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 Maryland 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 or on a wall next to a time clock. Posters must also be used in any areas used for the treatment of injured workers and the administration of first aid and on employee informational bulletin boards.

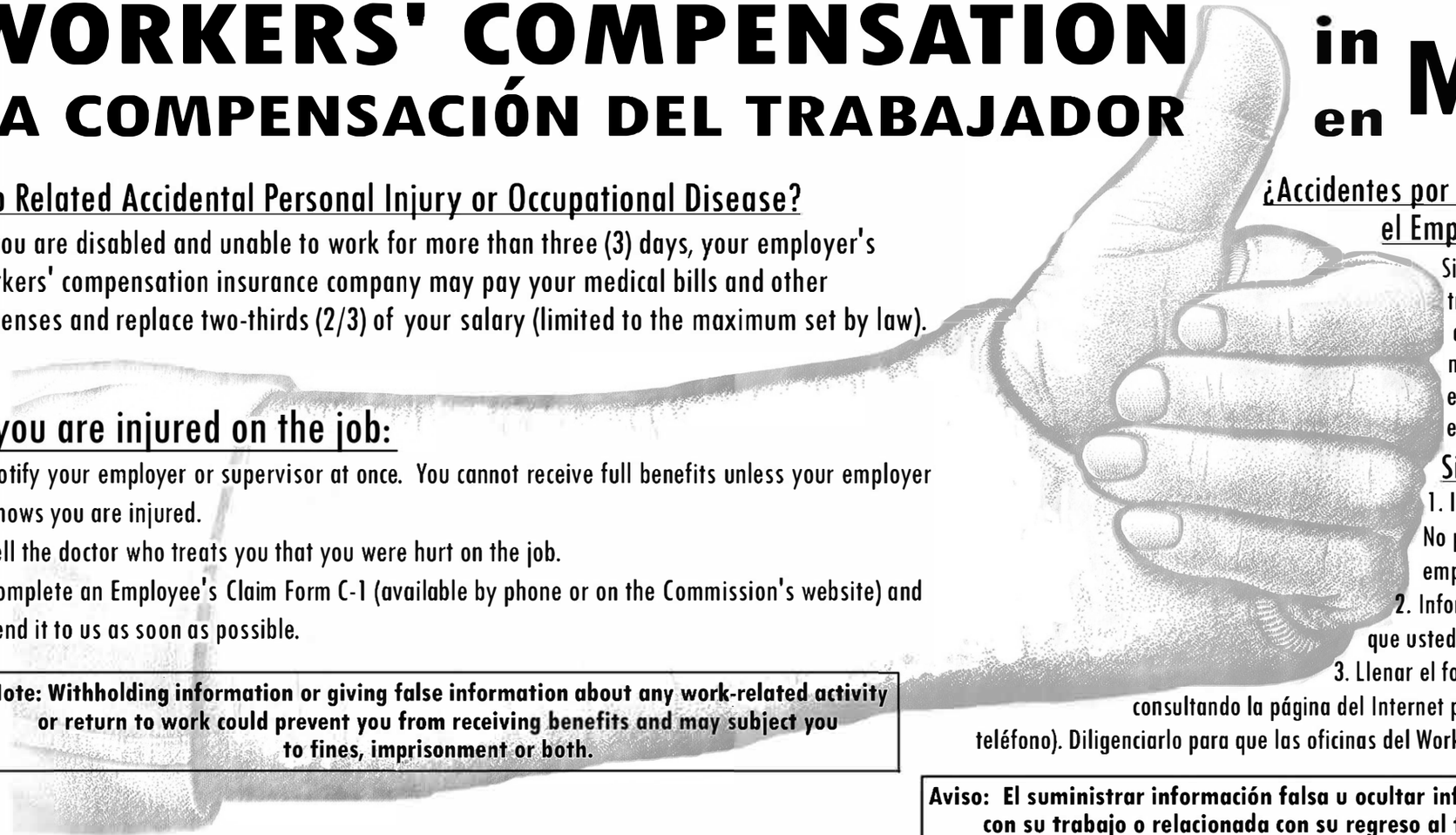
Form C-24: Employer's Posting Notice

This document serves as the mandatory workers compensation posting notice. Make sure to enter the employer/insurer information in the lower left corner of the poster. Select the appropriate insurance carrier from the dropdown list provided. This poster must be printed on 8.5" x 14" (legal size) paper. The paper must be a yellow or goldenrod color. Display the poster in a conspicuous place at all business locations.

