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 Indiana 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.

Worker's Compensation Notice:

This poster serves as the mandatory workers compensation posting notice. Post this notice in the same locations where any notices required by federal law are posted. You must provide any mobile or remote employees with a copy in an electronic format or in the same manner used to convey other employment related information. To complete the form, enter your company name, select the appropriate insurer name from the dropdown list, and include the posted date.

WCB Form 36097 – Notice for Worker's Compensation and Occupational Diseases Coverage:

When you elect to provide coverage for exempt employees, post this form with the mandatory posting notice addressed above.

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.

WORKER'S COMPENSATION NOTICE

Your employer is required to provide for payment of benefits under the Worker's Compensation Act of the State of Indiana.

Any employee who is injured while at work should report the injury immediately to their supervisor, employer, or designated representative.

The worker's compensation insurance carrier or the administrator for

_____ **is:** (Select Insurer Name)

(name of company) **(name of insurance carrier or administrator)**

Administrator - Omaha National Underwriters, LLC

(name of carrier/administrator)

P.O. Box 451139

(mailing address)

Omaha, NE 68145

(city, state, zip)

844-761-8400

(telephone number)

Anne Reed

(contact person)

For more information about rights or procedures under the Indiana Worker's Compensation system, call or write:

Worker's Compensation Board of Indiana
Ombudsman Division
402 W. Washington St., Rm W196
Indianapolis, IN 46204
(317) 232-3808
1-800-824-2667

Date Posted:

Indiana Worker's Compensation Board

NOTICE FOR WORKER'S COMPENSATION AND OCCUPATIONAL DISEASES COVERAGE

State Form 36097 (R8 / 6-15)

Mail to: Worker's Compensation Board of Indiana, 402 W. Washington St., Room W196, Indianapolis, IN 46204-2753.

APPLICANT INFORMATION		
Name of employer		Federal Identification number
Address *(number and street, city, state, and ZIP code)*		
Name of insurer	Insurer policy number	Policy effective dates *(mm/dd/yy)* Start: End:
Name of applicant	Telephone number ( )	E-mail address

STATEMENT OF VOLUNTARY EXCLUSION (IC 22-3-6-1 (b)(1) / IC 22-3-7-9 (b)(9))

An officer of a corporation may not be considered to be excluded as an employee under IC 22-3-2 through IC 22-3-6 until the notice is received by the insurance carrier and the board.

☐ I am an officer with an ownership interest in the above named corporation, and I elect not to be an employee; hereby excluding myself from workers compensation coverage.

Signature of corporate officer	Date *(mm/dd/yyyy)*

STATEMENT OF VOLUNTARY ELECTION (IC 22-3-6-1 (b))

☐ (2) I am the executive officer in the above named municipal corporation or other governmental subdivision or of a charitable, religious, educational or other nonprofit corporation and am electing worker's compensation coverage.

☐ (4) I am the sole proprietor in the above named entity and am electing worker's compensation coverage.

☐ (5) I am a partner in the above named entity and am electing worker's compensation coverage.

☐ (8) I am an owner-operator that provides a motor vehicle and the services of a driver under a written contract that is subject to IC 8-2.1-24-23, 45 IAC 16-1-13, or 49 CFR 376 to a motor carrier and am electing worker's compensation coverage.

☐ (9) I am a member or manager in the above named limited liability company and am electing worker's compensation coverage.

STATEMENT OF VOLUNTARY ELECTION (IC 22-3-2-9)

The notice of acceptance referred to in subsection 22-3-2-9(b) shall be given thirty (30) days prior to any accident resulting in injury or death, provided that if any such injury occurred less than thirty (30) days after the date of employment, notice of acceptance given at the time of employment shall be sufficient notice thereof. A copy of the notice in prescribed form shall also be filed with the Worker's Compensation Board, within five (5) days after its service in such manner upon the employee or employer.

☐ (1) I am the employer of casual laborers and hereby elect to provide worker's compensation coverage.

☐ (2) I am the employer of farm or agricultural employees and hereby elect to provide worker's compensation coverage.

☐ (3) I am the employer of household employees and hereby elect to provide worker's compensation coverage.

☐ (4) I am the employer of part-time volunteer coaches for a nonprofit corporation and hereby elect to provide worker's compensation coverage.

STATEMENT OF VOLUNTARY ELECTION (IC 22-3-2-5)

☐ I am the owner or representative of a state, county, township, city, town, school city, school town, school township, other municipal corporation, state institution, state board, state commission, bank, trust company or building and loan association and am electing worker's compensation coverage.

