



Workers Compensation Resource for Employers



Welcome,

Thank you for choosing Omaha National for your workers compensation needs. We take pride in the clients we support and will do everything we can to exceed your expectations.

This resource provides you with important information about the workers compensation laws in your state. It also provides guidance on reporting workplace injuries.

When a workplace injury occurs, it is important that you tell us right away. The sooner we know about it, the better we can manage the claim, including arranging for prompt medical care. The best way to let us know about an injury is to **call us anytime at 844-761-8400**.

Additional copies of all these documents can be printed from our website at omahanational.com.



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All documents are also available on our website at omahanational.com



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Non-Compliance Notice

Please note, the use of many of the documents within this packet is required. Additional fines and enforcement actions may result from non-compliance with Illinois law regarding these notices.

**If you have any questions regarding your responsibilities, please contact
Omaha National at 844-761-8400.**



POSTERS

Please post the following notices at all business locations in a common area that is visible to and frequented by employees during the workday. Examples of appropriate posting locations include a breakroom bulletin board or a wall next to a time clock.

ICPN – Workplace Notice:

This poster serves as the mandatory workers compensation posting notice. As required by law, the poster must include the following information: insurer name (under Party handling workers' compensation claims), insurer business address, insurer business phone number, the policy number, policy effective and termination dates, and the employer's Federal Employer Identification Number (FEIN). Make sure to select the appropriate insurer name from the dropdown list.

IDOI Workers' Compensation Fraud Poster:

The Illinois Department of Insurance (IDOI) developed this poster to provide specific examples of workers' compensation fraud and to remind employers and employees of the serious consequences of engaging in fraud. The poster also provides the IDOI's Workers' Comp Fraud Unit telephone number for reporting fraud.

Fraud Prevention Poster:

Use this poster to reinforce the message to employees that workers compensation fraud is a serious crime and to let employees know how they can report fraud.

WORKERS' COMPENSATION



is a system of benefits provided by law to most workers who have job-related injuries or illnesses. Benefits are paid for injuries that are caused, in whole or in part, by an employee's work. This may include the aggravation of a pre-existing condition, injuries brought on by the repetitive use of a part of the body, heart attacks, or any other physical problem caused by work. Benefits are paid regardless of fault.

IF YOU HAVE A WORK-RELATED INJURY OR ILLNESS, TAKE THE FOLLOWING STEPS:

1. GET MEDICAL ASSISTANCE. By law, your employer must pay for all necessary medical services required to cure or relieve the effects of the injury or illness. Where necessary, the employer must also pay for physical, mental, or vocational rehabilitation, within prescribed limits. The employee may choose two physicians, surgeons, or hospitals. If the employer notifies you that it has an approved Preferred Provider Program for workers' compensation, the PPP counts as one of your two choices of providers.

2. NOTIFY YOUR EMPLOYER. You must notify your employer of the accidental injury or illness within 45 days, either orally or in writing. To avoid possible delays, it is recommended the notice also include your name, address, telephone number, Social Security number, and a brief description of the injury or illness.

3. LEARN YOUR RIGHTS. Your employer is required by law to report accidents that result in more than three lost work days to the Workers' Compensation Commission. Once the accident is reported, you should receive a handbook that explains the law, benefits, and procedures. If you need a handbook, please call the Commission or go to the Web site.

If you must lose time from work to recover from the injury or illness, you may be entitled to receive weekly payments and necessary medical care until you are able to return to work that is reasonably available to you.

It is against the law for an employer to harass, discharge, refuse to rehire or in any way discriminate against an employee for exercising his or her rights under the Workers' Compensation or Occupational Diseases Acts. If you file a fraudulent claim, you may be penalized under the law.

4. KEEP WITHIN THE TIME LIMITS. Generally, claims must be filed within three years of the injury or disablement from an occupational disease, or within two years of the last workers' compensation payment, whichever is later. Claims for pneumoconiosis, radiological exposure, asbestosis, or similar diseases have special requirements.

Injured workers have the right to reopen their case within 30 months after an award is made if the disability increases, but cases that are resolved by a lump-sum settlement contract approved by the Commission cannot be reopened. Only settlements approved by the Commission are binding.

For more information, go to the Illinois Workers' Compensation Commission's Web site or call any office:

Toll-free: 866/352-3033

Chicago: 312/814-6611

Peoria: 309/671-3019

Springfield: 217/785-7087

Web site: www.iwcc.il.gov

Collinsville: 618/346-3450

Rockford: 815/987-7292

TDD (Deaf): 312/814-2959

BY LAW, EMPLOYERS MUST DISPLAY THIS NOTICE IN A PROMINENT PLACE IN EACH WORKPLACE AND COMPLETE THE INFORMATION BELOW.			
Party handling workers' compensation claims			
Business address			
Business phone			
Effective date		Termination date	
Policy number		Employer's FEIN	

Workers' Compensation Fraud is a Crime

If your company lies about job descriptions to pay lower insurance premiums or lies about your accident occurring at work, your company has committed fraud.

If you lie about a job-related injury or exaggerate your injury to remain off work, you have committed fraud.

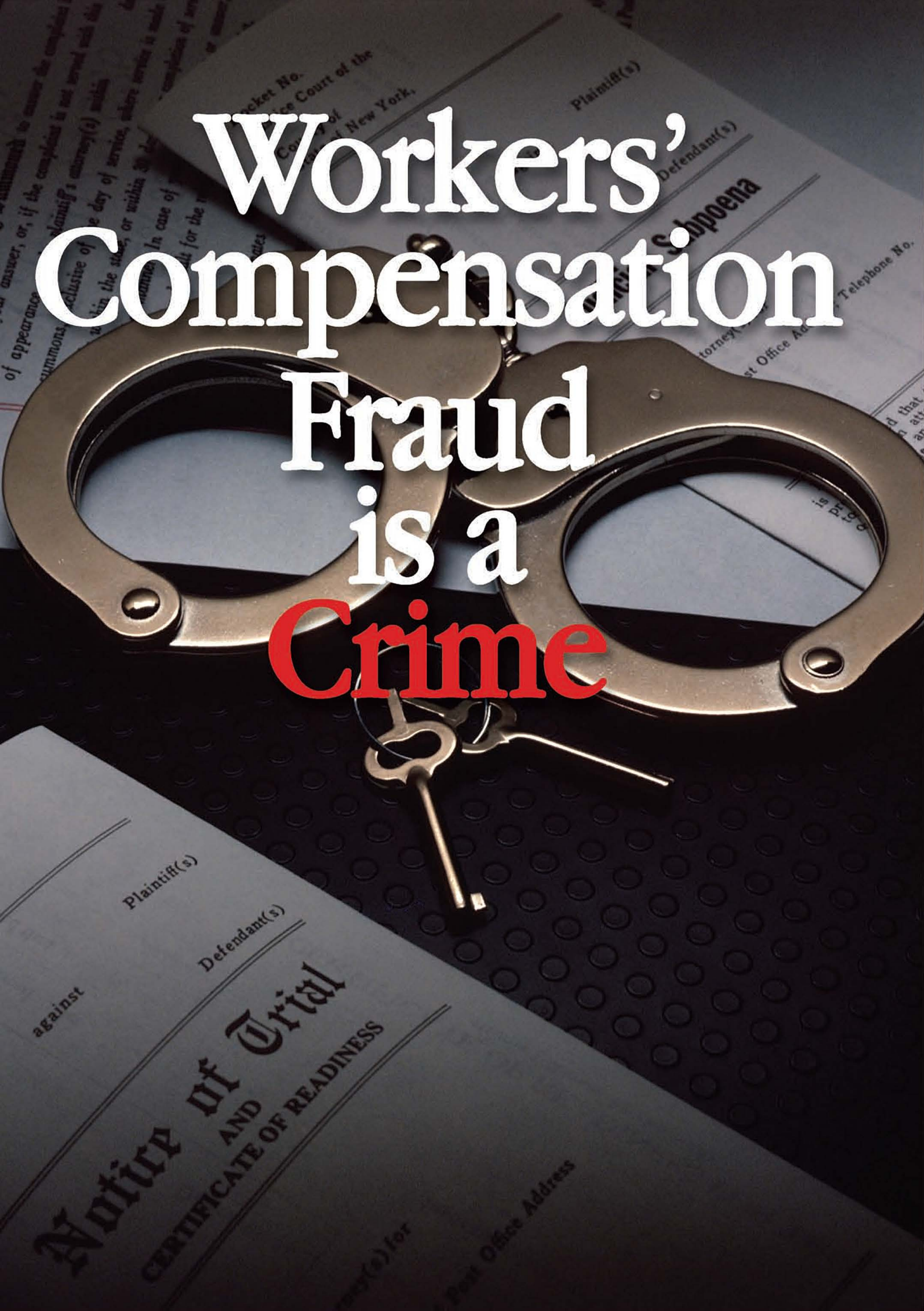
If you are convicted of fraud you can go to jail and be forced to repay up to three times the amount of money you collect on your claim.

If you fail to report alternate income received from other work activities while drawing Temporary Total Disability, you have committed fraud.

If someone is cheating the system, report it at **877-WCF-UNIT (923-8648)**.



J.B. Pritzker, Governor



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J.B. Pritzker, Governor

Fake an Injury And You Can Sit Around All Day



The Workers Compensation system was created to protect injured workers. Misrepresenting an injury to collect benefits is illegal.

If you suspect workers compensation fraud or abuse report it.

844-761-8400

All information will be kept confidential.





INJURY REPORT FORMS

These are documents to be completed after a workplace injury. Contact Omaha National at 844-761-8400 to report the claim.

IC-45 – Employer's First Report of Injury:

Employers are required to file this report with the Workers' Compensation Commission between the 15th and 25th day of the month after of learning about a non-fatal workplace injury or illness that results in lost time beyond three scheduled workdays. Reports on fatal accidental injuries or illnesses must be reported to the Commission immediately. Please note, you should promptly report **all injuries** to Omaha National, even those that only require first aid; sometimes an injury that seems minor at first can worsen and knowing about these Injuries allows us to manage them effectively.

IC-85 – Employer's Supplementary Report of Injury:

Employers must complete and submit this form to the Commission when it is determined that a workplace injury or illness involves permanent disability.

Incident, Supervisor, and Witness Reports:

When a workplace injury occurs, these forms may be used to gather information about an incident or injury. Copies should be sent to Omaha National at the same time you report the injury to us.

ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY*Please type or print.*

Employer's FEIN	Date of report	Case or File #	Is this a lost workday case? Yes No
Employer's name		Doing business as	
Employer's mailing address			Employer's email address
Nature of business or service			SIC code
Name of workers' compensation carrier/admin.		Policy/Contract #	Self-insured? Yes No
Employee's full name			Birthdate
Employee's mailing address			Employee's e-mail address
Gender Male Female	Marital status Married Single	# Dependents	Employee's average weekly wage
Job title or occupation			Date hired
Time employee began work	Date and time of accident		Last day employee worked
If the employee died as a result of the accident, give the date of death.		Did the accident occur on the employer's premises? Yes No	
Address of accident			
What was the employee doing when the accident occurred?			
How did the accident occur?			
What was the injury or illness? List the part of body affected and explain how it was affected.			
What object or substance, if any, directly harmed the employee?			
Name and address of physician/health care professional			
If treatment was given away from the worksite, list the name and address of the place it was given.			
Was the employee treated in an emergency room? Yes No		Was the employee hospitalized overnight as an inpatient? Yes No	
Report prepared by	Signature	Title and telephone #	Email address

Please send this form to: **ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE RD SPRINGFIELD, IL 62703**
By law, employers must keep accurate records of all work-related injuries and illness (except for certain minor injuries). Employers shall report to the Commission all injuries resulting in the loss of more than three scheduled workdays. Filing this form does not affect liability under the Workers' Compensation Act and is not incriminatory in any way. This information is confidential. IC45 8/12

ILLINOIS FORM 85: EMPLOYER'S SUPPLEMENTARY REPORT OF INJURY

Please type or print.

Employer's FEIN		Date of report		Case or File #		This report is Supplementary / Final	
Employer's name				Doing business as			
Employer's full mailing address				Employer's email address			
Nature of business or service					SIC code		
Name of workers' compensation carrier/admin.				Policy/Contract #		Self-insured? Yes / No	
Insurer's mailing address				City		State	Zip code
Employee's full name						Birthdate	
Employee's full mailing address				Employee's email address			
Date of injury/diagnosis		Date of first payment		Employee's average weekly wage		# Dependents	
Period of disability			If the employee died as a result of the accident, give the date of death.				

BENEFIT INFORMATION

Please provide a comprehensive history of payments.

Payment Type (TTD, medical, etc.)	Weekly Payment	Number of Weeks	Benefit Paid		Total Payments
			From	Through	
			Grand total		\$
Was this case closed by the Industrial Commission?		If so, how was the case resolved?			
Yes / No		Settlement contract / Arbitration decision / Commission decision			
Report prepared by		Signature		Title, telephone #, and email address	

Please send this form to: **ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE ROAD SPRINGFIELD, IL 62703-5118**

In addition to the *Employer's First Report of Injury* (IC45), employers shall file this report when 1) benefits begin or are stopped; 2) there is a change in the employee's status; 3) final compensation is made. This information is confidential. IC85 8/12



Incident Investigation Report

Tell us about the incident or injury right away by calling Omaha National at 844-761-8400 even if some spaces on this form are blank.

Today's Date _____

☐ Death ☐ Lost Time ☐ Medical Only

Type of Incident ☐ First Aid ☐ Property Damage

☐ Report Only / Near Miss

Date of Incident _____

Time of Incident _____ ☐ AM ☐ PM

Date Reported _____

Reported To _____

Injured Worker

Name _____

Department _____

Job Title _____

Supervisor _____

Work Schedule ☐ Mon ☐ Tue ☐ Wed ☐ Thurs
☐ Fri ☐ Sat ☐ Sun

Start Shift _____ ☐ AM ☐ PM

End Shift _____ ☐ AM ☐ PM

Length in Position _____

Sex ☐ Male ☐ Female

Date of Birth _____

Date of Hire _____

Employee Type ☐ Full Time ☐ Part Time
☐ Seasonal ☐ Temporary

Home Address _____

City, State, & Zip _____

Phone Number _____

Wages / Salary _____

Incident or Injury

Where incident occurred _____

Phase of workday ☐ During Break Period ☐ During Meal Period ☐ Working Overtime
☐ Entering or Leaving ☐ Performing Work Duties ☐ Other (Explain): _____

Description of incident (what the employee was doing and what happened):

Machines, materials, tools, or equipment used, handled, or involved:

Type of injury and body parts affected:

Witness(es) ☐ Yes ☐ No

Name _____

Name _____

Name _____

Phone Number _____

Phone Number _____

Phone Number _____

Medical Treatment and Work Status

First Aid Provided	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Describe	_____
Missed Time	<input type="checkbox"/> No	<input type="checkbox"/> Yes	List Day(s)	_____
Returned to Work	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date	_____
Emergency Care	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Work Status	<input type="checkbox"/> Off Work	<input type="checkbox"/> Light Duty	<input type="checkbox"/> Regular Duty	
Physician Name	_____		Hospital Name	_____
Address	_____		Address	_____
City, State, & Zip	_____		City, State, & Zip	_____
Phone Number	_____		Phone Number	_____

Contributing Factors

Unsafe Workplace Conditions: (Check All That Apply)

- ☐ Inadequate Guard
- ☐ Unguarded Hazard
- ☐ Safety Device Is Defective
- ☐ Tool or Equipment Defective
- ☐ Workstation Layout Is Hazardous
- ☐ Unsafe Lighting
- ☐ Unsafe Ventilation
- ☐ Lack of Needed Personal Protective Equipment
- ☐ Lack of Appropriate Equipment / Tools
- ☐ Unsafe Clothing
- ☐ No Training or Insufficient Training
- ☐ Other: _____

Unsafe Acts by People: (Check All That Apply)

- ☐ Operating Without Permission
- ☐ Operating at Unsafe Speed
- ☐ Servicing Equipment That Has Power to It
- ☐ Making A Safety Device Inoperative
- ☐ Using Defective Equipment
- ☐ Using Equipment in An Unapproved Way
- ☐ Unsafe / Improper Lifting
- ☐ Taking an Unsafe Position or Posture
- ☐ Distraction, Teasing, Horseplay
- ☐ Failure to Wear Personal Protective Equipment
- ☐ Failure to Use the Available Equipment / Tools
- ☐ Other: _____

Describe why the unsafe conditions exist:

Describe why the unsafe acts occurred:

Preventive Measures

- | | | |
|---|--|---|
| <input type="checkbox"/> Improve Enforcement | <input type="checkbox"/> Improve Clean-Up Procedures | <input type="checkbox"/> Repair / Replace Equipment |
| <input type="checkbox"/> Improve Storage / Arrangement | <input type="checkbox"/> Rotation of Employee | <input type="checkbox"/> Eliminate Congestion |
| <input type="checkbox"/> Identify / Improve Personal Protective Equipment | <input type="checkbox"/> Install / Revise Guards / Devices | <input type="checkbox"/> Task Analysis to Be Completed |
| <input type="checkbox"/> Task Analysis / Procedure Revision | <input type="checkbox"/> Improve Design/Construction | <input type="checkbox"/> Job Reassignment of Employees |
| <input type="checkbox"/> Use Other Materials / Supplies | <input type="checkbox"/> Improve Illumination | <input type="checkbox"/> Mandatory Pre-Job Instructions |
| <input type="checkbox"/> Improve Ventilation | <input type="checkbox"/> Reinstruction of Employees | <input type="checkbox"/> Corrective Counseling |
| <input type="checkbox"/> Improve/Change Work Method | <input type="checkbox"/> Other: _____ | |

Fax the completed form to us at 844-761-8402 or email it to claims@omahanational.com.

Completed By _____ Date of Completion _____
Signature _____ Title _____



Supervisor's Report of Employee Incident

Manager: Tell us about the injury or incident right away by calling Omaha National at 844-761-8400 even if some spaces on this form are blank.

Injured Employee

Name _____

Employee ID _____

Job Title _____

Company Name _____

Witnesses ☐ Yes ☐ No

Name _____

Phone Number _____

Name _____

Phone Number _____

Name _____

Phone Number _____

Incident

Date of Incident _____

Time of Incident _____ ☐ AM ☐ PM

Date Reported _____

Time Reported _____ ☐ AM ☐ PM

Was employee engaged in job duties at the time of incident? ☐ Yes ☐ No

Description of incident:

Machines, materials, tools, or equipment used, handled, or involved:

Type of injury and body parts affected:

Medical Treatment and Work Status

First Aid Provided ☐ No ☐ Yes

Describe _____

Missed Time ☐ No ☐ Yes

List Day(s) _____

Returned to Work ☐ No ☐ Yes

Date _____

Work Status ☐ Off Work ☐ Light Duty ☐ Regular Duty

Emergency Care ☐ No ☐ Yes

Physician Name _____

Hospital Name _____

Suggested Preventative and Corrective Measures

What actions can be taken to prevent future accidents?

Completed By _____

Date of Completion _____

Signature _____

Title _____

Fax the completed form to us at 844-761-8402 or email it to claims@omahanational.com.



Witness Statement of Injury or Incident

Manager: Tell us about the injury or incident right away by calling Omaha National at 844-761-8400 even if some spaces on this form are blank.

Witness Information

Name _____	Employee ID _____
Phone Number _____	Company Name _____
Address _____	City, State, & Zip _____
Other Witnesses <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name _____	Phone Number _____
Name _____	Phone Number _____
Name _____	Phone Number _____

Incident

Date of Incident _____	Time of Incident _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
Name of Injured Worker _____	Time Reported _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
Location of Incident _____	
Did You Observe the Incident Involving the Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, how did you learn of the incident?	
If yes, what did you see? (Use additional paper or write on the back if you need more space)	
Type of injury and body parts affected:	
What can be done to prevent an incident like this from happening again?	

Completed By _____

Date _____

Signature _____

Title _____

Fax the completed form to us at 844-761-8402 or email it to claims@omahanational.com.



INJURED WORKER HANDOUTS

As soon as you know one of your employees may have been injured at work, please provide the following documents to the injured worker.

Injured Worker's First Fill Prescription Form:

This document contains a first fill card that an injured worker can use for a one-time fill of prescription medicines for their work injury. **It is important that you give the worker this card right away when they report an injury.** The temporary card is only valid if used within 5 days of the reported date of injury. Once the injury is reported to us, our claims staff will provide further instructions to the worker on how to get subsequent prescription fills and refills.

Consent and Authorization for Release of Information and Request for Medical History Forms:

These forms help us to obtain the information and records needed to handle a claim and to make sure that the injured worker receives the best possible medical care. Have the injured worker sign the forms and send them to Omaha National.



Injured Workers First Fill Prescription Form

Injured Worker _____
Claim Number _____

Date of Injury _____
Phone Number _____

Notice to Injured Worker and Pharmacy

This temporary First Fill card is only valid if used within 5 days of the reported date of injury. Temporary eligibility through this program allows for a one-time fill of prescription medications. For assistance processing claims please contact EHIM at (800) 311-3446.