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 in Maryland
LA COMPENSACIÓN DEL TRABAJADOR en



Job Related Accidental Personal Injury or Occupational Disease?

If you are disabled and unable to work for more than three (3) days, your employer's workers' compensation insurance company may pay your medical bills and other expenses and replace two-thirds (2/3) of your salary (limited to the maximum set by law).

If you are injured on the job:

1. Notify your employer or supervisor at once. You cannot receive full benefits unless your employer knows you are injured.
2. Tell the doctor who treats you that you were hurt on the job.
3. Complete an Employee's Claim Form C-1 (available by phone or on the Commission's website) and send it to us as soon as possible.

Note: Withholding information or giving false information about any work-related activity or return to work could prevent you from receiving benefits and may subject you to fines, imprisonment or both.

¿Accidentes por lesión/daño corporal relacionados con el Empleo o Enfermedad Profesional?

Si usted se encuentra incapacitado o inhabilitado para trabajar por más de tres días, el seguro de trabajadores que tienen las compañías pudiera cubrir las facturas médicas y otros gastos relacionados. También le compensarían 2/3 de sus ingresos (Hasta un monto máximo estipulado por la ley).

Si usted sufre una lesión en el trabajo, debe:

1. Informarle a su empleador o supervisor de inmediato. No podría recibir todos sus beneficios a menos que su empleador fuere notificado que sufrió una lesión.
2. Informarle al médico quien le administre tratamiento que usted se lesionó en su trabajo.
3. Llenar el formulario Employee's Claim Form C-1 (disponible consultando la página del Internet para el Workers' Compensation o solicitándo uno por teléfono). Diligenciarlo para que las oficinas del Workers' Compensation lo reciban lo antes posible.

Aviso: El suministrar información falsa u ocultar información sobre cualquier actividad relacionada con su trabajo o relacionada con su regreso al trabajo, pudiera afectar los beneficios que recibiera o pudiera acarrearle multas, encarcelamiento o ambas.

Employer/Empleador _____

Business Address/Dirección _____

City/State/Zip
Ciudad/Estado/Código Postal _____

Federal Employer ID (FEIN)
Identificación Federal Del Empleador _____

Telephone Number/Número Telefónico _____

Insurance Company Name
La Compañía de Seguro Omaha National Underwriters, LLC on behalf of (Select Insurance Carrier Name)

Insurance Company Telephone
Telefónico de la Compañía de Seguro 844-761-8400

MD WCC Form C-24 05/2017

Click to clear

Maryland Workers' Compensation Commission
10 East Baltimore Street, Baltimore, Maryland 21202-1641
(410) 864-5100 / Outside Baltimore (800) 492-0479
Webpage - http://www.wcc.state.md.us / TTY Users - 711 in Maryland or (800) 735-2258

This notice must be printed on 8.5 "X 14" gold or yellow paper, display complete employer information and be posted in a conspicuous location at each work site or location in accordance with COMAR 14.09.01.02 and 14.09.01.10.

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.

Omaha NATIONAL

INJURY REPORT FORMS

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

Form IA-1 (r-1-1-02) - Employer's First Report of Injury:

Maryland law requires employers to report all injuries immediately to the insurer. Send the completed Form IA-1 (r-1-1-02) to Omaha National at the same time you report the claim to us. Any injuries causing disability for more than three days or death are required to be reported to the Worker's Compensation Commission. Reports to the Commission must be made within 10 days after oral or written notice of the accident. Once the claim is reported, we will submit electronic reports to the Commission on your behalf as needed. Keep a copy for your records.

Form C-2 - Statement of Wage Information:

Use this form to accurately document the injured employee's earnings and calculate their average weekly wage. Send one copy to Omaha National and keep the original document for your records.

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.

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS UNLESS APPROPRIATE

DATES:

Enter all dates in MM/DD/YY format. Enter all time in HH:MM format (e.g. 06:05)

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

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

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

DATE OF DEATH (if applicable)

This is a required field. Enter the date of death, if applicable.

TYPE OF INJURY/ILLNESS CODE

This is a required filed. Enter the two-digit code that corresponds to the type of injury/illness. A list of codes can be found at:

INITIAL TREATMENT

This is a required field. Select the item that corresponds to the initial treatment.

