Notice to All Pennsylvania Policyholders and Claimants

In accordance with the Anti-Fraud Legislation passed by the Commonwealth of Pennsylvania, insurance carriers are required to advise all policyholders and claimants of the following:

Any person who – knowingly and with intent to defraud any insurance company or other person – files an application for insurance or statement of claim containing any materially false information or conceals (for the purpose of misleading) information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PREVENTING FRAUD HELPS US ALL

By preventing fraud, the best interest of all parties can be protected. Both the employer's expenses and ours can be kept to a minimum, AND (most importantly) our resources can then be properly devoted to legitimate claims, helping to ensure the speedy return of an injured person to the job.

A message from the Management Team of Lackawanna Insurance Group

Accident and Illness Prevention Services

Lackawanna American Insurance Company, Lackawanna Casualty Company and Lackawanna National Insurance Company, members of Lackawanna Insurance Group, in accordance with the Pennsylvania Workers' Compensation Act, are required to provide accident and illness prevention services based on the nature of its business or its policyholders operations, which includes assistance in obtaining a possible 5% premier credit for forming and having a certified workplace safety committee.

For more information about these services contact:
James S. Kahn, CPCU, ARM, Loss Prevention Mgr.
@ 570-824-1400 ext: 704.

WORKERS' COMPENSATION INFORMATION

(1) The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

(2) Benefits are required to be paid by your employer when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.

(3) You should report immediately any injury or work-related illness to your employer.

(4) Your benefits could be delayed or denied if you do not notify your employer immediately.

(5) If your claim is denied by your employer, you have the right to request a hearing before a workers' compensation judge.

(6) The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at: Bureau of Workers' Compensation, 1171 South Cameron Street, Room 103, Harrisburg, Pennsylvania 17104-2501; telephone number within Pennsylvania (800) 482-2383; telephone number outside of this Commonwealth (717) 772-4447; TTY (800) 362-4228 (for hearing and speech impaired only); www.state.pa.us, PA Keyword: workers comp.

EMPLOYEE INITIAL ACKNOWLEDGEMENT OF RECEIPT OF WORKERS' COMPENSATION INFORMATION

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED AND READ THE WORKERS' COMPENSATION INFORMATION PROVIDED HEREIN.

_____ _____

Employee Name **Employee Signature** **Date**

EMPLOYEE ACKNOWLEDGEMENT OF RECEIPT OF WORKERS' COMPENSATION INFORMATION AT OR SOON AFTER THE TIME OF CLAIMED WORK INJURY
I HEREBY ACKNOWLEDGE THAT I HAVE AGAIN RECEIVED AND RE-READ THE WORKERS' COMPENSATION INFORMATION PROVIDED HEREIN.

_____ _____

Employee Name **Employee Signature** **Date**

INFORMACIÓN DE LA REMUNERACIÓN DE LOS TRABAJADORES

(1) El workers' la ley de la remuneración proporciona pérdida del salario y ventajas médicas a los empleados que no pueden trabajar, o que necesitan asistencia médica, debido a lesión relacionada con el trabajo.

(2) Las ventajas se requieren para ser pagadas por su patrón cuando los uno mismo-asegurados, o con el seguro proporcionado por su patrón. Requieren a su patrón fijar el nombre de la compañía responsable de pagar workers' ventajas de la remuneración en su lugar del negocio primario y en sus sitios del empleo en un lugar prominente y fácilmente accesible, incluyendo, sin la limitación, las áreas usadas para el tratamiento de empleados dañados o para la administración de los primeros auxilios.

(3) Usted debe divulgar inmediatamente cualquier lesión o enfermedad relacionada con el trabajo a su patrón.

(4) Sus ventajas podrían ser retrasadas o ser negadas si usted no notifica a su patrón inmediatamente.

(5) Si su demanda es negada por su patrón, usted tiene la derecha de solicitar una audiencia antes de un workers' juez de la remuneración.

