



Workers Compensation Resource for Employers



Welcome,

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

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

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

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



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



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Non-Compliance Notice

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

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



POSTERS

Please post the following notices at all business locations in a common area that is visible to and frequented by employees during the workday. Examples of appropriate posting locations include a breakroom or on a wall next to a time clock. Posters must also be used in any areas used for the treatment of injured workers and the administration of first aid and on employee informational bulletin boards.



Form 2 - Employer's Notice of Being Subject to the Act:

This document serves as the mandatory workers compensation poster notice. Make sure to select the appropriate insurance carrier from the dropdown list.



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.



South Carolina Workers' Compensation

Workers' Compensation Compliance Poster

We are operating under and subject to the South Carolina Workers' Compensation Act

In case of accidental injury or death to an employee, the injured employee, or someone acting in his or her behalf, must give immediate notice to the employer or general authorized agent. Failure to give such immediate notice may be the cause of serious delay in the payment of compensation to the injured employee or his or her dependents and may result in failure to receive any compensation benefits under the law.

Workers' Compensation:

1. Pays 100% of your medical bills and some other expenses.
2. Compensates you for 66 2/3% of your salary, limited to the maximum wage set by law, if you are unable to work for more than seven (7) calendar days.

If you are injured on the job, you should:

1. Notify your employer at once. You cannot receive benefits unless your employer knows you are injured.
2. Tell the doctor your employer sends you to that you are covered by workers' compensation.
3. Notify the Workers' Compensation Provider listed on this poster or the South Carolina Workers' Compensation Commission at 803.737.5700 if you experience undue delays or problems with your claim.

South Carolina
Workers' Compensation Commission
P.O. Box 1715, 1333 Main Street, Suite 500
Columbia, S.C. 29202-1715
803-737-5700

www.wcc.sc.gov

Workers' Compensation Provider Name

Mailing Address

Claims Telephone Number

Fake an Injury And You Can Sit Around All Day



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

If you suspect workers compensation fraud or abuse report it.

844-761-8400

All information will be kept confidential.





INJURY REPORT FORMS

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

Form 12A - First Report of Injury or Illness:

South Carolina law requires employers to report all employee injuries immediately to the insurer. Please read and carefully follow the Employer's Instructions provided on Form 12A. Send the completed Form 12A to Omaha National at the same time you report the claim to us. Please note, any injuries involving medical treatment or compensable lost time are required to be reported to the Workers' Compensation Commission. Once the claim is reported, we will submit an electronic report to the Commission on your behalf as needed.

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.

S.C. WORKERS' COMPENSATION COMMISSION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	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	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
	CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE	
CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN
AGENT NAME & CODE NUMBER		

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	MARITAL STATUS <input type="checkbox"/> Unmarried/Single/Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown	OCCUPATION/JOB TITLE	
			EMPLOYMENT STATUS	
			NCCI CLASS CODE	
PHONE	# OF DEPENDENTS			
RATE PER: <input type="checkbox"/> DAY <input type="checkbox"/> MONTH <input type="checkbox"/> WEEK <input type="checkbox"/> OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO DID SALARY CONTINUE? <input type="checkbox"/> YES <input type="checkbox"/> NO		

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK <input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE (<input type="checkbox"/>) CANNOT BE DETERMINED <input type="checkbox"/> AM <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO WERE THEY USED? <input type="checkbox"/> YES <input type="checkbox"/> NO		
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)		INITIAL TREATMENT
				0 <input type="checkbox"/> No Medical Treatment
				1 <input type="checkbox"/> MINOR: BY EMPLOYER
				2 <input type="checkbox"/> MINOR CLINIC/HOSP
				3 <input type="checkbox"/> EMERGENCY CARE
				4 <input type="checkbox"/> HOSPITALIZED > 24 HOURS
		5 <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED		

OTHER

WITNESSES (NAME & PHONE #)			
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER



South Carolina Workers' Compensation Commission

1333 Main Street, Suite 500

P.O. BOX 1715

Columbia, SC 29202-1715

803-737-5722

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YYYY 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, (e.g. Lacerations to the forearm).

PART OF BODY AFFECTED:

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

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(e.g. 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.



South Carolina Workers' Compensation Commission

1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5722

EMPLOYER'S INSTRUCTIONS – cont'd

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

(e.g. 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:

(e.g. 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 (e.g. 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 _____

☐ Death ☐ Lost Time ☐ Medical Only

Type of Incident ☐ First Aid ☐ Property Damage

☐ Report Only / Near Miss

Date of Incident _____

Time of Incident _____ ☐ AM ☐ PM

Date Reported _____

Reported To _____

Injured Worker

Name _____

Department _____

Job Title _____

Supervisor _____

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

Start Shift _____ ☐ AM ☐ PM

End Shift _____ ☐ AM ☐ PM

Length in Position _____

Sex ☐ Male ☐ Female

Date of Birth _____

Date of Hire _____

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

Home Address _____

City, State, & Zip _____

Phone Number _____

Wages / Salary _____

Incident or Injury

Where incident occurred _____

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

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

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

Type of injury and body parts affected:

Witness(es) ☐ Yes ☐ No

Name _____

Name _____

Name _____

Phone Number _____

Phone Number _____

Phone Number _____

Medical Treatment and Work Status

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

Contributing Factors

Unsafe Workplace Conditions: (Check All That Apply)

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

Unsafe Acts by People: (Check All That Apply)

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

Describe why the unsafe conditions exist:

Describe why the unsafe acts occurred:

Preventive Measures

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

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

Completed By _____ Date of Completion _____
Signature _____ Title _____



Supervisor's Report of Employee Incident

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

Injured Employee

Name _____

Employee ID _____

Job Title _____

Company Name _____

Witnesses ☐ Yes ☐ No

Name _____

Phone Number _____

Name _____

Phone Number _____

Name _____

Phone Number _____

Incident

Date of Incident _____

Time of Incident _____ ☐ AM ☐ PM

Date Reported _____

Time Reported _____ ☐ AM ☐ PM

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

Description of incident:

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

Type of injury and body parts affected:

Medical Treatment and Work Status

First Aid Provided ☐ No ☐ Yes

Describe _____

Missed Time ☐ No ☐ Yes

List Day(s) _____

Returned to Work ☐ No ☐ Yes

Date _____

Work Status ☐ Off Work ☐ Light Duty ☐ Regular Duty

Emergency Care ☐ No ☐ Yes

Physician Name _____

Hospital Name _____

Suggested Preventative and Corrective Measures

What actions can be taken to prevent future accidents?

Completed By _____

Date of Completion _____

Signature _____

Title _____

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



Witness Statement of Injury or Incident

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

Witness Information

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

Incident

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

Completed By _____

Date _____

Signature _____

Title _____

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



INJURED WORKER HANDOUTS

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

Injured Worker's First Fill Prescription Form:

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

Form 65 - Occupational Disease Waiver

Employees may want to stay in their current job at their own risk of aggravating their occupational disease. South Carolina law gives employees the option to waive their rights to additional benefits if their disease gets worse in their current job or a new job. Form 65 is only an option in occupational disease claims. The form should be filed with a physician's statement to the Judicial Department at the WCC at least ten days after signing Form 65.

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

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



Injured Workers First Fill Prescription Form

Injured Worker _____
Claim Number _____

Date of Injury _____
Phone Number _____

Notice to Injured Worker and Pharmacy

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

Injured Worker Instructions

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

Pharmacy Instructions

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



Pharmacy Help Desk:
800-311-3446

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

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

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

Costco Pharmacy
CVS
Kroger Pharmacy
Giant Eagle Pharmacy

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

Meijer Pharmacy
Publix Pharmacy
Walmart Pharmacy
Longs Drug Store

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

South Carolina Workers' Compensation Commission

1333 Main Street, Suite 500

P.O. BOX 1715

Columbia, SC 29202-1715

(803) 737-5675



WCC File #: _____

Carrier File #: _____

Carrier Code #: _____

Employer FEIN #: _____

Claimant's Name: _____ SSN: _____ Employer's Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Insurance Carrier: _____

Preparer's Name: _____ Law Firm: _____ Preparer's Phone #: _____

Occupational Disease Waiver

The undersigned applicant does hereby waive my right to make a claim for compensation for the occupational disease indicated while employed by the above employer. I understand my right to waive liability for the above-named disease as provided for in Section 42-11-80 and Regulation 67-1002 of the South Carolina Workers' Compensation Law, which reads in part:

"If an employee who had previously suffered from an occupational disease desires to continue in an employment to which such a disease is a hazard, he may waive his right to receive further benefits for disablement or disability from such disease by written agreement approved by the Commission in accordance with such rules as it may promulgate."

