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 Arizona 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.

- **Notice to Employees: Arizona Workers' Compensation Law:**
  This document serves as the mandatory workers compensation posting notice. It must be posted in both English and Spanish. To complete the form, enter the policy number and select the appropriate insurer name from the dropdown list.

- **Notice to Employees: Work Exposure to Bodily Fluids (HIV, AIDS, Hepatitis C) and Notice to Employees: Work Exposure to MRSA, Spinal Meningitis, or Tuberculosis (TB):**
  Post these immediately next to the Notice to Employees: Arizona Workers' Compensation Law poster.

- **Minimum Wage Poster and Earned Paid Sick Time Poster:**
  These posters provide important information regarding rights and requirements under the Arizona Fair Wages and Healthy Families Act.

- **Employee Safety and Health Protection Poster:**
  This poster informs employees of the protections and obligations within the Arizona Occupational Safety and Health Act of 1972. The poster must be printed on legal-sized (8½ × 14-inch) paper.

- **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.

TO BE POSTED BY EMPLOYER **POLICY NUMBER** _____

NOTICE TO EMPLOYEES

RE: ARIZONA WORKERS' COMPENSATION LAW

All employees are hereby notified that this employer has complied with the provisions of the Arizona Workers' Compensation Law (Title 23, Chapter 6, Arizona Revised Statutes) as amended, and all the rules and regulations of The Industrial Commission of Arizona made in pursuance thereof, and has secured the payment of compensation to employees by insuring the payment of such compensation with: Omaha National Underwriters for (Select Insurer Name)

Address - P.O. Box 451139, Omaha, NE 68145 Phone Number - 844-761-8400

All employees are hereby further notified that in the event they do not specifically reject the provisions of the said compulsory law, they are deemed by the laws of Arizona to have accepted the provisions of said law and to have elected to accept compensation under the terms thereof; and that under the terms thereof employees have the right to reject the same by written notice thereof prior to any injury sustained, and that the blanks and forms for such notice are available to all employees at the office of this employer.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

PARA SER COLOCADO POR EL PATRON **NUMERO DE POLIZA** _____

AVISO A LOS EMPLEADOS

RE: LEY DE COMPENSACION PARA LOS TRABAJADORES DE ARIZONA

A todos los empleados se les notifica por este medio que este patron ha cumplido con las provisiones de la Ley de Compensacion para los Trabajadores de Arizona (Titulo 23, Capitulo 6, Estatutos Enmendados de Arizona) tal como han sido enmendados, y con todas las regias y ordenanzas de La Comision Industrial de Arizona hechas en cumplimiento de esta, y ha asegurado el pago de compensacion a los empleados garantizando el pago de dicha compensacion por medio de: Omaha National Underwriters for (Select Insurer Name)

Address - P.O. Box 451139, Omaha, NE 68145 Phone Number - 844-761-8400

Ademas, a todos los empleados se les notifica por este medio que en caso de que especificadamente ellos no rechazen las disposiciones de dicha ley obligatoria, se les considerara bajo las leyes de Arizona de haber aceptado las provisiones de dicha ley y de haber escogido aceptar la compensacion bajo estos terminos; tambien bajo estos terminos los empleados tienen el derecho de rechazar la misma por medio de una notificacion por escrito antes de que sufran alguna lesion, todos los formularios o formas en blanco para tal notificacion por escrito estaran disponibles para todos los empleados en la oficina de este patron.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

KEEP POSTED IN A CONSPICUOUS PLACE.

COLOQUESE EN LUGAR VISIBLE.

WORK EXPOSURE TO BODILY FLUIDS

NOTICE TO EMPLOYEES

Re: Human Immunodeficiency Virus (HIV),
Acquired Immune Deficiency Syndrome (AIDS) & Hepatitis C

Employees are notified that a claim may be made for a condition, infection, disease, or disability involving or related to the Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or Hepatitis C within the provisions of the Arizona Workers' Compensation Law, and the rules of The Industrial Commission of Arizona. Such a claim shall include the occurrence of a significant exposure at work, which generally means contact of an employee's ruptured or broken skin or mucous membrane with a person's blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. **AN EMPLOYEE MUST CONSULT A PHYSICIAN TO SUPPORT A CLAIM.** Claims cannot arise from sexual activity or illegal drug use.

Certain classes of employees may more easily establish a claim related to HIV, AIDS, or Hepatitis C if they meet the following requirements:

1. The employee's regular course of employment involves handling or exposure to blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. Included in this category are health care providers, forensic laboratory workers, fire fighters, law enforcement officers, emergency medical technicians, paramedics and correctional officers.

2. **NO LATER THAN TEN (10) CALENDAR DAYS** after a possible significant exposure which arises out of and in the course of employment, the employee reports in writing to the employer the details of the exposure as provided by Commission rules. Reporting forms are available at the office of this employer or from the Industrial Commission of Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 or 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5181. If an employee chooses not to complete the reporting form, that employee may be at risk of losing a prima facie claim.

3. **NO LATER THAN TEN (10) CALENDAR DAYS** after the possible significant exposure the employee has blood drawn, and **NO LATER THAN THIRTY (30) CALENDAR DAYS** the blood is tested for **HIV OR HEPATITIS C** by antibody testing and the test results are negative.

4. **NO LATER THAN EIGHTEEN (18) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are HIV positive or the employee has been diagnosed as positive for the presence of HIV, or **NO LATER THAN SEVEN (7) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are positive for the presence of Hepatitis C or the employee has been diagnosed as positive for the presence of Hepatitis C.

KEEP POSTED IN CONSPICUOUS PLACE
NEXT TO WORKERS' COMPENSATION NOTICE TO EMPLOYEES

THIS NOTICE IS APPROVED BY THE INDUSTRIAL
COMMISSION OF ARIZONA FOR CARRIER USE

WORK EXPOSURE TO METHICILLIN-RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA), SPINAL MENINGITIS, OR TUBERCULOSIS (TB)

Notice to Employees

Employees are notified that a claim may be made for a condition, infection, disease or disability involving or related to MRSA, spinal meningitis, or TB within the provisions of the Arizona Workers' Compensation Law. (A.R.S. § 23-1043.04) Such a claim shall include the occurrence of a significant exposure at work, which is defined to mean an exposure in the course of employment to aerosolized MRSA, spinal meningitis or TB bacteria. Significant exposure also includes exposure in the course of employment to MRSA through bodily fluids or skin.

Certain classes of employees (as defined below) may more easily establish a claim related to MRSA, spinal meningitis or TB by meeting the following requirements:

1. The employee's regular course of employment involves handling or exposure to MRSA, spinal meningitis or TB. For purposes of establishing a claim under this section, "employee" is limited to firefighters, law enforcement officers, correction officers, probation officers, emergency medical technicians and paramedics who are not employed by a health care institution;

2. No later than thirty (30) calendar days after a possible significant exposure, the employee reports in writing to the employer the details of the exposure;

3. A diagnosis is made within the following time-frames:

    a. For a claim involving MRSA, the employee must be diagnosed with MRSA within fifteen (15) days after the employee reports pursuant to Item No. 2 above;

    b. For a claim involving spinal meningitis, the employee must be diagnosed with spinal meningitis within two (2) to eighteen (18) days of the possible significant exposure; and

    c. For a claim involving TB, the employee is diagnosed with TB within twelve (12) weeks of the possible significant exposure.

Expenses for post-exposure evaluation and follow-up, including reasonably required prophylactic treatment for MRSA, spinal meningitis, and TB is considered a medical benefit under the Arizona Workers' Compensation Act for any significant exposure that arises out of and in the course of employment if the employee files a claim for the significant exposure or the employee reports in writing the details of the exposure. Providing post-exposure evaluation and follow-up, including prophylactic treatment, does not, however, constitute acceptance of a claim for a condition, infection, disease or disability involving or related to a significant exposure.

Employers must post this notice in a conspicuous place next to the Workers' Compensation Notice to Employees.

THE FAIR WAGES AND HEALTHY FAMILIES ACT

Effective January 1, 2024, Arizona's Minimum Wage Is:

$14.35 per hour

EXEMPTIONS:

The Fair Wages and Healthy Families Act (the "Act") does not apply to any person who is employed by a parent or a sibling; any person who is employed performing babysitting services in the employer's home on a casual basis; any person employed by the State of Arizona or the United States government; or any person employed in a small business that grosses less than $500,000 in annual revenue, if that small business is exempt from having to pay a minimum wage under section 206(a) of title 29 of the United States Code.

TIPS AND GRATUITIES:

For any employee who customarily and regularly receives tips or gratuities, an employer may pay tipped employees a maximum of $3.00 per hour less than the minimum wage if the employer can establish by its records that for each week, when adding tips received to wages paid, the employee received not less than the minimum wage for all hours worked. Certain other conditions must be met.

RETALIATION & DISCRIMINATION PROHIBITED:

Employers are prohibited from discriminating against or subjecting any person to retaliation for: (1) asserting any claim or right under the Act; (2) assisting any person in doing so; or (3) informing any person of their rights under the Act.

ENFORCEMENT:

Any person or organization may file a complaint with the Industrial Commission's Labor Department alleging that an employer has violated the Act. Certain time limits apply. A civil action may also be filed as provided in the Act. Violations of the Act may result in penalties.

INFORMATION:

For additional information regarding the Act, you may refer to the Industrial Commission's website at www.azica.gov or contact the Industrial Commission's Labor Department: 800 W. Washington, Phoenix, Arizona 85007-2022; (602) 542-4515.

THIS POSTER MUST BE CONSPICUOUSLY DISPLAYED IN A PLACE THAT IS ACCESSIBLE TO EMPLOYEES

THE FAIR WAGES AND HEALTHY FAMILIES ACT

Earned Paid Sick Time

EXEMPTIONS: The Fair Wages and Healthy Families Act (the "Act") does not apply to any person who is employed by a parent or a sibling; any person who is employed performing babysitting services in the employer's home on a casual basis; or any person employed by the State of Arizona or the United States government.

ENTITLEMENT AND AMOUNT: Beginning July 1, 2017, employees are entitled to earned paid sick time and accrue a minimum of one hour of earned paid sick time for every 30 hours worked, subject to the following limitations:

- Employees whose employers have less than 15 employees may only accrue or use 24 hours of earned paid sick time per year.
- Employees whose employers have 15 or more employees may only accrue or use 40 hours of earned paid sick time per year.

Employers are permitted to select higher accrual and use limits.

TERMS OF USE: Earned paid sick time may be used for the following purposes: (1) medical care or mental or physical illness, injury, or health condition; or (2) a public health emergency; and (3) absence due to domestic violence, sexual violence, abuse, or stalking. Employees may use earned paid sick time for themselves or for family members. *See* Arizona Revised Statutes § 23-373 for more information.

RETALIATION & DISCRIMINATION PROHIBITED: Employers are prohibited from discriminating against or subjecting any person to retaliation for: (1) asserting any claim or right under the Act, including requesting or using earned paid sick time; (2) assisting any person in doing so; or (3) informing any person of their rights under the Act.

ENFORCEMENT: Each employee has the right to file a complaint with the Industrial Commission's Labor Department alleging that an employer has violated the Act. Certain time limits apply. A civil action may also be filed as provided in the Act. Violations of the Act may result in penalties.

INFORMATION: For additional information regarding the Act, you may refer to the Industrial Commission's website at www.azica.gov or contact the Industrial Commission's Labor Department: 800 W. Washington, Phoenix, Arizona 85007-2022; (602) 542-4515.

THIS POSTER MUST BE CONSPICUOUSLY POSTED IN A PLACE THAT IS ACCESSIBLE TO EMPLOYEES

EMPLOYEE SAFETY AND HEALTH PROTECTION

The Arizona Occupational Safety and Health Act of 1972 (Act), provides safety and health protection for employees in Arizona. The Act requires each employer to furnish his employees with a place of employment free from recognized hazards that might cause serious injury or death. The Act further requires that employers and employees comply with all workplace safety and health standards, rules and regulations promulgated by the Industrial Commission. The Arizona Division of Occupational Safety and Health (ADOSH), a division of the Industrial Commission of Arizona, administers and enforces the requirements of the Act.

As an employee, you have the following rights:

You have the right to notify your employer or ADOSH about workplace hazards. You may ask ADOSH to keep your name confidential.

You have the right to request that ADOSH conduct an inspection if you believe there are unsafe and/or unhealthful conditions in your workplace. You or your representative may participate in the inspection.

If you believe you have been discriminated against for making safety and health complaints, or for exercising your rights under the Act, you have a right to file a complaint with ADOSH within 30 days of the discriminatory action. You are also afforded protection from discrimination under the Federal Occupational Safety and Health Act and may file a complaint with the U.S. Secretary of Labor within 30 days of the discriminatory action.

You have the right to see any citations that have been issued to your employer. Your employer must post the citations at or near the location of the alleged violation.

You have the right to protest the time frame given for correction of any violation.

You have the right to obtain copies of your medical records or records of your exposure to toxic and harmful substances or conditions.

Your employer must post this notice in your workplace.

The Industrial Commission and ADOSH do not cover employers of household domestic labor, those in maritime activities (covered by OSHA), those in atomic energy activities (covered by the Atomic Energy Commission) and those in mining activities (covered by the Arizona Mine Inspector's office). To file a complaint, report an emergency or seek advice and assistance from ADOSH, contact the nearest ADOSH office:

Phoenix:
800 West Washington
Phoenix AZ. 85007
602-542-5795
Toll free: 855-268-5251

Tucson:
2675 East Broadway
Tucson, AZ. 85716
520-628-5478
Toll free: 855-268-5251

Industrial Commission web site: www.ica.state.az.us

Note: Persons wishing to register a complaint alleging inadequacy in the administration of the Arizona Occupational Safety and Health plan may do so at the following address:

U.S. Department of Labor – OSHA
230 N. 1st Ave., Ste. 202
Phoenix, AZ 85003
Telephone: 602-514-7250

Revised 10/11

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.

ICA 04-0101 - Employer's Report of Industrial Injury:

Employers are required to report workplace accidents and injuries to Omaha National and the Claims Division at the Arizona Industrial Commission within ten days after receiving notice of an accident. When an accident results in the death of a worker, the accident must be reported no later than the next business day following the death.

ICA 2212 - Serious Event Reporting Form:

Arizona law also requires employers to report serious injuries and deaths to the Division of Occupational Safety and Health at the Arizona Industrial Commission. All work-related fatalities must be reported within eight hours following the incident and all work-related inpatient hospitalizations, all amputations, and all losses of an eye must be reported within twenty-four hours.

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 REPORT OF INDUSTRIAL INJURY

COMPLETE AND SUBMIT THIS REPORT WITHIN 10 DAYS FROM NOTICE OF ACCIDENT. FATALITIES MUST BE REPORTED WITHIN 24 HOURS.

Employer must, on this form, notify his insurance carrier of every injury or disease suffered by an employee, fatal or otherwise, which is claimed to arise out of or in the course of employment.
ARIZONA REVISED STATUTES 23-908 & 23-1061

INDUSTRIAL COMMISSION OF ARIZONA
P.O. BOX 19070
PHOENIX, ARIZONA 85005-9070

FOR CARRIER USE ONLY

FOR OSHA PURPOSES ONLY

OSHA Case #: _____

RECORDABLE INJURY _____

NON-RECORDABLE INJURY _____

EMPLOYEE

1. LAST NAME | FIRST | M.I. | 2. SOCIAL SECURITY NUMBER * | 3. BIRTH DATE

4. HOME ADDRESS (NUMBER & STREET) | CITY | STATE | ZIP CODE | 5. TELEPHONE

6. SEX ◯ MALE ◯ FEMALE | 7. MARITAL STATUS: ◯ SINGLE ◯ MARRIED ◯ DIVORCED ◯ WIDOWED

EMPLOYER

8. EMPLOYER'S NAME | 9. POLICY NUMBER | 10. NATURE OF BUSINESS (MANUFACTURING, ETC.)

11. OFFICE ADDRESS (NUMBER & STREET) | CITY | STATE | ZIP CODE | 12. TELEPHONE

ACCIDENT

13. DATE OF INJURY OR ILLNESS | 14. TIME OF EVENT | 15. TIME EMPLOYEE BEGAN WORK | 16. DATE EMPLOYER NOTIFIED OF INJURY

17. LAST DAY OF WORK AFTER INJURY | 18. DATE OF RETURN TO WORK | 19. EMPLOYEE'S OCCUPATION (JOB TITLE) WHEN INJURED

20. CLASS CODE ON PAYROLL REPORT | 21. EMPLOYEE'S ASSIGNED DEPARTMENT | 22. DEPARTMENT NUMBER | 23. DID INJURY OCCUR ON EMPLOYER PREMISES? ◯ YES ◯ NO

24. ADDRESS OR LOCATION OF ACCIDENT | CITY | COUNTY | STATE | ZIP CODE

25. WHAT WAS THE INJURY OR ILLNESS? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or sore." *Examples:* "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."

26. PART OF BODY INJURED | 27. FATAL ◯ YES ◯ NO | 28. IF THE EMPLOYEE DIED, WHEN DID THE DEATH OCCUR? DATE OF DEATH

29. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? ◯ YES ◯ NO | NAME OF PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL | ADDRESS | CITY | STATE | ZIP CODE

30. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? ◯ YES ◯ NO | IF HOSPITALIZED, HOSPITAL NAME | ADDRESS | CITY | STATE | ZIP CODE

31. IS VALIDITY OF CLAIM DOUBTED ◯ YES ◯ NO | 31.a IF YES, STATE REASON

CAUSE OF ACCIDENT

32. **WHAT HAPPENED?** Tell us how the injury occurred. *Examples:* "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."

33. **WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE?** *Examples:* "concrete floor"; "chlorine"; "radial arm saw." *If this question does not apply to the incident, leave it blank.*

34. **WHAT WAS EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."

35. IF ANOTHER PERSON NOT IN COMPANY EMPLOY CAUSED ACCIDENT, GIVE NAME AND ADDRESS

EMPLOYEE'S WAGE DATA

36. WAS WORKER IN YOUR EMPLOY WHEN INJURED? ◯ YES ◯ NO | 37. HOURS PER DAY EMPLOYEE WORKED FROM THRU | 38. WAS EMPLOYEE ON OVERTIME WHEN INJURED? ◯ YES ◯ NO | 39. NUMBER OF DAYS PER WEEK USUALLY WORKED EMPLOYEE COMPANY

IMPORTANT

IF WORK LOSS IS EXPECTED TO EXCEED SEVEN CALENDAR DAYS, COMPLETE ITEMS 40 THRU 47

40. DATE OF LAST HIRE | 41. WAS WORKER PAID FOR DAY OF INJURY? ◯ YES ◯ NO IF YES, $ | 42. WAS EMPLOYEE HIRED FOR PERMANENT EMPLOYMENT? ◯ YES ◯ NO

43. NUMBER OF MONTHS EMPLOYMENT AVAILABLE DURING THE YEAR | 44. GIVE EMPLOYEE'S WAGE STATUS AS APPLICABLE HOUR DAY WEEK MONTH $ PER ◯ ◯ ◯ ◯ | 45. IS EMPLOYEE FURNISHED VALUE ◯ LODGING ◯ BOARD ◯ BOTH $

46. ACTUAL GROSS EARNINGS OF EMPLOYEE FOR THE 30 CALENDAR DAYS PRECEEDING INJURY (EXAMPLE: IF INJURED APRIL 8, GIVE EARNINGS FROM MARCH 9 THRU APRIL 7)

47. DOES EMPLOYEE CLAIM DEPENDENTS? ◯ YES ◯ NO

IMPORTANT

IF EMPLOYEE IS PAID OTHER THAN FIXED WEEKLY OR MONTHLY SALARY, COMPLETE ITEMS 48 THRU 55

48. IF EMPLOYEE EARNS EXTRA PAY FOR OVERTIME, WHAT IS BASIS OF PAYMENT? PER HOUR | 49. NUMBER OF HOURS OVERTIME CONSIDERED NORMAL PER WEEK

50. GROSS WAGES OF EMPLOYEE DURING 12 MONTHS PRECEEDING INJURY FROM THRU $

51. IF EMPLOYEE WORKED LESS THAN 12 MONTHS, SHOW GROSS WAGES FROM DATE OF HIRE THROUGH DAY PRIOR TO INJURY FROM THRU $

52. DATE OF LAST WAGE INCREASE IF WITHIN 12 MONTHS PRIOR TO INJURY | 53. WAGE BEFORE INCREASE $ | 54. WAGE AFTER INCREASE $ | 55. GROSS EARNINGS FROM DATE OF INCREASE THRU DAY PRIOR TO INJURY $

AUTHORIZED SIGNATURE

DATE | AUTHORIZED SIGNATURE | TITLE

SUBMITTER EMAIL ADDRESS

NOTE TO EMPLOYER:

1. Submit one copy to the Industrial Commission within 10 days.
2. Submit one copy to your insurance carrier within 10 days.
3. Keep one copy, for not less than five (5) years, as your supplementary record of injuries required by the Federal Occupational Safety and Health Act of 1970.

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

Serious Event Reporting Form

THE INDUSTRIAL COMMISSION OF ARIZONA

Division of Occupational Safety and Health
800 West Washington Street
Phoenix, Arizona 85007

Submit the completed form below;
or you may fax the form to (602) 542-1614 *or* send it as an email attachment to: comments@azdosh.gov

Information about the location where the incident occurred

***Name of Location (or Description)**	
Street Address 1	
Street Address 2	
***City**	
***State**	
***County**	
***ZIP Code**	

Information about the incident

***Date incident occurred** *Ex. mm/dd/yyyy*	
***Time incident occurred**	*Ex. 2300 (use 24-hour clock)*
***What happened?**	
Additional Information:	
Number of fatalities	
Number of hospitalizations	

Employer Information

***Legal Business Name**	
Other Name	
***Street Address 1**	
Street Address 2	
***City**	
***State**	
*** ZIP Code**	

Information about persons whom ADOSH can contact

Contact #1

***First Name**	
***Last Name**	
***Title**	
***Phone** *Ex. 602-999-9999*	
***Email Address** *Ex. jane.doe@rmail.com*	

Information about persons whom ADOSH can contact

Contact #2

First Name	
Last Name	
Title	
Phone *Ex. 602-999-9999*	
Email Address *Ex. jane.doe@rmail.com*	

Information for Each of the Victims

Victim #1

***Victim First Name**	
***Victim Last Name**	
***What was the employee doing just before the incident occurred?**	
***What was the injury or illness?**	
What object or substance directly harmed the employee?	

Was there a fatality?

- ( ) **Yes**
- ( ) **No**

Was victim hospitalized?

- ( ) **Yes**
- ( ) **No**

Was there an amputation?

- ( ) **Yes**
- ( ) **No**

Was there the loss of an eye?

- ( ) **Yes**
- ( ) **No**

Additional Victim Information:

Submitter Email Address:

Submit Date:

Submit

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.

ICA 0407 - Workers' Report of Injury:

Injured workers may use this to report a work injury or illness.

ICA 0124 - Report of Exposure to Bodily Fluids or Other Material:

Give this form to an employee when you learn of any significant work exposure to blood, bodily fluids, or other potentially infectious materials.

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

INDUSTRIAL COMMISSION OF ARIZONA

800 W WASHINGTON STREET
PHOENIX, ARIZONA 85007
(602) 542-4661

WORKER'S REPORT OF INJURY

Copies of the Arizona Workers' Compensation Laws and Arizona Workers' Compensation Practice and Procedure and information about the Industrial Commission of Arizona claims and hearing process are available at the Industrial Commission offices and through the ICA web-site located at: www.azica.gov

ANSWER ALL QUESTIONS FULLY

1. NAME OF INJURED WORKER: LAST FIRST M.I.
   SOCIAL SECURITY # *: BIRTH DATE: PHONE #:
2. ADDRESS: CITY STATE ZIP CODE
3. MARITAL STATUS: SINGLE ◯ MARRIED ◯ DIVORCED ◯ DEPENDENTS AT TIME OF INJURY: YES ◯ NO ◯
4. EMPLOYER: SUPERVISOR:
5. PHONE #: EMPLOYER ADDRESS: CITY STATE ZIP CODE
6. DATE HIRED: WHERE HIRED: OCCUPATION:
7. HOURS WORKED PER DAY: PER WEEK: HOURLY WAGE:
8. DID YOU RECEIVE FOOD OR LODGING IN ADDITION TO WAGE? YES ◯ NO ◯
9. DATE OF INJURY (MO/DAY/YEAR): TIME OF INJURY: AM ◯ PM ◯
10. ADDRESS OR LOCATION OF ACCIDENT:
11. DID YOU STOP WORK IMMEDIATELY? WHEN DID YOU STOP?
12. WHEN DID YOU REPORT THE INJURY? TO WHOM? TITLE:
13. WHEN DID YOU RETURN TO WORK? REGULAR WORK OTHER WORK
14. NAMES OF PERSONS WHO SAW THE ACCIDENT.
    1. NAME: ADDRESS: PHONE #:
    2. NAME: ADDRESS: PHONE #:
15. WAS ACCIDENT CAUSED BY ANOTHER PERSON? IF SO, BY WHOM?
16. NAME OF MACHINE OR TOOL WHICH MAY HAVE CAUSED THE ACCIDENT:
17. STATE HOW ACCIDENT HAPPENED:

18. BODY PART INJURED: DESCRIBE THE INJURY (CUT, BRUISE, ETC.):
19. WHERE WERE YOU FIRST TREATED: NAME: ADDRESS:
20. WHO TREATED YOU FOR THIS INJURY: NAME: ADDRESS:
21. OTHER THAN THIS INJURY, HAVE YOU LOST TIME FROM WORK DUE TO AN ACCIDENT IN THE PAST 12 MONTHS? YES ◯ NO ◯
    NAME OF STATE WHERE ACCIDENT HAPPENED: WORK INJURY: YES ◯ NO ◯
22. OTHER THAN THIS INJURY, HAVE YOU EVER RECEIVED ANY PERMANENT DISABLING INJURY? YES ◯ NO ◯
    DATE OF INJURY: WORK INJURY: YES ◯ NO ◯
    NAME OF STATE WHERE ACCIDENT HAPPENED:
23. OTHER THAN THIS INJURY, ARE YOU RECEIVING COMPENSATION FOR ANY DISABLING CONDITIONS? YES ◯ NO ◯
    IF SO, FROM WHOM? AMOUNT? WHY?

I make application for all benefits to which I may be entitled under the law. I certify, with full knowledge that it is a crime to make willful, false statements to obtain compensation and that all of my statements on this form are true, accurate and complete.

Signature of injured worker or injured worker's authorized representative is REQUIRED. **Date**

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

Submitter Email Address

Employer Email Address: **Worker Email Address:**

THE INDUSTRIAL COMMISSION COMPLIES WITH THE AMERICANS WITH DISABILITIES ACT OF 1990. IF YOU NEED THIS DOCUMENT IN ALTERNATIVE FORMAT, CONTACT CLAIMS AT (602 542-4661).

REPORT OF SIGNIFICANT WORK EXPOSURE TO BODILY FLUIDS OR OTHER INFECTIOUS MATERIAL

(This form is not a claim form, but a report of exposure. Forms to report a claim to the Industrial Commission are available at: www.azica.gov .)

1. Exposed Employee _____ (Last Name) _____ (First) _____ (M.I.) Birth Date _____ Job Title _____

2. Address _____ Phone No. _____

3. Employer's Full Name _____

4. Employer's Address _____

5. Date of Exposure _____ Time of Exposure _____

6. Address or Location of Exposure _____

7. Describe the circumstances surrounding the exposure, including (if applicable) personal protective equipment worn and the names of any witnesses to the exposure (be specific)

8. What were you exposed to? (Directly or indirectly via bandages, personal items, etc.) Check all that apply.

☐ Blood ☐ Vaginal fluid ☐ Broken skin ☐ Urine ☐ Any other fluid(s) containing blood or infectious material (Describe) _____

☐ Semen ☐ Surgical fluid(s) ☐ Mucous membrane ☐ Feces ☐ Airborne/Respiratory/Oral Secretions Other (specify): _____

☐ Saliva ☐ Vomitus ☐ Skin infection (e.g. abscesses, boils, or pus-filled/red/swollen/painful skin lesions)

9. Source person(s) information ○ Unknown ○ Known

Name _____ DOB _____ Phone No. _____

Address _____ City _____ State _____ Zip _____

10. What part(s) of your body was exposed to bodily fluids/infectious material? Did exposure take place through your skin or mucous membrane (be specific)?

11. Did you have any open cuts, sores, rashes, or other breaks/ruptures in your skin or mucous membrane that were exposed to bodily fluids/infectious material (please describe)?

I HAVE GIVEN THIS FORM TO MY EMPLOYER AND HAVE RECEIVED A COPY OF THIS COMPLETE FORM.

EMPLOYEE SIGNATURE _____ DATE _____

Other Required Steps to Establish Prima Facie Claim for HIV, AIDS or Hepatitis C (A.R.S. §§ 23-1043.02, -03; A.A.C. R20-5-164)

1. **You must file this report with your employer no later than ten (10) days after your exposure.**
2. **You must have blood drawn no later than ten (10) calendar days after exposure.**
3. **You must have blood tested for HIV or Hepatitis C by Antibody Testing no later than thirty (30) calendar days after exposure and test results must be negative.**
4. **You must be tested or diagnosed as HIV positive no later than eighteen (18) months after the exposure, or tested and diagnosed as positive for the presence of Hepatitis C within seven (7) months after the exposure.**
5. **You must file a workers' compensation claim with the Industrial Commission of Arizona no later than one (1) year from the date of diagnosis or positive blood test if you wish to receive benefits under the workers' compensation system.**

Other Required Steps to Establish Prima Facie Claim for MRSA (A.R.S. § 23-1043.04; A.A.C. R20-5-164)

1. **You must file this report with your employer no later than thirty (30) days after your exposure.**
2. **For a claim involving MRSA, you must be diagnosed with MRSA within fifteen (15) days after you report in writing to your employer the details of the exposure.**
3. **You must file a workers' compensation claim with the Industrial Commission of Arizona no later than one (1) year from the date of diagnosis if you wish to receive benefits under the workers' compensation system.**

Other Required Steps to Establish Prima Facie Claim for Spinal Meningitis or TB (A.R.S. § 23-1043.04; A.A.C. R20-5-164)

1. **You must file this report with your employer no later than ten (10) days after your exposure.**
2. **For a claim involving spinal meningitis, you must be diagnosed within two (2) to eighteen (18) days of the possible significant exposure and for a claim involving tuberculosis, you must be diagnosed within twelve (12) weeks of the possible significant exposure.**
3. **You must file a workers' compensation claim with the Industrial Commission of Arizona no later than one (1) year from the date of diagnosis if you wish to receive benefits under the workers' compensation system.**

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

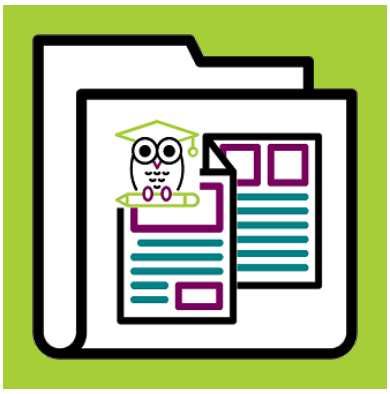
Hospitalizations and Surgical Procedures			
Date(s)	Diagnosis/Treatment/Procedure	Doctor	Hospital

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.

- **Significant Exposure Under the Arizona Workers' Compensation Act:**
  Document from the Industrial Commission of Arizona to provide guidance on reporting work exposure to blood, bodily fluids, or other potentially infectious materials.

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.

SIGNIFICANT EXPOSURE UNDER THE ARIZONA WORKERS' COMPENSATION ACT

In 2011, the Arizona Legislature amended the reporting requirements for a possible significant exposure to Methicillin-Resistant *Staphylococcus Aureus* (MRSA), which are found in Arizona Revised Statutes section 23-1043.04(B). Effective July 20, 2011, employees must report a possible significant exposure to MRSA that occurs at work to their employers within thirty calendar days after the possible significant exposure. Employees must also be diagnosed with MRSA within fifteen days after the employee reports the possible significant exposure to their employer(s). Employees should use the *updated form* to report significant exposure. Employers must display the updated *Notice to Employees* (poster) titled "Work Exposure to Methicillin-Resistant *Staphylococcus Aureus*, Spinal Meningitis or Tuberculosis (TB)." Reporting forms and posters, including the exposure reporting form and the Notice to Employees, are available from the Industrial Commission of Arizona's website at http://www.azica.gov.

What is a Significant Exposure Under the Arizona Workers' Compensation Act?

A report of significant work exposure to blood, bodily fluids, or other potentially infectious materials may be made by completing a form that reports this exposure. This form may be obtained from your employer or on the Industrial Commission of Arizona website at http://www.azica.gov. But, what is a "significant exposure"? In some instances, such as an exposure to bloodborne pathogens, you may not know if the blood, bodily fluids or other material to which you are exposed is infectious. In other instances, such as an exposure to Tuberculosis, MRSA, or Meningitis, you may know if the exposure is "significant" based on the symptoms of the person to whom you are exposed. Understanding the pathogens involved and how they are spread will help you answer the question, but if you have any concern as whether you should report the exposure, then you should "play it safe." Talk to your doctor, talk to your HR Department, or simply use this form to report what you believe to be a significant exposure. For more information regarding the requirements for filing a workers' compensation claim for a significant work exposure, and the presumptions that are available to certain classes of employees, please read the posters that are required to be posted at your workplace that contain this information. This information is also available on the Industrial Commission of Arizona website at http://www.azica.gov.

Bloodborne Pathogens

Bloodborne pathogens ("BBP") are disease causing organisms such as human immunodeficiency virus ("HIV"), hepatitis B, or hepatitis C that may be present in human blood or bodily fluids that are considered "other potentially infectious material." "Human Blood" includes human blood components and products made from human blood. "Other potentially infectious material" ("OPIM") includes semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, and any bodily fluid that is visibly contaminated with blood. Unless visibly contaminated with blood, these pathogens

are not transferred through tears, saliva (except in dental procedures), or perspiration. An easier way to think about this is to remember that OPIM are bodily fluids that are intended to always remain inside the body, sexual fluids, and any human tissue that is intended to be covered by skin. A significant exposure to BBP may occur when you come into contact with blood or OPIM through a break or rupture in your skin (e.g., needlestick injury or you cut yourself with a sharp instrument contaminated with blood), or your mucous membranes (e.g. blood or OPIM gets in your eyes, nose, mouth, or you engage in sexual activity with an infected person). The CDC indicates that a human bite that breaks the skin should also be considered a significant exposure. Additional information on HIV and Hepatitis may be found at www.cdc.gov.

Tuberculosis

Tuberculosis (TB) is a contagious disease that spreads through the air. Only people who are sick with active TB disease in their lungs are infectious. When infectious people cough, sneeze, talk or sing, they propel TB germs, known as droplet nuclei, into the air. These germs can stay in the air for several hours, depending on the environment. While not normally transmitted within minutes or hours of sharing the same "airspace," a person needs only to inhale a small number of the TB germs to be infected. You do not get TB by just touching the clothes or shaking the hands of someone who is infected. Tuberculosis is spread (transmitted) primarily from person to person by breathing infected air during close contact. A person infected with active TB may show general symptoms of unexplained weight loss, loss of appetite, night sweats, fever, fatigue, and chills. Other symptoms of TB of the lungs include coughing for 3 weeks or longer, coughing up blood, and chest pain. Additional information on TB can be found at www.cdc.gov.

MRSA

Methicillin-Resistant Staphylococcus Aureus, also known as MRSA, is a potentially dangerous type of staph bacteria that has become resistant to one family of common antibiotics. MRSA is a contact risk. You can get MRSA through direct contact with an infected person, sharing personal items (such as towels or razors that have touched infected skin) or touching shared items (clothing, door knobs, workout benches, etc.). Most staph skin infections, including MRSA, appear as a bump or infected area on the skin that may be red, swollen, painful, warm to the touch, full of pus or other drainage, and accompanied by a fever. Many people describe it as looking like a spider bite. Additional information on MRSA can be found at www.cdc.gov.

Meningitis

Meningitis is a disease caused by the inflammation of the protective membranes covering the brain and spinal cord known as the meninges. The inflammation is usually caused by an infection of the fluid surrounding the brain and spinal cord. Meningitis is also referred to as spinal meningitis. Meningitis may develop in response to a number of causes, but it is usually caused by bacteria or viruses. Bacterial meningitis is spread from person to person through the exchange of respiratory and throat secretions, normally occurring through coughing, kissing, and sneezing. It is not spread through casual contact or by simply breathing the air where a person

with meningitis has been. It is considered a "heavy droplet" contact risk, similar to a cold, but not nearly as contagious as the cold. Viral meningitis is also spread from person to person through respiratory secretions (saliva, sputum, or nasal mucus) of an infected person. It can also be spread from person to person through fecal contamination (which can occur when changing a diaper or using the toilet and not properly washing hands afterwards). An adult infected with meningitis may have a high fever, severe headache, stiff neck, sensitivity to bright light, sleepiness or trouble waking up, nausea, vomiting, or lack of appetite. Bacterial meningitis can be more severe and immediate care can be important. Additional information on meningitis can be found at www.cdc.gov.

GENERAL FORMS

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

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

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

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

Omaha NATIONAL

Request for Subrogation Waiver

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

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

General Information

Policyholder Name ______________________

FEIN ______________________

Policy Number ______________________

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

Job Information for Specific Waiver

Job Effective Date(s) From __________ To __________

Job Name or Number ______________________

Person or Organization ______________________

Brief Description of Job ______________________

Complete Address ______________________

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

Payroll Amount ________ Payroll Amount ________ Payroll Amount ________

Job Information for Specific Waiver

Job Effective Date(s) From __________ To __________

Job Name or Number ______________________

Person or Organization ______________________

Brief Description of Job ______________________

Complete Address ______________________

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

Payroll Amount ________ Payroll Amount ________ Payroll Amount ________

Job Information for Specific Waiver

Job Effective Date(s) From __________ To __________

Job Name or Number ______________________

Person or Organization ______________________

Brief Description of Job ______________________

Complete Address ______________________

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

Payroll Amount ________ Payroll Amount ________ Payroll Amount ________

Job Information for Specific Waiver

Job Effective Date(s) From __________ To __________

Job Name or Number ______________________

Person or Organization ______________________

Brief Description of Job ______________________

Complete Address ______________________

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

Payroll Amount ________ Payroll Amount ________ Payroll Amount ________

Job Information for Specific Waiver

Job Effective Date(s) From __________ To __________

Job Name or Number ______________________

Person or Organization ______________________

Brief Description of Job ______________________

Complete Address ______________________

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

Payroll Amount ________ Payroll Amount ________ Payroll Amount ________

Submitter Information

Completed by ______________________ Date ______________________

Title ______________________ Signature ______________________

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

REQUEST FOR OWNERSHIP INFORMATION—ERM-14 FORM

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

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

Section A—Contact Information

Name of person completing this form _____ Your Employer _____

Phone # _____ Email Address _____

Relationship to business entity reporting ownership information _____

Section B—Transaction Information

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

Section C—Description of Transaction(s)

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

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

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

_____

_____

_____

_____

Section D—Business Entity Information

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

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

Section E—Certification

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

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

Print name of above signature **Date**

Company Contacts Verification

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

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

General Information

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

Company Contacts for Invoice Questions/Issues

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

Company Contacts for Payroll Questions/Issues

☐ Check if same as above

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

Company Contacts for Policy Questions/Issues

☐ Check if same as above

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

Company Contacts for Claims Questions/Issues

☐ Check if same as above

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

Submitter Information

Completed by _____ Date _____
Title _____ Signature _____

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

STATE-SPECIFIC FORMS & DOCUMENTS

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

- **ICA 0113 - Employee's Notice of Rejection of Terms of the Arizona Workers' Compensation Law:**
  Employees may use this form to reject the provisions of Arizona's workers compensation laws. The form must be filled out in duplicate and filed with the employer prior to the occurrence of a workplace injury. The employer must send a copy of the completed form to Omaha National within five days.

- **ICA 0114 - Employee's Notice to Revoke Rejection of Terms of the Arizona Workers' Compensation Law:**
  This form may be used to reverse an employee's rejection of workers compensation coverage. The form must be filled out in duplicate and filed with the employer prior to the occurrence of a workplace injury. The employer must send a copy of the completed form to Omaha National within five days.

EMPLOYEE'S NOTICE OF REJECTION OF TERMS OF THE ARIZONA WORKERS' COMPENSATION LAW

POLICY NO. _____ DATE _____

To _____
Full Name of Employer

_____ _____ _____ _____
Employer Address City State Zip Code

YOU ARE HEREBY NOTIFIED THAT THE UNDERSIGNED ELECTS TO REJECT THE TERMS, CONDITIONS AND PROVISIONS OF THE LAW FOR THE PAYMENT OF COMPENSATION, AS PROVIDED BY THE COMPULSORY COMPENSATION LAW OF THE STATE OF ARIZONA, AND ACTS AMENDATORY THERETO.

_____ _____ _____
(Employee First Name) (Last Name) (Social Security Number of Employee)

_____ _____
(Address of Employee) (Signature of Employee)

_____ _____ _____
(City) (State) (Zip Code)

NOTE: This notice is of no effect unless it is filled out in duplicate and served upon the employer. The employer shall, in all cases, within five days of receipt of the notice, file a copy with the workers' compensation insurance carrier.

EMPLOYEE'S NOTICE TO REVOKE REJECTION OF
TERMS OF THE ARIZONA WORKERS' COMPENSATION LAW

POLICY NO. _____ DATE _____

To _____
Full Name of Employer

_____ _____ _____ _____
Employer Address City State Zip Code

I HEREBY REVOKE THE NOTICE OF REJECTION OF THE TERMS OF THE ARIZONA WORKERS' COMPENSATION LAW SIGNED BY ME ON _____.

_____ _____ _____
(Employee First Name) (Last Name) (Social Security Number of Employee)

_____ _____
(Address of Employee) (Signature of Employee)

_____ _____ _____
(City) (State) (Zip Code)

NOTE: This notice is of no effect unless it is filled out in duplicate and served upon the employer. The employer shall, in all cases, within five days of receipt of the notice, file a copy with the workers' compensation insurance carrier.