STATEMENT OF VOLUNTARY ELECTION (IC 22-3-2-2)

☐ I am the employer of members of a fire department or police department of a municipal corporation, who are also members of a firefighters' pension fund or a police officers' pension fund; and hereby elect to purchase and procure worker's compensation insurance to insure said employees with respect to medical benefits.

☐ I am the employer of "rostered volunteers"; and hereby elect to cover said volunteers under the medical treatment provisions of the worker's compensation act.

Signature of employer or authorized agent	Date *(mm/dd/yyyy)*

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.

- **WCB Form 34401 – Indiana Worker's Compensation First Report of Employee Injury, Illness:**
  Employers are required by law to report all employee injuries involving death or the need for medical care beyond first aid to the insurance company within seven days after knowledge of the injury. Please note, you should promptly report **all injuries** to Omaha National, even those that only require first aid; sometimes an injury that seems minor at first can worsen and knowing about these Injuries allows us to manage them effectively.

- **Incident, Supervisor, and Witness Reports:**
  When a workplace injury occurs, these forms may be used to gather information about an incident or injury. Copies should be sent to Omaha National at the same time you report the injury to us.

INSTRUCTIONS

General Instructions:

1. Please enter information into all of the areas of the First Report form, except the boxes at the top right corner of the form which is for office use only.

2. Enter all dates in MM/DD/YY format.

3. Please return completed form electronically by an approved EDI process.

4. For answers to questions, please call (317) 232-3808.

Definitions:

AGENT NAME AND CODE NUMBER: Enter the name of your insurance agent and his / her code number if known. This information can be found on your insurance policy.

ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR EXPOSURE OCCURRED: List anything the employee was using, applying, handling or operating when the injury or exposure occurred. If the injury involves a fall, indicate any surfaces and / or objects the claimant fell on and where they fell from. Enter "NA" if no equipment, materials or chemicals were being used (*e.g. Acetylene cutting torch, metal plate, etc.*).

AVG WG/WK: Claimant's average weekly wage, calculated by totaling the latest 52 weeks of wages (*including overtime, tips, etc.*) and dividing by 52.

CLAIMS ADMINISTRATOR: Enter the name of the carrier, third-party administrator, state fund, or self-insured responsible for administering the claim.

CONTACT NAME / TELEPHONE NUMBER: Enter the name of the individual at the employer's premises to be contacted for additional information (*i.e. Supervisor, HR Person, Nurse, etc.*)

DATE DISABILITY BEGAN: The first day on which the claimant originally lost time from work due to the occupational injury or disease or as otherwised deigned by statute.

DEPARTMENT OR LOCATION WHERE ACCIDENT OR EXPOSURE OCCURRED: If the accident or exposure did not occur on the employer's premises, enter address or location. Be specific (*e.g. Maintenance, Client's Office, Cafeteria, etc.*).

EMPLOYEE STATUS: Indicate the employee's work status from the following choices: Full-time, Part-time, Apprentice Full-time, Apprentice Part-time, Volunteer, Seasonal Worker, Piece Worker, On-Strike, Disabled, Retired, Not Employed or Unknown (you may also abbreviate the above as: (*FT, PT, AFT, APT, VO, SW, PW, OS, DI, RE, NE, or UK*).

HOW INJURY / ILLNESS OCCURRED: Describe the sequence of events leading to the injury or exposure (*e.g. Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, he brushed against the hot metal; Worker stepped to the edge of the scaffolding, lost balance and fell six feet to the concrete floor. The worker's right wrist was broken in the fall*).

NCCI CLASS CODE: A four-digit code classifying the occupation of the claimant.

OCCUPATION / JOB TITLE: Enter the primary occupation of the claimant at the time of the accident or exposure.

PART OF BODY AFFECTED: Indicate the part of body affected by the injury / illness (*e.g. Right forearm, Low Back, etc.*)

REPORT PURPOSE CODE: 00 = Original First Report of Injury; 02 = Updated or Amended First Report.

RTW DATE (*Return to Work Date)***:** Enter the date following the most recent disability period on which the employee returned to work.

SIC CODE: This is the code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

SPECIFIC ACTIVITY EMPLOYEE ENGAGED IN DURING ACCIDENT / EXPOSURE: Describe the specific activity the employee was engaged in during the accident or exposure (*e.g. Cutting metal plate for flooring, sanding ceiling woodwork in preparation for painting*).

TYPE OF INJURY / ILLNESS: Briefly describe the nature of the injury or illness (*e.g. Contusion, Laceration, Fracture, etc.*)

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN DURING ACCIDENT / EXPOSURE: Enter "NA" if employee was not engaged in a work process, such as if walking down the hallway (*e.g. Building maintenance*).

