___No
Hours per Week _____ ; Overtime Rate $_____per hour ; Overtime Hours Regularly Worked per week ____
Tips reported: $_____ per week

If employees' compensation package includes an allowance for any of the following, please indicate the actual or estimated value:
Meals: $_____per week Auto: $_____ Rent/Lodging: $_____per week Bonus $_____ per __wk__mth__yr

PLEASE COMPLETE THE BELOW FOR THE PERIOD _____ TO _____

WK	Pay Rate	Hrs Worked	Begin Date	End Date	Gross Salary	WK	Pay Rate	Hrs Worked	Begin Date	End Date	Gross Salary
1						27					
2						28					
3						29					
4						30					
5						31					
6						32					
7						33					
8						34					
9						35					
10						36					
11						37					
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23						49					
24						50					
25						51					
26						52					