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.

TABLE OF CONTENTS

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

Posters

Injury Report Forms

Injured Worker Handouts

Informational Documents

General Forms

State-Specific

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 Pennsylvania 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.

LIBC-500 – Workers' Compensation Insurance Posting:

This document serves as the mandatory workers compensation posting notice. The poster must be printed on 8½ × 11 or 8½ × 13-inch paper. Please note, the font size used for the text of the form fields must be at least 11-point type. To complete the form, enter your company name, select the appropriate insurer name and insurer code from the dropdown lists, and enter the date posted.

Employer Medical Provider Panel:

Post this document right next to the LIBC-500 addressed above. For additional information, please see Medical Provider Panel Information for Employers in the Informational Documents section. Contact your Account Manager for assistance with form completion.

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.

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

REMEMBER: IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR INJURY

The name, address and telephone number of your employer's workers' compensation insurance company, third-party administrator (TPA), or person handling workers' compensation claims for your company, are shown below.

Employer Name:

Date Posted: _____

IF INSURED:
(Complete all applicable spaces)

Name of Insurance Company: Preferred Professional Insurance Company

Address: 11605 Miracle Hills Dr., Ste 200, Omaha, NE 68154-4467

Telephone Number: 402-965-3300

IF SOMEONE OTHER THAN INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator): Omaha National Underwriters, LLC

Address: P.O. Box 451139 Omaha, NE 68145

Telephone Number: 844-761-8400

Insurer Code: Preferred Professional Insurance Company - 2285

IF SELF-INSURED
(Complete all applicable spaces)

Name of person handling claims at the self-insured: _____

Address: _____

Telephone Number: _____

Insurer Code: _____

IF SOMEONE OTHER THAN SELF-INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator): _____

Address: _____

Telephone Number: _____

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
PA Relay 7-1-1

Email
ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

Employer Medical Provider Panel

If you have been injured, please notify your supervisor immediately or call Omaha National at 844-761-8400

The following medical providers are authorized to provide treatment for a work-related injury or illness:

Provider Name		Provider Name	
Specialty		Specialty	
Clinic Name		Clinic Name	
Address		Address	
Phone		Phone	
Provider Name		Provider Name	
Specialty		Specialty	
Clinic Name		Clinic Name	
Address		Address	
Phone		Phone	
Provider Name		Provider Name	
Specialty		Specialty	
Clinic Name		Clinic Name	
Address		Address	
Phone		Phone	

In order to ensure that medical treatment during the initial 90 days of treatment will be paid for by the employer or the insurance company, injured workers must select from one of the designated health care providers listed above.

Requirements for Employer Medical Provider Panels:

- At least 6 medical providers must be listed, but there may be more than 6 included.
- At least 3 of the providers listed must be physicians
- No more than 4 of the listed providers may be coordinated care organizations (CCOs)
- The list must include the names, addresses, phone numbers and medical specialties for all providers
- Providers listed must be geographically accessible and have medical specialties appropriate to treat the anticipated medical conditions for work-related injuries and illnesses
- Any providers that are employed, owned, or controlled by the employer or the workers' compensation insurance company must be identified as such

All requirements listed above must be met for a panel to be valid. If the list does not meet all requirements, an injured worker is not required to treat with a provider on the list and can receive treatment from any provider of their choice.

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.

IA-1 – First Report of Injury or Illness:

Pennsylvania law requires employers to report all employee injuries immediately to the insurer. Send the completed IA-1 form to Omaha National at the same time you report the claim to us. Any injuries resulting in the loss of a day, shift, or turn (or more) of work are required to be reported to the Bureau of Workers' Compensation. Reports to the Bureau must be made within 48 hours for injuries resulting in death and within 7 days after the date of injury for all other reportable injuries. Once the claim is reported, we will submit electronic reports to the Bureau on your behalf. Please note, you are required to maintain records of any injuries reported by employees to be available for inspection by the Bureau or another governmental agency.

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.

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG CASE #	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
INDUSTRY CODE / EMPLOYER FEIN			PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD TO CHECK IF APPROPRIATE ☐ SELF INSURANCE	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX M MALE F FEMALE U UNKNOWN	MARITAL STATUS U UNMARRIED SINGLE/DIVORCED M MARRIED S SEPARATED K UNKNOWN	OCCUPATION/JOB TITLE EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE	

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED ☐ 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

DEPARTMENT OR LOCATION WHERE 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(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)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT
		0 NO MEDICAL TREATMENT 1 MINOR: BY EMPLOYER 2 MINOR CLINIC/HOSP 3 EMERGENCY CARE 4 HOSPITALIZED > 24 HOURS 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

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.

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.

LIBC-100 - Workers' Compensation and the Injured Worker:

This serves as a general guide for injured workers on the Pennsylvania Workers' Compensation Act.