(6) La oficina de Workers' La remuneración no puede proporcionar asesoramiento jurídico. Sin embargo, usted puede entrar en contacto con la oficina de Workers' Remuneración para la información de carácter general adicional en: Oficina de Workers' Remuneración, calle del sur de 1171 Cameron, sitio 103, Harrisburg, Pennsylvania 17104-2501; número de teléfono dentro de Pennsylvania (800) 482-2383; número de teléfono fuera de la esta Commonwealth (717) 772-4447; Equipo teleescritor (800) 362-4228 (para la audiencia y el discurso deteriorados solamente); www.state.pa.us, palabra clave del PA: compartimiento de los trabajadores.

ACUSE INICIAL DEL EMPLEADO DE RECIBO DE WORKERS' INFORMACIÓN DE LA REMUNERACIÓN

RECONOZCO POR ESTE MEDIO QUE HE RECIBIDO Y LEÍ EL WORKERS' LA INFORMACIÓN DE LA REMUNERACIÓN PROPORCIONÓ ADJUNTO.

_____ _____

Nombre del empleado Firma del empleado Fecha

ACUSE DE EMPLYEE DE RECIBO DE WORKERS' INFORMACIÓN DE LA REMUNERACIÓN EN O PRONTO DESPUÉS DE LA ÉPOCA DE LA LESIÓN DE TRABAJO DEMANDADA

RECONOZCO POR ESTE MEDIO QUE HE RECIBIDO Y RELEÍA OTRA VEZ EL WORKERS' LA INFORMACIÓN DE LA REMUNERACIÓN PROPORCIONÓ ADJUNTO.

_____ _____

Nombre del empleado Firma del empleado Fecha

WORKERS' COMPENSATION EMPLOYEE NOTIFICATION

The Pennsylvania Workers' Compensation Act is designed to provide reimbursement for reasonable medical care for someone who suffers an injury arising in the course of his/her employment and causally related thereto. Pursuant to the Act, your employer will provide payment for reasonable surgical and medical services, services rendered by physicians or other health care providers, medicines and supplies, as and when needed.

If you require emergency medical treatment, you may seek it from any provider; however, any subsequent non-emergency treatment shall be obtained from one of the designated health care providers whose names appear on the list posted on your employer's premises. If you are faced with a medical emergency, you may secure assistance from a hospital or physician/health care provider of your choice. However, once the emergency no longer exists, the injured employee must treat with a listed provider for the remainder of the ninety (90) day period.

During the initial ninety (90) days from the date of your first visit, you have the right to switch from one health care provider on the list to another, and your employer will pay for that treatment.

If a designated health care provider refers you for treatment to another health care provider whose name is not on the list, your employer will pay for the treatment rendered by the provider to whom you were referred.

Naturally, you have the right to seek treatment or medical consultation from a non-designated health care provider during the initial ninety (90) day period following the first visit, but you are personally responsible for payment for those services.

You have the right to seek treatment from any health care provider at the expiration of the ninety (90) day period from the date of first visit. Your employer will pay for this treatment unless the treatment is found to be unreasonable or unnecessary by a utilization review organization pursuant to the utilization review process contained in the Workers' Compensation Act.

Your employer will be responsible for the cost of that treatment after the initial ninety (90) day period has ended but only if you notify the employer that you are receiving treatment from non-designated health care provider and only if that notice is provided to your employer within five (5) days of the first visit to that provider. If you provide notice to your employer of treatment by a non-designated provider more than five (5) days after the first visit to that provider, the employer will not be responsible to pay for treatment rendered by that non-designated provider until it receives notification from you that you are receiving such treatment.

Should a designated health care provider prescribe invasive surgery, your employer will pay for an additional opinion from a health care provider of your choice. If the additional opinion differs from the opinion of the designated health care provider and if the additional opinion provides a specific and detailed course of treatment, you will then determine which course of treatment to follow. If you choose to follow the procedures recommended in the additional opinion, your employer will pay to have such procedures performed by one of its designated health care providers and will not be responsible for payment for treatment provided by a non-designated provider for a period of ninety (90) days from the date of your visit to the health care provider from whom you obtained the additional opinion.

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF AND UNDERSTAND MY RIGHTS AND DUTIES UNDER THE PENNSYLVANIA WORKERS' COMPENSATION ACT AS SET FORTH HEREIN.

_____	_____	_____
Employee Name	**Employee Signature**	**Date**

EMPLOYEE RE-NOTIFICATION AT OR NEAR THE TIME OF THE CLAIMED WORK INJURY

I hereby acknowledge that I have been informed again and that I understand my rights and duties under the Pennsylvania Workers' Compensation Act. I have received a copy of this workers' compensation employee notification form.

_____	_____	_____
Employee Name	**Employee Signature**	**Date**

NOTIFICACIÓN AL EMPLEADO DEL SISTEMA DE INDEMNIZACIÓN AL TRABAJADOR

El uso del género masculino en este documento implica tanto el género masculino como el género femenino.

El Decreto del Estado de Pennsylvania de la Indemnización al Trabajador esta diseñado para proveer cuidados médicos razonables, a quien sufre una lesión que ocurre en el transcurso de su empleo y cuya causa esta relacionada a ello. De acuerdo al Decreto, su empleador proporcionará el pago por servicios médicos y quirúrgicos razonables, por servicios suministrados por médicos y otros proveedores del cuidado de la salud, por medicinas y por suministros que son necesarios y cuando sean necesarios.

Si usted requiere tratamiento médico de emergencia, usted puede conseguirlo con cualquier proveedor médico, sin embargo, cualquier otro tratamiento subsiguiente que no sea de emergencia, tiene que ser obtenido y suministrado por uno de los designados proveedores del cuidado de la salud cuyos nombres aparecen en la lista de anuncio presentada en los establecimientos de su empleador. Si usted se encuentra con una emergencia médica, usted puede obtener asistencia o ayuda de parte de un hospital o médico de su elección. Sin embargo, una vez que la emergencia ya no existe, el empleado lesionado tiene que ser tratado por uno de los proveedores nombrados en la lista, por el resto del período de noventa (90) días.

Durante los primeros noventa (90) días a partir de la fecha de su primera visita, usted puede y tiene el derecho de cambiar el proveedor por otro en la lista, y su empleador pagará por ese tratamiento o cita.

Si un proveedor designado del cuidado de la salud, lo manda o recomienda a usted para ser tratado por otro proveedor del cuidado de la salud cuyo nombre no está en la lista, su empleador pagará por el tratamiento suministrado por el proveedor al cual usted fue mandado o recomendado.

Naturalmente, usted tiene el derecho de conseguir tratamiento o consulta médica de parte de un proveedor del cuidado de la salud, el cual no es uno de los designados en la lista, durante los primeros noventa (90) días a partir de la primera visita, pero entonces usted es la persona responsable por el pago de esos servicios.

Usted tiene el derecho de conseguir tratamiento de parte de cualquier proveedor del cuidado de la salud, una vez terminado el período de noventa (90) días a partir de la primera visita. Su empleador pagará por ese tratamiento a menos que dicho tratamiento sea evaluado como innecesario o irrazonable por una organización de reevaluación de utilización de acuerdo al proceso de reevaluación de utilización contenido en el Decreto de Indemnización al Trabajador.

Su empleador será responsable por el costo de ese tratamiento después de que el período inicial de noventa (90) días ha terminado pero, solamente si usted notifica a su empleador, que usted esta recibiendo tratamiento de parte de un proveedor del cuidado de la salud el cual no es uno de los designados en la lista, y solo si esa notificación es dada a su empleador dentro de cinco (5) días a partir de la primera visita a ese proveedor. Si usted proporciona la notificación a su empleador acerca del tratamiento por un proveedor del cuidado de la salud el cual no es uno de los designados en la lista, más allá de cinco (5) días después de la primera visita a ese proveedor, el empleador no será responsable por el pago del tratamiento suministrado por ese proveedor no-designado en la lista, hasta que no reciba notificación de su parte de que usted está recibiendo dicho tratamiento.

