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 California 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.

DWC-7 – Notice to Employees – Injuries Caused by Work:

This document serves as the mandatory workers compensation posting notice. If there are Spanish-speaking employees, it must be posted in both English and Spanish. Copies must be printed on legal-sized paper (8½ x 14). To complete the form, please select the appropriate insurer name from the dropdown list and enter the address of the nearest Division of Workers' Compensation Information and Assistance Unit. The Division provides a listing of the Information and Assistance Offices with their contact information on the DWC website at dir.ca.gov/dwc/IandA.html.

> *Failure to post the Form DWC-7 constitutes a misdemeanor and is considered prima facie evidence of noninsurance. Failure to provide the notice may also lead to loss of medical control for an injury occurring during the time of that failure. Such failure may result in the assessment of a civil penalty up to $12,471.00 for each violation.*

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.

STATE OF CALIFORNIA - DEPARTMENT OF INDUSTRIAL RELATIONS
Division of Workers' Compensation

Notice to Employees--Injuries Caused By Work

You may be entitled to workers' compensation benefits if you are injured or become ill because of your job. Workers' compensation covers most work-related physical or mental injuries and illnesses. An injury or illness can be caused by one event (such as hurting your back in a fall) or by repeated exposures (such as hurting your wrist from doing the same motion over and over).

Benefits. Workers' compensation benefits include:

- **Medical Care:** Doctor visits, hospital services, physical therapy, lab tests, x-rays, medicines, medical equipment and travel costs that are reasonably necessary to treat your injury. You should never see a bill. There are limits on chiropractic, physical therapy and occupational therapy visits.
- **Temporary Disability (TD) Benefits:** Payments if you lose wages while recovering. For most injuries, TD benefits may not be paid for more than 104 weeks within five years from the date of injury.
- **Permanent Disability (PD) Benefits:** Payments if you do not recover completely and your injury causes a permanent loss of physical or mental function that a doctor can measure.
- **Supplemental Job Displacement Benefit:** A nontransferable voucher, if you are injured on or after 1/1/2004, your injury causes permanent disability, and your employer does not offer you regular, modified, or alternative work.
- **Death Benefits:** Paid to your dependents if you die from a work-related injury or illness.

Naming Your Own Physician Before Injury or Illness (Predesignation). You may be able to choose the doctor who will treat you for a job injury or illness. If eligible, you must tell your employer, in writing, the name and address of your personal physician or medical group *before* you are injured. You must obtain their agreement to treat you for your work injury. For instructions, see the written information about workers' compensation that your employer is required to give to new employees.

If You Get Hurt:

1. **Get Medical Care.** If you need emergency care, call 911 for help immediately from the hospital, ambulance, fire department or police department. If you need first aid, contact your employer.
2. **Report Your Injury.** Report the injury immediately to your supervisor or to an employer representative. Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you with a claim form within one working day after learning about your injury. Within one working day after you file a claim form, your employer or claims administrator must authorize the provision of all treatment, up to ten thousand dollars, consistent with the applicable treatment guidelines, for your alleged injury until the claim is accepted or rejected.
3. **See Your Primary Treating Physician (PTP).** This is the doctor with overall responsibility for treating your injury or illness.
   - If you predesignated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
   - If your employer is using a medical provider network (MPN) or a health care organization (HCO), in most cases you will be treated within the MPN or HCO unless you predesignated a personal physician or medical group. An MPN is a group of physicians and health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
   - If your employer is not using an MPN or HCO, in most cases the claims administrator can choose the doctor who first treats you when you are injured, unless you predesignated a personal physician or medical group.
4. You may consult a licensed attorney to advise you of your rights under workers' compensation laws. In most instances, attorney's fees will be paid from your recovery.
5. **Medical Provider Networks.** Your employer may be using an MPN, which is a group of health care providers designated to provide treatment to workers injured on the job. If you have predesignated a personal physician or medical group prior to your work injury, then you may go there to receive treatment from your predesignated doctor. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN. For more information, see the MPN contact information below:

MPN website: **mpn.omahanational.com**

MPN Effective Date: **12/4/2017** MPN Identification number: **3064**

If you need help locating an MPN physician, call your MPN access assistant at: **844-761-8400**

If you have questions about the MPN or want to file a complaint against the MPN, call the MPN Contact Person at: **844-761-8400**

Discrimination. It is illegal for your employer to punish or fire you for having a work injury or illness, for filing a claim, or testifying in another person's workers' compensation case. If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

Questions? Learn more about workers' compensation by reading the information that your employer is required to give you at time of hire. If you have questions, see your employer or the claims administrator (who handles workers' compensation claims for your employer):

Claims Administrator **Omaha National Underwriters** Phone **844-761-8400**

Workers' compensation insurer **(Select Insurer Name)** (Enter "self-insured" if appropriate)

You can also get free information from a State Division of Workers' Compensation Information (DWC) & Assistance Officer. The nearest Information & Assistance Officer can be found at location: _____ or by calling toll-free **(800) 736-7401**. Learn more information about workers' compensation online: www.dwc.ca.gov and access a useful booklet "Workers' Compensation in California: A Guidebook for Injured Workers."

