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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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 Missouri 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.

- **DWC Form WC-106 – Workers' Compensation Law: Roles and Responsibilities for Employers and Employees:**
  This document serves as the mandatory workers compensation posting notice. You must provide paper copies of this document to any employees that work remotely. The poster must be printed on one piece of 11 × 17-inch paper, or two pieces of 8½ × 11-inch paper taped together. Please note, the font size used for the text of the form fields must be at least 10-point type. To complete the form, select the appropriate insurer name from the dropdown list and insert a company contact name and phone number.

- **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.

DIVISION OF WORKERS' COMPENSATION

Missouri Division of Workers' Compensation
P.O. Box 58, Jefferson City, MO 65102
573-751-4231

Insurance Company, Third Party Administrator, Service Company, or Designated Individual If Self-Insured

Name (Select Insurer Name)
Administrator - Omaha National Underwriters
Address P.O. Box 451139
Omaha, NE 68145

Phone 844-761-8400

Employee Information

The Missouri Division of Workers' Compensation (DWC) administers programs for workers who have been injured on the job or exposed to an occupational disease arising out of and in the course of employment. The Division's Administrative Law Judges have the authority to approve settlements or issue awards after a hearing relating to an injured employee's entitlement to benefits.

Steps to Take When Injured on the Job

1. Notify your employer immediately (written notice must be provided within 30 days of the accident/or 30 days after the diagnosis of any occupational disease or repetitive trauma) by contacting _____, _____.
   employer representative *phone number*

   Failure to do so may jeopardize your ability to receive benefits
2. **Ask your employer to provide medical treatment (your employer/insurer is responsible for providing medical treatment and paying the medical fees and charges unless you choose to treat with another doctor at your own expense without your employer/insurer's approval).**
3. Get more information about the benefits available under the Workers' Compensation Program or about the steps you may take to get the benefits you need. **Visit www.labor.mo.gov/DWC or call 800-775-COMP.**

Benefits for Injured Employees

Medical Care:
The employer or insurer is required to provide medical treatment and care that is reasonably required to cure and relieve the effects of the injury. This includes all costs for authorized medical treatment, prescriptions, and medical devices. There is no deductible, and all costs are paid by the employer or its workers' compensation insurance company. If you receive a bill, **contact your employer or the insurance company immediately**. The employer/insurer has the right to choose the healthcare provider or treating physician. You may select a different healthcare provider or treating physician, but if you do so, it may be at your own expense.

Payment for Lost Wages:
- If a doctor says you are unable to work due to your injuries or recovery from a surgery, you may be entitled to **temporary total disability** (TTD) benefits. If a doctor says that you can perform light or modified duty work and your employer offers you such work, you may not be eligible for TTD benefits. TTD benefits should be continued until the doctor says you can return to work, or when your treatment is concluded because your condition has reached "maximum medical improvement," whichever occurs first.
- If you return to light or modified duty at less than full pay, you may be entitled to **temporary partial disability** benefits.

Permanent Disability Benefits:
If the injury or illness results in a permanent disability, you may be entitled to receive either permanent partial or permanent total disability benefits.

Survivor Benefits:
If a work-related injury causes an employee's death, the surviving dependents may receive weekly death benefits paid at 66 2/3% of the deceased employee's average weekly wage along with funeral expenses up to $5,000 from the employer/insurer. For additional information relating to survivor's benefits, including college scholarship opportunities for surviving children, please visit www.labor.mo.gov/DWC.

Additional Benefits for Occupational Diseases Due to Toxic Exposure - Permanent Total Disability and/or Death:
For information relating to additional benefits available, please refer to the Division's website at www.labor.mo.gov/DWC/Injured_Workers/benefits_available.

**Make sure your data is turned on and scan the QR Code with your smartphone's camera to go to the Division of Workers Compensation's Website for more information. If you are not redirected, you may need to update your smartphone's operating system or download a QR Code reader app.

Workers' Compensation Law

Roles and Responsibilities for Employers and Employees

EMPLOYER INFORMATION

With some exceptions, all employers with five or more employees, and construction industry employers with one or more employees, are required to insure their workers' compensation liability, either by purchasing a policy or obtaining self-insurance authority. Workers' compensation insurance provides benefits to workers injured on the job. Employers also are required to post this notice in the workplace for employees to view. This poster is required by section 287.127, RSMo, and is available to employers and insurers free of charge by contacting the Division at 800-775-Comp.

Steps to Take When an Injury Occurs

1. Be sure first aid is administered and the employee is taken to a physician or hospital for further medical care, if necessary.
2. Report the injury to the insurance company or Third Party Administrator (TPA) within five days of the date of injury or within five days of the date on which the injury was reported to the employer by the employee, whichever is later. The insurer, TPA, or Division approved self-insurer is responsible for filing a First Report of Injury with the Division of Workers' Compensation **within 30 days** of knowledge of the injury.
3. Pay medical bills related to the work injury for treatment reasonably required to cure and relieve the employee of the effects of the injury. This includes all costs for authorized medical treatment, prescriptions, and medical devices. The employer has the right to choose the healthcare provider or treating physician. (The employee may select a different healthcare provider or treating physician, but if the employee does so, it may be at his/her own expense.)
4. For more liability and insurance information relating to the Workers' Compensation Program, visit www.labor.mo.gov/DWC or call 800-775-COMP.

Workers' Safety

Developing and implementing a comprehensive safety and health program can reduce occupational injuries and help lower workers' compensation costs. Insurance carriers in the state of Missouri must provide safety assistance at the request of the insured employer. The Missouri Department of Labor evaluates these services and provides additional assistance through its Missouri Workers' Safety Program.
Visit www.labor.mo.gov/MWSP or call 573-751-4231 for more information about these programs or for a registry of independent consultants who are certified in the state of Missouri to provide safety assistance.

Fraud/Noncompliance

Employee Fraud – knowingly making a claim for workers' compensation benefits to which an employee knows he/she is not entitled or knowingly presenting multiple claims for the same occurrence with intent to defraud is a class E felony, punishable by a fine of up to $10,000, or double the value of the fraud, whichever is greater. A subsequent violation is a class D felony.

Employer Fraud – knowingly misrepresenting an employee's job classification or any other fact to obtain insurance at less than the proper rate is a class A misdemeanor. A subsequent violation is a class E felony. An employer who knowingly makes a false or fraudulent statement regarding an employee's entitlement to benefits to discourage the worker from making a legitimate claim or who knowingly makes a false or fraudulent material statement or material representation to deny benefits to a worker is guilty of a class A misdemeanor punishable by a fine of up to $10,000. A subsequent violation is a class D felony.

Insurer Fraud – knowingly and intentionally refusing to comply with workers' compensation obligations to which an insurance company or self-insurer knows an employee is entitled is a class E felony, punishable by a fine of up to $10,000 or double the value of the fraud, whichever is greater. A subsequent violation is a class D felony.

Employer Noncompliance – knowingly failing to insure workers' compensation liability under the law is a class A misdemeanor punishable by a fine of up to three times the annual premium the employer would have paid had it been insured or up to $50,000, whichever is greater. A subsequent violation is a class E felony. An employer who willfully fails to post the notice of workers' compensation at the workplace is guilty of a class A misdemeanor punishable by a fine of $50 to $1,000 or by imprisonment or both fine and imprisonment.

WC-106 (07-19) AI

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.

DWC Form WC-1-EDI – Report of Injury:

Missouri law requires employers to report injuries to the insurance company or claims administrator within five days of the date of injury or the date the injury was reported, whichever date is later. Send the completed Form WC-1-EDI to Omaha National at the same time you report the claim to us. Any injuries involving lost time or medical treatment beyond first aid must also be reported to the Division of Workers' Compensation. Once the claim is reported, we will submit an electronic report to the Division on your behalf. 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.

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.

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

REPORT OF INJURY

P.O. Box 58
Jefferson City, MO 65102-0058

(To complete form, see attached instructions)

GENERAL

EMPLOYER *(NAME, ADDRESS, INCL ZIP CODE)*

CARRIER ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYERS LOCATION ADDRESS *(IF DIFFERENT)*

LOCATION #

PHONE #

SIC CODE

EMPLOYER FEIN

CARRIER / CLAIMS ADMIN

CARRIER *(NAME, ADDRESS & PHONE NO.)*

POLICY PERIOD

to

CHECK IF APPROPRIATE

☐ SELF INSURANCE

CLAIMS ADMINISTRATOR *(NAME, ADDRESS & PHONE NO.)*

CARRIER FEIN

INSURANCE POLICY NUMBER

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE

NAME *(LAST, FIRST, MIDDLE)*

DATE OF BIRTH

SOCIAL SECURITY #

DATE HIRED

STATE OF HIRE

ADDRESS *(INCLUDE ZIP)*

SEX
☐ MALE
☐ FEMALE
☐ UNKNOWN

MARITAL STATUS
☐ UNMARRIED
SINGLE DIVORCED
☐ MARRIED
☐ SEPARATED
☐ UNKNOWN

OCCUPATION JOB TITLE

EMPLOYMENT STATUS

PHONE #

OF DEPENDENTS

NCCI CLASS CODE

WAGE

RATE

PER ☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER

OF DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY / ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME PHONE NUMBER

TYPE OF INJURY ILLNESS

PART OF BODY AFFECTED

DID INJURY ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

ZIP CODE OF THE LOCATION WHERE THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

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 TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

TREATMENT

PHYSICIAN HEALTH CARE PROVIDER *(NAME & ADDRESS)*

HOSPITAL *(NAME & ADDRESS)*

INITIAL TREATMENT
☐ 0 - NO MEDICAL TREATMENT
☐ 1 – MINOR: BY EMPLOYER
☐ 2 – MINOR CLINIC HOSPITAL
☐ 3 – EMERGENCY CASE
☐ 4 – HOSPITALIZED > 24 HOURS
☐ 5 – FUTURE MAJ. MED. LOST TIME ANTICIPATED

OTHERS

WITNESS *(NAME & PHONE #)*

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

NOTE: This form constitutes the detailed report of injury required by §287.380, RSMo, and rules applicable thereto. An injury that requires immediate first aid, but does not result in further medical treatment or lost time from work, need not be reported to the Division. Employers should report all injuries to their workers' compensation insurance carrier or third-party administrator (TPA) within five days of the date of the injury or within five days of the date on which the injury was reported to the employer by the employee, whichever is later. See §287.380, RSMo. If the employer has been granted self-insurance authority by the Division pursuant to §287.280, RSMo, and rules applicable thereto, please report all injuries to your TPA or Service Company to enable them to file this report with the Division.

PRINT QUALITY: All reports of injury and supporting documents received by the Division will be processed electronically. All forms submitted to the Division MUST be of clear and legible quality. Handwritten forms will not be accepted. Computer generated forms shall use a **minimum** type size of **10 points**. All documents not meeting the above criteria will be returned.

TO BE ANSWERED ONLY IN CASE OF DEATH

DATE OF DEATH

EMPLOYEE'S DEPENDENTS

NAME OF DEPENDENT	RELATION TO EMPLOYEE	ADDRESS OF DEPENDENT			
		ADDRESS	CITY	STATE	ZIP CODE

Missouri Division of Workers' Compensation is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. TDD/TTY: 800-735-2966 Relay Missouri: 711

Data Element Dictionary for Hard Copy Report of Injury

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Employer (Name & Address)	The name of the employer where the employee was employed at the time of the injury.	This is the name the employer does business under followed by the FULL address including mailing address, city, state and zip code.	M
Industry Code	The code which represents the nature of the employer's business which is contained in the North American Industry Classification System Manual published by the Federal Office of Management and Budget. See implementation note below: The industry code selected should represent the primary nature of the employer's business. If the employer is assigned multiple industry codes, use the code that relates to the specific business operation for which the employee was employed at the time of the injury. The data element may contain an SIC code or NAICS Code. SIC code will be identified with the characters 'SC' as the last two characters of the data element. If SC is not present, the code is presumed to be NAICS.	This is the Standard Industrial Classification Code for the employer. SIC/NAICS codes can be found at www.census.gov/epcd/www/naics.html	M
Employer FEIN	The FEIN of the employer where the employee was employed at the time of the injury.	Must be the primary FEIN for the Employer listed above.	M
Report Purpose Code (RPC)	Defines the specific purpose of the report being filed with the state of Missouri. 00 = Original FROI 02=Change CO=Correction AQ=Acquired Report of Injury AU=Acquired Unallocated Report of Injury	The Report of Injury that the employer is required to file with the Division of Workers' Compensation (Division) through the insurance carrier or third party administrator (TPA).	M
Claims Administrator's Number	Identifies a specific claim within a claim administrator's claims processing system.	Number used by the organization adjusting the claim (insurance company, third party administrator, etc.).	M
Jurisdiction	The governing body or territory whose statute applies.	This must always be Missouri.	M
Jurisdiction Claim Number		The injury number assigned by the Division upon receipt of the First Report of Injury with all mandatory information provided. The reporting entity is to leave this field blank.	

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Insured Report Number	A number used by the insured to identify a specific claim.		O
Employer's Location Address	List the physical address of where the employee sustained the accident or illness if that location is different from where the employer wishes to have correspondence sent.		O
Insured Location Number	A code defined by the insurer/employer, which is used to identify the employer's location of the accident.		O
Phone Number	List a phone number of the employer location where the employee worked at the time of the accident.		O
Carrier (insurer) Name & Address	The name and mailing address of the carrier or self-insured entity assuming the employer's financial responsibility for the workers' compensation claim.	If the employer is **individually** self-insured, the **individual** self-insured employer's name and mailing address would be indicated in this field. The FEIN and Name must match. **If the employer is self-insured by a trust, the trust's name would be submitted in this field.**	M
Carrier (insurer) FEIN Number	The FEIN of the carrier or self-insured assuming the employer's financial responsibility for the workers' compensation claim(s).		M
Carrier Policy Number	The number assigned to the contract/policy for the employer or association group.	A number assigned by the **insurance company, *(Not a number assigned by a TPA)*** for the specific workers' compensation policy for that employer. Not a required field for Division approved self-insureds.	M
Policy Period	List the effective and expiration dates of the contract/policy.	The date that the policy became effective and the date the policy expires or is no longer in effect. No date is required in this field if the injury falls within the Division approved self-insurer's self-insurance period.	M
Self-Insured Indicator	An indicator that identifies the employer as one who is authorized by the state of Missouri to retain the risks arising from their operations and bears the financial responsibility. Y=Yes, N=No	Condition – Must indicate Y(Yes) ONLY for an individual employer or a member of a self-insured trust authorized by the Missouri Division of Workers' Compensation to self-insure under § 287.280, RSMo. It does not include uninsured employers or employers under deductible insurance policies.	C
Claim Administrator (TPA) Name & Address	The name and mailing address of the Third Party Administrator (TPA), independent administrator, contracted to adjust the claim on behalf of the carrier or self-insured.	Name and mailing address of the Third Party Administrator (TPA), independent adjuster, contracted to adjust the claim and phone number of the office adjusting the claim. If there is not a TPA, independent adjuster/administrator, contracted to adjust the claim please leave blank.	C

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Claim Administrator (TPA) FEIN Number	The FEIN of the Third Party Administrator (TPA), independent adjuster/administrator, contracted to adjust the claim on behalf of the carrier or self-insured.	FEIN number for the company hired as a TPA. Note: If there is no Third Party Administrator, please leave blank.	C
Agent Name & Code Number	List the name and code number of the carrier or claim administrator agent who administers the workers' compensation claims for the employer.		O
Employee Name	The injured worker's legally recognized name which is used on legal documents, employment, Social Security, banking, records, etc.	Name to include last, first and middle initial.	M
Employee Date of Birth	The date the injured worker was born.	Must be a valid date.	M
Social Security Number	A number assigned by the Social Security Administration used to identify the employee.	If a SSN is not available please call 573-526-3542.	M
Date of Hire	The date the injured worker began his/her employment with the employer under which the claim is being filed. If there have been multiple periods of employment, this would be the beginning date of the current employment period.	Must be valid date.	O
State of Hire	List the state where the employer hired the employee.		O
Employee Address	The mailing address used by the injured worker.	The address should not be listed as unknown. Please include the last known address provided by the injured worker that is on file with the employer.	M
Employee Phone	A telephone number where the injured worker can be reached.	This is an optional field, although if the employer or insurance company has this information, **please** report it to the Division. This will improve communication between the parties. This will be a numeric field only *5736367777.*	O
Gender Code	The code which indicates the sex of the employee. Gender of employee F=Female M=Male U=Unknown		M
Number of Dependents	The number of dependents as defined by the administrating jurisdiction.	Spouse, minor children or others if known. Required if date of death is entered. Numeric field 0-9.	C
Marital Status Code	The code, which indicates the marital status of the employee. U = Widowed, divorced, single, unmarried, M = Married, S = Separated, K = Unknown		O

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Occupational/ Job Title or Description	Identifies the primary occupation of the employee at the time of the accident or injurious exposure.		O
Employment Status Code	Indicate the employee's primary work code status at the time of the injury with the covered employer.		O
NCCI Class Code	A code, which, corresponds to the primary occupation in which the employee was engaged at the time of the accident/injury or injurious exposure.	MO uses NCCI codes.	M
Wage	The reported employee's pre-injury wage for the wage period. Implementation Note: This amount may include commission, piecework earnings, and other forms of income converted to a normal scheduled work week, plus the estimated value of lodging, food, laundry and other payments in kind; and concurrent employment earnings, as prejurisdictional requirement.	"Gross Wages" includes, in addition to money paid by the employer for services rendered by the employee, the reasonable value of board, rent, housing, lodging or similar advance by the employer, except if it continues to be provided to the employee for the period of disability, it is not included in calculating the average weekly wage. "Wages" also includes gratuity received in the course of employment from individuals other than the employer that are reported for income tax purposes. "Wages" does not include fringe benefits such as retirement, pension, health and welfare, life insurance, training, Social Security or other employee or dependent benefit plan provided by the employer. **Please See Special Notes #1**	M
Wage Period	A code indicating the time period during which the wage was earned.	Please use the weekly wage rate paid to the employee.	M
Number of Days Worked	The number of the employee's regularly scheduled workdays per week.		O
Full Wages Paid for the Date of Injury Indicator	Indicates whether full wages for the date of the accident/injury or illness were paid by the employer.		O
Salary Continued Indicator	The employer has paid or is paying the employee's salary in lieu of compensation during an absence caused by a work-related injury.	Did the employer continue to pay salary to the employee after the injury? N=No Y=Yes	O
Time Employee Began Work	Time at which the employee began work on the day of the accident/injury or illness.		O
Date of Injury/Illness	For traumatic injury, the date on which the accident occurred. For occupational disease or cumulative injury, the date of injury is the date of last injurious exposure to the cause or substance creating the condition, unless otherwise defined by statute.	Date that injury/illness occurred or became known to employee; whichever is later.	M

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Time of Occurrence	The time at which the accident occurred.	To the extent that the time of the occurrence of the accident/injury is available, you should provide it to the Division. Please indicate a.m. or p.m.	O
Date Last Day Worked	The last paid workday prior to the initial date of disability as defined by jurisdiction.	Must be valid date.	O
Date Employer Notified	The date that the injury was reported to a representative of the employer.		M
Date Disability Began	The first day on which the employee originally lost time from work due to the occupational injury or disease or as otherwise defined by jurisdiction.	**Date of disability must be greater than Date of Injury.** First date employee starts losing time from work after the date of injury. This is the day after the date of injury or the first day of work missed, if later. The three-day waiting period is calculated from the first date of lost time and the lost time does not need to be consecutive days. **Please See Special Notes #2**	C
Contact Name & Phone Number	List the name and phone number for a representative of the employer.		C
Type of Injury/Illness	List the type of injury/illness sustained by the employee.		O
Part of Body Affected	List the part of body to which the employee sustained injury.		O
Employer Premises Indicator	An indicator to denote whether the accident occurred at the employer's address provided.	If the injury/illness occurred on the employer's property indicate "YES." If it occurred elsewhere indicate "NO."	M
Type of Injury/Illness Code	The code, which corresponds to the nature of the injury sustained by the employee.	Choose from the list of code numbers, which corresponds with the nature of the injury. A list of codes with description of each code is available at www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx **Please See Special Notes #2**	M
Part of Body Affected Code	The code, which corresponds to the part of the body to which the employee sustained injury.	Choose from the list of code numbers, which corresponds with the part of body injured. A list of codes with a description of each code is available at www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx	M

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Zip Code of the Location Where Accident or Illness Exposure Occurred	The zip (postal code) that corresponds to the location where the injury occurred.	The code is required to assist with docket setting if needed.	M
All Equipment Using	List all the equipment; materials or chemicals the employee was using at the time of the accident/injury or illness exposure occurred.		O
Specific Activity Engaged In	Describe the specific activity that the employee was doing at the time the accident/injury or illness exposure occurred.		O
Work Process Engaged In	Describe the work process the employee was doing when the accident/injury or illness exposure occurred.		O
How the Injury or Illness Occurred	A free form description of how the accident occurred and the resulting injuries.	Describe how the injury/illness occurred. Please include the events that led to the injury/illness and any objects or substances that directly injured the employee or made the employee ill. Maximum of 150 characters, including spaces. *For example: Employee was on ladder putting away product, fell on chemical barrel breaking lower arm; arm lacerations; exposed to chemical liquid and fumes (141 characters).*	M
Cause of Injury Code	The code which corresponds to the cause of injury.	Choose from the list of code numbers, which corresponds with the cause of the injury. A list of codes with a description of each code is available at www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx (Struck by, fell, auto accident, exposure, etc.)	M
Date Returned to Work	The first date on which the employee returned to work following the injury.	Must be a valid date. Must be entered if employee lost days of work and returned to work before first report of injury is filed.	C
Employee Date of Death	The date the injured worker died.	Must be a valid date.	C
Safeguards	Indicate whether safeguards or safety equipment was provided by checking “Yes” or “No.”		O
Were They Used	Indicate whether the safeguards or safety equipment was used by the employee by checking “Yes” or “No.”		O
Physician/Health Care Provider	List the name and address of the physician or health care provider who provided initial medical treatment to the injured employee after the accident/injury or illness.		O

Data Element	IAIABC Data Definition	Missouri Notes	Mandatory Field
Hospital	List the name and address of the hospital where the employee received initial medical treatment.		O
Initial Treatment	A code used to identify the extent of medical treatment received by the employee immediately following the accident. 0= No medical treatment 1= Minor on-site remedies by employer medical staff 2= Minor clinic/hospital medical remedies and diagnostic testing 3= Emergency evaluation, diagnostic testing, and medical procedures 4= Hospitalization > 24 hours 5= Future major medical/lost time anticipated	First Aid includes the administration of immediate and temporary medical aid to the employee that a lay person may provide, such as the application of Band-Aid to treat a minor scratch or the removal of a splinter that would not result in the need for a referral to a doctor or other health care professional for additional medical treatment or would not result in further lost-time from work. The on-site company nurse or physician may be the individual that provides the first aid. If the company nurse or physician provides service beyond first aid, then the injury must be reported even if the treatment occurs on-site. **Please see Special Notes #2**	M
Witness	List the name and address of all witnesses who were present when the employee sustained the accident/injury or illness.		O
Date Reported to Claims Administrator	The date the claim administrator who is processing the claim received notice of the loss or occurrence.		M
Date Prepared	List the date that the representative for the claims administrator prepared this report of injury.		O
Preparer's Name and Title	List the name and title of the claims administrator's representative who prepared this report of injury.		C
Phone Number	List the phone number of the representative preparing this report of injury.		C

M – Mandatory – Cases missing mandatory information will NOT be accepted by the Missouri Division of Workers' Compensation system.

C – Conditional – Data Elements with Conditional fields indicate a value is required based on another Data Element or pre-existing condition.

Examples: When a death case is reported then the death date would be required.
If the employee has returned to work prior to the report being filed, the date of return to work would be entered.

O – Optional – Data Elements identified as Optional may be entered but are not required.

Special Notes

1) Wage Instructions

A) Missouri Notes: Report the wage information as the average weekly wage (AWW) of the employee. These rules apply for calculating the average weekly wage.

1) If the employee's wage is fixed by the year, the AWW is the yearly wage divided by 52;

2) If the employee's wage is fixed by the month, the AWW is the monthly wage multiplied by 12 and divided by 52;

3) If the employee's wage is fixed by the week, that amount is the AWW;

4) If the employee's wages are fixed by the day, hour or output, the numerator is the actual gross wages earned by the employee in the last thirteen calendar weeks immediately preceding the week in which the injury occurred; and the denominator is 13 to calculate the AWW.

i) The formula is: Actual gross wages earned in prior 13 weeks/13=AWW. *For example, the employee's hourly wage is $9.00/hour. The overtime rate is $13.50/hour. The employee works 40 hours per week at $9.00 an hour plus occasional overtime. Employee worked overtime of 44 hours in the 13-week period immediately preceding the week of the injury. The employer has employed the employee for 2 years.*

The gross wages are $9.00 X 40 hours X 13 weeks = $4,680. You also need to include the overtime 44 hours. Therefore, $13.50 X 44 hours = $594. The total wages are $4,680 plus $594 = $5,274. The AWW is $5,274/13=$405.69.

ii) If the employee misses nonconsecutive workdays during the 13-week period in multiples of 5 those days shall be subtracted from the denominator. *For example: if the employee misses 5 days, one week is subtracted from 13 and the denominator becomes 12; if the employee misses 10 days, two weeks are subtracted from 13 and the denominator becomes 11; and so on.*

iii) Partial weeks of time missed by the employee do not count to change the denominator. *For example: if the employee misses 4 days, the denominator is 13; if the employee misses 6 days, one week is subtracted from 13 and the denominator becomes 12; and so on.*

iv) If the employee works less than 13 weeks but more than 2 weeks, the AWW is the same formula with the numerator as the gross wages calculated for the number of weeks of employment and the denominator is the number of weeks of employment. *For example, the employee worked for the employer 8 weeks prior to the week of the injury. The employee was paid $9.00 per hour and worked 40 hours per week. The employee worked 13 hours of overtime. The overtime rate is $13.50. The gross wages are $9.00 X 40 hours X 8 weeks plus $13.50 X 13 hours = $3,055.50. The AWW is $3,055.50/8=$381.94.*

5) If the employee works less than two weeks the AWW shall be equivalent to the AWW for the same or similar employment. However, if the employer has agreed to a certain hourly wage, then the hourly wage agreed upon multiplied by the number of weekly hours scheduled shall be the employee's AWW.

B) **When the Date Returned to Work is more than three days from the Date Disability Began, the workers' compensation case will be considered an indemnity case. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.**

C) When Initial Treatment Code is reported as equal to 00, 01 or 02, the case will be considered as a medical only case. If the time period between the Date Disability Began and the Date Returned to Work is three days or less, the case will be classified as a medical only case. You will receive a request for the cost of medical treatment and the date returned to work, if not supplied. After all required information has been filed and there is no further activity on a case for six months, the case may be administratively closed. When the Initial Treatment Code is reported as equal to 03, 04 or 05, the case will be considered as an indemnity case. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.

2) Initial Treatment Code, Date Disability Began and Date Returned to Work:

A) When Initial Treatment Code is reported as 00, 01 or 02, the case will be considered a medical only case. If the time period between the Date Disability Began and the Date Returned to Work is three days or less, the case will be classified as a medical only case. You will receive a request for the cost of medical treatment and the date returned to work, if not supplied. After all required information has been filed and there is no further activity on a case for six months, the case may be administratively closed.

B) When the Initial Treatment Code is reported as 03, 04 or 05, the workers' compensation case will be considered an indemnity case. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.

1) When the Date Returned to Work is more than three days from the Date Disability Began, the workers' compensation case will be considered an indemnity case. The three-day waiting period is calculated from the first date of lost time and the lost time does not need to be consecutive days. You will receive a request for the cost of medical treatment, the date returned to work, and the total amount of temporary total disability benefits paid to the employee.

C) The following are examples of First Aid treatment:

a) Use of non-prescription medication at non-prescription strength.

b) Cleaning, flushing or soaking wounds on the surface of the skin.

c) Using wound coverings such as bandages, Band-Aids, gauze pads, etc. or using butterfly bandages or Steri-Strips. (Other wound closing devises such as sutures, staples, glues, etc. are considered medical treatment.)

d) Use of any non-rigid means of support such as an elastic bandage, wrap, or non-rigid belt. (The use of devices with rigid stays or other systems designed to immobilize body parts is considered medical treatment.)

e) Use of temporary immobilization devices (e.g., splints, slings, neck collars, etc.) while transporting an accident victim.

f) Removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs, or other simple means.

g) Use of finger guards.

h) Drinking of fluids for relief of heat stress.

3) Mesothelioma Liability: Several changes to the Workers' Compensation Law went into effect January 1, 2014. Pursuant to §287.200.4, RSMo, employers may elect to accept mesothelioma liability in one of the following ways:

a. Insuring their liability by purchasing a workers' compensation policy;

b. Meeting the requirements of the Division of Workers' Compensation to qualify as a self-insurer;

c. Joining a Group Insurance Pool that complies with §287.223. (An employer may become a member of the Missouri Mesothelioma Risk Management Fund);

d. Rejecting *mesothelioma* liability under the Missouri Workers' Compensation Law.

Please note that if an employer has rejected *mesothelioma* liability coverage under the Workers' Compensation Law, the exclusive remedy provision of the Workers' Compensation Law, §287.120, RSMo, does not apply.

4) **Occupational diseases:** Occupational diseases due to toxic exposure have been defined effective January 1, 2014. The "occupational diseases due to toxic exposure" includes the following: asbestosis, berylliosis, coal worker's pneumoconiosis, bronchiolitis obliterans, silicosis, silicotuberculosis, manganism, acute myelogenous leukemia and myelodysplastic syndrome. The reporting requirements relating to other occupational diseases such as carpal tunnel syndrome, etc. remains the same.

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. I**t 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.

- **DWC Form WC-280 - Report Your Workplace Injury, Occupational Disease, or Repetitive Trauma Injury:**
  This form may be used by an injured worker to provide written notice of injury.

- **DWC Form WC-303 - Claimant Authorization to Disclose Worker's Compensation Records:**
  This form is used to obtain copies of the claimant's records for any past claims from the Division. Have the injured worker complete and sign this form. Then, send a copy 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

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

DIVISION OF WORKERS' COMPENSATION

REPORT YOUR WORKPLACE INJURY/OCCUPATIONAL DISEASE OR REPETITIVE TRAUMA INJURY

800-775-2667
www.labor.mo.gov/DWC

- If your employer does **not** provide you with a form to complete to report your injury, you may use this form to provide the employer with written notice of your accident or injury;
- If you choose to use this form it **does not** replace the incident or accident form that your employer may require you to complete;
- **If you choose to use this form, PLEASE DO NOT send it to the state or to the Missouri Division of Workers' Compensation (Division);**
- **This is not a Claim for Compensation form**;
- Under Missouri law you are required to report your injury to your employer in writing within 30 days of the injury. Failure to report your injury to your employer within 30 days **may** jeopardize your ability to receive workers' compensation benefits **UNLESS** the Division or Commission finds that the employer is not prejudiced by failure to receive the notice;
- Under Missouri law, your employer or its workers' compensation insurance company or third-party administrator should arrange for you to receive the medical treatment as may be reasonably required to cure and relieve you from the effects of the injury.
- **Under Missouri law, the employer files a separate First Report of Injury with the Division pursuant to §287.380, RSMo.**

Your written notification to the employer should include the following information:

Date Written Notice Given: _____

Name of Person Injured: _____

Address of Person Injured: _____

Date of Injury: ____/____/_____

Time of Injury: _____:_____ ☐ a.m. / ☐ p.m.

Place of Injury: _____

Nature of the Injury: _____

NOTE:

Failure to provide written notice of your occupational disease or repetitive trauma injury to your employer within 30 days of the diagnosis of your condition may jeopardize your ability to receive workers' compensation benefits UNLESS the Division or Commission finds that the employer is not prejudiced by failure to receive the notice.

Make a copy of this written notice or the written notice your employer gives you to complete and keep a record of the date you provided your notice. If you hand-deliver your notice, keep a record of the date and time of the delivery along with the full name and title of the person you delivered it to.

To verify that your injury has been reported or to speak to an Information Specialist, please call the Division's toll free number 800-775-2667. If you experience difficulty in obtaining medical treatment or other benefits, call the number above and request Dispute Management Assistance.

DIVISION OF WORKERS' COMPENSATION

CLAIMANT AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

1. I _____ authorize the use or disclosure of my workers' compensation records that are described below in paragraphs three and five.
   The last four digits of my social security number are XXX-XX-_____.
2. The following individual or organization is authorized to make the disclosure:

   Missouri Department of Labor and Industrial Relations – Division of Workers' Compensation

   Address: P.O. Box 58, Jefferson City. MO 65102-0058
3. The type of records and information to be used or disclosed is as follows. **Please strike through all records that should not be disclosed**:

   Any and all records concerning all injuries reported to the Division of Workers' Compensation, including, but not limited to, reports of injury, employer's report of injury or accident, supplemental records, medical records, administrative records and claims filed, wage statements, transcripts of any and all hearings, awards, records of benefits paid, minute sheets, rehabilitation forms, medical fee dispute filings, stipulations for compromise settlement with exhibits or addendums including information that is confidential under federal or state laws, and all other documents in the possession of the Missouri Division of Workers' Compensation regarding all current and prior injuries or claims for workers' compensation benefits.
4. I am restricting the release of records for a certain period which is from _____ to _____.
5. I understand that the information in my workers' compensation records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

   ☐ My initials specifically authorize disclosure of such records

   ☐ My initials do not authorize disclosure of such records
6. The records may be disclosed to and used by the following individual or organization:

   _____

   Address: _____

   For the purpose of: _____
7. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present any written revocation to the Division of Workers' Compensation. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in ONE YEAR from the date of execution.
8. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I understand I may inspect or copy the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Claimant or Legal Representative (if claimant is deceased, a minor, or incapacitated) Date

_____ _____
Printed Name of Claimant or Legal Representative (if claimant is deceased, a minor, or incapacitated) Claimant's Date of Birth

_____
Claimant Address

_____
If signed by Legal Representative, relationship to Claimant Date

Missouri Division of Workers' Compensation is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. TDD/TTY: 800-735-2966 Relay Missouri: 711

A PHOTOCOPY OF THIS RELEASE IS VALID AS ORIGINAL

STATE OF MISSOURI)

COUNTY OF)

Subscribed and sworn to before me this _____day of _____, 20___.

_____

Notary Public

My Commission Expires:

(Notarial Seal)

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

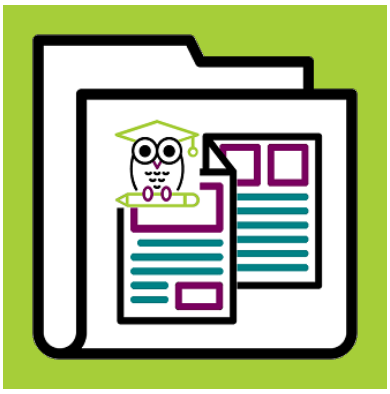
Hospitalizations and Surgical Procedures			
Date(s)	Diagnosis/Treatment/Procedure	Doctor	Hospital

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.

- **DWC Brochure WC-259 – Workers' Compensation Requirements for the Missouri Construction Industry:**
  This document from the Division of Workers' Compensation was designed to provide guidance for employers in the construction industry. It focuses on the employer roles and responsibilities under the Missouri workers compensation laws.

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.

printed from the web site. It is unlawful for a contractor to provide fraudulent information pursuant to section 287.061, RSMo.

Employees covered under the law: The definition of "employee" includes both full and part-time employees, and includes every person in the service of an employer under any contract of hire, express or implied, oral or written, or under any appointment or election, including executive officers of a corporation. The definition of "employee" does not include the owner and operator of a motor vehicle which is leased or contracted with a driver to a for-hire motor carrier operating in a commercial zone or operating under a certificate issued by the Missouri Department of Transportation or by the U.S. Department of Transportation, or any of its sub agencies.

Coverage for family members: The Law does provide that certain close family members of employers may be withdrawn from coverage, although they remain "countable" employees, meaning they still count toward the five or more or one or more criteria in the Law. However, this is only available if the business is a sole proprietorship or a partnership. Corporations or LLC's do not have family members. (§§287.030.1(3) and 287.035.6, RSMo).

Coverage for the self-employed: Sole proprietors and partners are themselves not covered unless they individually elect to purchase workers' compensation insurance. If the only people working in a business are either the sole proprietors or the partners, then workers' compensation insurance is not required by the Law, although it may be purchased voluntarily as indicated in §287.035, RSMo.

Report fraud and non-compliance: If you suspect fraud or non-compliance with the Law, you may call the DWC's Fraud and Non-Compliance Unit at 800-592-6003. The Unit will investigate and may refer the results of its investigation to the Attorney General's Office for possible criminal prosecution.

Please Note: *disputes between a workers' compensation insurance policy holder and an insurance company are under the jurisdiction of the Missouri Department of Insurance, Financial Institutions and Professional Registration's Property and Casualty Section.*

Contact Information

Missouri Division of Workers' Compensation (Central Office)
P.O. Box 58
Jefferson City, MO 65102
Phone: 573-751-4231
Website: www.labor.mo.gov/DWC

Customer Service Unit
(call to see if you are covered)
Information Line: 800-775-2667
Email: workerscomp@labor.mo.gov

Fraud and Noncompliance Unit
P.O. Box 1009
Jefferson City, MO 65102
Toll Free: 800-592-6003

Missouri Department of Insurance, Financial Institutions and Professional Registration
Property and Casualty Section
P.O. Box 690
Jefferson City, MO 65102
Phone: 573-751-3365
(Please call DIFP with questions relating to policy and premium information.)

Missouri Division of Workers' Compensation is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities.
TDD/TTY: 800-735-2966 Relay Missouri: 711

MISSOURI DEPARTMENT OF LABOR & INDUSTRIAL RELATIONS

WC-259 (01-18) AI

Workers' Compensation Requirements

For the Missouri Construction Industry

A guide for employers in high-hazard industries to better understand the laws protecting the rights of injured workers.

DIVISION OF WORKERS' COMPENSATION

The Missouri Department of Labor's Division of Workers' Compensation (DWC) is responsible for administering and enforcing the Missouri Workers' Compensation Law which protects employees in the event of on-the-job injuries.

Employer Roles and Responsibilities

Employers liable under the Law: In the state of Missouri, employers with five or more employees are required to carry workers' compensation insurance. Employers in the construction industry with one or more employees who erect, demolish, alter or repair improvements must carry workers' compensation insurance. Employers cover their liability for on-the-job injuries sustained by their employees usually through the purchase of a workers' compensation insurance policy. Some employers join with others to form "group self-insurance trusts" and some employers qualify to be "individually self-insured." It is a criminal offense to operate a business without having the required insurance, and it may also expose an employer to civil liability. If a business is organized as a corporation or a limited liability company (LLC), the corporation or LLC is regarded as the "employer" who is subject to the requirements of the Missouri Workers' Compensation Law. All the persons who work for the corporation or LLC are considered its employees even if such persons are the owners or executive officers of the corporation or members of the LLC.

IMPORTANT NOTE: Those considering "withdrawing" or "rejecting coverage" should bear in mind that health insurance plans generally refuse to pay for medical treatment resulting from on-the-job injuries.

Corporation Exemption Requirements: A corporation may elect to withdraw from the workers' compensation requirements if there are no more than two owners of the corporation who are also the only employees of the corporation. The corporation should contact the Division's Customer Service Unit *(see contact information on the back of this pamphlet)* to obtain further information on the paperwork that needs to be submitted to file the notice of election to be withdrawn.

"S" Corporations: Effective January 1, 2018, a shareholder in an "S" Corporation (as defined by Section 143.471.1, RSMo) who owns at least 40% of the outstanding stock in that corporation may individually reject workers' compensation insurance coverage for himself or herself by giving written notice of such rejection to the corporation and its workers' compensation insurer. There has been no change in the law generally requiring workers' compensation coverage to be in force on all construction industry employers (those who erect, demolish, alter or repair improvements) if they have even one employee. So, If the "S" corporation is operating in the construction industry, there still must be a workers' compensation insurance policy in force on the corporation itself (and on any of its employees who are not eligible to reject individual coverage on themselves) unless the corporation has no more than two owners who are also the corporation's only employees and it has notified the Division of Workers' Compensation that is has withdrawn from the provisions of the Missouri Workers' Compensation Law- as explained earlier in this pamphlet.

Limited Liability Company Coverage Requirements: An LLC, as defined in section 347.015, RSMo, needs to obtain coverage for the employees of the LLC so long as the LLC is an employer who is subject to the requirements of the workers' compensation law. The LLC is required to carry coverage even if all employees are members. While members of the LLC are provided coverage, such members may individually elect to reject such coverage by providing a written notice of such rejection on a form developed by the Department of Insurance, Financial Institutions and Professional Registration to the LLC and its insurer. The form may be found at www.insurance.mo.gov/industry/forms/LLC-WC.pdf. A member who elects to reject such coverage shall not thereafter be entitled to workers' compensation benefits under the policy, even if serving or working in the capacity of an employee of the LLC. The member may rescind his/her rejection of coverage.

General and Subcontractor Coverage Relationship: A general contractor can require subcontractors to carry workers' compensation insurance. Generally, the Law says that the general contractor is liable for any injuries sustained by uninsured subcontractors or their uninsured employees (§287.040, RSMo). Because of this, the general contractor's insurer will charge an additional premium if the subcontractor cannot provide proof of coverage, even if the subcontractor has no employees. If the general contractor says he/she will not hire the subcontractor unless he/she has a policy and insures him/herself, the subcontractor would need to buy a policy covering his/her business or him/herself or work for a general contractor who does not make this a requirement.

Providing proof of coverage when applying for a city or county business license: This requirement was placed in Law by the Legislature in 1993 for any business that is a "contractor in the construction industry." Any city or county that issues an occupational or business license for a contractor in the construction industry is required to obtain proof of insurance coverage or have the completed affidavit of exemption submitted by the contractor. The DWC has developed a form titled, "Affidavit of Exemption for Workers' Compensation Insurance Pursuant to §287.061, RSMo" that can be

Verifying Proof of Coverage

Check to see if an employer or subcontractor has current workers' compensation coverage by calling 800-775-2667. Have the following information on hand: name of employer, employer's federal ID number, and the location of the employer. If the employer is a franchise, please provide the name of the company that owns and operates the business.

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.