En caso de que un designado proveedor del cuidado de la salud, prescribiera, recetara o recomendara cirugía de procedimiento invasivo, su empleador pagará por una opinión adicional de parte de un proveedor del cuidado de la salud de su elección. Si esta opinión adicional no concuerda con la opinión del designado proveedor del cuidado de la salud, y si la opinión adicional proporciona un detallado y específico curso de tratamiento, usted determinará que curso de tratamiento a seguir. Si usted elige seguir el tratamiento recomendado en la opinión adicional, su empleador pagará para que dichos procedimientos sean suministrados por uno de sus designados proveedores del cuidado de la salud y no será responsable por el pago de tratamientos suministrados por proveedores no-designados por un período de noventa (90) días a partir de la fecha de su visita al proveedor que proporcionó la opinión adicional.

YO POR LA PRESENTE RECONOZCO QUE HE SIDO INFORMADO DE Y QUE ENTIENDO MIS DERECHOS Y DEBERES BAJO EL DECRETO DE LA INDEMNIZACIÓN DEL TRABAJADOR COMO HAN SIDO PRESENTADOS AQUÍ.

Nombre del Empleado	Firma del Empleado	Fecha

RE-NOTIFICACIÓN AL EMPLEADO EN EL O CERCA DEL MOMENTO DE LA RECLAMADA LESIÓN EN EL TRABAJO

Yo por la presente reconozco que he sido informado de nuevo y que entiendo mis derechos y deberes bajo el Decreto de la Indemnización del Trabajador de Pennsylvania. Yo he recibido una copia de este formulario de notificación de la Indemnización al Trabajador.

Nombre del Empleado	Firma del Empleado	Fecha

The Flow of a Pennsylvania Workers' Compensation Claim

Before An Injury

- ➢Post a Panel Physician List.
- ➢Inform employees of their responsibility to report all injuries immediately.
- ➢Have employees sign a Workers' Compensation Employee Notification.
- ➢Have employees sign a Workers' Compensation Information Form.
- ➢Inform all supervisors of claim reporting procedures.
- ➢Implement a Modified Duty Program.

Immediately After an Injury

- ➢Complete a First Report of Injury form and forward to the claims office within 48 hours for a fatality and 7 days for all other injuries.
- ➢Have the injured employee re-sign the Workers' Compensation Notification Form and send a copy to the claims office. (If you have a list of panel providers.)

Have the injured employee re-sign the Workers' Compensation Information Form and send a copy to the claims office.

- ➢Have the employee sign an Authorization Form.
- ➢Refer the employee to one of the panel physicians, or if an emergency to the nearest E/R.
- ➢Forward all claim documentation to the claims office.

The Compensability Decision

- ➢Communicate any concerns regarding questionable claims to your claims representative.
- ➢Upon receipt immediately complete the Statement of Wages and forward to the claims office.
- ➢Within 21 days from the Date of Notice to the Employer the Claims Representative must investigate, determine compensability, and file the appropriate Bureau forms.

Controlling the Claim

- ➢Maintain contact with the injured employee and Claims Representative.
- ➢Offer Transitional Work within the employee's restrictions as soon as a light duty release is obtained.
- ➢Notify the Claim Representative immediately of any change in injured employees work status or attorney involvement.
- ➢Promptly send any medical bills to the claims office.

Lackawanna Insurance Group
Claims Reporting Procedures

The Pennsylvania Bureau of Workers' Compensation only accepts electronic injury reports from Insurers and requires submission of an injury report within 48 hours for injuries resulting in death and within 7 days for all other injuries.