Workers' Compensation Information Handout:

This handout must be provided to injured workers as soon as possible after a workplace injury occurs. Obtain the employee's signature to confirm their receipt and send a copy to Omaha National. This document must be printed on 8½ × 11-inch paper.

Employee Acknowledgement Form:

This form is used to provide notice of an injured worker's rights and duties under Section 306 of the Pennsylvania Workers' Compensation Act. Obtain the employee's signature to confirm their receipt and send a copy to Omaha National.

Panel Acknowledgement and Physician Selection:

Provide a copy of your Employer Medical Provider Panel and then have the injured worker complete and sign this form. Send copies of both documents 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

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

WORKERS' COMPENSATION AND THE INJURED WORKER

www.dli.pa.gov

This brochure is a general guide for injured workers on the Pennsylvania Workers' Compensation Act for work injuries and illnesses occurring on or after June 24, 1996. This is general information only and does not represent official interpretations of the law. Injured workers are encouraged to discuss questions and concerns regarding the workers' compensation law and the additional options with legal counsel.

What is workers' compensation?

If you sustain a job injury or a work-related illness, the Pennsylvania Workers' Compensation Act, or Act provides payment for your medical expenses and, in the event you are unable to work, wage-loss compensation benefits until you're able to go back to work. Additionally, death benefits for work-related deaths are paid to your dependent survivors.

Benefits are paid by private insurance companies (also includes third-party administrators) or the State Workers' Insurance Fund (a state-run workers' compensation insurance carrier) or by self-insured employers.

Are you covered?

Nearly every Pennsylvania worker is covered by the Act. Employers must provide workers' compensation coverage for all of their employees, including seasonal and part-time workers. Nonprofit corporations, unincorporated businesses and even employers with only one employee must comply with the Act's requirements.

Some employees are covered by other compensation laws, including federal civilian employees, railroad workers, longshoremen, shipyard and harbor workers. Others who may not be covered include volunteer workers, agricultural laborers, casual employees, domestics and employees who have been granted a personal religious exemption from the Act. Certain types of executive officers of corporations may elect exemption from the Act. A worker should seek further information if there is any doubt as to coverage.

If you learn that your employer does not have insurance or is not self-insured for workers' compensation, you may be eligible for benefits from the Uninsured Employer Guaranty Fund. For details, see our website (www.dli.pa.gov) or call the Bureau of Workers' Compensation, toll free, at 800-482-2383 or locally and outside Pennsylvania at 717-772-4447.

What is covered?

If your work causes an injury, illness or disease, you may be entitled to WC. No compensation shall be paid when an injury or death is intentionally self-inflicted, or is caused by an employee's violation of the law including, but not limited to, the illegal use of drugs. An injury or death caused by intoxication also may not be covered.

When am I covered?

Coverage begins on the date of hire. Medical benefits are payable from the first day of injury; payment of lost wages is addressed on Page 3.

How do I get the benefits?

Prompt reporting is the key. Report any injury or work-related illness to your employer or supervisor immediately. You must tell your employer that you were injured in the course of employment and inform your employer of the date and place of injury. Failure to notify the employer can result in the delay or denial of benefits. Once you have lost a day, shift or turn of work, your employer is required to report your injury to the Bureau of Workers' Compensation by filing a first report of injury.

The employer may choose to either accept or deny the claim. If your claim is denied, you have the right to file a claim petition with the bureau for a hearing before a WC judge.

What are the benefits?

The law provides several types of workers' compensation benefits:

Payments For Lost Wages

Wage-loss benefits are available if it is determined that you are totally disabled and unable to work or partially disabled and receiving wages less than your pre-injury earnings. Please see the Total and Partial Disability Benefits Status section for further information as to disability status.

Death Benefits

If the injury results in death, surviving dependents may be entitled to benefits.

Specific Loss Benefits

If you have lost the permanent use of all or part of your thumb, finger, hand, arm, leg, foot, toe, sight, hearing or have a serious and permanent disfigurement on your head, face or neck, you may be entitled to a specific loss award.

Medical Care

Employers are responsible for advising workers of their rights and duties under Section 306(f.1)(1)(i) of the Act. The written notice of these rights and duties is to be provided to the employee at the time of injury or as soon after the injury as is practicable.

In the event of a work-related illness or injury, you are entitled, if covered under the Act, to the payment of related reasonable surgical and medical services rendered by a physician or other health care provider.

Medicine, supplies, hospital treatment and services, orthopedic appliances and prostheses are also covered for as long as they are needed. (To assure payment of medical services, see the Choice of Doctor section.) Even if you have lost no time from work, health care costs for a work-related injury or illness are payable at the fee schedule rate. However, an employee may not be charged the difference between the health care provider's charge and the amount paid by the employer or its insurance carrier. In other words, there can be no balance billing to you.

