



Workers' Compensation CLAIMS KIT

ATTENTION WORKERS' COMPENSATION POLICYHOLDERS!

Thank you for placing your Workers' Compensation insurance through CIA Managing General Agency. The carrier for your policy is

Claims will be handled through Anchor Claims Management (ACM).

CIA is providing masters of the required posting, publications, and forms which should be duplicated, completed when applicable, copied, and distributed per the instructions on the back of the masters. We have also included recommended guidelines for claims reporting. Please familiarize yourself with these forms and guidelines in order to assist us with the proper handling of your claims. If you should have questions, please contact your Anchor Claims Management representative.

Claims Kit

REPORTING GUIDELINES:

- Anchor Risk Management claims reporting guidelines
- Oklahoma reporting guidelines
- Supervisor's accident investigation report

POSTING NOTICES:

- Form 1A
- Forma 1A

CLAIM FORMS:

- Employer's First Report Of Injury Or Illness
- Employer's Wage Statement

GUIDELINES FOR CLAIMS REPORTING

When an accident (or alleged accident) occurs:

1. See that the injured employee receives prompt medical attention.
2. Obtain pertinent information about the claim.
 - * To assist you with this, we suggest that you have the supervisor fill out a Supervisor's Accident Investigation Report.
3. Immediately submit an injury report online at:

https://www.combinedgroup.com/acm/first_report

Alternatively, you may complete the enclosed form and mail or fax to:

ANCHOR CLAIMS MANAGEMENT
P.O. BOX 819045
DALLAS, TX
75381-9045

FAX 1-800-275-3194

4. Send in signed arbitration agreement by mail or fax.
5. Accidents resulting in death or severe injury should be reported immediately by telephone. Call toll free 1-800-275-3193.
6. After we have received the accident report, you will be contacted to assist us in the investigation of the claim.
7. Following the investigation, we will commence benefits if it is a compensable claim. We ask that you contact us immediately if you obtain any new information regarding the claim.
8. On lost-time cases, call us the day the employee returns to work.
9. Submit all medical bills and reports to ACM. If the bill falls below the S.I.R, we will complete a bill review and advise you of the recommended payment.
10. If you should have any questions concerning a claim, do not hesitate to call us at 1-800-275-3193 between 8:00 A.M. and 5:00 P.M. Monday through Friday.

GUIDELINES AND SUGGESTIONS FOR IMPLEMENTING EMPLOYER'S RESPONSIBILITY
UNDER THE OKLAHOMA WORKERS' COMPENSATION ACT

I. Employer's Responsibility for Prompt Claim Reporting - Employer's Reporting of Occupational Injury or Disease

- A. Submit an original Employer's First Notice of Injury Report to Anchor Claims Management, Inc. (ACM) immediately. This must be typed or printed in ink.
- B. In case of death, heart attack, spine fracture or other serious injuries, call ACM Claims Department and submit an Employer's First Notice of Injury Report to ACM immediately.

If at all possible we encourage the use of our FAX machine to expedite the arrival. Our FAX number is 1-800-275-3194.

- C. Keep a copy of the Employer's First Report of Injury for your records.
- D. ACM will file:

A copy of the Employer's First Notice of Injury Report with the Oklahoma Workers' Compensation Bureau within 14 days of the injury if the claim is a lost time case.

- E. Complete proper wage information on the fifth line down from the top of the Employer's First Notice of Injury, showing the average weekly wage (AWW) of the employee on the original copy of the Employer's First Notice of Injury Report. Average Weekly Wage is based on the prior 52 weeks of gross income from the date of the accident.
- F. There is a 3 day waiting period before compensation is paid. ACM should pay or deny compensation no later than 60 days from the date that the injury was reported to you. We have a reasonable amount of time to investigate a questionable claim.
- G. Return to work status:

If the employee has not lost any time or has returned to work, notify ACM by the following:

1. Complete line 7 on the Employer's First Notice of Injury Report by answering yes or no and then fill in the date of return to work.
2. If the employee has returned to work after the employer has sent the First Report, call ACM Claims Department at 1-800-275-3193 and advise us of return to work date, type of duty, and pay rate of the employee.