For Lackawanna Insurance Group to timely report injuries to the Pennsylvania Bureau of Workers' Compensation the Insured must immediately after an injury complete and submit our First Report of Injury Form. It is necessary to complete at least the required fields on our First Report of Injury Form since this information is required by the Pennsylvania Bureau of Workers' Compensation.

We provide three (3) methods to submit our First Report of Injury form, and they are listed in order of preference:

On-Line Reporting: Log onto LIGINS.com

Click on Report a Claim Online Filing
Complete the On-Line First Report of Injury Form
Click on Print and maintain a copy for your records
Click on Acknowledge & SUBMIT
You will receive a confirmation that your on-line First Report of Injury was successful

Fax: Complete the First Report of Injury form and fax to:
Lackawanna Insurance Group @ 570-824-7969

Mail: Complete the First Report of Injury form and mail to:
Lackawanna Insurance Group
PO Box 270
Wilkes Barre, PA 18703

Important Notice

If you have a panel list of physicians that includes the appointment scheduling services by Premier Comp Solutions please be advised that scheduling an appointment is not the same as reporting the injury. You must submit a First Report of Injury form to Lackawanna Insurance Group.

Lackawanna Insurance Group
PO Box 270
Wilkes Barre, PA 18703
(570) 824-1400 (888) 280-5225
Fax: (570) 824-7969

First Report of Injury Check-List

	1. Complete the First Report of Injury form and submit to the claims office within 48 hrs. for a fatality and 7 days for all other injuries (see Claims Reporting Procedures).
	2. Have the employee re-sign the Workers' Compensation Information form. Forward a copy to the claims office.
	3. Have the employee re-sign the Workers' Compensation Notification form. Forward a copy to the claims office. ***(Only if you have a list of panel providers is posted.)***
	4. Have the employee sign an Authorization form. Forward to the claims office.
	5. If an emergency, refer the injured employee to the nearest E/R. For non-emergencies, if you have a list of panel providers the injured employee must choose one of the providers on the list to seek treatment with.
	6 a. If the employee is released to return to work regular duty forward a copy of the return to work slip to the claims office. 6 b1. If the employee is released to return to work with restrictions that you are able to accommodate forward a copy of the return to work slip to the claims office notating you are able to accommodate the restrictions. Also, forward a copy of the injured employee's job duties. 6 b2. If the employee is released to return to work with restrictions that you are not able to accommodate forward a copy of the return to work slip to the claims office notating you are not able to accommodate the restrictions. Also, forward a copy of the injured employee's job duties. 6 c. If the employee is taken out of work, forward a copy of the disability slip to the claims office. Also forward a copy of the claimant's job duties. This will assist the treating physician in accurately determining the claimant's ability to return to work with restrictions.

Lackawanna Insurance Group
PO Box 270, Wilkes Barre, PA 18703
Phone No: (570) 824-1400 ♦(888) 280-5225 ♦ Fax No: (570) 824-7969
www.ligins.com

First Report of Injury Form

(* DENOTES REQUIRED FIELDS)

Employee Social Security No: *

Date of Injury: *

Employee First Name: *

Employee Last Name: *

Street Address: *

City: * **State:** * **Zip Code:** *

County: **Phone No:** *

Date of Birth: * **Gender:** * Marital Status: No. of Dependents:

Occupation or Job Title: * **Employment Status:** * **Date of Hire:** *

Employer: *

Employer Contact Name: *

Employer Contact Phone No: * Employer Contact Fax No:

Employer Contact E-Mail Address:

Street Address: *

City: * **State:** * **Zip Code:** *

County: **Phone No:** *

Employer Federal ID No.: Policy No.: Policy Period Dates:

Did injury or illness occur on employer's premises?: * **State of Injury:** *

Address where injury occurred if different than Employer's address listed above
Street Address:
*

City: | State: | Zip Code:
* | * | *

Date Employer Notified: | **Time employee began work:** | **Time of occurrence:**
* | * | *

Full pay for day of injury? | Last day worked: | Date of disability: | Date returned to work *(if applicable)*:
* | | | |