If you seek medical treatment outside Pennsylvania, you may be subject to the risk of balance billing by the medical provider. You should discuss this with your medical provider prior to initiating treatment.

Choice of Health Care Provider

You are free to choose your own health care provider to treat your work injury unless the employer accepts your claim and has posted in your workplace a list of six or more physicians or health care providers. You are required to visit a provider on the list for initial treatment. You are to continue treatment with that provider or another on the list for a period of 90 days following the first visit. You may see any provider on the list; your employer may not require or direct you to any specific provider on the list.

If a listed provider prescribes invasive surgery, you are entitled to a second opinion that will be paid for by your employer/insurer. Treatment recommended as a result of the second opinion must be provided by a listed provider for 90 days.

If during the 90-day period you visit a provider(s) not on the list, your employer or your employer's insurance carrier may refuse to pay for such treatment. After the 90 days, and in situations where your employer has no posted list or an improper list, you may seek treatment with any physician or other health care provider you select. You must notify your employer of the provider you have selected. During treatment, the employer or the employer's insurance carrier is entitled to receive monthly reports from your physician or provider.

Injured workers should be advised that your health care providers may need information concerning your claim. Some of this information may be contained in correspondence you receive from your insurance carrier, and you may want to provide copies of letters or forms to your health care provider.

Once you begin receiving WC benefits, the employer/insurer has the right to ask you to see a doctor of their choice for examination. If you refuse, the employer is entitled to request an order from the WC judge requiring you to attend an examination. Failure to then attend may result in a suspension of your benefits.

Occupational Disease

Occupational diseases under the Act are covered if caused by or aggravated by employment. Your disability must occur within 300 weeks of your last employment in an occupation where you were exposed to the hazard.

For certain lung diseases, you must have worked in an occupation with a silica, coal or asbestos hazard for at least two years in Pennsylvania during the 10 years prior to your disability.

Total and Partial Disability Benefits Status

Total Disability Benefits Status

Applies to injured workers for a period during which they are considered totally disabled and unable to work. After 104 weeks of such status, the employer/insurer can require a medical examination to determine if the employee is at least 35 percent impaired based upon his/her work injury according to American Medical Association standards. If the 35 percent threshold is not met, the employee's status can change to partial disability.

Partial Disability Benefits Status

This benefit status is for a maximum of 500 weeks. If, while on partial disability status, you obtain a qualified impairment-rating physician's determination of impairment that is equal to or greater than 35 percent, you may file a petition for reinstatement of total disability status.

Partial disability of up to 500 weeks of benefits are paid if you can, or do, return to work at a lower paying job within work-related restrictions or you are found not totally disabled.

How much are the payments for lost wages?

Wage-loss benefits are equal to approximately two-thirds of your average weekly wage, up to a weekly maximum. WC wage-loss benefits can be offset for 50 percent of Social Security (old age) benefits, the employer-paid portion of a retirement pension, severance pay, unemployment compensation or other earnings the employee receives. The law does not allow for a cost-of-living increase.

There are several different ways to calculate the average weekly wage under the Act. The minimum compensation rate is the lower of 90 percent of the workers' average weekly wage or 50 percent of the statewide average weekly wage.

Reporting Wages and Other Benefits Received

Under the Act, any worker who has filed a petition for total or partial disability benefits or who is receiving such benefits is required to report, in writing to the insurer, any information that is relevant in determining entitlement to, or amount of, compensation including, but not limited to, information

Workers' Compensation & the Injured Worker is published by the Dept. of Labor & Industry,
Bureau of Workers' Compensation, 1171 S. Cameron St., Room 324, Harrisburg, PA 17104-2501

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
PA Relay 7-1-1

Email
ra-li-bwc-helpline@pa.gov

regarding the receipt of wages from another employer or from self-employment. The worker is obligated to cooperate with the carrier in an investigation of employment, self-employment, wages and physical condition.

Insurance Fraud is a Crime

The above-mentioned reports and other WC forms must be honestly completed to avoid violating PA fraud provisions.

When are wage-loss payments made?

You must be disabled more than seven calendar days (including weekends) before WC payments for disability are payable. Benefits for time lost from work are payable on the eighth day after injury. Once you have been off work 14 days, you receive retroactive payment for the first seven days.

If you report the injury promptly, miss more than seven days of work and your claim is accepted by the insurance carrier, you should receive your first compensation check within 21 days of your absence from work. After that, you will receive a check on a regular basis.

Payments of temporary compensation may be made by your employer or the insurance carrier for up to 90 days, even if your claim is not accepted by your employer or its insurance carrier. If your employer or the company's insurance carrier advises you that it will not continue your temporary compensation checks past 90 days, or if they deny your claim, you have the right to file a claim petition with the Office of Adjudication for a hearing if you believe you are entitled to benefits.

Offer of Employment

If, after you begin to receive benefits, your employer has evidence to prove that employment is available to you, within your medical restrictions and in your local area, you may receive an offer of employment.

If you decline the job offer, the employer may then petition a WC judge to either reduce or stop your wage-loss benefits based upon that job. The insurer/employer must continue to pay benefits during the hearing process unless the judge orders otherwise.

In open hearings, the judge will hear and receive medical evidence, both from you and your insurer/employer, on the availability of the work and your ability to do it, before rendering a decision.

When Wage-Loss Payments Stop

Wage-loss benefits can be stopped by an employer/ insurer that has evidence that you have returned to work at wages equal to or more than your earnings level prior to the injury and after providing a timely notice of that fact. If you are receiving temporary compensation benefits during the 90 days following the report of injury, the insurance carrier/ employer may notify you they are stopping benefits because they are not accepting the claim of a work-related injury.

Other reasons that benefits may be stopped include, but are not limited to: a WC judge stopped benefits after a hearing; the employee signs either a supplemental agreement or an agreement to stop workers' compensation (commonly referred to as a final receipt); the 500-week period of partial disability status expires.

What if there is a problem?

If you think you haven't received benefits that you are due, contact your employer or your employer's insurance carrier. The insurance carrier is allowed 21 days from your notice to the employer of your disability to decide to accept or deny your claim or to make payments of temporary compensation for up to 90 days.

Cooperative communication with your insurance carrier and employer is recommended. If the problem is not resolved, it may be necessary for you to file a petition with the Office of Adjudication. Forms can either be obtained online at www.dli.pa.gov or through the Claims Information Helpline at 800-482-2383. The Office of Adjudication is responsible for resolving disputes by assigning petitions to WC judges who decide each case after holding hearings on the issues.

Time Limits

Unless an employer has knowledge of the injury or the employee gives notice to the employer within 21 days of the injury, no compensation is due until notice is given. Notice must be given no later than 120 days after the injury for compensation to be allowed. If your request for WC benefits is denied by your employer or your employer's insurance carrier, you have three years from the date of injury to file a claim petition.

In occupational disease cases, injury/disability must occur within 300 weeks from the date of last employment in an occupation in which you had exposure to a hazard, and a petition must be filed no later than three years from the date of injury/disability.

Failure to file a petition on a timely basis may result in forfeiture of your right to benefits.

If your benefits were terminated, you may file a petition to reinstate WC benefits within three years after the date of your most recent WC check.

If your benefits were suspended, you may file a petition to have benefits reinstated. This petition must be filed within 500 weeks from the date of suspension.

Payment of medical benefits by your employer does not mean that your claim has been accepted or reopened.

Alternative Dispute Resolution

In alternative dispute resolution, a WC judge helps the parties settle the case by talking through their differences. Alternative dispute resolution may take the form of mediation, settlement conference or informal conference.

If either you or your employer files a petition with the Office of Adjudication, the WC judge will schedule mediation unless a judge determines it would be futile. If the case does not settle at this mediation, the parties may resume mediation or a settlement conference later in the proceedings. The parties may also request mediation or a settlement conference later in the proceedings if the judge had previously found mediation to be futile.

You may also request an informal conference to try to resolve your issues. If you are not represented by an attorney at an informal conference, your employer is not entitled to be represented either. Informal conference forms are available online at www.dli.pa.gov or through the Bureau of Workers' Compensation Claims Information Helpline at 800-482-2383.

Do I need an attorney?

You may represent yourself in WC proceedings, but a non-attorney cannot represent you. However, you should be aware that WC litigation is complex, and your employer or your employer's insurance carrier will be represented by an experienced attorney. If you hire an attorney, you should discuss fee and cost arrangements. The fee agreement must be approved by a WC judge or the Workers' Compensation Appeal Board. Your local bar association, or the Pennsylvania Bar Association's Lawyer Referral Service at 800-692-7375, can help you find an attorney.

Appeals

WC judge decisions can be appealed to the Workers' Compensation Appeal Board and then to Commonwealth Court. You will be informed of appeal rights upon receiving the WC judge's decision.

Other Benefits

If the injury is a very serious one where you won't be able to work for a year or more you may be eligible for additional disability benefits from Social Security. For information, visit the Social Security Administration's website at www.socialsecurity.gov or contact your nearest Social Security Administration office.

General Information

If you require a special accommodation to participate in a hearing due to a physical impairment, or need a sign language interpreter or an interpreter for your own language other than English, without cost, request one online at www.dli.pa.gov or contact the Bureau of Workers' Compensation Helpline and describe the accommodation:

Email: ra-li-bwc-helpline@pa.gov

Helpline voice telephone numbers:
toll free in Pennsylvania: 800-482-2383
local and outside Pennsylvania: 717-772-4447

Only people with hearing loss:
PA Relay 7-1-1

You may also ask your employer or supervisor for information on WC or contact your employer's WC insurance carrier, your union or an attorney.

The WC Act is available on the department website at www.dli.pa.gov.

Workers' Compensation Information

If you have been injured, please notify your supervisor immediately or call Omaha National at 844-761-8400

The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury. Benefits are required to be paid by your employer when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.

You should report immediately any injury or work-related illness to your employer. Your benefits could be delayed or denied if you do not notify your employer immediately.

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

The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at:

Bureau of Workers' Compensation
1171 South Cameron Street, Room 103,
Harrisburg, Pennsylvania 17104-2501
Telephone number within Pennsylvania - (800) 482-2383
Telephone number outside of this Commonwealth - (717) 772-4447
TTY (for hearing and speech impaired only) - (800) 362-4228
www.state.pa.us (PA Keyword: workers comp)

I have read this document. I fully understand its entire contents. I have asked questions about anything that was not clear to me. I am satisfied with the answers I have received. I understand I have a right to ask for a copy of this.

Complete at the time of hire:

Signature _____

Printed Name _____ Date _____

Complete after an injury:

Signature _____

Printed Name _____ Date _____

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

Employee Acknowledgement Form

This contains important information about medical care for work injuries or illnesses.

Employee Name _____ Employer _____

Date Hired _____

Section 306 of the Pennsylvania Workers' Compensation Act gives legal rights and duties to workers that are injured at work or suffer an occupational illness. These rights and duties are addressed below.

Your Rights and Duties During the First 90 Days:

- You have the right to receive all reasonable and necessary medical supplies and treatment for a work injury or occupational illness. Your employer must pay for the treatment, when the treatment is given by one of the providers from the Employer's Medical Provider Panel.
- You have a duty to get treatment for your work injury or illness from one or more of the providers listed on the panel for a period of 90 days from the date of the first visit to a designated provider. In cases of an emergency, you have the right to get emergency medical treatment from any provider, but any subsequent non-emergency treatment must be received from a listed provider for the rest of the 90-day period.
- You have the right to choose which of the listed providers will provide treatment for your work injury or occupational illness and the right to switch from one listed provider to another on the list. Treatment from the prior selected provider and the new designated provider will be paid by your employer. If a designated provider refers you to another medical provider not listed on the panel, you have the right to obtain treatment from the referral provider.
- If a listed provider prescribes surgery as part of your treatment, you have the right to get a second opinion from any medical provider. If the second opinion differs from the designated provider's and includes a specific and detailed course of alternative treatment, you may determine which course of treatment to follow. If you decide to follow the course of treatment outlined in the second opinion, the treatment must be performed by a listed medical provider for 90 days from the date of the first visit to the provider that gave the second opinion.
- You may get treatment or a medical consultation from a provider not listed on the panel during the 90-day period, but you are responsible for the payment of such services.

Your Rights and Duties After the First 90 Days:

- After the 90-day period has ended, you have the right to receive treatment from any health care provider, whether or not they are listed by your employer. Your employer must pay for this treatment if it is reasonable and necessary for your work injury or occupational illness and has been properly documented by the physician or other health care provider.
- You must notify your employer if you receive treatment from a provider who is not listed by your employer. You must notify your employer within 5 days of the first visit to any provider who is not on your employer's list. The employer may not be required to pay for the treatment received until you have given this notice.

Acknowledgement

I have read this form. I fully understand its entire contents. I have asked questions about anything that was not clear to me. I am satisfied with the answers I have received. I understand I have a right to ask for a copy of this form.

- ☐ I have received a copy of the Workers' Compensation Information Handout
- ☐ I have read and understand my rights and duties under Section 306 of the Pennsylvania Workers' Compensation Act as described above
- ☐ I understand it is my duty to tell my employer I have a work injury as soon as the injury happens
- ☐ I acknowledge my employer's Medical Provider Panel and understand that I must treat with a provider from the list for the first 90 days of treatment

Complete at the time of hire:

Signature _____

Printed Name _____ Date _____

Complete after an injury:

Signature _____

Printed Name _____ Date _____

Panel Acknowledgement and Physician Selection

By signing this form, I accept my employer's posted medical provider panel. I understand that I must choose a provider from the panel list to give me treatment for a work injury or illness during the first 90 days of treatment. I also understand that if I get treatment from a provider that is not listed on the panel, my employer may not be required to pay for such treatment.

I also understand that I have the right to change to another provider listed on the panel if I am not satisfied with the first doctor I choose.

I choose the following medical provider to give me treatment and services for my work injury or illness:

Provider/Physician Name _____

Specialty _____

Clinic Name _____

Address _____

Phone Number _____

I have read this document. I fully understand its entire contents. I have asked questions about anything that was not clear to me. I am satisfied with the answers I have received. I understand I have a right to ask for a copy of this.

Signature _____

Printed Name _____ Date _____

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

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

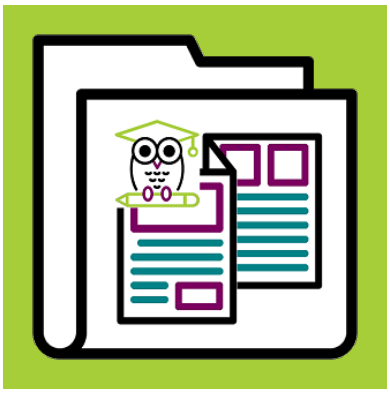
Hospitalizations and Surgical Procedures			
Date(s)	Diagnosis/Treatment/Procedure	Doctor	Hospital

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.

- **Medical Provider Panel Information for Employers:**
  Information about medical provider panels and the employer actions necessary for us to require treatment with listed providers during the initial 90 days.

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.

Medical Provider Panel Information for Employers

Designated Medical Providers for Treating Workplace Injuries

The right physician can have a substantial impact on the successful recovery of an injured employee and on the cost of a workers compensation claim. High quality, cost effective care for your injured employees is our top priority. Pennsylvania employers only have the first 90 days of treatment to influence an injured worker's selection of the treating physician. We recommend the use of medical provider panels to ensure that your employees receive medical care from highly qualified physicians and other skilled medical providers during the 90-day period. Our panels consist of providers who are experienced in treating workplace injuries, are familiar with the workers compensation system, and are strong advocates of an early, safe return to work. Please contact your Account Manager to discuss how we can work together to ensure injured workers receive appropriate and timely care.

Preserve Your Rights

We can only require that injured workers treat with panel providers if these steps are followed:

- **Post Workers Compensation Notices:** Employers are required to post mandatory notices regarding employees' workers compensation rights. We have provided those notices to you along with instructions on where to post them.
- **Medical Provider Panel:** The law instructs employers to post their panel in prominent and readily accessible places at all business locations and work sites. This includes places used for treatment and first aid and any employee informational bulletin boards. Omaha National has designed an Employer Medical Provider Panel that can be used to meet the posting requirements.
- **Offer Immediate Medical Care:** Upon learning of a work injury, an employer should offer immediate medical treatment to the injured employee. Let us know about any injury right away so we can help arrange for appropriate medical care. The failure to offer medical care may constitute a refusal or denial of care which may result in an employee being able to treat with providers outside the panel listing.
- **Workers' Compensation Information Handout:** The law directs employers to provide information about workers compensation to employees at the time of hire and after a work injury. Use this handout to obtain a new employee's signature and save it within their employee records. If an injury or illness occurs, have the employee sign again to confirm that the information was provided. Send a copy of the signed handout to Omaha National when the injury is reported.
- **Employee Acknowledgment Form:** Employers are required to inform employees of their rights and duties under Section 306 of the Pennsylvania Workers' Compensation Act. This notice must also be provided at the time of hire and after a work injury or illness. Omaha National has created an Employee Acknowledgement Form to be used to address the requirements and to obtain an employee's confirmation that the mandatory notices were received and understood. Make sure to send a copy of the completed form to Omaha National.
- **Panel Acknowledgement and Physician Selection:** Upon knowledge of an employee's work injury or occupational illness, have the injured worker complete this form to confirm their knowledge of the provider panel and to designate the medical provider they have chosen to treat their injury or illness. Send a copy of the posted panel and the completed panel acknowledgment when the claim is reported to Omaha National. This documentation is needed to enforce panel use.

GENERAL FORMS

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

- **Request for Subrogation Waiver:**
  Use this form to request to have a subrogation waiver added to your policy.

- **Form ERM-14 - Confidential Request for Ownership Information:**
  Changes in ownership may impact your policy and the factors used to determine your premium. These changes must be reported to us right away.

- **Company Contacts Verification:**
  This form is used to provide your company contacts for questions and issues pertaining to your payroll and/or workers compensation policy.