Injured Worker Instructions

On your first pharmacy visit, please give this notice to any participating pharmacy. This will expedite the processing of your approved workers compensation prescriptions, based on the parameters established by **Omaha National**. With EHIM you do not need to complete any paperwork or claim forms. Simply present this EHIM First Fill Prescription Form to the pharmacy. You should not incur any costs or co-pays at the pharmacy and you will be allowed up to a 10 day supply of medications.

Pharmacy Instructions

For assistance processing claims please contact EHIM at **(800) 311-3446**. Please use the BIN, and Rx Group number below to process an online/electronic claim to EHIM:



Pharmacy Help Desk:
800-311-3446

BIN: 005285
Group ID: 60011150FF
ID #: ONFFS + employee 10-digit phone
Number
Member: MEMBER NAME

To generate member ID: Using ONFFS as a prefix and then using the Injured Workers 10-digit phone number will be used as their member identification number when processing their First Fill Prescription.

Below is a sample listing of some of the over 72,000 Participating Pharmacies in the EHIM network. Please call **(800) 311-3446** for a participating pharmacy near you.

Costco Pharmacy
CVS
Kroger Pharmacy
Giant Eagle Pharmacy

H.E.B. Pharmacies
Hy-Vee Pharmacy
Safeway Pharmacy
Wegman Pharmacy

Meijer Pharmacy
Publix Pharmacy
Walmart Pharmacy
Longs Drug Store

Smith's Food & Drug Centers
Target Pharmacy
Walgreens Pharmacy
Ingles Pharmacy



Consent and Authorization for Release of Information

Injured Worker _____	Provider Name _____
Employer _____	Address _____
Date of Birth _____	City and State _____
Date of Injury _____	Phone Number _____

The above entity, facility, or medical practitioner is authorized to release my information as provided below:

I authorize Omaha National, their staff, representatives, or bearer, to review, inspect, copy, and/or photograph all records or files, including but not limited to the following:

- **Medical Records:** All medical charts, files, records, and reports, including office and hospital records, laboratory results, diagnostic reports and films, psychiatric records, medical correspondences, doctor's and nurse's notes, and medical histories relevant to my workers compensation claim. I also give my permission for Omaha National to contact the attending physicians involved in the treatment of all related conditions.

Please note, 45 CFR 164.512(l) states, "A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault."

- **Employment Records:** All employment and human resource information, including hiring and employment records, payroll and income statements, documentation related to this or any other relevant injury, and any other information pertinent to providing benefits and services necessary for the completion of this claim.

This consent and authorization is effective immediately. A photocopy of the authorization may be accepted in place of the original. This authorization is subject to revocation by the undersigned at any time, except to the extent that action has already been taken in reliance on this consent, and it terminates on conclusion of the workers compensation claim without express revocation. A request for revocation may be submitted in writing to Omaha National Underwriters at P.O. Box 451139, Omaha, NE 68145.

This information is required for the following:

- For the investigation, review, analysis, and discovery of a workers compensation claim and to determine the causation, nature, and extent of any possible pre-existing, concurrent, or aggravating medical conditions with potential medical, legal, or factual implications for the work-related injury or injuries.
- To provide important medical information to the treating physician, consultant, or evaluator so the injured worker may receive the best possible medical care and advice.
- To facilitate recovery from any third party responsible for the injury.
- To ensure that the injured work is accurately compensated for any amount of lost wages, time, or resources while undergoing evaluation, treatment, and recovery for the injury.
- To develop an appropriate plan of action for resolving the claim.

I have read this authorization and fully understand its entire contents. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received. I understand that I have a right to receive a copy of this authorization upon my request.

Signature _____	
Printed Name _____	Date _____

Fax the completed form to us at 844-761-8402 or email it to claims@omahanational.com.



Request for Medical History

Injured Worker _____
Employer _____

Date of Injury _____
Current Date _____

Provide your medical history to ensure that you receive the proper medical care for your work injury.

Family Doctor / Primary Health Care Provider and Other Treating Doctors

Name	Address	Phone	Condition Being Treated

Medications / Prescriptions

Name	Description/Purpose	Dosage	Prescribing Doctor

Hospitalizations and Surgical Procedures

Date(s)	Diagnosis/Treatment/Procedure	Doctor	Hospital

Please check to indicate if you have ever had any of the following conditions:

- | | | |
|---|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Back problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stomach or peptic ulcer | <input type="checkbox"/> Knee, hip, or foot problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Shoulder, elbow, or wrist problems |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Carpal tunnel |
| <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Blood clotting disorders |
| <input type="checkbox"/> Cancer – type: _____ | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Psychological condition |

Fax the completed form to us at 844-761-8402 or email it to claims@omahanational.com.

Signature _____

Date _____



INFORMATIONAL DOCUMENTS

Keep these documents for your future reference.



Omaha National Contact Information:

This document contains the contact information for our Claims department.



Reduce Your Workers Compensation Costs:

Tips for lowering your company's workers compensation costs.



Handbook on Workers' Compensation and Occupational Diseases:

The Illinois Workers' Compensation Commission created this to serve as a general guide for employers and injured workers about their rights and responsibilities under the Illinois Workers' Compensation and Occupational Diseases Acts. It contains basic explanations about the program, benefits, and procedures at the Commission.



Contact Information

Claims:

Phone	844-761-8400
Fax	844-761-8402
Online	omahanational.com
Email	claims@omahanational.com
Mail	P.O. Box 451139, Omaha, NE 68145



Reduce Your Workers Compensation Costs

Injury Prevention and Safety Training

According to the Occupational Safety and Health Administration (OSHA), businesses spend \$170 billion a year on occupational injuries and illnesses. Companies that establish safety programs to prevent injuries can reduce those costs by 20 to 40 percent. Safe workplaces also improve employee morale and can lead to increased productivity and improved service. Omaha National has resources to help you develop a program focused on the hazards specific to your business.

Report Injuries Immediately

The single most important thing you can do to reduce your claim costs is to report injuries to us immediately. The best way to do that is to call us anytime an injury occurs, 24 hours a day, seven days a week. The sooner we learn of an injury the better we can investigate the claim and arrange for appropriate medical care. It also helps prevent financial penalties from state regulatory agencies.



Ways to report an injury:

- **Phone: 844-761-8400**
- Fax: 844-761-8402
- Online: omahanational.com
- Email: claims@omahanational.com
- Mail: P.O. Box 451139, Omaha, NE 68145

High-Quality Medical Care

Ensuring that injured workers receive quality medical treatment is important. The right doctor can have a big impact on the successful recovery of an injured employee and on the cost of a claim. In certain states, Omaha National has established custom medical networks and panels including the right specialists to treat each injury in a safe, cost-effective manner, with a focus on early return-to-work.

Establish a Return-To-Work Program

Another way to reduce claim costs is to implement a return-to-work program that helps your injured worker get back to work quickly and safely while recovering from the injury. The program does not need to be complicated: the most important thing is to work with our claims adjuster to coordinate a successful return to work. The program can also include accommodations such as altered schedules, transitional work duties, or reassignment to an alternate position. Omaha National can provide helpful suggestions and advice to administer a return-to-work program.

ILLINOIS WORKERS' COMPENSATION COMMISSION

**HANDBOOK ON
WORKERS'
COMPENSATION
AND
OCCUPATIONAL
DISEASES**



This handbook is designed to serve as a general guide to the rights and obligations of employees who have experienced work-related injuries or diseases, as well as the rights and obligations of their employers, under the Illinois Workers' Compensation and Occupational Diseases Acts.

While this handbook attempts to provide both employees and employers with an overview of the Act, the facts and circumstances of each workplace injury will affect the outcome of each case. If you still have questions, please contact one of our Commission offices listed below. While the Commission staff is happy to try to answer your questions, this handbook is not intended to, nor does it constitute legal advice. Should you seek legal advice, please consult an attorney.

COMMISSION OFFICES

Toll-free:	Within Illinois only	866/352-3033
Chicago:	100 W. Randolph St., #8-200, 60601	312/814-6611
Peoria:	401 Main Street, Ste 640, 61602	309/671-3019
Rockford:	200 S. Wyman, 61101	815/987-7292
Springfield:	4500 S. Sixth St. Frontage Road, 62703	217/785-7087
TDD:	Telecomm. Device for the Deaf	312/814-2959

This handbook is also available in Spanish. This handbook, as well as the statute, rules, forms, and more information are available for free at <http://www.iwcc.il.gov/>.

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SECTION 1: Overview

1. *What is workers' compensation?*

Workers' compensation is a system of benefits provided by law to most employees who experience work-related injuries or occupational diseases. Generally, benefits are paid regardless of fault.

2. *What is the Illinois Workers' Compensation Commission?*

The Illinois Workers' Compensation Commission is the State agency that administers the judicial process that resolves disputed workers' compensation claims between employees and employers. The Commission acts as an administrative court system for these claims.

As the administrative court system, the Commission must be impartial. Staff explains procedures and basic provisions of the law to members of the public, but cannot provide legal advice or act as an advocate for either the employee or employer.

3. *Which employees are covered by the Workers' Compensation Act?*

Most employees who are hired, injured, or whose employment is localized in the State of Illinois are covered by the Act. These employees are covered from the moment they begin their jobs.

4. *What injuries and diseases are covered under the law?*

The Workers' Compensation Act provides that accidents that arise out of and in the course of employment are eligible to receive workers' compensation benefits. This generally means that the Act covers injuries that result in whole or in part from the employee's work.

5. *What benefits are provided?*

The Act provides the following benefit categories, which are explained in later sections of this handbook:

- a) Medical care that is reasonably required to cure or relieve the employee of the effects of the injury;
- b) Temporary total disability (TTD) benefits while the employee is off work, recovering from the injury;
- c) For injuries that occur on or after February 1, 2006, temporary partial disability (TPD) benefits while the employee is recovering from the injury but working on light duty for less compensation;
- d) Vocational rehabilitation/maintenance benefits are provided to an injured employee who is participating in an approved vocational rehabilitation program;
- e) Permanent partial disability (PPD) benefits for an employee who sustains some permanent disability or disfigurement, but can work;
- f) Permanent total disability (PTD) benefits for an employee who is rendered permanently unable to work;
- g) Death benefits for surviving family members.

6. *Are workers' compensation benefits taxable income?*

No. Workers' compensation benefits are not taxable under state or federal law and need not be reported as income on tax returns.