II. Employer's Responsibility for Medical Treatment

- A. Medical Control is given to the employee, but if an injured employee seeks medical treatment, he should treat with the physician that is used by your company. Although we do not have Medical Control in Oklahoma, you should set up a physician or medical clinic of your choice. The employer can control many small claims in this manner.
- B. ACM may at any time require a medical evaluation by a physician of their choice.
- C. Once the employee chooses a physician, he cannot change again unless he pays for it himself. ACM would pick up only \$500 of his second choice.

III. Employer's Notice of Dispute

- A. Form 3 - This form is used by an employee when he files a dispute with the Oklahoma Workers' Compensation Court. In most cases, when the employer receives this form, the employee has obtained legal counsel.
- B. Keep a copy for your records and immediately submit to ACM. Call ACM Claims Department and inform us of this form. ACM must obtain legal counsel and answer this claim with the Workers' Compensation Court within 20 days.

IV. Employer's Responsibility to Return Employees to Work - Modified Job Program

The employer should try to provide a job for the injured employee in the form of light duty if released to do so by the attending physician.

- A. Light duty jobs save your claim dollars since the employer can terminate compensation by notifying the employee that light duty is available during the healing of the injured employee.
- B. The created or modified job is a very important tool in returning employees to work and therefore reducing the overall exposure of the claim.
- C. Please call your Oklahoma Claims Adjuster concerning any specific return to work problems.

V. Summary

As an ACM subscriber, it is imperative that we receive your full cooperation in administering and complying with the Oklahoma Workers' Compensation Court. We need your assistance to ensure that all proper forms are filled out completely and timely. If you should have any questions concerning any of your Oklahoma Workers' Compensation needs, please feel free to contact your ACM representatives at 1-800-275-3193.

Please direct all correspondence to: ANCHOR CLAIMS MANAGEMENT
P.O. BOX 819045
DALLAS, TX 75381-9045

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT
work related or on-the-job incident/injury

Send this form to your company's main office, Manager, Risk Manager, or designee within 24 hours.

Employee Name _____
Date of birth: _____ Sex _____ Wage _____ SSN _____
Employee Address _____ Phone No. (work) _____ Phone No. (home) _____
Department/Shift: _____ Occupation: _____ How Long on Job? _____

Date of work injury _____ Exact time of injury _____ Where did this happen?,
incl. street address or department/location the employee was in at the time. _____
List witnesses, addresses and phone numbers, including any persons that may have
knowledge of the injury or incident, if known.
Name _____ Address _____ Ph.# _____
Name _____ Address _____ Ph.# _____
Name _____ Address _____ Ph.# _____
Did you take the employee to the doctor? Yes _____ No _____
Did the employee go to a doctor on own? Yes _____ No _____
Did the employee lose any work time due to the alleged injury i.e. unable to report to work for the
next regular shift? Yes _____ No _____
List attending physician and or Hospital, if known.
Doctor Name _____ Address _____ Ph.# _____
Hospital Name _____ Address _____ Ph.# _____
How long is the employee expected to be off work, if any?
Has the employee returned to work? Yes _____ No _____ (as of date of this report)

A. What Happened? *Describe what took place or what caused you to make this investigation.*

B. Why Did It Happen? *Get all the facts by studying the job and the situation involved. Question by use of WHY, WHAT, WHERE, WHEN, WHO, AND HOW. (Do not use words, like "careless", "not alert" state why such acts or inattention were involved in the first place)*

C. What Should Be Done to prevent repeat of similar incident? (To be completed by the injured employees immediate supervisor ... Manager should suggest any additional action).
Number each action. Determine which items need additional attention (people, equipment, material). Do not use words/phrases like "cautioned" "Told to be careful".