Request for Subrogation Waiver

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

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

General Information

Policyholder Name ______________________

FEIN ______________________

Policy Number ______________________

Waiver Type Requested ☐ Blanket Waiver ☐ Specific Waiver (if applicable, please complete fields below)

Job Information for Specific Waiver

Job Effective Date(s) From __________ To __________

Job Name or Number ______________________

Person or Organization ______________________

Brief Description of Job ______________________

Complete Address ______________________

Employee Class Code ________ Employee Class Code ________ Employee Class Code ________

Payroll Amount ________ Payroll Amount ________ Payroll Amount ________

Job Information for Specific Waiver

Job Effective Date(s) From __________ To __________

Job Name or Number ______________________

Person or Organization ______________________

Brief Description of Job ______________________

Complete Address ______________________

Employee Class Code ________ Employee Class Code ________ Employee Class Code ________

Payroll Amount ________ Payroll Amount ________ Payroll Amount ________

Job Information for Specific Waiver

Job Effective Date(s) From __________ To __________

Job Name or Number ______________________

Person or Organization ______________________

Brief Description of Job ______________________

Complete Address ______________________

Employee Class Code ________ Employee Class Code ________ Employee Class Code ________

Payroll Amount ________ Payroll Amount ________ Payroll Amount ________

Job Information for Specific Waiver

Job Effective Date(s) From __________ To __________

Job Name or Number ______________________

Person or Organization ______________________

Brief Description of Job ______________________

Complete Address ______________________

Employee Class Code ________ Employee Class Code ________ Employee Class Code ________

Payroll Amount ________ Payroll Amount ________ Payroll Amount ________

Job Information for Specific Waiver

Job Effective Date(s) From __________ To __________

Job Name or Number ______________________

Person or Organization ______________________

Brief Description of Job ______________________

Complete Address ______________________

Employee Class Code ________ Employee Class Code ________ Employee Class Code ________

Payroll Amount ________ Payroll Amount ________ Payroll Amount ________

Submitter Information

Completed by ______________________ Date ______________________

Title ______________________ Signature ______________________

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

CONFIDENTIAL REQUEST FOR OWNERSHIP INFORMATION

The following confidential ownership statements may be used only in establishing premiums for your insurance coverages. It is extremely important all questions be answered completely. Your workers' compensation policy requires you report all ownership changes and other changes as detailed below to your insurance carrier in writing within ninety (90) days of the change. If you have questions, contact your agent & your insurance carrier or the appropriate rating organization. **Incomplete information or a missing signature may result in a delay in processing.**

PURPOSE (Check One)

☐ **Name or Entity Status Change Only**
Complete Column A for former name and Column B for new name. Complete questions 1, 2, and 3 on page 2.

☐ **Combination of Separate Entities**
Complete a separate column for each entity related through common majority ownership. (Add forms if needed)

☐ **Sale, Transfer or Conveyance of All or a Portion of an Entity's Ownership Interest**
Complete column A for the ownership prior to the change and column B for the ownership after the change

☐ **Merger or Consolidation**
Complete columns A & B for the former entities and column C for the remaining entity

☐ **Formation of a New Entity**
Complete column A

☐ **Sale, Transfer or Conveyance of an Entity's Physical Assets to Another Entity That Takes Over its Operations**
Complete column A for the original entity and column B for the acquitting entity

☐ **Irrevocable Trust or Receiver Established Voluntarily or by Court Mandate or Revocable Trust or Franchisor**
Complete column A for ownership prior to the change and column B for the trustee or receiver established

Entity Information	**A**	**B**	**C**
Name of Business Provide legal name of entity.			
Primary Address Street, City, State, Zip			
Legal Status			
Ownership **Corporations**: List names of all owners of 5% or more of voting stock and number of shares owned. **Partnerships:** List each general partner and appropriate share in profits. **Other**: If no voting stock, list sole proprietor, members of LLC & percentage, members of boards of directors or comparable governing body. Ownership totals should equal 100%			
FEIN			
Change Effective Date			
Policy Number			
Policy Effective Date			

CONFIDENTIAL REQUEST FOR OWNERSHIP INFORMATION

1. Has this entity operated under another name in the last four years? _____

2. Is this entity **currently** related through common majority ownership to any entity not listed on page 1 of the form? _____

3. Has this entity been previously related through common majority ownership to other entity in the last four (4) years? _____

   If you answered yes to question 1, 2, or 3, please provide the following information:

Name of Business	Principal Location	Carrier and Policy Number	Effective Date

4. Were the assets and/or ownership interest (all or a portion) of this entity acquired from a previously existing business? ☐
   If yes, provide complete ownership information of the prior owner in column A and ownership information of the new owner in column B on the reverse side on page 1 of this form.

5. If this is a partial sale, transfer, or conveyance of an existing business (I.E. – sale of one or more than one location, etc.)

   a. Explain what portion or location of the entire operations was sold, transferred, or conveyed. _____

   _____

   b. Was this entity insured under a separate policy from the remaining portion? _____ If not, specify the entities with which it was combined: _____

6. If this entity has operations in Delaware or Pennsylvania, provide the number of employees from each state retained from the prior ownership _____ out of _____ Indicate the percentage or number retained out of the total from each of these states:

   _____% _____state.

   NOTE: If your business has changed significantly to result in a change to the primary (governing) classification and the process and hazard of the operation also changed, contact your agent, insurance carrier or rating organization for additional information.

CERTIFICATION

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

Name of Insured: _____

Name of person completing the form: _____

Date this ownership change was reported in writing to your insurance carrier: _____

Signature of Owner, Partner or Executive Officer	Title	Insurance Carrier
Print name of above signature	Date	Carrier Address

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

Please provide these documents to all new employees at the time of hire.

Workers' Compensation Information Handout:

This handout provides important information about workers compensation. The law requires that this information be provided to all employees at the time of hire. Obtain the employee's signature to confirm their receipt and save a copy in their employment file. This document must be printed on 8½ × 11-inch paper.

Employee Acknowledgement Form:

This form is used to provide notice of an injured worker's rights and duties under Section 306 of the Pennsylvania Workers' Compensation Act. It must be given to all employees at the time of hire. Obtain the employee's signature to confirm their receipt and save a copy in their employment file.

Workers' Compensation Information

If you have been injured, please notify your supervisor immediately or call Omaha National at 844-761-8400

The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury. Benefits are required to be paid by your employer when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.

You should report immediately any injury or work-related illness to your employer. Your benefits could be delayed or denied if you do not notify your employer immediately.

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

The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at:

Bureau of Workers' Compensation
1171 South Cameron Street, Room 103,
Harrisburg, Pennsylvania 17104-2501
Telephone number within Pennsylvania - (800) 482-2383
Telephone number outside of this Commonwealth - (717) 772-4447
TTY (for hearing and speech impaired only) - (800) 362-4228
www.state.pa.us (PA Keyword: workers comp)

I have read this document. I fully understand its entire contents. I have asked questions about anything that was not clear to me. I am satisfied with the answers I have received. I understand I have a right to ask for a copy of this.

Complete at the time of hire:

Signature _____

Printed Name _____ Date _____

Complete after an injury:

Signature _____

Printed Name _____ Date _____

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

Employee Acknowledgement Form

This contains important information about medical care for work injuries or illnesses.

Employee Name _____ Employer _____

Date Hired _____

Section 306 of the Pennsylvania Workers' Compensation Act gives legal rights and duties to workers that are injured at work or suffer an occupational illness. These rights and duties are addressed below.

Your Rights and Duties During the First 90 Days:

- You have the right to receive all reasonable and necessary medical supplies and treatment for a work injury or occupational illness. Your employer must pay for the treatment, when the treatment is given by one of the providers from the Employer's Medical Provider Panel.
- You have a duty to get treatment for your work injury or illness from one or more of the providers listed on the panel for a period of 90 days from the date of the first visit to a designated provider. In cases of an emergency, you have the right to get emergency medical treatment from any provider, but any subsequent non-emergency treatment must be received from a listed provider for the rest of the 90-day period.
- You have the right to choose which of the listed providers will provide treatment for your work injury or occupational illness and the right to switch from one listed provider to another on the list. Treatment from the prior selected provider and the new designated provider will be paid by your employer. If a designated provider refers you to another medical provider not listed on the panel, you have the right to obtain treatment from the referral provider.
- If a listed provider prescribes surgery as part of your treatment, you have the right to get a second opinion from any medical provider. If the second opinion differs from the designated provider's and includes a specific and detailed course of alternative treatment, you may determine which course of treatment to follow. If you decide to follow the course of treatment outlined in the second opinion, the treatment must be performed by a listed medical provider for 90 days from the date of the first visit to the provider that gave the second opinion.
- You may get treatment or a medical consultation from a provider not listed on the panel during the 90-day period, but you are responsible for the payment of such services.

Your Rights and Duties After the First 90 Days:

- After the 90-day period has ended, you have the right to receive treatment from any health care provider, whether or not they are listed by your employer. Your employer must pay for this treatment if it is reasonable and necessary for your work injury or occupational illness and has been properly documented by the physician or other health care provider.
- You must notify your employer if you receive treatment from a provider who is not listed by your employer. You must notify your employer within 5 days of the first visit to any provider who is not on your employer's list. The employer may not be required to pay for the treatment received until you have given this notice.

Acknowledgement

I have read this form. I fully understand its entire contents. I have asked questions about anything that was not clear to me. I am satisfied with the answers I have received. I understand I have a right to ask for a copy of this form.

- ☐ I have received a copy of the Workers' Compensation Information Handout
- ☐ I have read and understand my rights and duties under Section 306 of the Pennsylvania Workers' Compensation Act as described above
- ☐ I understand it is my duty to tell my employer I have a work injury as soon as the injury happens
- ☐ I acknowledge my employer's Medical Provider Panel and understand that I must treat with a provider from the list for the first 90 days of treatment

Complete at the time of hire:

Signature _____

Printed Name _____ Date _____

Complete after an injury:

Signature _____

Printed Name _____ Date _____