Type of Injury: | **Part of Body Affected:** | **Cause of Injury:**
* | * | *

Were safeguards or safety equipment provided?: | **Were safeguards or safety equipment used?:**
* | *

All equipment, material, or chemicals employee was using when accident or illness exposure started:

How injury/illness/abnormal health condition occurred. Describe sequence of events including objects/substances directly responsible:
*

If fatal, give date of death:
*

Hospital /Healthcare Provider Name

Street Address:

City: | State: | Zip Code

Phone No:

Check	Initial Treatment
	No Medical Treatment/ Minor by Employee
	Healthcare Provider
	Panel Physician
	Employee Physician

Witness Name:

Witness Phone No.:

Name of Person Completing This Form:
*

Title:
*

Phone No: | **Fax No:**
* | *

Lackawanna Insurance Group

Lackawanna Casualty Company • Lackawanna American Insurance Company
• Lackawanna National Insurance Company

Authorization to Release Information

To Whom It May Concern:

I hereby request and authorize you to furnish to Lackawanna Insurance Group any and all information you have concerning

_____,
with respect to any illness or injury, medical history, consultation, treatment, including x-rays, as well as copies of all hospital or medical records, military records and / or other Workers' Compensation records.

I further request and authorize employers to furnish complete information including but not limited to wages, commissions, and any other form of compensation.

A photocopy of this authorization shall be considered as effective and valid as the original authorization.

Date: _____

Signature: _____

Print Name: _____

Street Address:
_____

City: _____ State: _____ Zip: _____

Lackawanna Insurance Group

Lackawanna Casualty Company • Lackawanna American Insurance Company • Lackawanna National Insurance Company

Autorización a la información de lanzamiento

A quien pueda interesar:

Le solicito y autorizo por este medio suministrar al grupo del seguro de Lackawanna y toda la información que usted tiene referente a _____, con respecto a cualquier enfermedad o lesión, historial médico, consultas, tratamiento, incluyendo radiografías, así como las copias de todo el hospital o informes médicos, los expedientes de los militares y/o el otro Workers' Expedientes de la remuneración.

Solicito y autorizo más lejos a patrones suministrar la información completa que incluye pero no limitada a los salarios, a las comisiones, y a cualquier otra forma de remuneración.

Una fotocopia de esta autorización será considerada como eficaz y válido como la autorización del orgional.

Fecha:_____ Firma:_____

Nombre de la impresión: _____

Dirección de calle:_____

Ciudad: _____ Estado: _____ Cierre relámpago: _____

Lackawanna Insurance Group provides the services of Premier Comp Solutions at no charge to our insureds.

Premier Comp Solutions, LLC
Description of Services

Workers' Compensation Provider Panels

Premier Comp specializes in the development of functional provider panels in Pennsylvania. Premier Comp selects licensed healthcare providers for placement on panels based on the following criteria:

- Client Preference
- Specialties appropriate for the anticipated work injuries.
- Quality of care and reputation in their field of specialty.
- Timeliness of consultations, evaluations, and follow up appointments.
- Willingness to address return-to-work status and modified duty.
- Ability to provide timely written medical reports.

Premier Comp customizes panels to meet the specific needs of our clients as follows:

- If a client utilizes the services of a PPO network, they will place providers from the network on the client's panel to maximize their total PPO savings.
- If a client requires a special format, language, or logos on their panel, they can accommodate this or any other custom format.
- They provide ongoing customer service to ensure the panel meets with the needs of our client.

24-Hour, Toll Free Appointment Scheduling

Premier Comp places its toll free appointment scheduling number (1-888-594-4001) on every provider panel. When our clients or injured workers call this number they will have access to a Premier Comp representative 24 hours a day, 7 days a week. Through this user-friendly process, the injured worker selects the provider they wish to initially treat with, and Premier Comp will immediately schedule an appointment for them.

Access to Discounted Physical Therapy/Diagnostic Services Networks

- **Physical Therapy Services:** Physical Therapy (PT) costs account for the majority of the total costs that employers pay on workers' compensation (WC) claims in PA. Consequently, it is important to understand that there is not just one mandated PA WC fee schedule for PT services. 70% of all PA PT providers are classified as cost-reimbursed or Medicare Part "A" providers. The remainder are classified as physician-based Medicare Part "B" providers and are reimbursed under one significantly reduced lower fee schedule. Premier Comp assists our clients in significantly reducing their costs associated with PT by offering one of the most comprehensive, discounted PT networks available in PA. This network is comprised of the highest quality PT providers available in the state, including both Part "A" and "B" providers. Through the use of their PT network our clients have obtained average savings of 50% on their PT services scheduled through Premier Comp's network.

- **Diagnostic Services:** Premier Comp offers access to an extensive group of diagnostic networks at a 10% discount below the PA WC Part "B" fee schedule.

Premier Comp Solutions does not provide injury-reporting services. The Insured is required to report employee injuries to Lackawanna Insurance Group.

Refer to Lackawanna Insurance Group's Claims Reporting Procedures

Accommodating Restrictions/Limitations

Employees often miss time from work due to an occupational injury that is often minor, but results in unnecessary, extended work absences due to temporary limitations/restrictions.

Employers who accommodate restrictions/limitations for employees during an occupational injury, even if only for a few hours a day or week, find it beneficial to themselves and their employees.

By providing modified/light duty work, an employer can reduce workers' compensation costs, avoid costs of hiring and training a replacement worker, reduce fraud, and promote employee moral.

Employers are encouraged to establish a program whereby employees continue to work during their healing and recovery period. It has been recognized that employees that continue to work with limitations/restrictions have a quicker recovery rate and a better outcome, as opposed to an employee who remains out of work and receives disability wage loss benefits.

Workers' Compensation
Disability/Wage Loss Benefits

An injured employee must be disabled for more than seven calendar days before workers' compensation disability/wage loss benefits are payable. Benefits for time lost from work are payable on the eighth day after an injury. Once an injured employee has been off work 14 days, s/he will receive retroactive payment for the first seven days. The first wage loss benefits payment is issued on the 21st day of disability, with subsequent payments issued on a bi-weekly basis thereafter.

To initiate disability/wage loss benefits:

When an injured employee presents proper medical documentation taking him/her out of work immediately contact the claims representative and fax the documentation to the claims office. The injured employee may be eligible for wage loss benefits.

When an injured employee presents proper medical documentation releasing him/her to return to work with restrictions that you are not able to accommodate immediately contact the claims representative and fax the documentation to the claims office, notating that you cannot accommodate the restrictions. The injured employee may be eligible for wage loss benefits.

When an injured employee presents proper medical documentation releasing him/her to return to work with restrictions that you are able to accommodate immediately contact the claims representative and fax the documentation to the claims office, notating that you can accommodate the restrictions. If the employee refuses the modified duty work and/or fails to return to work, immediately advise your claims representative so that required documents are completed. The injured employee may not be eligible for wage loss benefits.

Workers Compensation
Modifying or Suspending
Disability/Wage Loss Benefits

Immediately advise your claims representative when an employee returns to work in any type of capacity (with restrictions you can accommodate or regular duty).

The insurance carrier must send the Notice of Modification / Suspension (a form the employee does not have to sign) to the employee and Bureau within 7 days after the employee returns to work.

If a Notice of Modification / Suspension is not sent within the 7 days, a form agreeing to the modification or suspension of benefits must be sent to the employee for signature. ***Payment of disability/wage loss benefits must continue, even though the employee is working and earning wages, until the form is signed by the employee and received by the insurance company.***

If the employee fails to sign the agreement a claim petition must be filed to modify or suspend benefits. ***Payment of disability/wage loss benefits must continue, even though the employee is working and earning wages, until a decision is rendered by a Workers' Compensation Judge.***