Continued on back

D. What Have You Done Thus Far? *Use the same action numbers as above. Take recommended action, depending on your authority. Follow-up: Was action effective? Insert work order numbers.*

_____ Date _____

_____ Date _____

E. How Will This Improve Operations?

Name of the injured employees immediate supervisor _____ Ph.# _____

Investigated By: _____ Title _____ Date _____ Ph.# _____

Employee signature _____

Name of company nurse, if any _____ Ph.# _____

Reviewing Dept. or Area Manager: _____ Date _____

Date this report was completed _____

Date this report was forwarded to the company manager or front office _____

FORM 2

**WORKERS' COMPENSATION COURT
1915 NORTH STILES
OKLAHOMA CITY, OK 73105-4918**

EMPLOYER'S FIRST NOTICE OF INJURY

Send original to
Workers' Compensation Court and 1 copy to
Insurance Carrier
Please type or print. Enter all dates in MM/DD/YY format.

Full Name of Employee - LAST, FIRST, MIDDLE			
Complete Address		City	State
Telephone Number		Social Security Number	
Date of Birth	Sex	Length of Employment Years _____ Months _____	
Average Weekly Wage	Occupation (job description)		Was employment agreement made in Oklahoma? YES <input type="checkbox"/> NO <input type="checkbox"/>

NOTE: A voluntary Mediation Program to address certain workers' compensation disputes is available through the Workers' Compensation Court. For information, call (405) 528760 or (800) 522-8210.

Date of accident or last exposure	Time of accident or exposure _____ o'clock AM <input type="checkbox"/> PM <input type="checkbox"/>	Date Employer Notified	Time workday began _____ o'clock AM <input type="checkbox"/> PM <input type="checkbox"/>
Last date employee worked	Has employee returned to work? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, on what date _____	Did the employee die? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, on what date _____	
OSHA Log Case #	Place of Accident or Occurrence City: _____ County: _____ State: _____		
Injury Resulted from: Single Incident <input type="checkbox"/> Cumulative Trauma <input type="checkbox"/>	Does employee participate in a certified workplace medical plan: YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, name of CWMP: _____		
Nature of Injury or Illness			
Describe activities when injury occurred with details of how event occurred. Include object or substance which directly injured the employee.			
Identify part(s) of body involved in injury or illness			
Full Name and address of Treating Physician (please be complete)			
Employer's Insurance Carrier or Own Risk Group		Policy/Self-Insured Number	
Name	Phone	Policy Period—from _____ to _____	
Address	City	State	Zip
Employer's Name and Complete Address		Federal ID#	
Name	Address	Phone #	State
Type of business (Example: manufacturing, food service, construction)			SIC Number
Type of Ownership: Private <input type="checkbox"/>	State Government <input type="checkbox"/>	County Government <input type="checkbox"/>	Local Government <input type="checkbox"/>

Upon filing this Notice of Injury, permission is given to the Administrator of the Workers' Compensation Court, the Insurance Commissioner, the Attorney General, a District Attorney or their designees to examine all records relating to the notice, any matter contained in the notice, and any matter relating to the notice.

Any person receiving temporary disability benefits from an employer or the employer's insurance carrier shall promptly report in writing to the employer or insurance carrier any change in a material fact or the amount of income the employee is receiving or any change in the employee's employment status, occurring during the period of receipt of such benefits.

I hereby declare under penalty of perjury that I have examined this notice, and all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

Signed this _____ day _____, _____ I hereby certify that this Form 2 was sent to the Workers' Compensation Court and a copy thereof to the insurer on the date described below:

Prepared by _____

Title _____

SUBMISSION OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

A Form 2 must be sent to the Workers' Compensation Court and to the Employer's Workers' Compensation Insurance Carrier within 10 days, or a reasonable time thereafter, of learning that an employee has suffered an accidental injury which results in lost time beyond the shift, or requires medical attention away from the work site, fatal or otherwise.

WAGE SCHEDULE

EMPLOYER: _____ FILE NO. _____

INJURED EMPLOYEE: _____

Job Classification Hourly Wage

Please complete this form, indicating the earnings of _____ for a period of 52 weeks immediately preceeding _____. If employee has worked less than 52 weeks then cover entire period of employment.