Therefore, it is my understanding that I only waive my right to receive compensation for the above-named disease and still retain all other rights given an employee under the South Carolina Workers' Compensation Law.

Applicant Name_____
Applicant Signature/Date_____
Employee's Legal Representative Name_____
Signature of Claimant or Legal Representative/Date_____
Witness Name_____
Witness Signature/Date_____
Approving Commissioner's Name_____
Signature of Approving Commissioner/Date

Employee's representative must complete and file Form 65 and physician's statement (per R.67-1002) with the Judicial Department.



Consent and Authorization for Release of Information

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

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

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

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

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

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

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

This information is required for the following:

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

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

Signature _____	
Printed Name _____	Date _____

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



Request for Medical History

Injured Worker _____
Employer _____

Date of Injury _____
Current Date _____

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

Family Doctor / Primary Health Care Provider and Other Treating Doctors

Name	Address	Phone	Condition Being Treated

Medications / Prescriptions

Name	Description/Purpose	Dosage	Prescribing Doctor

Hospitalizations and Surgical Procedures

Date(s)	Diagnosis/Treatment/Procedure	Doctor	Hospital

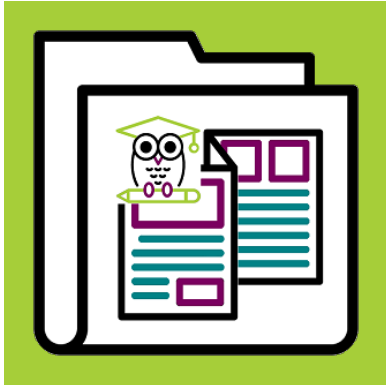
Please check to indicate if you have ever had any of the following conditions:

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

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

Signature _____

Date _____



INFORMATIONAL DOCUMENTS

Keep these documents for your future reference.



Omaha National Contact Information:

This document contains the contact information for our Claims department.



Reduce Your Workers Compensation Costs:

Tips for lowering your company's workers compensation costs.



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.



GENERAL FORMS

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



Request for Subrogation Waiver:

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



Form ERM-14 - Confidential Request for Ownership Information:

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



Company Contacts Verification:

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



Request for Subrogation Waiver

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

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

General Information

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

Job Information for Specific Waiver

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

Job Information for Specific Waiver

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

Job Information for Specific Waiver

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

Job Information for Specific Waiver

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

Job Information for Specific Waiver

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

Submitter Information

Completed by _____ Date _____
Title _____ Signature _____

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

REQUEST FOR OWNERSHIP INFORMATION—ERM-14 FORM

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

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

Section A—Contact Information

Name of person completing this form _____ Your Employer _____

Phone # _____ Email Address _____

Relationship to business entity reporting ownership information _____

Section B—Transaction Information

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

Section C—Description of Transaction(s)

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

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

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Section D—Business Entity Information

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

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

Section E—Certification

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

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

Business Name

Print name of above signature

Date



Company Contacts Verification

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

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

General Information

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

Company Contacts for Invoice Questions/Issues

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

Company Contacts for Payroll Questions/Issues

☐ Check if same as above

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

Company Contacts for Policy Questions/Issues

☐ Check if same as above

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

Company Contacts for Claims Questions/Issues

☐ Check if same as above

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

Submitter Information

Completed by _____ Date _____
Title _____ Signature _____

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



STATE-SPECIFIC FORMS & DOCUMENTS

Use these forms as needed. Send copies of any completed coverage forms to Omaha National.

Form 5 - Corporate Officer Notice to Reject:

Corporate officers may use this form to reject the provisions of South Carolina's workers compensation laws. A completed Form 5 should be sent to Omaha National. A copy of the form must either be hand-delivered personally to the employer or sent to the employer by registered or certified mail.