False claims and false denials. Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony and may be fined and imprisoned.

Your employer may not be liable for the payment of workers' compensation benefits for any injury that arises from your voluntary participation in any **off-duty, recreational, social, or athletic activity** that is not part of your work-related duties.

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.

DLSR-5020 – Employer's Report of Occupational Injury or Illness:

Employers are required to file this report with the Division of Workers' Compensation within five days of learning about a workplace injury that results in lost time beyond the date of the incident or requires medical treatment beyond first aid. 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.

DIA-510 – Notice of Employee Death:

California law requires employers to report the death of any current employee, regardless of the cause of death, when the employer has actual knowledge or notice that the deceased has no surviving minor child. If the death may be due to a workplace injury, send the completed form DIA-510 to Omaha National at the same time you report the claim to us. For death not caused by a workplace injury, send the completed form to the Division of Workers' Compensation as directed on the form.

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.

State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:

OSHA CASE NO.

FATALITY ☐

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME
1a. Policy Number
2. MAILING ADDRESS: (Number, Street, City, Zip)
2a. Phone Number
3. LOCATION if different from Mailing Address (Number, Street, City and Zip)
3a. Location Code
4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.
5. State unemployment insurance acct.no
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)
8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM
9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy)
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)
20a. COUNTY
21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.
23. Other Workers injured or ill in this event? ☐ Yes ☐ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURYIILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY
27. Name and address of physician (number, street, city, zip)
27a. Phone Number
28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number
29. Employee treated in emergency room? ☐ Yes ☐ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.

Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, Street, City,Zip)
33a. PHONE NUMBER
34. SEX ☐ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED
38. GROSS WAGES/SALARY $ _____ per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGESISALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Please do not use this column

CASE NUMBER

OWNERSHIP

INDUSTRY

OCCUPATION

SEX

AGE

DAILY HOURS

DAYS PER WEEK

WEEKLY HOURS

WEEKLY WAGE

COUNTY

NATURE OF INJURY

PART OF BODY

SOURCE

EVENT

SECONDARY SOURCE

EXTENT OF INJURY

Completed By (type or print)	Signature & Title	Date (mm/dd/yy)

• Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

SAVE PRINT CLEAR

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

FORWARD TO

P.O. BOX 422400
SAN FRANCISCO CA 94142

NOTICE OF EMPLOYEE DEATH

==========

EACH EMPLOYER SHALL NOTIFY THE ADMINISTRATIVE DIRECTOR OF THE DEATH OF EVERY EMPLOYEE REGARDLESS OF THE CAUSE OF DEATH EXCEPT WHERE THE EMPLOYER HAS ACTUAL KNOWLEDGE OR NOTICE THAT THE DECEASED EMPLOYEE LEFT A SURVIVING MINOR CHILD (TITLE 8, CHAPTER 4.5, SECTION 9900).

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DECEASED EMPLOYEE:

NAME: _____ AGE: _____ SOCIAL SECURITY NUMBER: _____

LAST KNOWN ADDRESS: _____

NAME, RELATIONSHIP AND LAST KNOWN ADDRESS OF NEXT OF KIN: _____

_____

JOB TITLE AND NATURE OF DUTIES: _____

_____

DATE, TIME AND PLACE OF ACCIDENT: _____

DATE, TIME AND PLACE OF DEATH: _____

CIRCUMSTANCES OF DEATH (DESCRIBE FULLY THE EVENTS WHICH RESULTED IN DEATH. TELL WHAT HAPPENED. USE ADDITIONAL SHEET IF NECESSARY):

_____

CAUSE OF DEATH (ATTACH COPY OF DEATH CERTIFICATE OR CORONER'S REPORT):

_____

HAVE ANY WORKERS' COMPENSATION DEATH BENEFITS BEEN PROVIDED IN CONNECTION WITH THIS DEATH? ____ YES ____ NO

IF YES, TO WHOM: _____

ATTACH A COPY OF THE FORM 5020, "EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS," IF ONE WAS FILED.

.....

PLEASE NOTE:

IF THE DEATH IS WORK-RELATED, THE EMPLOYER ALSO IS REQUIRED TO REPORT THE DEATH TO HIS OR HER WORKERS' COMPENSATION INSURANCE CARRIER AND TO THE NEAREST OFFICE OF THE DIVISION OF INDUSTRIAL SAFETY IMMEDIATELY BY TELEPHONE OR TELEGRAPH. AN EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS SHOULD ALSO BE FILED WITH THE WORKERS' COMPENSATION INSURANCE CARRIER.