7. *Who pays for workers' compensation benefits?*

By law, the employer is responsible for the cost of workers' compensation benefits. Most employers buy workers' compensation insurance, and the insurance company pays the benefits on the employer's behalf. No part of the workers' compensation insurance premium or benefit can be charged to the employee. Other employers obtain the state's approval to self-insure, which means that the employer will be responsible for paying its own claims.

To identify the party responsible for paying benefits, an employee may check the employer's workplace notice, check the Commission's website, or contact the Commission at inscompquestions.wcc@illinois.gov or toll-free at 866/352-3033.

8. *What does the law require of employers?*

Employers are obligated to follow the provisions of the Workers' Compensation Act. Employers must:

- a) purchase workers' compensation insurance or obtain permission to self-insure from the Commission;
- b) post a notice in the workplace. Employers can obtain this notice at <http://www.iwcc.il.gov/forms.htm>; and
- c) keep records of work-related injuries and report to the Commission those accidents involving more than three lost workdays.

Employers are prohibited from doing the following:

- a) charging the employee for any part of the workers' compensation insurance premium or benefits; and
- e) harass, discharge, refuse to rehire, or in any way discriminate against an employee for exercising his or her rights under the Workers' Compensation Act.

9. *What should an employee do if his or her employer does not have workers' compensation insurance?*

The employee should give the employer's name and address, and the date of injury, to the Commission's Insurance Compliance Division. The Division can be reached at inscompquestions.wcc@illinois.gov or at 312/814-6611, toll-free 866/352-3033.

10. *Is an employer subject to any penalties if they do not purchase workers' compensation insurance?*

Yes. There are various provisions in the Workers' Compensation Act that address this issue.

Negligent failure to provide workers' compensation insurance coverage is punishable by a Class A misdemeanor for each day without coverage (maximum 12 months imprisonment, \$2,500 fine).

Knowing failure to provide workers' compensation insurance coverage is punishable by a Class 4 felony for each day without coverage (maximum 1-3 years imprisonment, \$25,000 fine).

An uninsured employer may also be subject to a civil penalty of \$500 for every day it lacked insurance, with a minimum \$10,000 fine.

Employers without workers' compensation insurance may be subject to a citation issued by the Insurance Compliance Division. The citation fine may range from \$500 to \$2,500.

An uninsured employer loses the protections of the Workers' Compensation Act for the period of noncompliance. That means an employee who was injured during the period of noncompliance may choose to sue in civil court.

In addition, if the Commission finds that an employer knowingly failed to provide insurance coverage, it may issue a stop-work order and shut the company down until it obtains insurance.

11. *Does the Workers' Compensation Act address workers' compensation fraud?*

Yes. Workers' compensation fraud falls into many different categories that affect employees, employers, and healthcare providers. The Act prohibits the intentional filing of any fraudulent workers' compensation claims or making a fraudulent statement to obtain workers' compensation benefits. Workers' compensation fraud may also involve making false statements in order to deny workers' compensation benefits. It is also unlawful to intentionally present a bill or statement for the payment of medical services that were not provided.

Assisting or conspiring in any of these actions may also be considered workers' compensation fraud.

12. *What are the penalties for workers' compensation fraud?*

The penalties for violations of the fraud provisions increase with the value of the property obtained or attempted to be obtained, starting with a Class A Misdemeanor for property valued at \$300 or less (maximum 12 months imprisonment and a \$2,500 fine), and ranging upwards to a Class 1 felony (maximum 4-15 years imprisonment, \$25,000 fine) for property valued at more than \$100,000. A convicted party is required to pay complete restitution, as well as court costs and attorney fees.

13. *What should I do if I suspect workers' compensation fraud?*

If you wish to report a possibly fraudulent situation, contact the Workers' Compensation Fraud Unit, Department of Insurance (DOI.WorkCompFraud@illinois.gov; toll-free 877/923-8648).

Anyone who intentionally makes a false report of fraud is subject to a Class A misdemeanor (maximum 12 months imprisonment, \$2,500 fine).

SECTION 2: Reporting An Injury or Exposure

1. *Who should an employee notify if injured at work?*

The employee should inform their employer if they are injured at work.

2. *Are there any specific requirements for a notice of an accident to an employer?*

The Act provides that the notice of accident shall include the approximate date and place of the accident, if known. Notice may be given orally or in writing.

3. *What are the time limits for notifying the employer of a workplace accident?*

Generally, the employee must notify the employer as soon as practicable, but no later than 45 days after the accident. Any delay in the notice to the employer can delay the payment of benefits.

For injuries resulting from radiological exposure, the employee must notify the employer 90 days after the employee knows or suspects that he or she has received an excessive dose of radiation.

For occupational diseases, the employee must notify the employer as soon as practicable after he or she becomes aware of the condition.

4. *What should the employer do after receiving notice of accident?*

The employer should promptly take the following steps:

- a) provide all necessary first aid and medical services;
- b) inform the insurance carrier or workers' compensation administrator, even if the employer disputes the employee's claim;
- c) if the employee cannot work for more than three days because of the injury, the employer must do one of the following:
 - (i) Begin payments of TTD; or
 - (ii) Give the employee a written explanation of the additional information the employer needs before it will begin payments; or
 - (iii) Give the employee a written explanation of why benefits are being denied.

5. *What records about workplace injuries must the employer maintain?*

Employers must maintain accurate records of work-related deaths, injuries, or illnesses. This does not include minor injuries requiring only first aid and not involving further medical treatment, loss of consciousness, restriction of work or motion, or transfer to another job.

6. *Are employers required to submit any reports to the Commission?*

Yes. Employers are required to report accidents to the Commission on the form, "Employer's First Report of Injury" which is known as the Form 45. The Form 45 is available on the Commission's website, <http://www.iwcc.il.gov/forms.htm>.

Written reports of all job-related deaths must be made to the Commission within two working days. Written reports of job-related injuries or illnesses resulting in the loss of more than three scheduled workdays must be made within one month. Employers are not required to submit a Form 45 for injuries that do not result in three or less days of lost work.

7. *How do employers submit accident reports?*

Accident reports should be submitted electronically. For information on how to submit accident reports electronically, please visit the Commission's website at <http://www.iwcc.il.gov/forms.htm>.

8. *Are employers required to post any notices in the workplace?*

Yes. Employers are required to post a notice developed by the Commission at each respective place of employment. The Commission maintains a copy of this notice on its website at <http://www.iwcc.il.gov/forms.htm>.

9. *What are an employee's options if the employer refuses to pay for workers' compensation benefits?*

The employee or the employee's attorney should contact the employer directly to determine why benefits are not being paid. Poor communication often causes delays and misunderstanding.

If the employer still does not pay any benefits, the employee's other option is to file a claim at the Commission. Please note that an accident report does not trigger any action by the Commission.

The Commission becomes involved only if the employee files a claim and follows the procedures to request a hearing. For more information about the claims process at the Commission, please see the next section of the handbook.

10. *Can an employee be fired for reporting an accident or filing a claim?*

It is illegal for an employer to harass, discharge, refuse to rehire, or discriminate in any way against an employee for exercising his or her rights under the law. Such conduct by the employer may give rise to a right to file a separate suit for damages in the circuit court.

An employee with a pending workers' compensation claim may still be disciplined or fired for other valid reasons.

SECTION 3: Filing a Claim at the Commission

1. *How is a claim filed at the Commission?*

To start your claim at the Commission, you must file three copies of the *Application for Adjustment of Claim*, along with a *Proof of Service* stating that a copy of the application was served upon the employer. Claims may be filed by mail or in person at any Commission office. You can find these forms on the Commission's website at <http://www.iwcc.il.gov/forms.htm>.

2. *Is there a filing fee for filing documents at the Commission?*

No. There are no fees for the forms or to file a claim.

3. *Where are the required claim forms at the Commission posted?*

All forms are posted on the Commission's website at <http://www.iwcc.il.gov/forms.htm>. These forms are available in Microsoft Word and Adobe Acrobat format and can be filled in on a personal computer.

4. *What happens after a claim is filed?*

The Commission assigns a case number and an arbitrator to the case. For cases in Cook County, cases are randomly assigned among the Chicago arbitrators. For cases outside of Cook County, cases are assigned to the hearing site closest to the site of the accident.

Every three months, the case will automatically be set for a status call. At the call, the parties may request a trial. If neither party requests a trial, the case is continued for another three months.

This rotation continues for three years. For the first three years after a case is filed, it is the parties' responsibility to move the case along. After three years, the arbitrator may dismiss the case at the status call unless the parties show there is a good reason to continue it.

It is important to realize that each arbitrator is responsible for thousands of cases, cannot monitor individual cases, and has no information as to whether benefits are or are not being paid. It is the parties' responsibility to track the case and take action when appropriate.

5. *How can I determine the status of a case at the Commission?*

The Commission maintains an online database of cases on its website. You can search that database by name or case number at <http://www.iwcc.il.gov/caseinfo.htm>.

6. *Is an employee required to file a claim at the Commission in order to receive benefits?*

No. However, many employees choose to file a claim. If the employee wants the Commission to order benefits to be paid, he or she must file a claim. An employee who is receiving benefits but is concerned about protecting his or her rights to receive future benefits may also wish to file a claim.

7. *What are the time limits for filing a claim at the Commission?*

Generally, an employee who fails to file a claim within the time limits loses his or her right to claim future benefits.

In most cases, the employee must file a claim within three years after an injury, death, or disablement from an occupational disease, or within two years of the last payment of TTD or a medical bill, whichever is later.

Some cases involving specific diseases or death of an employee have different time limits. You may wish to consult an attorney in those instances.

8. *Does the voluntary payment of benefits affect a claim?*

If the employee accepts benefits from their employer, he or she does not give up any rights under the law. Similarly, if the employer pays benefits, it does not waive its right to dispute the claim. Even if a claim is filed with the Commission after some benefits have been paid, the employer still has the right to contest its liability to pay any compensation at all.

9. *Does the employee have to hire an attorney to file a claim?*

No, but in disputed cases, most employees and employers do hire attorneys.

If the employee does not hire an attorney, it is the employee's responsibility to keep track of the claim, appear at hearings when necessary, and present evidence at hearings that proves his or her eligibility under the law.

Arbitrators and commissioners must be neutral and are subject to the Code of Judicial Conduct. They cannot act as an advocate for the employee or for the employer.

The Commission cannot recommend attorneys. Employees seeking an attorney may wish to ask friends for a recommendation or call an attorney referral service. The Commission has a list of bar associations that make referrals at <http://www.iwcc.il.gov/attys.pdf>.