Form 38 - Employer's Withdrawal of Election to Adopt the South Carolina Workers' Compensation Act:

This form may be used to reverse an exempt employer's adoption of South Carolina's workers compensation law provisions. The employer may select one of the two following methods for filing Form 38:

- **File directly with the Coverage and Compliance Department of the Workers' Compensation Commission (WCC).** Send the original Form 38 and one copy of Form 38 to the WCC for review. Make sure the completed form is signed and notarized.
- **File by notifying Omaha National in writing of your withdrawal from the Workers' Compensation Act.** We will file Form 38 with the Coverage and Compliance Department at the WCC on your behalf. A copy of Form 38 is required to be sent to you for a signature. Once the form is approved by the WCC, we will provide you with the approved Form 38.

Both methods share an important requirement. The employer must provide notice to all employees before the effective date of the withdrawal by either: (1) posting the approved Form 38 in a conspicuous place at the business location, or (2) hand-delivering copies of the approved Form 38 to each employee.



CORPORATE OFFICER NOTICE TO REJECT

To the Employer of the Undersigned and the Employer's Insurance Carrier:

The undersigned officer rejects the terms, conditions, and provisions of the South Carolina Workers' Compensation Act and elects to pursue compensation for personal injuries under the common law and statutes of South Carolina.

As provided by law (Section 42-1-520), "An officer of a corporation who elects not to operate under this title shall, in any action to recover damages for personal injury or death brought against an employer accepting the compensation provisions of this title, proceed at common law and the employer may avail himself of the defenses of contributory negligence, negligence of a fellow servant, and assumption of risk, as such defenses exist at common law."

This notice becomes effective on the date listed below, no sooner than the day following the date signed by the corporate officer.

**** PLEASE PRINT OR TYPE ALL INFORMATION ** ORIGINAL SIGNATURES REQUIRED ****

Name of Officer

Corporate Title

Name of Business (Legal Name)

Street Address

P.O. Box

Street Address

P.O. Box

City

State

Zip

City

State

Zip

Social Security Number

Federal Employer ID #

Area Code

Telephone Number

Area Code

Telephone Number

Signature of Officer

Date

Effective Date

Subscribed and sworn to me this ____ day of ____, ____.

Notary Public

My Commission Expires: _____

This form may be used when an officer desires to become exempt from the provisions of the South Carolina Workers' Compensation Act. For additional information regarding the provision of Section 42-1-520 and this form, contact your insurance carrier or the South Carolina Workers' Compensation Commission, Coverage Division, Post Office Box 1715, Columbia, South Carolina 29202-1715. (803) 737-6203.



EMPLOYER'S WITHDRAWAL OF ELECTION TO ADOPT THE SOUTH CAROLINA WORKERS' COMPENSATION ACT

This form is required if an employer who elected to adopt the Workers' Compensation Act, being previously exempt as prescribed in Section 42-1-360 of the Act, now desires to withdraw its election.

Date: _____, _____.

To the South Carolina Workers' Compensation Commission:

The undersigned employer, who has voluntarily elected to operate under the South Carolina Workers' Compensation Act, being previously exempt as prescribed under Section 42-1-360 of the Act, withdraws that election to operate under the Workers' Compensation Act.

As provided by law (Section 42-1-390), the employer must give notice in writing to the Commission that the business shall no longer operate under the S.C. Workers' Compensation Act.

This rejection takes effect sixty (60) days after the date it is received by the South Carolina Workers' Compensation Commission.

*** * PLEASE PRINT OR TYPE ALL INFORMATION * * ORIGINAL SIGNATURES REQUIRED * ***

SWORN TO AND SUBSCRIBED BEFORE ME at

EMPLOYER

this _____ of _____, _____

Name of Business (Legal Name)

Federal I.D. #

Street Address

Post Office Box

Notary Public for South Carolina

City

State

Zip Code

My Commission Expires: _____

By:

Name and Title

For Official Use Only:

Date Received: _____

Effective Date: _____

Approved By: _____

Telephone Number: _____

Signature of Employer Official

Date

Area Code

Telephone Number

Reference Summary: Sections 42-1-310, 42-1-380, and 42-1-390. For more information about the provisions of these Sections and this form, please contact the Commission at the address above.