ANCHOR CLAIMS MANAGEMENT
P. O. Box 819045
Dallas, TX 75381-9045

PLEASE RETURN THIS COMPLETED FORM IMMEDIATELY TO:

NO COMPENSATION CAN BE PAID TO INJURED EMPLOYEE UNTIL THIS INFORMATION IS RECEIVED.

WEEK	WEEK ENDING	GROSS WAGES	DAYS EMPL. WORKED	DAYS PLANT WORKED	WEEK	WEEK ENDING	GROSS WAGES	DAYS EMPL. WORKED	DAYS PLANT WORKED
1					27				
2					28				
3					29				
4					30				
5					31				
6					32				
7					33				
8					34				
9					35				
10					36				
11					37				
12					38				
13					39				
14					40				
15					41				
16					42				
17					43				
18					44				
19					45				
20					46				
21					47				
22					48				
23					49				
24					50				
25					51				
26					52				
TOTALS					TOTALS				

SIGNATURE _____ POSITION _____

DATE _____ IMPORTANT: PLEASE FILL ALL COLUMNS

Form 1A Oklahoma Workers' Compensation Notice and Instruction to Employers and Employees

All Employees of this employer who are entitled to benefits of the Workers' Compensation Act are hereby notified that this employer has complied with all rules of the Workers' Compensation Court and that this employer has secured payment of compensation for all employees and their dependents in accordance with the Act. All employees are further notified this employer will furnish first aid, medical, surgical and any other like services required by law as well as payments of compensation awarded by the Workers' Compensation Court to any injured employee.

Any employee who has suffered an accidental injury or occupational disease covered by the Workers' Compensation Act shall be entitled to vocational rehabilitation services, including retraining and job placement, if, as a result of the injury, the employee is unable to perform the same occupational duties the employee was performing prior to the injury.

NOTE: A voluntary Mediation Program to address certain workers' compensation disputes is available through the Workers' Compensation Court. For information, call (405) 522-8760 or (800) 522-8210.

In compliance with 85 O.S., § 3.9, the Oklahoma Workers' Compensation Court has a counselor program to provide information to injured workers and employers. The counselors shall assist unrepresented parties to enable them to protect their rights under the workers' compensation system.



Signature of Employer

Insurer & Insurer Phone Number

Employee's Responsibilities in Case of Accidental Injury or Occupational Disease

If accidentally injured or affected by an occupational disease arising out of and in the course of employment, however slight, the employee should notify the employer immediately. If this employer is a partnership, notice shall be given to any partner. If this employer is a corporation, notice shall be given to any agent or officer of the corporation upon whom legal process may be served. Notice shall also be given to the person in charge of business at the location of operations where the injury occurred. Unless notice is given to the employer or medical treatment is rendered within thirty (30) days of injury, any claim for compensation may be forever barred.

If accidentally injured or affected by an occupational disease, the employee may file a claim for compensation with the Workers' Compensation Court. This employer is required to furnish the employee with appropriate forms to file a compensation claim.

If a claim for compensation for any accidental injury or death is not filed with the Court within two (2) years from the date of the accidental injury or death or if a claim for compensation for occupational disease or cumulative trauma is not filed within two (2) years of either the last hazardous exposure or from the date the disease first became manifest, which ever last occurred, the claim for compensation may be forever barred. Provided, claims may be filed within two (2) years of the date of last payment of any compensation or remuneration received instead of compensation or within two (2) years from the date of the last medical treatment authorized by the employer.

Any person receiving temporary disability benefits from an employer or the employer's insurance carrier shall promptly report in writing to the employer or insurance carrier any change in a material fact or the amount of income the employer is receiving or any change in the employee's employment status, occurring during the period of receipt of such benefits.

Employer's Responsibilities

The employer must provide employees with immediate first aid, medical and surgical care and other like services necessary. This applies to care for all injuries and illnesses arising out of and in the course of employment, regardless of their character. If an employee is injured and this results in the loss of time beyond his/her shift, or requires medical attention away from the work site (fatal or otherwise), the employer MUST file a Form 2 within ten (10) days of the notice of injury or a reasonable time thereafter. A copy of such Form 2 shall be provided to the employer's workers' compensation insurance carrier, if any.

No agreement by any employee to pay any portion of premiums paid by the employer to maintain or carry compensation insurance as required by law shall be valid. Any employer who deducts money from the wages or salary of any employee for that purpose who is entitled to workers' compensation shall be guilty of a misdemeanor.

If the employer has notice of an undisputed injury and the employer's insurance carrier fails to commence weekly temporary total disability benefit payments due within the time provided by law, the insurer may be subject to a penalty of fifteen percent (15%) of the unpaid or delayed weekly benefits due and payable to the employee.

No agreement by any employee to waive workers' compensation rights and benefits shall be valid.

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

**Workers' Compensation Court
1915 North Stiles Avenue
Oklahoma City, Oklahoma 73105-4918
(405) 522-8600 WATS # 1-800-522-8210**

This notice must be posted and maintained by the employer in one or more conspicuous places.

Aviso E Instrucciones Para Todos Los Empleadores Y Trabajadores Sobre La Compensación Para Los Trabajadores De Oklahoma

Todos los trabajadores (los empleados) de este empleador (de este patrón) que tengan el derecho a recibir beneficios del Acta de Compensación para los Trabajadores son avisados por esta notificación que este empleador ha cumplido con todas las reglas de la Corte de Compensación para los Trabajadores y que este empleador ha obtenido pagos de compensación para todos los trabajadores y sus mantenidos de acuerdo con el Acta. También se les notifica a todos los trabajadores que este empleador proveerá primeros auxilios, servicios de asistencia médica y quirúrgica, y otros servicios similares requeridos por la Ley, así como pagos de compensación adjudicados por la Corte de Compensación para los Trabajadores a cualquier trabajador lesionado (lastimado).

Cualquier trabajador que haya sufrido una lesión accidental o enfermedad profesional (enfermedad que ocurra como resultado de su ocupación) cubierta por el Acta de Compensación para los Trabajadores, tendrá el derecho a recibir servicios de enseñanza de oficios (rehabilitación profesional), incluyendo readiestramiento y colocación de empleo, si, con motivo de una lesión, el trabajador no puede desempeñar los mismos deberes profesionales que el trabajador desempeñaba antes de la lesión. La denegación de aceptar servicios de rehabilitación por parte del trabajador no disminuye en lo más mínimo los beneficios permisibles para el trabajador.

NOTA: Existe un Programa Voluntario de Mediación en ciertos conflictos de compensación laboral, que pone a la disponibilidad de los trabajadores la Corte de Compensación. Los interesados deben llamar al (405) 522-8760 o al (800) 522-8210 (llamada gratis) para más información.

En cumplimiento de 85 O.S. § 3.9, la Corte de Compensación para los Trabajadores de Oklahoma tiene un equipo de consejeros (asesores) para proveerles información a los trabajadores lesionados y a los empleadores. Los consejeros le pueden suministrar ayuda a las personas no representadas por abogados para protegerles sus derechos bajo el sistema de Compensación de Trabajadores.



Firma del Patrón

Compañía de Seguros
Número Telefónico de la Compañía de Seguros

Las Responsabilidades De Los Trabajadores En Caso De Lesión Accidental O Enfermedad Profesional

Si se lesiona (se lastima) accidentalmente o es afectado por una enfermedad profesional como resultado de, o en el transcurso de, su empleo, aún si es leve, el trabajador debe notificarle al empleador inmediatamente. Si dicho empleador es una sociedad colectiva, se le puede dar notificación a cualquier socio. Si el empleador es una sociedad anónima (corporación), se debe notificar a cualquier agente u oficial de la corporación autorizado a recibir notificación. También se debe dar notificación a la persona que esté a cargo del negocio en el lugar de operación del negocio en donde ocurrió la lesión. A menos que se le haya otorgado notificación al empleador o que se haya otorgado asistencia médica dentro de un plazo de treinta (30) días a partir de la lesión, cualquier reclamo por compensación podría estar exceptuado.

Si el trabajador se lesiona o es afectado por una enfermedad profesional, puede presentarle un reclamo para compensación a la Corte de Compensación para los Trabajadores. El empleador está requerido a proveerle al trabajador las formas apropiadas (los formularios) para poder presentar el reclamo de compensación. Si el trabajador no presenta el reclamo (la demanda) de compensación por lesión accidental o muerte dentro de un plazo de dos (2) años a partir desde la fecha del accidente, lesión o muerte, o si no se presenta un reclamo (demanda) por enfermedad profesional o por trauma acumulativo dentro de un plazo de dos (2) años desde la fecha en que estuvo expuesto al peligro por última vez o la fecha en que la enfermedad se manifestó por primera vez, cual ocurriera último, su reclamo (demanda) de compensación podría ser invalidado permanentemente. Sin embargo, se puede presentar un reclamo dentro de un plazo de dos (2) años a partir de la fecha en que se le dio el último pago de compensación (o remuneración recibida en vez de compensación) o dentro de un plazo de dos (2) años a partir del último tratamiento médico rendido por el empleador.

Cualquier persona que reciba beneficios de incapacidad temporal de un empleador, o de la compañía de seguros ("aseguranza") que asegure al trabajador, deberá reportarle sin demora por escrito al patrón o a la compañía de seguros cualquier cambio en los hechos pertinentes, cambio en la cantidad de ingresos que el trabajador esté recibiendo, o cambio en su situación de empleo, que ocurra durante el plazo de tiempo en el que el trabajador esté recibiendo dichos beneficios.

Responsabilidades Del Empleador

El empleador debe rendirle de inmediato a los trabajadores primeros auxilios, atención médica, cirugía y otros servicios similares cuando sea necesario. Esto es igualmente aplicable para todas las lesiones y enfermedades que resulten del empleo o durante la labor, sin importar de que tipo sean. Si un trabajador se lesiona (se lastima) y esto resulta en que el trabajador pierda tiempo de trabajo, además del tiempo perdido en su turno de trabajo, o requiere asistencia médica en un lugar fuera del sitio de trabajo (lesión mortal o no), el empleador **ESTA OBLIGADO** a presentar la Forma 2 dentro de un plazo de diez (10) días a partir del día en que se le notificó que había ocurrido la lesión, o después de un plazo de tiempo razonable. Se le deberá presentar una copia de dicha Forma 2 a la compañía de seguros de Compensación para los Trabajadores, si tiene alguna.

No será válido ningún acuerdo entre un empleador y un trabajador de compartir el pago para mantener en vigor el seguro de compensación tal como lo requiere la Ley. Cualquier empleador que tome deducciones de dinero del sueldo o salario de un trabajador que tenga derecho a la compensación de trabajadores será culpable de un delito menor.

Si el empleador tiene notificación de una lesión incontrovertible y la compañía de seguros del trabajadores falla en iniciar los pagos por beneficios semanales de incapacidad total temporal dentro del plazo de tiempo que requiere la Ley, la compañía de seguros puede estar sujeta a la imposición de una sanción del quince por ciento (15%) de los beneficios semanales impagados o pospuestos vencidos y pagaderos al trabajador.

Nunca se considerará válido ningún acuerdo por parte de cualquier trabajador a renunciar a sus derechos o beneficios de compensación para los trabajadores.

Cualquier persona que cometa fraude de compensación para los trabajadores, una vez se le haya procesado, será culpable de un delito mayor.

**Workers' Compensation Court
1915 North Stiles Avenue
Oklahoma City, OK 73105-4918
(405) 522-8600 WATS # 1-800-522-8210**

Este aviso será puesto y mantenido por el empleador en uno o más lugares conspicuos.