10. *How much can an attorney charge for their services on a workers' compensation case?*

The law limits the claimant attorney's fee:

- a) An attorney shall not charge any fee on payments the employer voluntarily made in a timely and proper manner for medical care, TTD, and any other compensation.
- b) The attorney's fee is limited to 20% of compensation recovered, up to 20% of 364 weeks of the maximum TTD benefit, unless a hearing is held and the Commission approves additional fees.
- c) If the employer made a written offer to the employee, the attorney may only charge a fee on the amount recovered in excess of this offer. In this case, the attorney's fee may exceed 20% of the additional amount recovered, but in no event may the fee exceed 20% of the total award.
- d) The attorney's fee must be stated on the *Attorney Representation Agreement* form, signed by the employee (or in death cases, by the beneficiaries) and approved by the Commission.

11. What if the employee is dissatisfied with his or her attorney?

The Commission cannot resolve problems between an injured employee and his or her attorney.

SECTION 4: Resolving a Dispute at the Commission

1. What must the employee demonstrate to obtain an order from the Commission awarding benefits?

In cases before the Commission, it is the employee's responsibility to prove he or she is eligible for benefits. The employer does not need to disprove an employee's claim. By law, the burden of proof rests with the employee.

2. What are the most commonly disputed issues in cases filed at the Commission?

Some of the main issues in a workers' compensation case are listed below. The employee must prove all of them to qualify for benefits.

- a) Jurisdiction: on the date of the accident, the employer was subject to the Illinois Workers' Compensation or Occupational Diseases Act.
- b) Employment: on the date of the accident, a relationship of employee and employer existed between the parties.
- c) Accident or exposure: the employee sustained accidental injuries or was exposed to an occupational disease that arose out of and in the course of employment.
- d) Causal connection: the medical condition was caused or aggravated by the alleged accident or exposure.
- e) Notice: the employer received notice of the accident or exposure within the time limits set by law.

If the employee prevails on these issues, he or she will generally qualify for some benefit, but there may be other issues in dispute. For example, the parties may disagree over the extent of the employee's disability, or the employee's average weekly wage, or whether the medical treatments and/or bills were reasonable and necessary, or whether the employee is entitled to penalties.

3. How are claims before the Commission resolved?

An arbitrator of the Commission will conduct a trial, relying on Illinois law, rules of evidence, precedent set by previous workers' compensation cases, and the *Rules Governing Practice Before the Commission*. A court reporter will make a record of the hearing.

Except for emergency hearings, an arbitrator cannot resolve a case until the employee has reached maximum medical improvement. Once the employee has healed to the extent possible, the parties need to prepare the case for trial by obtaining medical records, doctors' depositions, and other paperwork. By the time everything is ready for trial, it is not uncommon for one to two years to have elapsed since the filing of the claim with the Commission.

In order to proceed to a trial, a trial date must be requested at the arbitrator's status call. The schedules for arbitrator status calls are available at the Commission's website at <http://www.iwcc.il.gov/calendars.htm>. After the trial, the arbitrator will issue a decision within 60 days, stating the amount of benefits, if any, to which the employee is entitled.

4. *Is there a way to get a quicker decision if there is an emergency?*

Yes. There are two methods of obtaining an emergency decision. They are commonly referred to 19(b) hearings and 19(b-1) hearings. For both 19(b) and 19(b-1) hearings, once the issues contained in the emergency process are decided, the case will go back on the arbitration call to resolve other issues in dispute, such as the degree of permanent disability.

19(b) Hearings

Under Section 19(b) of the Workers' Compensation Act, the Commission is required to issue a decision within 180 days of the date the *Petition for Review* was filed.

An employee who claims to be owed medical or compensation benefits may file a 19(b) petition, regardless of whether the employee is working.

An employer that is paying TTD may also file a 19(b) petition, as long as it keeps paying TTD until:

- a) the arbitrator rules on the petition;
- b) the employee's medical provider releases him or her back to regular work; or
- c) the employee starts work of any kind.

Neither the employee nor the employer is entitled to a 19(b) hearing if the employee has returned to work and the only benefit in dispute amounts to less than 12 weeks of TTD.

19(b-1) Hearings

Under Section 19(b-1), the Commission is required to issue a decision within 180 days, but it should be noted that there are many technical requirements to this process.

An employee who claims to be unable to work as the result of an injury and who is not receiving medical benefits or TTD may file a 19(b-1) petition to obtain a quick ruling on the medical care and/or TTD issues.

5. *Is it possible to appeal the arbitrator's decision?*

Yes. The employee and the employer each have the right to appeal a decision. A panel of three commissioners (usually called the Commission) will review the arbitrator's decision, as well as the evidence and transcript of the trial. Both sides may submit written arguments to the Commission. The Commission will then conduct a hearing (called an oral argument) at which the parties may present a brief, 5-10 minute argument for their position. The Commission is required to issue its decision within 60 days.

6. *Does the employer have to pay the award for benefits while the appeal is pending?*

While an appeal is pending, the employer is not required to pay the benefits awarded by the arbitrator. If the case is ultimately resolved completely in the employee's favor, interest will be added to the award, based on governmental bond rates at the time of the decision. There is also a 1% per month interest charge on medical bills, payable to the medical provider.

7. *Is there any way to appeal the Commission's decision?*

Commission decisions are final for cases involving employees of the State of Illinois. In all other cases and for cases involving Workers' Compensation Commission employees, either party may appeal to the circuit court, which may result in further appeals to the Appellate Court, and in some cases, to the Illinois Supreme Court. A chart at the end of this section illustrates the process.

8. *Is there any other way to resolve disputes?*

As in other court systems, most cases filed at the Commission are resolved through a compromise settlement between the parties. For cases at the Commission, these arrangements are referred to as “settlement contracts.” A settlement contract is an agreement between the employee and the employer to close a claim in exchange for an agreed-upon amount of money.

9. *Why do employers and employees enter into settlement contracts?*

By settling a case, the employee avoids the risk of either getting no compensation or less than is provided in the settlement, and the employer avoids the risk of paying more. Usually, cases are resolved faster by settlement than by trial. On average, a settlement is approved approximately two years after a claim is filed.

10. *How do employers and employees enter into settlement contracts?*

If the employer and employee reach an agreement, they should write down the terms of their agreement on the Commission’s Settlement Contract form and present it for approval to the arbitrator assigned to the case. A settlement is not legally binding unless the Commission approves it.

An employee who does not have an attorney (called a “pro se” petitioner) must appear in person before the arbitrator who, before approving it, will review the settlement and make sure it is fair and that the employee understands its effect. Please note that the arbitrator will act as a neutral adjudicator, not as the employee’s advocate.

11. *Are there any consequences to a settlement contract?*

It is important for all parties to review a settlement contract carefully. An approved settlement contract generally terminates the employee’s rights to any future cash or medical benefits, even if his or her condition worsens. If the parties want to keep a benefit open, this should be clearly stated in the settlement contract.

12. *Can a settlement be made without the Commission’s approval?*

A settlement that is made without Commission approval does not close out the employee's rights, and the time in which an employee may file a claim with the Commission is extended indefinitely.

Any settlement contract made within seven days of the injury is presumed to be fraudulent.

13. *What is a lump sum settlement?*

The Workers’ Compensation Act also allows for settlements that pay an injured employee in a single payment. Lump sum settlements may end other rights. It is important to read any settlement carefully and consult an attorney for legal advice.

14. *Does a decision or settlement close a case forever?*

A settlement contract usually closes a case forever unless the parties specifically state otherwise in the terms of the settlement contract. The following changes may occur after a decision or settlement is approved:

- a) At any time after a decision, the employee may request additional medical services that are reasonably required to cure or relieve the effects of the injury or disease. If the employer does

not agree to the request, the employee may file a petition asking the Commission to resolve the dispute.

- b) Within 30 months after the Commission issues a decision or approves a settlement contract payable in installments, if an employer can show that the disability has decreased, it may file a petition for a reduction in benefits. Conversely, if an employee can show that the disability has increased, he or she may file a petition for additional benefits.
- c) Within 30-60 months after the Commission issues a decision or approves a settlement contract payable in installments for wage differential benefits, if an employer can show that the disability has decreased, it may file a petition for a reduction in benefits. Conversely, if an employee can show that the disability has increased, he or she may file a petition for an increase in benefits.
- d) Anytime after the Commission issues a decision for permanent total disability, if the employer can show that the employee is no longer totally disabled, the employer may petition the Commission for an order terminating the PTD payments.

15. *What if the Commission awards benefits, but the employer won't pay?*

The employee may take one or more of the following actions:

- a) file a petition in the circuit court, asking the court to order payment under Section 19(g) of the Act;
- b) file a petition with the Commission for penalties and/or attorneys' fees for delay in payment, as appropriate, under Sections 16, 19(k), and/or 19(l) of the Act;
- c) file a petition with the Commission alleging a policy of delay or unfairness by the insurer or self-insurer under Section 4(c) of the Act; or
- d) call the Consumer Services Division of the Illinois Department of Insurance (toll-free 866/445-5364 or 217/782-4515).

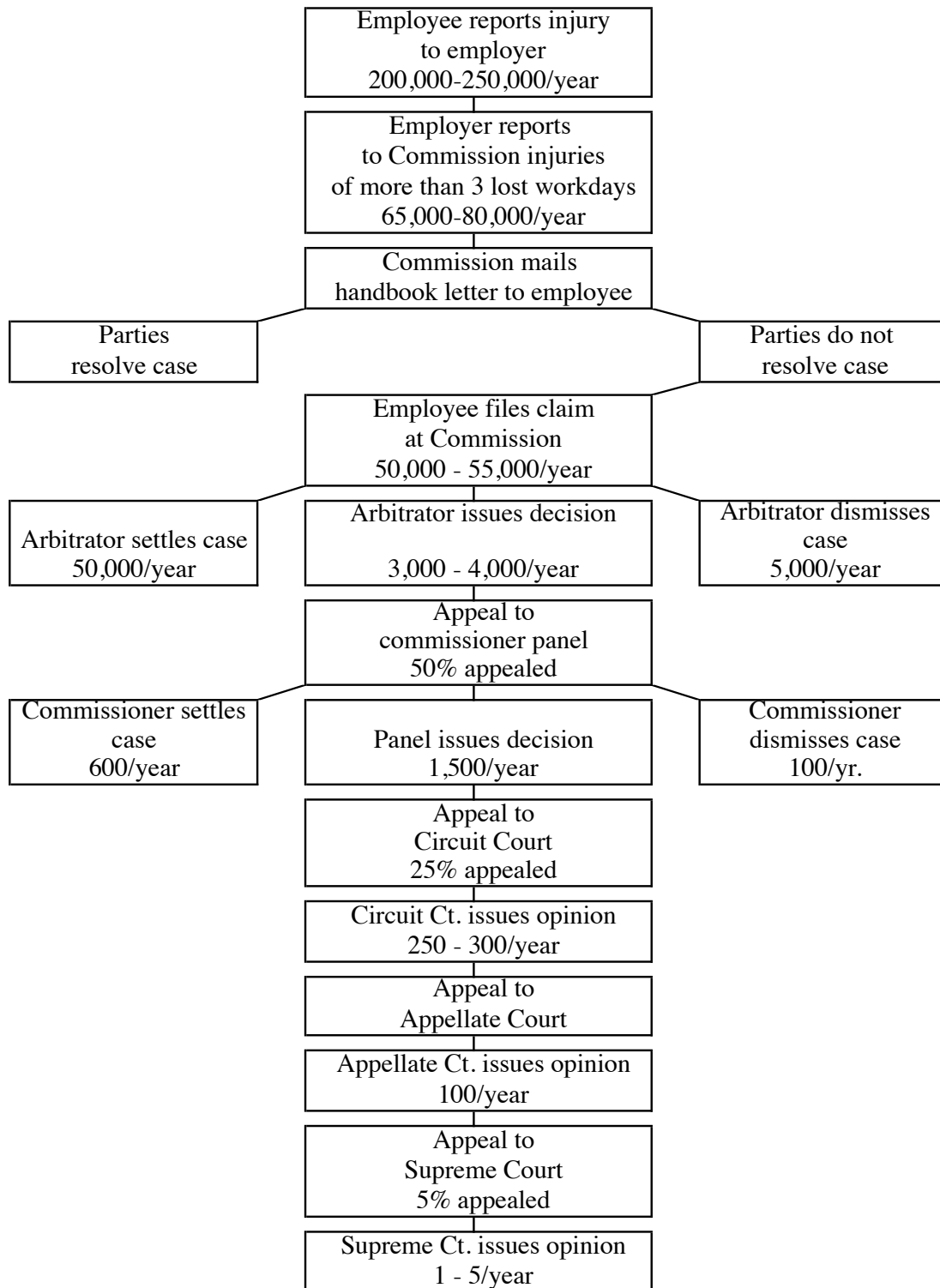
16. *Where are hearings held?*

Arbitrators hold hearings at numerous sites around Illinois. The employee and named employer on a claim will receive a notice from the Commission indicating the hearing site where the status hearings for the case are to be held.

For cases that have been appealed to the Commission after a decision has been entered by an arbitrator, the commissioners hold oral arguments in Springfield and Chicago.

For a complete schedule and list of hearing sites, please visit the Commission's website at <http://www.iwcc.il.gov/calendars.htm>.

Flow Chart of Dispute Resolution Process



Note: Cases can go back and forth. There are also many other processes to hear various motions, insurance compliance cases, etc.

SECTION 5: Medical Benefits

1. *What medical benefits are covered under the Act for work-related injuries?*

The employer is required to pay for all medical care that is reasonably necessary to cure or relieve the employee from the effects of the injury. This includes, but is not limited to first aid, emergency care, doctor visits, hospital care, surgery, physical therapy, chiropractic treatment, pharmaceuticals, prosthetic devices, and prescribed medical appliances.

The cost of devices, such as a shoe lift or a wheelchair, may be covered. If the work injuries result in a disability that requires physical modifications to the employee's home, such as a wheelchair ramp, the employer may have to pay those costs as well.

2. *Who pays for the medical care?*

If the employer does not dispute a medical bill, it will pay the medical provider directly. The employee is not required to pay co-payments or deductibles, unless the service is covered under a group health plan.

3. *Can a doctor send the employee a bill for the medical care for a work-related injury while a case is pending at the Commission?*

While a case is pending at the Commission, the provider cannot try to collect payment from the employee once the employee notifies the provider that he or she has filed a claim with the Commission to resolve this dispute. This is a practice known as "balance billing."

The provider may send the employee reminders of the outstanding bill, and ask for information about the case such as the case number and status of case. If the employee does not provide the information within 90 days of the date of the reminder, the provider may resume its efforts to collect payment.

4. *Can the employee choose a doctor or hospital from which to receive treatment?*

Generally, the employee may choose the provider where he or she seeks treatment. However, there may be some limitations both on the number of providers seen by the employee or on which particular providers that an employee may choose. The employee must choose carefully so that he or she does not end up becoming personally responsible for medical bills.

The employee's choice of provider will be limited to a selected network of providers if an employer has established what is called a Preferred Provider Program or "PPP." If there is a PPP, the employee has a choice of two physicians from the network within the PPP.

If an employer does not have a PPP, then the employee has a choice of any two providers. This does not include referrals from those two providers. First aid and emergency care are not considered to be one of the employee's two choices. Nonemergency care obtained before the employee reports the injury to the employer does not count as one of the two choices.

5. *How will an employee know if their employer has a PPP?*

If an employer has established a PPP, it must inform the employee about the PPP in writing on a form that is promulgated by the Commission.

6. *Is an employee only allowed to choose providers from the PPP network?*

The employee may decline participation in the PPP at any time by sending the employer a written statement. If the employee declines participation, it counts as one of the two choices of medical providers.

If the employee declines participation in the PPP, the employee may choose any doctor or hospital, and go to any doctor to whom the employee is referred by that provider. If the employee wishes to see another chain of providers, however, the employer must approve.

7. *What if the employee believes the PPP or the second choice of provider is providing improper or inadequate medical care?*

In this situation, the employee may petition the Commission. If the Commission finds the provider's care is improper or inadequate, the employee may choose a provider at the employer's expense.

8. *Where can employers obtain the form informing employees about its PPP?*

This form is available on the Commission's website at <http://www.iwcc.il.gov/forms.htm> .

9. *As long as the employee stays within the limits on their choice of provider, will the employer then pay for all medical care?*

Employers may use other methods under the Workers' Compensation Act to evaluate or challenge the necessity of medical care sought by an injured employee.

An employer may perform what is called a "utilization review," which is a review of the employee's past, present, and future medical treatments related to the work injury, and analyze the necessity of those treatments. The Commission will consider the utilization review finding, along with all other evidence, when determining whether a treatment was reasonably necessary.

If the Commission finds that a medical treatment was not reasonably necessary, the employer will not be responsible for paying the bill. The employee is not responsible for any treatment the Commission finds to be excessive or unnecessary. The employee may be held responsible for treatment that is deemed not covered under the Act.

10. *What are the employee's responsibilities regarding medical care?*

The employee should take the following steps in terms of medical care:

- a) Seek first aid or medical attention immediately after the injury or the point at which gradual symptoms first begin affecting physical activities at work or at home.
- b) Cooperate with the doctors and make efforts to achieve a complete recovery and full return to work, if possible. An employee may lose their eligibility for benefits for injurious or unsanitary activities.
- c) Tell the medical providers that the treatment is for a work-related condition. This lets the providers know that the employer is responsible for the medical bill.
- d) Give the employer the name and address of the doctor or hospital chosen. If the employee changes providers, the employee should again notify the employer.

The employee must also give the employer enough medical information for the employer to determine whether to accept or deny the claim. This includes all medical records relevant to the condition for which benefits are sought. An employee is not required to give anyone free access to his or her doctor or medical records, however.

The employer is not required to provide benefits if it does not receive the medical information necessary to determine the employee's medical status and fitness to work.

11. *What if an injured employee has religious beliefs that prevent him or her from seeking medical treatment?*

If an employee and employer agree in writing, and if the employee submits to all physical examinations required by the Act, the employee may, in good faith, rely on treatment by prayer or spiritual means alone in accordance with the tenets and practice of a recognized church or religious denomination. An injured employee who denies treatment in accordance with this provision will not suffer any loss or reduction of workers' compensation benefits.

12. *Does an employee have to allow employer-hired case managers to manage his or her care?*

No. An employee may, without penalty, refuse or limit the involvement of nurses or case managers hired by the employer. The employee is obligated to provide medical records that are relevant to the case, but otherwise an employee's medical care is confidential.

While case management is not mandatory, an employee may find the assistance of case management helpful.

13. *Can the employer ask for an evaluation of an employee by its own doctor?*

Yes. The employer may order a full medical exam by the doctor of its choice. The employer must provide notice of the exam to the employee and the exam must be at a time and place reasonably convenient for the employee. If submitting to the examination causes the employee loss of wages, the employer must provide reimbursement for the wages and also the expense of travel and meals.

14. *Can the employee review the examiner's report?*

The employer's doctor must give both parties the examiner's report as soon as practicable, but not less than 48 hours before an arbitration hearing.

15. *How are prices for medical care determined?*

Most treatments that are covered under the Act and were provided on or after February 1, 2006, are subject to a medical fee schedule. The employer shall pay the lesser of the provider's actual charge or the amount set by the fee schedule.

If, however, an employer or insurance carrier contracts with a provider for the purpose of providing services under the Act, the rate negotiated in the contract shall prevail.

The schedule is posted on the Commission's website. Please also refer to the law, rules, *Instructions and Guidelines*, and the "Medical: Frequently Asked Questions" web page at www.iwcc.il.gov/faqmed.htm.

SECTION 6: Temporary Total Disability (TTD) Benefits

1. *What are temporary total disability (TTD) benefits?*

TTD is the benefit that an injured employee receives during the period in which the employee is either: (a) temporarily unable to return to any work, as indicated by his or her doctor, or (b) is released to do light-duty work but whose employer is unable to accommodate him or her.

2. *How long can an employee receive TTD benefits?*

The employer pays TTD benefits to an injured employee until the employee has returned to work or has reached maximum medical improvement or “MMI.”

3. *How is the amount of the TTD benefit calculated?*

The TTD benefit is two-thirds (66 2/3%) of the employee’s average weekly wage, subject to minimum and maximum limits. The minimums and maximums for TTD are available in Commission offices and online at www.iwcc.il.gov/benefits.htm.

4. *How is the employee’s average weekly wage (AWW) calculated?*

The calculation of AWW can be complicated and will depend on the facts of each case. Generally, AWW is based on the employee’s gross (pre-tax) wages during the 52 weeks before the date of injury or exposure. However, the calculation of AWW may be affected by many different factors, including, but not limited to: if the employee had more than one job at the time of the injury, worked less than 52 weeks, or on a casual basis.

5. *Is there a waiting period for TTD benefits?*

TTD is not paid for the first three lost workdays, unless the employee misses 14 or more calendar days due to the injury.

6. *When is TTD paid?*

The employer should make the first TTD payment within 14 days after receiving notice of the injury. Since delays are common, to facilitate the prompt payment of benefits, we encourage the employee to give the employer a written demand for TTD benefits along with the doctor’s note.

If the employer does not pay promptly and cannot justify the delay, the employee may petition the arbitrator to order the employer to pay penalties and/or attorneys’ fees to the employee.

The employer should pay TTD at the same interval the employee was paid before the injury (e.g., weekly or biweekly).

If an employer stops paying TTD before the employee returns to work, it must give the employee a written explanation no later than the date of the last TTD payment. If the employer fails to provide this explanation, the employee may petition the arbitrator to assess penalties and/or attorneys’ fees.

SECTION 7: Temporary Partial Disability (TPD) Benefits

1. *What are temporary partial disability (TPD) benefits?*

TPD is the benefit that may be received during the period in which an injured employee is still healing and is working light duty, on a part-time or full-time basis, and earning less than he or she would earn in the pre-injury employment. The employer pays TPD benefits to an injured employee until the employee has returned to his or her regular job or has reached maximum medical improvement.

2. How is the TPD benefit calculated?

For injuries that occurred **before June 28, 2011**, the TPD benefit is two-thirds (66 2/3%) of the difference between the average amount the employee would be able to earn in the pre-injury job(s) and the net amount he or she earns in the light-duty job.

For injuries that occurred **on or after June 28, 2011**, the TPD benefit is two-thirds (66 2/3%) of the difference between the average amount the employee would be able to earn in the pre-injury job(s) and the gross amount he or she earns in the light-duty job.

Example:

An employee was earning \$900/week at the time of injury. While the employee was off work and recuperating, the pay for the job increased to \$925/week. The employee returns to a light-duty job and earns \$500/week.

Pre-injury average weekly wage (AWW)	=		\$900
Current AWW of pre-injury job	=		\$925
Post-injury gross pay	=		\$500
Wage differential	=	\$925 - \$500	= \$425
TPD	=	\$425 X 66 2/3%	= \$283.33/week

The minimums and maximums for TPD are available in Commission offices and online at www.iwcc.il.gov/benefits.htm.

3. Who is eligible for the TPD benefit?

Individuals whose injuries occurred on or after February 1, 2006 are eligible to receive TPD benefits.

SECTION 8: Vocational Rehabilitation/Maintenance Benefits

1. What is vocational rehabilitation?

Vocational rehabilitation includes but is not limited to counseling for job searches, supervising a job search program, and vocational retraining, including education at an accredited learning institution.

2. When is the employee entitled to vocational rehabilitation?

If the employee cannot return to the pre-injury job, the employer must pay for treatment, instruction, and training necessary for the physical, mental, and vocational rehabilitation of the employee, including all maintenance costs and incidental expenses. The employee must cooperate in a reasonable rehabilitation program.

The employee may choose the provider of such reasonable vocational rehabilitation services or may accept the services of a provider selected by the employer.

3. What benefit is the employee entitled to while participating in an approved vocational rehabilitation program?

An employee is entitled to maintenance benefits, plus costs and expenses incidental to the vocational rehabilitation program.

4. *How is the maintenance benefit calculated?*

The maintenance benefit shall not be less than the employee's TTD rate.

5. *Who is eligible for the maintenance benefit?*

Individuals whose injuries occurred on or after February 1, 2006 are eligible for the maintenance benefit.

SECTION 9: Permanent Partial Disability (PPD) Benefits

1. *What is permanent partial disability (PPD)?*

PPD is:

- a) the complete or partial loss of a part of the body; or
- b) the complete or partial loss of use of a part of the body; or
- c) the partial loss of use of the body as a whole.

"Loss of use" is not specifically defined in the law, but it generally means the employee is unable to do things he or she was able to do before the injury.

The Commission cannot make a PPD determination until the employee has reached maximum medical improvement or "MMI." PPD is paid only if the job-related injury results in some permanent physical loss.

2. *What types of PPD benefits are awarded by the Commission?*

There are four types of PPD benefits:

a. Wage differential (Section 8(d)(1) of Workers' Compensation Act)

If, due to the injury, the employee obtains a new job that pays less than the pre-injury employment, he or she may be entitled to receive a wage differential award. The wage differential award is two-thirds (66 2/3%) of the difference between the amount the employee earns in the new job and the amount he or she would be earning in their prior employment.

For injuries that occur before September 1, 2011, benefits shall be paid for the life of the employee. For injuries that occur on or after September 1, 2011, benefits shall be paid for five years after the date of the award or until the employee reaches age 67, whichever is later.

An employee may be compensated for either the loss of wages or the permanent disability related to the same injury, but not both.

Example:

An employee was earning \$1,000/week at the time of injury. While the employee was off work and recuperating, the pay for the job increased to \$1,040/week. Due to the injury, the employee can only find a job that pays \$500/week.

Pre-injury average weekly wage (AWW) =		\$1,000
Current AWW of pre-injury job =		\$1,040
AWW of post-injury job =		\$500
Wage differential =	\$1,040 - \$500 =	\$540
PPD benefit =	\$540 X 66 2/3% =	\$360/week

b. Schedule of injuries (Section 8(e) of Workers' Compensation Act)

The Act sets a value on certain body parts, expressed as a number of weeks of compensation for each part. (See the chart at the end of this section). The number of weeks is then multiplied by 60% of the employee's AWW.

If a body part is amputated or if it cannot be used at all, that represents a 100% loss, and the employee is awarded the entire number of weeks listed on the chart. If the employee sustains a partial loss, the benefit is calculated by multiplying the percentage of loss by the number of weeks listed.

Example:

An employee earning \$500 per week injures his or her thumb, and it is later determined there is a 10% loss of the use of the thumb.

PPD weekly rate	= \$500 X 60% =	\$300
Number of weeks	= 76 weeks X 10% =	7.6
PPD benefit	= 7.6 weeks X \$300 =	\$2,280

c. Non-schedule injuries (person as a whole) (Section 8(d)2)

If the condition is not listed on the schedule of injuries, but it imposes certain limitations, the employee may be entitled to a percentage of 500 weeks of benefits, based on the loss of the person as a whole. The number of weeks is then multiplied times 60% of the employee's AWW.

Example:

An employee earning \$500/week suffers a back injury that is determined to have caused a 10% loss of the person as a whole.

PPD weekly rate	= \$500 X 60% =	\$300
Number of weeks	= 500 weeks X 10% =	50 weeks
PPD benefit	= 50 weeks X \$300 =	\$15,000

d. Disfigurement (Section 8(c) of Workers' Compensation Act)

An employee who suffers a serious and permanent disfigurement to the head, face, neck, chest above the armpits, arm, hand, or leg below the knee, is entitled to a maximum of 162 weeks of benefits at the PPD rate. The number of weeks is then multiplied by 60% of the employee's AWW.

A scar must heal for at least six months before a hearing to assess the disfigurement can be held.

An employee may not collect compensation for disfigurement and the loss of use for the same body part. For example, a person who undergoes carpal tunnel surgery and is found to have experienced some loss of use, may be awarded a benefit based on the body part or on the disfigurement from the surgery scars, but not both.

3. How is the level of disability assessed?

For injuries occurring before September 1, 2011, the Commission evaluates the physical impairment and the effect of the disability on the injured employee's life. Factors that may be considered include the individual's age, skill, occupation, training, inability to engage in certain kinds of activities, pain, stiffness, or limitation of motion.

For injuries occurring on or after September 1, 2011, the Commission bases the determination of disability on five factors:

- (1) an impairment report prepared by a physician using the most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment"
- (2) the occupation of the injured employee;
- (3) the age of the employee at the time of the injury;
- (4) the employee's future earning capacity; and
- (5) evidence of disability corroborated by the treating medical records.

One of these factors may not be the sole determinant of disability. The relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained by the arbitrator in the decision.

4. *Is an employee eligible for compensation for pain and suffering for a work-related injury?*

Employees are not compensated for past pain and suffering, only for the residual pain that is part of the permanent disability.

5. *What if the employee's condition changes?*

For wage differential benefits where the injury occurred on or after February 1, 2006, if the employee's physical condition changes during the 60 months after the award becomes final, either party may ask the Commission to adjust the award.

For all other PPD categories: if the employee's physical condition changes during the 30 months after the award becomes final, either party may ask the Commission to adjust the award.

**PERMANENT PARTIAL DISABILITY BENEFITS
SCHEDULE OF BODY PARTS**

For injuries occurring

	<u>Before 7/20/2005</u>	<u>7/20/2005 - 11/15/2005</u>	<u>11/16/2005 - 1/31/2006</u>	<u>2/1/2006 - 6/27/2011</u>	<u>On or after 6/28/2011</u>
Disfigurement	150	162	150	162	162
Thumb	70	76	70	76	76
First (index) finger	40	43	40	43	43
Second (middle) finger	35	38	35	38	38
Third (ring) finger	25	27	25	27	27
Fourth (little) finger	20	22	20	22	22
Great toe	35	38	35	38	38
Each other toe	12	13	12	13	13
Hand	190	205	190	205	205
--Carpal tunnel due to repetitive trauma					28.5 - 57
Arm	235	253	235	253	253
--Amputation above elbow	250	270	250	270	270
--Amputation at shoulder joint	300	323	300	323	323
Foot	155	167	155	167	167
Leg	200	215	200	215	215
--Amputation above knee	225	242	225	242	242
--Amputation at hip joint	275	296	275	296	296
Eye	150	162	150	162	162
--Enucleation of eye	160	173	160	173	173
Hearing loss of one ear (under WC Act)	50	54	50	54	54
Hearing loss of both ears (under WC Act)	200	215	200	215	215
Testicle--1	50	54	50	54	54
Testicle--2	150	162	150	162	162

The law places a value on certain body parts,
expressed as a number of weeks of compensation for each part.

SECTION 10: Permanent Total Disability (PTD) Benefits

1. *What is permanent total disability (PTD)?*

PTD is either:

- a) The permanent and complete loss of use of both hands, both arms, both feet, both legs, both eyes, or any two such parts, e.g., one leg and one arm; or
- b) A complete disability that renders the employee permanently unable to do any kind of work for which there is a reasonably stable employment market.

2. *What is the PTD benefit?*

A claimant who is found to be permanently and totally disabled is entitled to a weekly benefit equal to two-thirds (66 2/3%) of his or her average weekly wage, subject to minimum and maximum limits, for life.

The minimums and maximums for PTD benefits are available in Commission offices and online at www.iwcc.il.gov/benefits.htm.

3. *Can a PTD recipient ever work?*

If an employee experiences a complete disability that renders the employee permanently unable to do any kind of work, and returns to work or is able to return to work, the employer may petition the Commission to terminate or modify the PTD benefit.

4. *Does the PTD benefit amount stay fixed for life?*

If a case is decided by an arbitrator, an employee will be entitled to cost-of-living adjustments. Beginning on the second July 15th after the award became final, the recipient will receive an cost-of-living payment from the Commission's Rate Adjustment Fund that reflects the increase in the statewide average weekly wage during the preceding year. These payments are made monthly.

5. *Can an employee receive both PTD and Social Security?*

Yes, if the employee qualifies under the terms of each program. If an employee receives both benefits, the Social Security Administration will apply a formula that may result in a reduction in the Social Security benefit.

SECTION 11: Death/Survivors' Benefits

1. *What is the burial benefit?*

For injuries resulting in death that occurred before February 1, 2006, a benefit of \$4,200 is provided to the survivor or the person paying for the burial. For injuries resulting in death occurring after February 1, 2006, the benefit is \$8,000.

2. *How is the amount of the survivors' benefit calculated?*

The benefit is two-thirds (66 2/3%) of the employee's gross average weekly wage during the 52 weeks before the injury, subject to minimum and maximum limits.

The minimums and maximums for the survivors' benefit are available in Commission offices and online at www.iwcc.il.gov/benefits.htm.

3. *Who is entitled to the survivors' benefit?*

The primary beneficiaries of the survivors' benefit are the spouse and children under the age of 18. If no primary beneficiaries exist, benefits may be paid to totally dependent parents. If no totally dependent parents exist, benefits may be paid to persons who were at least 50% dependent on the employee at the time of death.

4. *If the surviving spouse remarries, does this have an effect on eligibility for survivors' benefits?*

If there are eligible children at the time of remarriage, benefits will continue.

If there are no eligible children at the time of remarriage, the spouse is entitled to a final lump sum payment equal to two years of compensation. All rights to further benefits are extinguished.

5. *Does the benefit amount stay fixed for life?*

If a case is decided by an arbitrator, recipients of the survivors' benefit will be entitled to cost-of-living adjustments. Beginning on the second July 15th after the award became final, the recipient will receive an amount from the Commission's Rate Adjustment Fund that reflects the increase in the statewide average weekly wage during the preceding year. These payments are made monthly.



GENERAL FORMS

Use these forms as needed and send to Omaha National. Forms may be faxed to 844-761-8402.



Request for Subrogation Waiver:

Use this form to request to have a subrogation waiver added to your policy.



Form ERM-14 - Confidential Request for Ownership Information:

Changes in ownership may impact your policy and the factors used to determine your premium. These changes must be reported to us right away.



Company Contacts Verification:

This form is used to provide your company contacts for questions and issues pertaining to your payroll and/or workers compensation policy.



Request for Subrogation Waiver

Please complete the information below to request the addition of a subrogation waiver to your policy. A subrogation waiver may only be obtained if your company performs work under a written contract that requires such a waiver. You must maintain payroll records accurately segregating the payroll of your employees engaged in the specified job(s).

Please contact your Account Manager at 844-761-8400 if you have any questions.

General Information

Policyholder Name _____
FEIN _____
Policy Number _____
Waiver Type Requested ☐ Blanket Waiver ☐ Specific Waiver (if applicable, please complete fields below)

Job Information for Specific Waiver

Job Effective Date(s) From _____ To _____
Job Name or Number _____
Person or Organization _____
Brief Description of Job _____
Complete Address _____
Employee Class Code _____ Employee Class Code _____ Employee Class Code _____
Payroll Amount _____ Payroll Amount _____ Payroll Amount _____

Job Information for Specific Waiver

Job Effective Date(s) From _____ To _____
Job Name or Number _____
Person or Organization _____
Brief Description of Job _____
Complete Address _____
Employee Class Code _____ Employee Class Code _____ Employee Class Code _____
Payroll Amount _____ Payroll Amount _____ Payroll Amount _____

Job Information for Specific Waiver

Job Effective Date(s) From _____ To _____
Job Name or Number _____
Person or Organization _____
Brief Description of Job _____
Complete Address _____
Employee Class Code _____ Employee Class Code _____ Employee Class Code _____
Payroll Amount _____ Payroll Amount _____ Payroll Amount _____

Job Information for Specific Waiver

Job Effective Date(s) From _____ To _____
Job Name or Number _____
Person or Organization _____
Brief Description of Job _____
Complete Address _____
Employee Class Code _____ Employee Class Code _____ Employee Class Code _____
Payroll Amount _____ Payroll Amount _____ Payroll Amount _____

Job Information for Specific Waiver

Job Effective Date(s) From _____ To _____
Job Name or Number _____
Person or Organization _____
Brief Description of Job _____
Complete Address _____
Employee Class Code _____ Employee Class Code _____ Employee Class Code _____
Payroll Amount _____ Payroll Amount _____ Payroll Amount _____

Submitter Information

Completed by _____ Date _____
Title _____ Signature _____

Fax the completed form to us at 844-761-8402 or email it to customerrelations@omahanational.com.

REQUEST FOR OWNERSHIP INFORMATION—ERM-14 FORM

The purpose of this **confidential** form is to obtain ownership information to assist in calculating premium for your workers compensation insurance policy. Your policy requires that you report ownership changes, and other changes as detailed below, to your insurance carrier in writing within 90 days of the change. If you have questions, contact your agent, insurance company, or the appropriate rating organization. **Incomplete information or a missing signature may result in a delay in processing.**

The ownership information required on this ERM-14 Form can also be submitted in narrative form on the letterhead of the employer, signed by an owner, partner, member, or executive officer.

Section A—Contact Information

Name of person completing this form _____ Your Employer _____

Phone # _____ Email Address _____

Relationship to business entity reporting ownership information _____

Section B—Transaction Information

Type of Transaction (check all that apply)	Transaction Effective Date
<input type="checkbox"/> Name and/or legal entity change The name and/or legal status of the entity has changed. DBA name changes do not need to be reported.	
<input type="checkbox"/> Sale, transfer, or conveyance of all or a portion of an entity's ownership interest Complete or partial sale of the business entity's ownership interest.	
<input type="checkbox"/> Sale, transfer, or conveyance of an entity's physical assets to another entity that takes over its operations An entity's assets have been sold or transferred. The acquiring entity has taken over the operations, and the selling entity retained its legal business name.	
<input type="checkbox"/> Merger or consolidation Two or more entities have merged or combined to form a single entity.	
<input type="checkbox"/> Formation of a new entity that acts as, or in effect is, a successor to another entity that: (Select one) <input type="checkbox"/> Has dissolved <input type="checkbox"/> Is nonoperative <input type="checkbox"/> May continue to operate in a limited capacity	
<input type="checkbox"/> Formation of a new entity A new entity has formed that is not a successor to another entity. Report this change only to determine combinability with another entity.	
<input type="checkbox"/> An irrevocable trust or receiver, established either voluntarily or by court mandate A change has occurred to the business, either voluntarily or by court mandate, requiring the entity to be put in a trust or receivership.	
<input type="checkbox"/> Determination of combinability of separate entities Two or more entities may need to be combined or separated based on their ownership interest.	

Section C—Description of Transaction(s)

Include a brief description of the transaction(s) selected above. Attach additional information on the employer's letterhead, if needed.

- If this is a partial sale, transfer, or conveyance of an existing business (e.g., sale of one or more plants or locations), explain what portion or location of the entire operation was sold, transferred, or conveyed.
- If any of the entities that underwent a change in ownership were related through common ownership to any other entity before the transaction described above, list the entities and their current owners' names and percentages of ownership below.

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Section D—Business Entity Information

Copies of this page may be submitted for transactions with more than three entities.

Entity Information	Entity 1 Entity before the change or to determine combinability with another entity	Entity 2 Entity after the change or to determine combinability with another entity	Entity 3 Entity after a merger or consolidation or to determine combinability with another entity
1. Name of Business Provide the legal name of the business entity.			
2. Primary Address (Street, City, State, Zip)			
3. Legal Status (See examples in item 4 below)			
4. Ownership List names of individual owners, partners, etc. and percentages of ownership (if applicable). Ownership should total 100%. – Sole Proprietorship: Owner – Corporation: Owner(s) and percentages of ownership – General Partnership: Partners and percentages of ownership – Limited Partnership: General partners and percentages of ownership – Limited Liability Company: Members and percentages of ownership – Revocable Trust: Grantor(s) – Irrevocable Trust: Trustee(s) – Other: If no voting stock, list members of board of directors or comparable governing body			
5. FEIN			
6. Risk ID Number			
7. Policy Number			
8. Policy Effective Date			
9. Contact Name			
10. Contact Phone/Email			

Section E—Certification

This is to certify that the information contained on this form is complete and correct.

Signature of Owner, Partner, Member, or Executive Officer Title

Business Name

Print name of above signature

Date



Company Contacts Verification

Please complete the information below to confirm your company contacts for questions and issues pertaining to your payroll and/or workers compensation policy.

Please contact your Account Manager at 844-761-8400 if you have any questions.

General Information

Policyholder Name _____
FEIN _____
Policy Number _____
Main Address _____
Phone Number _____
Fax Number _____
Company Website _____

Company Contacts for Invoice Questions/Issues

Primary Contact Name _____	Alternate Contact Name _____
Office Phone Number _____	Office Phone Number _____
Cell Phone Number _____	Cell Phone Number _____
Fax Number _____	Fax Number _____
Email Address _____	Email Address _____

Company Contacts for Payroll Questions/Issues

☐ Check if same as above

Primary Contact Name _____	Alternate Contact Name _____
Office Phone Number _____	Office Phone Number _____
Cell Phone Number _____	Cell Phone Number _____
Fax Number _____	Fax Number _____
Email Address _____	Email Address _____

Company Contacts for Policy Questions/Issues

☐ Check if same as above

Primary Contact Name _____	Alternate Contact Name _____
Office Phone Number _____	Office Phone Number _____
Cell Phone Number _____	Cell Phone Number _____
Fax Number _____	Fax Number _____
Email Address _____	Email Address _____

Company Contacts for Claims Questions/Issues

☐ Check if same as above

Primary Contact Name _____	Alternate Contact Name _____
Office Phone Number _____	Office Phone Number _____
Cell Phone Number _____	Cell Phone Number _____
Fax Number _____	Fax Number _____
Email Address _____	Email Address _____

Submitter Information

Completed by _____ Date _____
Title _____ Signature _____

Fax the completed form to us at 844-761-8402 or email it to customerrelations@omahanational.com.