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)
Name
Address
City
State --
Zip
INDUSTRY CODE
EMPLOYER FEIN

CARRIER/ADMINISTRATOR CLAIM
OSHA LOG
REPORT PURPOSE
JURISDICTION
JURISDICTION CLAIM NUMBER
INSURED REPORT NUMBER
EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)
LOCATION #
Address
PHONE #
City
State --
Zip

CARRIER (NAME, ADDRESS, & PHONE #)
Name
Address
City
State --
Zip
Phone
CARRIER FEIN
POLICY/SELF-INSURED NUMBER

POLICY PERIOD
TO
CHECK IF APPROPRIATE
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
Name
Address
City
State --
Zip
Phone
ADMINISTRATOR FEIN

EMPLOYEE Last Name
Middle
First Name
Address
City
State --
Zip
Phone
OF DEPENDENTS

DATE OF BIRTH
SOCIAL SECURITY
DATE HIRED
STATE OF HIRE --
SEX
○ Male ○ Female ○ Unknown
MARITAL STATUS
○ Unmarried Single/Divorced ○ Married ○ Separated ○ Unknown
OCCUPATION/JOB TITLE
EMPLOYMENT STATUS
Please select...
NCCI CLASS CODE

WAGE RATE
PER: ○ Day ○ Week ○ Month ○ Other
DAYS WORKED/WEEK --
FULL PAY FOR DAY OF INJURY? ○ Yes ○ No
DID SALARY CONTINUE? ○ Yes ○ No

TIME EMPLOYEE BEGAN ○ AM ○ PM
DATE OF INJURY/ILLNESS
TIME OF OCCURRENCE ○ AM ○ PM ○ Unknown
LAST WORK DATE
DATE EMPLOYER NOTIFIED
DATE DISABILITY BEGAN

CONTACT NAME
CONTACT PHONE
TYPE OF INJURY/ILLNESS
PART OF BODY AFFECTED

DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ○ Yes ○ No
TYPE OF INJURY/ILLNESS CODE
Please select...
PART OF BODY AFFECTED CODE

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

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED
WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL
CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK
IF FATAL, GIVE DATE OF DEATH
WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ○ Yes ○ No
WERE THEY USED? ○ Yes ○ No

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)
Name
Address
City
State --

HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)
Name
Address
City
State --

INITIAL TREATMENT
○ NO MEDICAL TREATMENT
○ MINOR BY EMPLOYER
○ MINOR CLINIC/HOSP
○ EMERGENCY CARE
○ HOSPITALIZED > 24 HOURS
○ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

WITNESS NAME
PHONE
ADMINISTRATOR NOTIFIED
DATE PREPARED
PREPARER'S NAME & TITLE
PHONE NUMBER
PREPARER'S EMAIL ID:

FORM IA-1(r 1-1-02) IAIABC 2002

WCC Web Form IA-1

WORKERS' COMPENSATION COMMISSION

STATEMENT OF WAGE INFORMATION

The information below is provided pursuant to LE, §9-602(a)(2), Annotated Code of Maryland and COMAR 14.09.03.06.
This form should be submitted before the consideration date or to provide updated wage information.

Claimant Name _____

WCC Claim Number _____

*Was this employee provided free rent, lodging, board, tips or other allowances in addition to the above earnings?
If "yes", the weekly or bi-weekly value must be included in the "Other Allowances" Column.

When the employee is paid weekly, complete each row for the most recent 14 weeks where wages were paid. If paid alternate weeks please enter in the clear, even-numbered rows. If paid on any other schedule, please use the worksheet on page 2 to calculate the average weekly wage. If less than 14 weeks were worked by the employee, use the worksheet on page 2.

Week #	Week Ending (MM/DD/YYYY)	Days Worked	Gross Wages *including overtime*	Other Allowances*	Total Amount Paid
1					0.00
2					0.00
3					0.00
4					0.00
5					0.00
6					0.00
7					0.00
8					0.00
9					0.00
10					0.00
11					0.00
12					0.00
13					0.00
14					0.00
TOTALS		0	0.00	0.00	0.00

TOTAL	0.00	**divided by number weeks worked (where wages are paid/indicated)**	**14**	=	**Average Weekly Wage**	$0.00

I HEREBY CERTIFY that on this _____ day of _____, _____, service of the foregoing was made in accordance with COMAR 14.09.01.03.

SUBMITTED BY:

Name Signature

Company Title

Street

City State ZIP Code

Telephone Email address

CLEAR THIS FORM SAVE THIS FORM PRINT THIS FORM

STATEMENT OF WAGE INFORMATION

CALCULATION OF AVERAGE WEEKLY WAGE WHEN CLAIMANT IS PAID OTHER THAN WEEKLY OR BI-WEEKLY

(Monthly, Semi-Monthly or other, attach details)

A. Inclusive dates used in wage statement ____ to ____

B. Number of days used in calculation
(Minimum 98 days to capture 14 weeks)

C. Gross wages
(including overtime, free rent, lodging, board, tips & other allowances)

D. Daily Rate (**C ÷ B**) Calculate

Average Weekly Wage (**D x 7**) $ 0.00

CLEAR THIS FORM SAVE THIS FORM PRINT THIS FORM

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 _____

Type of Incident ☐ Death ☐ Lost Time ☐ Medical Only ☐ 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 _____ Phone Number _____

Name _____ Phone Number _____

Name _____ Phone Number _____

Medical Treatment and Work Status

First Aid Provided ☐ No ☐ Yes Describe _____

Missed Time ☐ No ☐ Yes List Day(s) _____

Returned to Work ☐ No ☐ Yes Date _____

Emergency Care ☐ No ☐ Yes

Work Status ☐ Off Work ☐ Light Duty ☐ 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

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

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 ☐ Yes ☐ No

Name _____ Phone Number _____

Name _____ Phone Number _____

Name _____ Phone Number _____

Incident

Date of Incident _____ Time of Incident _____ ☐ AM ☐ PM

Name of Injured Worker _____ Time Reported _____ ☐ AM ☐ PM

Location of Incident _____

Did You Observe the Incident Involving the Employee? ☐ Yes ☐ 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.

Form A-25R - Authorization for Disclosure of Health Information:

The Maryland Workers' Compensation Commission developed this release form to be used to obtain the documents and records needed to process a claim. Please have the injured worker complete and sign this document. The employee must scan/upload the form as part of reporting their claim electronically. Send a copy of the signed form to Omaha National when the injury is reported.

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 _____ Date of Injury _____

Claim Number _____ 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	H.E.B. Pharmacies	Meijer Pharmacy	Smith's Food & Drug Centers
CVS	Hy-Vee Pharmacy	Publix Pharmacy	Target Pharmacy
Kroger Pharmacy	Safeway Pharmacy	Walmart Pharmacy	Walgreens Pharmacy
Giant Eagle Pharmacy	Wegman Pharmacy	Longs Drug Store	Ingles Pharmacy

MD WORKERS' COMPENSATION COMMISSION AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Authority COMAR 14.09.03.07B: Unless the Commission orders otherwise for good cause shown, a party shall provide to any other party, on written request, a medical authorization or release.

A. Person Covered by Authorization This document authorizes the disclosure of protected health information regarding:

Name/Claimant _____ Date of Birth _____

B. Purpose of Disclosure

This document authorizes the disclosure of protected health information for the purpose of processing, adjudicating and resolving workers' compensation claims.

C. Entities Authorized to Make Disclosure

This document authorizes any health plan, physician, health care professional, dentist, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf to disclose my protected health information consistent with this directive.

D. Entities Authorized to Receive Protected Health Information

This document authorizes the disclosure of my protected health information to the following entities and their agents: my attorney, my employer, my employer's workers' compensation insurer, the Uninsured Employers' Fund and the Subsequent Injury Fund.

E. Information to be disclosed This document authorizes the entities listed in C to disclose protected health information that is relevant to:

1. The member of the body that was injured:
2. The description of how the accidental injury occurred:
3. The description of how the occupational disease occurred:

The protected health information that may be disclosed includes, but is not limited to: history, findings, office and patient charts, files, examination and progress notes, and physical evidence.

F. I understand that I may revoke this authorization by giving written notice to all parties to my claim for workers' compensation, except to the extent that this authorization has already been acted on prior to receipt of my revocation.

I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient to a medical manager, health care professional or registered rehabilitation practitioner, and others consistent with state and federal law.

By signing this form, I am authorizing the disclosure of my protected health information. This authorization is valid for one year from the date this form is signed.

Patient/Claimant Signature: _____ Date: _____

A photocopy, facsimile or electronic transmission of this signed authorization form is valid.

CLICK HERE TO CLEAR THIS FORM

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 _____ Date of Injury _____

Employer _____ 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

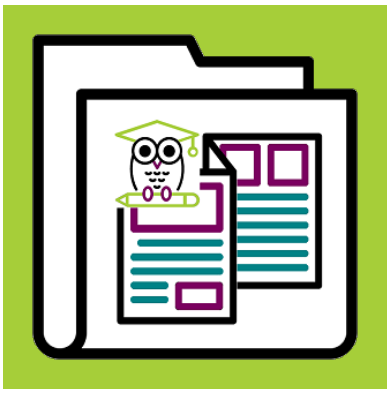
Hospitalizations and Surgical Procedures			
Date(s)	Diagnosis/Treatment/Procedure	Doctor	Hospital

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

- ☐ Arthritis
- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Thyroid disorder
- ☐ Cancer – type: _____
- ☐ Stroke
- ☐ Stomach or peptic ulcer
- ☐ Kidney stones
- ☐ Kidney disease
- ☐ Epilepsy (seizures)
- ☐ Heart problems
- ☐ Back problems
- ☐ Knee, hip, or foot problems
- ☐ Shoulder, elbow, or wrist problems
- ☐ Carpal tunnel
- ☐ Blood clotting disorders
- ☐ 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.

- **Claim Process Diagram:**
  The Maryland Workers' Compensation Commission developed this document to show how claims are managed through the Maryland workers' compensation system.

- **FAQs for Employers About Maryland Workers' Compensation Law:**
  The Maryland Workers' Compensation Commission developed this document to answer frequently asked questions about the Maryland workers' compensation system. Please review this document to ensure you are aware of key procedures and requirements provided by the Workers' Compensation Commission. Additional FAQs are available at https://www.wcc.state.md.us/Gen_Info/WCC_FAQ.html.

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.

MARYLAND WORKERS' COMPENSATION COMMISSION CLAIM PROCESS

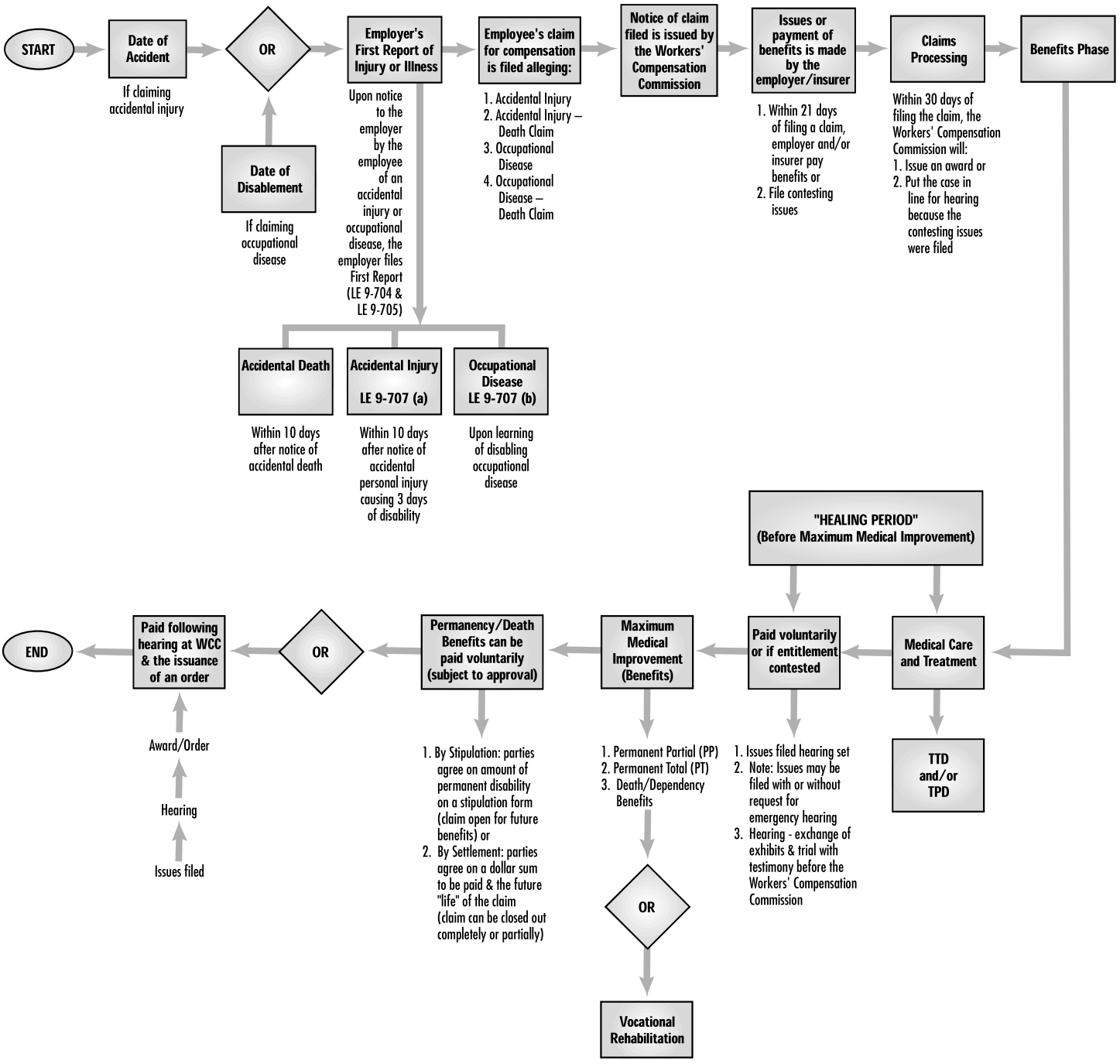
Diagram of the flow of an Employee Claim through the WCC

The filing of a claim is the first step in a process that generally results in the acceptance or denial by the carrier or self-insured employer that the workers injury, illness or fatality is work related.

If the claim is accepted, medical care is paid by the carrier or the self-insurer employer.

The worker also receives compensation benefits to partially replace the wages that would have otherwise been lost because of the injury.

The carrier or self-insured employer may deny the claim on the grounds the injury is not work related. Claims involving a dispute may end up in a hearing before the commission.



FAQ's FOR EMPLOYERS ABOUT MD WORKERS' COMPENSATION LAW

Who is required to carry Workers' Compensation Insurance?
With few exceptions, every employer in the State of Maryland with one or more employees is required by law to provide workers' compensation coverage for their employees.

How does an employer comply with the workers' compensation law?
Employers in the State of Maryland are required to obtain workers' compensation insurance from any insurance company licensed to write workers' compensation insurance in the State of MD, including the Chesapeake Employers' Insurance Company, Maryland's insurer of guaranteed market.
Large Employers (net worth of $10 million or greater) may also apply to become a self- insured employer, which requires prior approval of the Workers' Compensation Commission.

Employers failing to secure workers' compensation insurance as required by law shall be subject to a fine of not more than $10,000. If the employer is a corporation, the officers of the corporation having the responsibility for the general management of the corporation in the State shall be personally liable for such fine.

The entire cost of workers' compensation insurance must be borne by the employer. Any employer, who deducts any portion of this premium from the wages of his /her employee entitled to the benefits under this Law, shall be guilty of a misdemeanor.

Who is responsible for providing medical care?
The employer and insurer are responsible for the payment of medical care and treatment of the injured employee. All medical bills must be forwarded to your insurance carrier for payment.

Are accident reports required by law?
If an accident occurs and results in an injury to an employee and a disability of the employee for a period of more than 3 days, it shall be the responsibility of the employer to report this accident to the Workers' Compensation Commission on a "First Report of Injury" form within 10 days after notice of such accident, whether oral or written. Copies of this report must also be sent to your insurance carrier. The First Report of Injury can be filled out and submitted online at: https://www.wcc.state.md.us/WFMS/Med_WebForms.html

The form is also available online at https://www.wcc.state.md.us/Adjud_Claims/Forms.html and is available free of cost from the Commission and/or your insurance carrier. ***This is not an employee claim for compensation.***

How does an employee file a claim?
An employee has the responsibility of filing the Employee Claim Form with the Workers' Compensation Commission. This form may be found on our website at https://www.wcc.state.md.us/WFMS/C1_WebForms.html
An employee may also complete a paper Claim Form and mail it to the Commission. Employers shall have the claim form available for its employees at all times; however, if the employer does

not have one of these claim forms, please call the Commission or visit our website and request a paper claim form. More information may be found here:
http://www.wcc.state.md.us/Gen_Info/Claim_Instr.html

Please Note that employees may not print the electronic claim form and use it as a paper claim form.
Paper forms are provided by the Commission without charge.

How is the average weekly wage determined?
The average weekly wage of the employee is determined from gross wages, including overtime, and will be based on the information in the Commission file prior to a hearing. The average weekly wage is based on: 1) the average weekly wage earned by the employee during the 14 weeks prior to the accident; or 2) those weeks the employee actually worked during the period. If there is a dispute as to the average weekly wage, it may be resolved either by the submission of a statement of the employee's weekly pay for the weeks prior to the accident OR by a hearing before the Commission. Vacation wages paid shall be included in computing average weekly wage.

Are work permits required?
With a few exceptions, every person hired under the age of 18 MUST have a work permit. If an employer fails to obtain a work permit and the minor employee is injured or killed in the course of employment, all compensation and death benefits provided under the Workers' Compensation Laws may be doubled by the Commission. The employer is solely liable for the increased amount of compensation since an employer is not covered under any workers' compensation policy for these additional benefits.

Notices
All posters or notices prepared and mailed or published online by the Workers' Compensation Commission, that give instruction or information about workers' compensation, shall be posted in a conspicuous place at the work site.

Hearing requests
Each request for hearing shall be filed with the Commission in writing and shall state clearly the issues to be raised at the hearing. All hearing requests must be in compliance with the Commission's "Rules of Procedure." On the day of the hearing, all necessary papers, medical reports, etc. must be available.

Waiver
Neither an employer nor employee can waive provisions of the Workers' Compensation Law.

Do I need a lawyer?
Only Employers who are individuals may represent themselves; however, corporate entities, including LLC's, may NOT represent themselves, representation must be through an attorney.

Insurance rates
Employers having questions on insurance or premiums should contact the:

Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
(410) 468-2000
(800) 492-6116 Toll free in Maryland http://www.insurance.maryland.gov

How do I find the forms needed for a claim?
All necessary forms are supplied by the Workers' Compensation Commission at no charge. Most forms are available on the Commission's website at: https://www.wcc.state.md.us/Adjud_Claims/Forms.html

You may also write to:
State of Maryland
Workers' Compensation Commission
10 East Baltimore Street
Baltimore, MD 21202-1641

(410) 864-5100
(800) 492-0479 Toll free Outside Metro Baltimore 711 or
(800) 735-2258 (Maryland Relay - Hearing Impaired)

Email: info@wcc.state.md.us

Visit our web page at: https://www.wcc.state.md.us

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.

Omaha National

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**
☐ **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.	
☐ **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.	
☐ **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.	
☐ **Merger or consolidation** Two or more entities have merged or combined to form a single entity.	
☐ **Formation of a new entity that acts as, or in effect is, a successor to another entity that:** (Select one) ☐ Has dissolved ☐ Is nonoperative ☐ May continue to operate in a limited capacity	
☐ **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.	
☐ **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.	
☐ **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.

_____

_____

_____

_____

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.

Omaha NATIONAL

STATE-SPECIFIC FORMS & DOCUMENTS

Keep blank copies of these forms to be provided to employees upon their request. Send copies of the completed forms to Omaha National.

Form C-15R - Inclusion Form for Sole Proprietors/Partners Election:

Sole proprietors and partners of a business may use this form to elect coverage as employees under the provisions of Maryland's workers compensation laws. Submit the completed, original form to the Workers' Compensation Commission. Send one copy of the form to Omaha National and keep another copy for your records.

Form H-23R - Request for Employer Designee to Receive Notice of Employee Claims:

Maryland workers compensation law gives the employer the option to designate a person to receive courtesy copies of Form C-30 - Notice of Employee's Claim. The Workers' Compensation Commission always sends Form C-30 by mail to the employee when their claim is accepted and processed. Submit this form to the Workers' Compensation Commission.

Form IC-03 - Joint Election Form:

The employer may use this form to elect coverage for their employee under the provisions of Maryland's workers compensation laws. Both the employer and the employee electing coverage must sign this form. Submit the form to the Workers' Compensation Commission and keep a copy for your records.

Form IC-16 - Exclusion Form:

Members of certain business types (e.g. a limited liability company) or up to five corporate officers of a business may use this form to be exempt from coverage under the provisions of Maryland's workers compensation laws. Each officer or member must sign the form. Submit the original, completed form to the Workers' Compensation Commission. Send a copy to Omaha National and keep a copy for your records.

INCLUSION FORM FOR SOLE PROPRIETORS/ PARTNERS ELECTION

Pursuant to the Workers' Compensation Act, Annotated Code of Maryland, Labor and Employment Article, §§ 9-219 and 9-227, sole proprietors and partners are excluded from coverage under the Act; however, such persons may elect to become covered employees under the Act.

To exercise this option, any sole proprietor or partner electing to be a covered employee must complete and sign this document.

IMPORTANT:
Submit this form to the Workers' Compensation Commission, a copy to the insurer, and keep a copy for your records.

Unless otherwise agreed, this election will be effective upon the date of receipt of this form by the MD Workers' Compensation Commission.

CURRENT DATE: _____ DATE INSURANCE COMPANY WAS NOTIFIED: _____

NAME OF INSURANCE COMPANY: _____

COMPANY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Name and Title of Person Electing Coverage	Personal Signature

10 E. Baltimore Street Baltimore, MD 21202

REQUEST FOR EMPLOYER DESIGNEE TO RECEIVE NOTICE OF EMPLOYEE CLAIMS

This form is to be used only for employers to designate a person to receive a copy of each Notice of Employee's Claim (C-30) pursuant to Regulation 14.09.01.23(c)(2). *Please note that this request will apply to all locations with the identical Employer name, regardless of the address. For special circumstances, please contact the Claims Division.*

Name of Employer: _____

Address: _____

_____ _____ _____

Telephone Number: _____

The above-named employer, pursuant to Regulation 14.09.01.23(c)(2), requests that a copy of each Notice of Employee's Claim (C-30) filed against it be sent to:

Name of Designee: _____

Address: _____

_____ _____ _____

Telephone Number: _____

Requested By: _____
Employer

_____ _____
Authorized Signature **Date**

Title _____ **Telephone Number** _____

Address _____

_____ _____ _____

WCC Form H23R (06/15/09)

Click to Clear the Form

WORKERS' COMPENSATION COMMISSION • 10 East Baltimore Street • Baltimore • Maryland • 21202-1641

(410) 864-5100 • Email: info@wcc.state.md.us • Web: http://www.wcc.state.md.us

WORKERS' COMPENSATION COMMISSION

JOINT ELECTION FORM

Pursuant to the provisions of § 9-204 of the Labor and Employment Article ("LE") of the Annotated Code of Maryland, the employer of an individual who otherwise would not be a covered employee, may elect to make the individual a covered employee by filing a joint election with the Commission. An individual who is not a covered employee pursuant to LE § 9-223(c) of this subtitle, the employer of that individual may not make an election under this section, if prohibited by federal law.

To exercise this option, both the individual electing to become a covered employee **and** the employer must sign this document.

IMPORTANT:

Submit form to the Workers' Compensation Commission and retain a copy.

Unless otherwise agreed upon, this election will be effective upon the date of receipt by the Workers' Compensation Commission.

CURRENT DATE: _____

EMPLOYER NAME: _____

COMPANY NAME(if applicable): _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER SIGNATURE: _____

Name of Employee Electing Coverage

Personal Signature

_____

_____ _____

EXCLUSION FORM

INSTRUCTIONS: Pursuant to Labor & Employment Article §9-206, Annotated Code of Maryland, officers or members of certain business entities may elect to be exempt from workers' compensation insurance coverage by filing this Exclusion Form with the Commission. To exercise this option, the officer or member making the election must sign this document, submit the form to the Workers' Compensation Commission, a copy to the insurer of the company/corporation, and keep a copy for your files.

Company Name: _____

Address: _____

City: _____ State: _____ ZIP _____

Type of Company:

☐ Close Corporation ☐ General Corporation ☐ Farm Corporation

☐ Professional Corporation ☐ Limited Liability Company

Insurance Company Name: _____

Date Insurance Company Notified:_____

Typed Name and Title of the Officer or Member Electing Exclusion	% of Ownership	Personal Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

NOTE: By signing this Exclusion Form, each officer or member affirms under the penalties of perjury that the information contained in this form is true and correct as to that officer or member, to the best of the officer's or member's knowledge, information, and belief.