.....

( ) INSURED ( ) SELF-INSURED ( ) LEGALLY UNINSURED

EMPLOYER: _____

STREET: _____

CITY/STATE: _____ ZIP: _____

TELEPHONE: _____
(INCLUDE AREA CODE)

INSURANCE CARRIER
OR ADJUSTING AGENT: Omaha National Underwriters

STREET: 9110 W Dodge Rd. Suite 300,

CITY/STATE: Omaha, NE ZIP: 68114-3346

TELEPHONE: 844-761-8400
(INCLUDE AREA CODE)

BY:_____

TITLE: _____

DATE: ----------

DIA 510 (REV. 9/84)

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, or that a crime has occurred at the workplace, please provide the following documents to the injured worker. Delivery may be made personally or by first-class mail.

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.

DWC-1 – Claim Form and Notice of Potential Eligibility:

When a workplace injury causes an employee to miss work past the employee's shift or requires any medical treatment beyond first aid, this form must be given to the injured worker or to the deceased worker's dependents within one working day of your knowledge. Then, within one working day after you receive the claim form from the injured worker, you must sign and date the form and send completed copies to Omaha National and the worker. Make sure to save a copy for your records.

Employee Medical Provider Network Notice:

Give this form to an employee when you learn of a workplace injury that may require medical treatment. The notification must be provided in Spanish if the injured worker primarily speaks Spanish.

Notice to Victims of Workplace Crimes:

Employers are required to provide employees who are victims of a crime at their place of employment written notice that the employees are eligible for workers compensation benefits for injuries, including psychological injuries, that may result from the crime. This notice must be provided within one working day of the crime or within one working day of the employer's knowledge of the crime.

Employee Acknowledgement Form – Part Two:

Have the injured worker complete and sign part two of this form to indicate they received the Employee Medical Provider Network Notification. If you are unable to locate the original document with part one completed, please have the employee complete both sections.

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

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility
Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Use the attached form to file a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If you file a claim, the claims administrator, who is responsible for handling your claim, must notify you within 14 days whether your claim is accepted or whether additional investigation is needed.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Do this right away to avoid problems with your claim. In some cases, benefits will not start until you inform your employer about your injury by filing a claim form. Describe your injury completely. Include every part of your body affected by the injury. If you mail the form to your employer, use first-class or certified mail. If you buy a return receipt, you will be able to prove that the claim form was mailed and when it was delivered. Within one working day after you file the claim form, your employer must complete the "Employer" section, give you a dated copy, keep one copy, and send one to the claims administrator.

Medical Care: Your claims administrator will pay for all reasonable and necessary medical care for your work injury or illness. Medical benefits are subject to approval and may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, medicines, equipment and travel costs. Your claims administrator will pay the costs of approved medical services directly so you should never see a bill. There are limits on chiropractic, physical therapy, and other occupational therapy visits.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness.

- If you previously designated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
- If your employer is using a medical provider network (MPN) or Health Care Organization (HCO), in most cases, you will be treated in the MPN or HCO unless you predesignated your personal physician or a medical group. An MPN is a group of health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
- If your employer is not using an MPN or HCO, in most cases, the claims administrator can choose the doctor who first treats you unless you predesignated your personal physician or a medical group.
- If your employer has not put up a poster describing your rights to workers' compensation, you may be able to be treated by your personal physician right after you are injured.

Within one working day after you file a claim form, your employer or the claims administrator must authorize up to $10,000 in treatment for your injury, consistent with the applicable treating guidelines until the claim is accepted or rejected. If the employer or claims administrator does not authorize treatment right away, talk to your supervisor, someone else in management, or the claims administrator. Ask for treatment to be authorized right now, while waiting for a decision on your claim. If the employer or claims administrator will not authorize treatment, use your own health insurance to get medical care. Your health insurer will seek reimbursement from the claims administrator. If you do not have health insurance, there are doctors, clinics or hospitals that will treat you without immediate payment. They will seek reimbursement from the claims administrator.

Switching to a Different Doctor as Your PTP:

- If you are being treated in a Medical Provider Network (MPN), you may switch to other doctors within the MPN after the first visit.
- If you are being treated in a Health Care Organization (HCO), you may switch at least one time to another doctor within the HCO. You may switch to a doctor outside the HCO 90 or 180 days after your injury is reported to your employer (depending on whether you are covered by employer-provided health insurance).
- If you are not being treated in an MPN or HCO and did not predesignate, you may switch to a new doctor one time during the first 30 days after your injury is reported to your employer. Contact the claims administrator to switch doctors. After 30 days, you may switch to a doctor of your choice if

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Utilice el formulario adjunto para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran dependiendo de la índole de su reclamo. