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 Wisconsin law regarding these notices.

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

POSTERS

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

- **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.

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.

DWD-DWC Form WKC-12-E – Employer's First Report of Injury or Disease:

Use this form to report work-related injuries to Omaha National. Injuries resulting in death must be reported to us and the Workers' Compensation Division of the Wisconsin Department of Workforce Development within one day after the worker's death. Employers are required to notify us of other reportable work-related injuries and disability from occupational disease within seven days after the accident or the start of disability. Send the completed Form WKC-12-E to Omaha National at the same time you report the claim to us. Once the claim is reported, we will submit an electronic report to the Division on your behalf. Please note, you should promptly report **all injuries** to Omaha National, even those that only require first aid; sometimes an injury that seems minor at first can worsen and knowing about these Injuries allows us to manage them effectively.

DWD-DWC Form WKC-13-A-E – Wage Information Supplement:

This form may be used to provide information about an injured worker's wages. Send a completed copy to Omaha National at the same time you report the injury to us.

Incident, Supervisor, and Witness Reports:

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

EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

Fatal Injuries: Employers subject to ch.102, Wis. Stats., must report injuries resulting in death to the Department and to their insurance carrier, if insured, within one day after the death of the employee.
Non-Fatal Injuries: If the injury or occupational illness results in disability beyond the three-day waiting period, the employer, if insured, must notify its insurance carrier within 7 days after the injury or beginning of disability. Medical-only claims are to be reported to the insurance carrier only, not the Department.
Electronic Reporting Requirement: All work-related injuries and illnesses resulting in compensable lost time, with the exception of fatalities, must be reported electronically to the Department via EDI or Internet by the insurance carrier or self-insured employer within 14 days of the date of injury or beginning of disability. Employer may fax claims for fatal injuries to (608) 267-0394.

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
https://dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.

The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats. The purpose of this form is to assist with the procurement of information related to or required by Chapter 102. Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102. DWD may use the personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

(**Please read the instructions on page 2 for completing this form**)

EMPLOYEE

Employee Name (First, Middle, Last)	Social Security Number*	Sex ☐M ☐F	Employee Home Telephone No.

Employee Street Address	City	State	Zip Code	Occupation

Birthdate	Date of Hire	County and State Where Accident or Exposure Occurred?

EMPLOYER

Employer Name	WI Unemployment Ins. Acct No.	Self-Insured? ☐ Yes ☐ No	Nature of Business (Specific Product)

Employer Mailing Address	City	State	Zip Code	Employer FEIN -

Name of Worker's Compensation Insurance Co. or Self-Insured Employer	Insurer FEIN -

Name and Address of Third Party Administrator (TPA) Used by the Insurance Company or Self-Insured Employer	TPA FEIN -

WAGE INFORMATION

Wage at Time of Injury $	Specify per hr., wk., mo., yr., etc. Per:	In Addition to Wages, Check Box(es) if Employee Received: ☐ Meals ☐ Room ☐ Tips	No. of Meals/wk. No. of Days/wk Avg. Weekly Amt

Is Worker Paid for Overtime? ☐ Yes ☐ No If Yes, After How Many Hours of Work Per Week?

For the 52 Week Period Prior to the Week the Injury Occurred, Report Below the Number of Weeks Worked in the Same Kind of Work, and the Total Wages, Salary, Commission and Bonus or Premium Earned for Such Weeks.

No. of Weeks:	Gross Amount Excluding Tips: $	If Piece-Work, No. of Hrs. Excluding Overtime:

	Start Time	Hours Per Day	Hours Per Week	Days Per Week
Employee's Usual Work Schedule When Injured:	: ☐ AM ☐ PM			
Employer's Usual Full-Time Schedule for This Type of Work at Time of Employee's Injury:				

Part-Time Employment Information:	Are there Other Part-Time Workers Doing the Same Work With the Same Schedule? ☐ Yes ☐ No If Yes, how many?	Number of **Full-Time** Employees Doing The Same Type Of Work:

INJURY INFORMATION

Injury Date	Time of Injury : ☐AM ☐PM	Last Day Worked	Date Employer Notified	☐ Date Returned to Work ☐ Estimated Date of Return

Did Injury Cause Death? ☐ Yes ☐ No	Date of Death	Was This a Lost Time or Other Compensable Injury? ☐ Yes ☐ No	Did Injury Occur Because of: ☐ Substance Abuse ☐ Failure to Use Safety Devices ☐ Failure to Obey Rules

Was Employee Treated in an Emergency Room? ☐ Yes ☐ No Was Employee Hospitalized Overnight as an In-Patient? ☐ Yes ☐ No

Name and Address of Treating Practitioner and Hospital:

Case Number from the OSHA Log:

Injury Description - Describe Activities of Employee When Injury or Illness Occurred and What Tools, Machinery, Objects, Chemicals, Etc. Were Involved.

What Happened to Cause This Injury or Illness? (Describe How The Injury Occurred)

What Was The Injury or Illness? (State the Part of Body Affected and How It Was Affected)

Report Prepared By	Work Phone Number	Position	Date Signed

SEND REPORT IMMEDIATELY DO NOT WAIT FOR MEDICAL REPORT

EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS

The employer must complete all relevant sections on this form and submit it to the employer's worker's compensation insurance carrier or third party claim administrator within seven (7) days after the date of a work-related injury which causes permanent or temporary disability resulting in compensation for lost time. The employer's insurance carrier or the third-party claim's administrator may request that this form also be used to immediately report any injury requiring medical treatment, even though it does not involve lost work time.

For any work injury resulting in a **fatality**, the employer must also submit this form directly to the Department of Workforce Development **within 24 hours of the fatality**.

An employer exempt from the duty to insure under s. 102.28, Wis. Stats., and an insurance carrier administering claims for an insured employer are required to submit this form to the Department of Workforce Development within 14 days of the date of work injury.

MANDATORY INFORMATION

In order to accurately administer claims, each of the following sections of this form must be completed. The First Report of Injury will be returned to the sender if the mandatory information is not provided.

Employee Section: Provide all requested information to identify the injured employee. If an employee has multiple dates of employment, the "Date of Hire" is the date the employee was hired for the job on which he or she was injured.

Employer Section: Provide all requested information to identify the injured worker's employer at the time of injury. Provide the name and Federal Employer Identification Number (FEIN) for the insurance carrier or self-insured employer responsible for the worker's compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

Wage Information Section: Provide the information requested regarding the injured employee's wage and hours worked for the job being performed at the time of injury.

Injury Information Section: Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the body injured, the specific nature of the injury (i.e., fracture, strain, concussion, burn, etc.) and the use of any objects or tools (i.e., saw, ladder, vehicle, etc.) that may have caused the injury. Provide the name of the person preparing this report and the telephone number at which they may be reached, if additional information is needed. This form was designed to include information required by OSHA on form 301. If this section is completed and retained, the employer will not have to complete the OSHA 301 form.

WAGE INFORMATION SUPPLEMENT*

Use this form (WKC-13-A1-E) only for injuries occurring on or after April 10, 2022.

Insurers, including self-insured employers, must submit this form with the first **WKC-13 report** for each claim where TTD is less than the maximum rate in the year the injury occurred.

Read instructions on reverse carefully before completing.

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
Fax: (608) 267-0394
https://dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats. The purpose of this form is to assist with the procurement of information related to or required by Chapter 102. Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102. DWD may use the personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

Employee Name	Employee Social Security Number*	Date of Injury

Employer Name

Name of Insurance Company or Self-Insured Employer (do not list adjusting company)

Claims Handling Address (number, city, state, zip code)

Complete Section 4 for part-time employees (include anyone working less than 35 hours per week) before completing Sections 1 and 2.)

1. Hourly Wage — Multiply — Equals — Add — Equals

a. Hourly rate at time of injury:	x	b. Hours per week: (fill in "usual scheduled hours," check the box you use to set the wages)	=	c. Base weekly rate: (See reverse for computing rates for time and a half employees)	+	d. Additional weekly compensation from Section 3 below: (exclude tips)	=	e. Average weekly earnings: (hourly)
☐ Standard Base $_____ ☐ Piece Rate (if higher than the standard rate) ☐ Standard base rate plus tips Tip Rate only: $_____ Base + Tip $_____		☐ **Normal scheduled hours:** _____ Includes those hours paid at time-and-a-half: **(See Instructions)** _____ ☐ Actually Worked: (use with piece rate, or tips in Section 1a.) _____ ☐ Expand to Normal Full-time: _____ ☐ Average weekly hours (see sec 4c) _____ ☐ Seasonal: (See instructions) 44		$_____		$_____		$_____

2. Gross Wage — Divide — Equals — Add — Equals

a. Gross taxable wages in 52-week period prior to date of injury: (Exclude tips)	÷	b. Number of weeks worked in 52-week period prior to injury:	=	c. Base Gross Wage:	+	d. Additional weekly compensation from Section 3 below:	=	e. Actual average weekly earnings:
$_____		_____		$_____		$_____		$_____

3. Additions to Cash Wage Received by Employee Per Week (Mark any that apply)

☐ Free meals (Number/week) _____ Weekly Amount $_____		☐ Fuel Weekly Amount	$_____
☐ Room (Number of days/wk) _____ Weekly Amount $_____		☐ Lights Weekly Amount	$_____
☐ Tips Amount/Week $_____ (Add only to Section 2d., not 1d.)		☐ Other Weekly Amount	$_____
☐ House or Apartment Weekly Amt $_____ ☐ Check if this is continued during disability		**Total Weekly Value:**	**$_____**

4. Part-Time Employment (Worked less than 35 hrs/wk)

a. Does the claimant have employment outside of the employer at which the injury occurred?	b. Did the claimant work less than full-time for less than 12 months prior to the injury?	c. Average weekly hours worked in the 52 weeks prior to the injury	d. Does the employee restrict availability to less than full-time work?
☐ Yes ☐ No	☐ Yes ☐ No	_____	☐ Yes ☐ No

5. Weekly Wage and TTD Rate Computation — Multiply — Equals

a. Weekly Wage (Greater of #1 or #2 above) $_____	x	**b.** ☐ 66.67% **OR** ☐ 100% (use for non-expanded part-time employee)	=	c. Weekly TTD Rate: $_____

Insurance Claim Representative	Telephone Number

(See reverse side for instructions)

Instructions for Completing the Wage Information Supplement, Form WKC-13-A

These instructions will help you complete the WKC-13-A and compute the TTD rate correctly. If more help is needed, please contact a wage specialist at (608) 266-1340 or send an e-mail to **wcpendrpt@dwd.wisconsin.gov.** Section DWD 80.02(2)(c) of the Wis. Admin. Code requires insurers, including self-insured employers, to submit this form within 30 days after the injury. It must be submitted for every claim where the TTD rate is less than the maximum rate for the year the injury occurred. For a reference to the maximum rates, see our website at: **https://dwd.wisconsin.gov/dwd/publications/wc/WKC-9572-P.pdf**

Section 1a- Hourly Rate at Time of Injury: Enter the standard base rate at the time of injury. Include in the hourly rate any additional hourly amounts which the employee received at the time of injury, e.g., shift differentials. For employees receiving time-and-a-half, enter the standard base rate, not time and a half rate. If this employee did not have an hourly rate but had a weekly, bi-weekly or monthly salary and has scheduled hours of work, divide the salary by the number of hours worked in the pay period to arrive at the hourly rate. If an employee is paid solely by commission or by mileage or some other method where scheduled hours are not used, the TTD rate will be based only on gross earnings. In such a case, enter "NA" in Section 1 and go on to Section 2. For employees paid on a piece work basis, compute the hourly piece work rate by dividing the earnings from piece work by the number of hours actually worked while on piece rate. Exclude time and a half earnings and hours in this computation. Use the piece rate amount only if the resulting rate is higher than the standard hourly rate. If the employee received tips, compute the additional hourly amount of tips. Enter that amount next to **"tip rate"** and add the hourly tip rate to the standard hourly rate to get the "standard base rate plus tips". Compute the tip rate by dividing total tip earnings (only the earnings received in tips) by total hours actually worked on a tip basis. The total hourly rate must be at least the legal minimum hourly wage.

Section 1b- Hours Per Week: Enter the normal number of hours scheduled (regular fixed schedule) at the time of injury). Include the number of hours the employee is paid at the time and a half rate. If the employee does not have regular scheduled hours, enter the number of hours which full-time employees normally work for the employer in this occupation. Include scheduled hours paid at a time-and-a-half rate in the number of "normally scheduled hours". If scheduled hours vary by more than 5 hours from week to week during the 90-day period immediately preceding the injury, use the number of hours that is normal for full time employees for this occupation. Check the box "Actually Worked" in Section 1b and enter the hours actually worked if the hourly rate in Section 1a is piece rate or includes tips. Check the "seasonal" box with **44** hours entered for employees who meet the definition of **"seasonal"** employees in s.102.11(1)(b) Wis. Stats. Seasonal employment cannot exceed 14 weeks. For part time employees, follow the instructions in Section 4.

Section 1c- Base Weekly Rate: Multiply the hourly rate in Section 1a times the hours used in Section 1b. For employees who worked a time and a half schedule at the time of injury and at least 13 consecutive weeks immediately prior to the injury, use the following formula: multiply the standard rate times the normal scheduled hours excluding those hours paid at the time-and-a-half rate; then multiply the time and a half rate times the time and a half hours, and add the two results to get the Base Weekly Rate.

Sections 1d & 1e- Hourly Wages/Additions to Base Average Weekly Wages and Average Weekly Earnings: Enter here and in Section 2d (except for tips) the weekly value of any other type of compensation the employee received, as shown in Section 3.

Section 2a-e Gross Wages and Average Weekly Earnings Enter the gross wages and the number of weeks the employee worked on that job (same type of work) in the 52-week period prior to the date of injury. When counting weeks for Section 2b, do not Include the week of injury in the 52-week period. Count partial weeks as whole weeks. Include tips and additions to wages from Section 3 in section 2e. For employees who worked less than 6 weeks, TTD will be determined solely by the hourly rate in Section 1 or, if the employee does not have an hourly rate, by wages paid in a "same or similar" occupation. Enter "same or similar" wages in Section 2e and skip 2a, 2c and 2d. Complete the computations in Sections 2c, d and e for all others.

Section 3- Additions to Cash Wages: Enter the weekly value of any additional compensation paid to the employee. This value is added to the computations in Sections 1 and 2. The standard value of **"meals"** and **"room"** is set in Wis. Admin. Code DWD 80.29 and DWD 272. The value of all other items is set by common marketplace value to the employee.

Section 4a-d- Part-Time Employment: If a part-time employee has additional employment outside of the employer at which the injury occurred, check "yes" in Section 4a; their Average Weekly Wage will be calculated as if they are a full-time employee. Check the box "Expand to Normal Full-time" in Section 1 and enter the normal full-full time hours for the employer. If the answer in Section 4a is "no" move on to Section 4b and answer the question. Enter the average weekly hours for the 52 weeks prior to the injury in Section 4c, do not include any weeks in which no work was performed. If the answer to Section 4a is "no", check the box for "Average Weekly Hours Worked" in Section 1b and put this number in the space. In claims where the employee restrict availability to less than full-time work answer "yes" to Section 4d and attach a self-restriction statement or other evidence of the employee's choice to work less than full-time.

Section 5-- Wage and Rate Computation: Enter the wage used to compute the TTD rate (the higher amount from Section 1e or 2e). The rate in Section 5c is computed by multiplying the wage by either 66.67% or by 100% (used for non-expanded part-time employees).
Exception to using 100% in Section 5b: If using 100% in Section 5b exceeds 66.67% of the wages of a full-time employee doing this job, use 66.67% of wages (higher of 1e or 2e) after expanding the hours in Section 1b to full-time.
Exception Note: If this employee's employment situation is unique and you cannot use the computation formulas in Sections 1 and 2, indicate the wage and TTD rate in Section 5, and attach an explanation of how you computed the wage and TTD rate to this request.

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.

- **DWD-DWC Form WKC-9488-E – Voluntary and Informed Consent for Disclosure of Health Care Information:**
  The Workers' Compensation Division of the Wisconsin Department of Workforce Development designed this release form to be used to obtain the documents and records needed to process a claim. An injured worker uses this form to provide consent for the release of their medical information. Please have the injured worker sign this document and send a copy of the signed form to Omaha National when the injury is reported.

- **DWD-DWC Form WKC-12698-E – Statement of Self-Restriction to Part-Time Work:**
  This form is used to affirm the injured worker's part-time employment status. Have any part-time employees that are injured at work complete and sign this form. Then, send a copy to Omaha National when the injury is reported.

- **Consent and Authorization for Release of Information and Request for Medical History Forms:**
  These forms help us to obtain the information and records needed to handle a claim and to make sure that the injured worker receives the best possible medical care. Have the injured worker sign the forms and send them to Omaha National.

Injured Workers First Fill Prescription Form

Injured Worker _____ Date of Injury _____

Claim Number _____ Phone Number _____

Notice to Injured Worker and Pharmacy

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

Injured Worker Instructions

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

Pharmacy Instructions

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

Pharmacy Help Desk:
800-311-3446

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

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

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

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

Voluntary and Informed Consent for Disclosure of Health Care Information

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats. The purpose of this form is to assist with the procurement of information related to or required by Chapter 102. Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102. DWD may use the personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707
Telephone: (608) 266-1340
Fax: (608) 267-0394
https://dwd.wisconsin.gov/wc/
e-mail: DWDDWC@dwd.wisconsin.gov

By law, all health care providers must provide to any employee, employer, worker's compensation insurer or their representative any information reasonably related to any alleged work injury. However, determining the relationship of prior medical records to a work injury can be difficult and time-consuming. Therefore, to assist in the timely investigation of your claim, this document authorizes the health care provider to release medical information without attempting to determine the extent of its relationship to your alleged work injury.

You are not required to sign this document. You may refuse to sign this document without jeopardizing your right to collect worker's compensation benefits. However, by assisting in the investigation of your claim, you are likely to receive benefits quicker than if you refuse to authorize the release of medical information.

Health Care Provider Name		Street Address	
P.O. Box	City	State	Zip Code
Patient (Employee) Name	Employer Name		
Patient Social Security Number*	Patient Birth Date	WC Claim No.	

The patient named above hereby authorizes the health care provider named above to disclose all records checked below in its possession relating to the patient's health, treatment and evaluation to:

Name and Address of Party Authorized to Receive Protected Information

or its designated representatives, and to furnish to them a legible, certified duplicate of all records, writings, reports, test results and x-rays in its possession containing such information. This authorization includes *all* records, reports, correspondence, or other materials in the possession of the health care provider authorized, even if those materials were not generated by the health care provider, and the redisclosure of such materials is hereby authorized. This release is for use in the investigation, preparation, evaluation, and/or hearing of the worker's compensation claim described above.

CHECK ONE:

☐ **A.** **Physical Only**. Release all records, correspondence, and any other information from whatever source regarding the patient's physical health, treatment and evaluation including, but not limited to, any made or provided by any physician, nurse, chiropractor, osteopath, dentist, physical therapist, hospital, or any other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited to Wis. Stat. §§ 146.81 and 146.82, and 45 C.F.R. § 164.508.

☐ **B.** **Physical and Other**. Release all records, correspondence, and any other information from whatever source regarding the patient's physical and mental health, drug and alcohol abuse, HIV and AIDS tests, treatment, and evaluation including, but not limited to, any made or provided by any physician, psychiatrist, psychologist, nurse, chiropractor, osteopath, dentist, physical therapist, hospital or any other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited Wis. Stat. §§ 51.30, 146.025, 146.81 and 146.82, 42 C.F.R., Chap. 1, subpart C, § 2.31 and 45 C.F.R. § 164.508.

Patient Signature (or Person Authorized to Sign for Patient) — for Option B

Patient Signature (or Person Authorized to Sign for Patient)	Date Signed

In signing this consent form, I acknowledge that I understand that:

- I am authorizing release of the records and information listed above.
- I am waiving any privilege that may otherwise prevent disclosure of the records and information listed above.
- I understand that the health care provider named above, whom I am authorizing to disclose my protected health information, may not condition my treatment, payment, enrollment or eligibility for benefits (if applicable) on whether I sign this authorization, except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.
- I may revoke this authorization at any time by written request to the party authorized above to receive information. However, I understand that my revocation is not effective with respect to actions a covered entity took in reliance on this authorization or as needed for an insurer to contest a claim/policy authorized by law if signing the authorization was a condition to obtaining insurance coverage.
- I may obtain a copy of the disclosed records and information, upon written request to the party authorized above to receive information, at no charge to me.
- My personal health information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by federal law. My personal health information may be released to any of the following: the employer, the worker's compensation insurer, the Department of Workforce Development, other parties to this matter or their attorneys; the Labor and Industry Review Commission; any court on any action or proceeding relating to this matter; experts retained or consulted by any party; and any of their agents, employees, or representatives. I specifically authorize and consent to any such disclosure and redisclosure.
- I am entitled to a copy of this consent form after I sign it.

If you have any questions about this document, you should contact the Worker's Compensation Division at (608) 266-1340. You should not sign this document if the name of the health care provider is blank.

This consent is subject to revocation at any time. If not revoked, this consent is effective for two (2) years from date signed. This authorization expressly waives any requirement that it must be used within a certain number of days after the date of signing, or that it must be dated within any time period before the date it is used. This authorization shall also extend to records of future treatment, after the date of signing of this authorization, as long as such treatment occurs while this authorization is still in effect. A photocopy copy shall be as valid as the original.

Patient Signature (or Person Authorized to Sign for Patient)	Date Signed
If not signed by patient, authority/designation to sign is based on the fact that the patient is ☐ A minor ☐ Incompetent ☐ Disabled ☐ Deceased ☐ Other:	

Department of Workforce Development
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201 E. Washington Ave., Rm. C100
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Telephone: (608) 266-1340
Imaging Fax Server: (608) 260-2503
Fax: (608) 267-0394
https://dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

STATEMENT OF SELF-RESTRICTION TO PART-TIME WORK

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats. The purpose of this form is to assist with the procurement of information related to or required by Chapter 102. Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102. DWD may use the personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

EMPLOYEE NAME:

EMPLOYEE S.S. #*:

DATE OF INJURY:

This form is needed to properly compute the wage for your Worker's Compensation benefits. Please answer the following questions, sign, date and return to your insurance carrier or self-insured employer.

1. At the time of your injury, did you limit your availability in the labor market to part-time work or to work only with the employer where you were injured?
☐ Yes ☐ No

   If Yes, explain your limitation:

2. At the time of your injury, were you also employed by another employer or self-employed?
☐ Yes ☐ No

   If Yes, please provide us with the name and address of your other employer below:

   Employer Name:

   Employer Address:

Signed_____ Dated_____

Phone Number: (_____) _____ - _____
Area Code

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

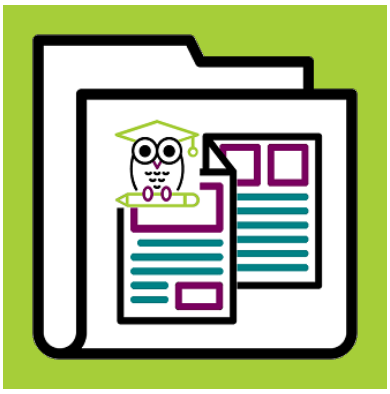
Hospitalizations and Surgical Procedures			
Date(s)	Diagnosis/Treatment/Procedure	Doctor	Hospital

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.

- **DWD-DWC Brochure WKC-7317-P – Wisconsin Worker's Compensation Law: Employer Facts:**
  This document from the Division of Workers' Compensation was designed to provide general information and guidance on the requirements for employers under the Wisconsin workers compensation laws.

Contact Information

Claims:

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

Reduce Your Workers Compensation Costs

Injury Prevention and Safety Training

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

Report Injuries Immediately

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

Ways to report an injury:

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

High-Quality Medical Care

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

Establish a Return-To-Work Program

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

Is There Any Penalty For Negligence By The Employer Or The Employee?

Negligence, either by the employer or employee, is not an issue except when the injury occurs because:

- An employer violated a safety order/statute and/or, disobeyed an established safety rule resulting in the employer possibly being liable for a 15 percent increase in compensation, up to a maximum of $15,000.
- An employee fails to use safety devices that are provided by the employer and that are adequately maintained, and the use of which is reasonably enforced by the employer resulting in the employee's compensation possibly being reduced by 15 percent with a maximum reduction of $15,000.
- An employee violated the employer's drug and/or alcohol policy and there is direct causation between the violation and the workplace injury. Under this circumstance, medical expense is due, but no wage replacement or death benefits are payable to the employee or his/her dependents.

What Injuries Must An Employer Report?

All employers must report, by phone, all work-related fatalities to the Worker's Compensation Division, Madison Office, (WC-Madison) within 24 hours. All employers must also report all work-related fatalities to their insurance carrier within 24 hours. Additionally:

- Employers are required to provide the WC-Madison, with U.S. Department of Labor – Occupational Safety and Health Administration (OSHA) survey information when requested.
- Insured employers must report any claim of an injury to their insurance carrier within 7 days.
- Self-insured employers and insurance carriers must report the following to the WC-Madison:
  - Injuries that result in time lost from work 4 days or more after the date of injury. Except in the case of fatalities, such reports must be made electronically within 14 days after the injury.
  - Claim payment and wage-related information within 30 days after injury, with some exceptions. Exceptions to electronic reporting are for litigated, permanent total disability and fatal claims.
  - A final treating practitioner's medical report for injuries resulting in disabilities of more than 3 weeks, any permanent disability, surgery other than to correct a hernia or eye injuries requiring medical treatment on 3 or more occasions off the employer's premises.

What Are The Penalties For Not Filing Injury Reports?

If an employer intentionally fails to file a report of injury, the employer may be assessed a penalty for bad faith up to 200% of compensation due up to a $30,000 maximum. An employer may be assessed a 10% penalty payable to the injured worker for delay in reporting an injury that causes an untimely payment.

Who Picks The Doctor For Treatment?

The employee has the right to select any physician, psychologist, podiatrist, dentist, chiropractor, physician assistant or advanced practice nurse prescriber, unless there is an emergency. The employee has the right to a provider of second choice through notice to the employer or insurer. An employer may require an employee to submit to reasonable medical examinations for the purpose of reviewing claims for compensation. Out-of-state treatment requires an insurer's consent, unless it is based upon a referral from an in-state provider.

Is The Injured Employee Guaranteed A Job?

The employer may not "unreasonably" refuse to rehire an injured employee, if suitable employment is available within the employee's physical and mental limitations. If the employer has suitable employment available and unreasonably refuses to rehire the worker, the employer is liable for any lost wages, up to a total of one year's wages. The employer is not required to hold or create a job to guarantee the employee a job after an injury.

What If I Suspect Fraud?

dwd.wisconsin.gov/wc/insurance/fraud/

If you suspect fraud from an employee, employer, medical provider or insurance carrier, you may report it to the Worker's Compensation Division. The Division has an agreement with the Department of Justice for assistance with investigating and prosecuting fraud.

Questions about Worker's Compensation should be directed to:

Wisconsin Department of Workforce Development
Worker's Compensation Division
Room C100
201 E. Washington Avenue
P.O. Box 7901
Madison, WI 53707-7901

(608) 266-1340
(608) 267-0394 (Fax)

Website: dwd.wisconsin.gov/wc/

DWD is an equal opportunity employer and service provider. If you have a disability and need assistance with this information, please dial 7-1-1 for Wisconsin Relay Service. Please contact the Workers Compensation Division at (608) 266-1340 to request information in an alternate format, including translated to another language.

WKC-7317-P (R 4/2017)

Wisconsin Worker's Compensation Law

EMPLOYER FACTS

STATE OF WISCONSIN
DWD
Department of Workforce Development

Worker's Compensation

What Is Worker's Compensation?

dwd.wisconsin.gov/dwd/publications/wc/WKC_13328_P.pdf

Worker's compensation is a system of no-fault insurance that pays benefits to employees for injuries or diseases related to the employee's work. In return for prompt and certain payment of benefits to an employee, an employer's liability is limited.

Who Must Have Worker's Compensation Insurance?

Most Wisconsin employers are required by law to have worker's compensation insurance, including:

- Employers who employ 3 or more workers on a full-time or part-time basis must have insurance.
- Employers who employ 1 or more workers on a full-time or part-time basis and who pay gross, combined wages of $500 or more in any calendar quarter for work done in Wisconsin must have insurance by the 10th day of the first month of the next calendar quarter.
- Farmers employing 6 or more workers on any 20 days during a calendar year must have insurance 10 days after the 20th day of employment.

Are There Any Exemptions?

There are special provisions in the law covering independent contractors. An independent contractor, sub-contractor or owner/operator may actually be a statutory employee of the employer for whom he or she is working, unless they meet the Workers Compensation 9-point test under s. 102.07(8)(b) of the Wisconsin statutes. An independent contractor, sub-contractor or owner/operator who employs others must provide insurance for employees, as well as obtain insurance in his or her personal or trade name. No employer may elect to be under the insurance coverage of another employer or contractor. Independent contractors who do not have employees or who are not required to be insured may choose to purchase insurance for self-coverage. The policy must be endorsed to name the sole proprietor or partners for them to be covered. Employers and independent contractors may purchase insurance without personal benefit coverage. Find more online at:

dwd.wisconsin.gov/dwd/publications/wc/WKC_13324_P.pdf

In addition, there are specific provisions under s. 452.38 for a real estate broker, agent or salesperson that may exempt them from the Act. For more information, visit:

dwd.wisconsin.gov/dwd/publications/wc/WKC_10466_P.pdf

How About Sole Proprietors, Partners and Limited Liability Companies?

dwd.wisconsin.gov/dwd/publications/wc/WKC_13964_P.pdf

Sole proprietors, partners and members of limited liability companies are not considered or counted as employees. Generally, policies exclude sole proprietors, partners and members of limited liability companies, unless they are specifically endorsed to include them. Sole proprietors, partners and members of limited liability companies may voluntarily purchase insurance to cover their own work-related injuries and illnesses.

What About Corporations?

Corporate officers are employees. Generally, policies covering corporations include corporate officers. In closely held corporations with not more than 10 stockholders, no more than 2 officers can be excluded from insurance coverage. If the corporation has other employees and/or officers, a policy is required and the election must be made by endorsement on the worker's compensation policy. Officers who have made this election will still be counted in determining whether the employer is subject to the Worker's Compensation Act. If a closely held corporation has no more than 2 corporate officers and has no other employees, a worker's compensation policy is not required, if both officers elect not to be subject to the Worker's Compensation Act. This election must be completed by filing a Corporate Officer Option Notice with the Worker's Compensation Division.

Who Pays For Worker's Compensation Insurance?

The employer pays for the insurance and may not withhold, deduct or collect payment for premiums from any employee or any other person. Agreements made by employees who waive rights to compensation are not valid.

What Will Insurance Cost and Where Do Employers Get It?

wcrb.org

The cost of insurance will vary and is based on payroll. The amount due is determined through approximately 650 separate job classifications rated on past experience in the industry. Insurance will cost more for most hazardous occupations. With approval of the Commissioner of Insurance, rates are set statewide by the Wisconsin Compensation Rating Bureau (WCRB). To obtain a policy, there are approximately 400 insurance companies licensed to write Worker's Compensation insurance in Wisconsin. If any insurance carrier denies your application for insurance, you may apply to another carrier or to the WCRB for assigning an insurer to write a policy for you. The cost is the same for assigned coverage.

Contact WCRB:

20700 W. Swenson Drive, Suite 100
Waukesha, WI 53186

(262) 796-4540

What Is Self-Insurance?

Approximately 180 private sector and 55 municipal employers are self-insured. Self-insured entities pay their claims using their own funds, instead of purchasing insurance. Self-insurers must have written approval from the Worker's Compensation Division before becoming self-insured. The approval process includes submitting an application with 5 years of audited financial data and documentation demonstrating expertise in safety and claims management. Self-insurers are required to have excess insurance and other security to protect against potential claims.

What Are The Penalties For Failure To Insure?

The penalty for any lapse in worker's compensation coverage is twice the amount of premium not paid during the uninsured time period or $750, whichever is greater. An employer who has a coverage lapse of 7 consecutive days or less is subject to a $100 penalty for each uninsured day up to 7 days, if the employer has not previously had an illegal lapse in coverage and that no injury occurred during the uninsured period. In addition, employers that fail to obtain required insurance may be ordered by the Worker's Compensation Division to cease operations until coverage is obtained.

What If An Injury Occurs Without A Policy?

dwd.wisconsin.gov/wc/employers/uef_info_doc.htm

The Uninsured Employers Fund (UEF) pays benefits on valid claims filed by employees who are injured while working for illegally uninsured employers. When an employee files a compensable claim, the UEF pays benefits as if the uninsured employer had been insured. The uninsured employer is required to reimburse the UEF for all costs of a paid claim. The uninsured employer is personally liable to reimburse the UEF for benefit payments to an injured employee. Aggressive collection, including warrants, levies, garnishment and execution against property, are used to ensure reimbursement. The normal exemptions of property from seizure and sale on execution of a judgment do not apply to uninsured employers.

What Benefits Are Payable To An Injured Employee?

- All reasonable and necessary medical costs.
- Lost time benefits for wage loss (temporary disability) while recovering from an injury. These are based on two-thirds of the employee's wage rate up to a specified maximum.
- Benefits for permanent disability, if the employee does not fully recover from the injury. The amount of benefit depends on the severity of the permanent disability.
- Job retraining or placement.
- Death benefits and burial expenses up to specific limits.

What Liability Is Covered Under A Policy?

Any worker's compensation insurance policy covers liability for compensation and medical expenses for all employees. Policies do not cover:

- Penalties for false reporting.
- Penalties for refusal to rehire an injured employee, if otherwise medically able.
- Increased penalties for safety violations.
- Illegal employment of a minor.
- Penalties for untimely payments caused by delays in reporting.

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

Section C—Description of Transaction(s)

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

– If this is a partial sale, transfer, or conveyance of an existing business (e.g., sale of one or more plants or locations), explain what portion or location of the entire operation was sold, transferred, or conveyed.

– If any of the entities that underwent a change in ownership were related through common ownership to any other entity before the transaction described above, list the entities and their current owners' names and percentages of ownership below.

_____

_____

_____

_____

Section D—Business Entity Information

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

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

Section E—Certification

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

Signature of Owner, Partner, Member, or Executive Officer **Title** **Business Name**

Print name of above signature **Date**

Company Contacts Verification

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

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

General Information

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

Company Contacts for Invoice Questions/Issues

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

Company Contacts for Payroll Questions/Issues

☐ Check if same as above

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

Company Contacts for Policy Questions/Issues

☐ Check if same as above

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

Company Contacts for Claims Questions/Issues

☐ Check if same as above

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

Submitter Information

Completed by _____ Date _____
Title _____ Signature _____

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