Reset Form

INDIANA WORKER'S COMPENSATION FIRST REPORT OF EMPLOYEE INJURY, ILLNESS

State Form 34401 (R10 / 1-02)

FOR WORKER'S COMPENSATION BOARD USE ONLY		
Jurisdiction	Jurisdiction claim number	Process date

Please return completed form electronically by an approved EDI process.

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

EMPLOYEE INFORMATION

Social Security number	Date of birth	Sex ☐ Male ☐ Female ☐ Unknown	Occupation / Job title	NCCI class code
Name (*last, first, middle*)		Marital status ☐ Unmarried ☐ Married ☐ Separated ☐ Unknown	Date hired / State of hire	Employee status
Address (*number and street, city, state, ZIP code)*			Hrs / Day / Days / Wk / Avg Wg / Wk	☐ Paid Day of Injury ☐ Salary Continued
Telephone number (include area		Number of dependents	Wage $ Per ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year ☐ Other	

EMPLOYER INFORMATION

Name of employer	Employer ID#	SIC code	Insured report number
Address of employer (*number and street, city, state, ZIP code*)	Location number / Telephone number	Employer's location address (*if different)*	
	Carrier / Administrator claim number	OSHA log number	Report purpose code
Actual location of accident / exposure (*if not on employer's premises*)			

CARRIER / CLAIMS ADMINISTRATOR INFORMATION

Name of claims administrator	Carrier federal ID number	Check if appropriate ☐ Self Insurance
Address of claims administrator (*number and street, city, state, ZIP code*)	☐ Insurance Carrier ☐ Third Party Admin.	Policy / Self-insured number
Telephone number		Policy period From To
Name of agent	Code number	

OCCURRENCE / TREATMENT INFORMATION

Date of Inj./ Exp.	Time of occurrence ☐ AM ☐ PM ☐ Cannot be determined	Date employer notified	Type of injury / exposure	Type code
Last work date	Time workday began	Date disability began	Part of body	Part code
RTW date	Date of death	Injury / Exposure occurred on employer's premises? ☐ Yes ☐ No	Name of contact	Telephone number
Department or location where accident / exposure occurred			All equipment, materials, or chemicals involved in accident	
Specific activity engaged in during accident / exposure			Work process employee engaged in during accident / exposure	
How injury / exposure occurred. Describe the sequence of events and include any relevant objects or substances.				Cause of injury code
Name of physician / health care provider				
Hospital or offsite treatment (*name and address*)				INITIAL TREATMENT ☐ No Medical Treatment ☐ Minor: By Employer ☐ Minor: Clinic / Hospital ☐ Emergency Care ☐ Hospitalized > 24 Hours ☐ Future Major Medical / Lost Time Anticipated
Name of witness	Telephone number	Date administrator notified		
Date prepared	Name of preparer	Title	Telephone number	

An employer's failure to report an occupational injury or illness may result in a $50 fine (IC 22-3-4-13).

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.

- **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

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

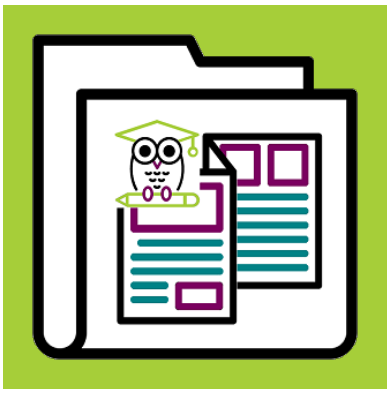
Hospitalizations and Surgical Procedures			
Date(s)	Diagnosis/Treatment/Procedure	Doctor	Hospital

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.

Contact Information

Claims:

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

Reduce Your Workers Compensation Costs

Injury Prevention and Safety Training

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

Report Injuries Immediately

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

Ways to report an injury:

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

High-Quality Medical Care

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

Establish a Return-To-Work Program

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

GENERAL FORMS

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

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

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

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

Request for Subrogation Waiver

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

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

General Information

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

Job Information for Specific Waiver

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

Job Information for Specific Waiver

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

Job Information for Specific Waiver

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

Job Information for Specific Waiver

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

Job Information for Specific Waiver

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

Submitter Information

Completed by ____________ Date ____________
Title ____________ Signature ____________

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

REQUEST FOR OWNERSHIP INFORMATION—ERM-14 FORM

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

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

Section A—Contact Information

Name of person completing this form _____ Your Employer _____

Phone # _____ Email Address _____

Relationship to business entity reporting ownership information _____

Section B—Transaction Information

Type of Transaction (check all that apply)	**Transaction Effective Date**
☐ **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.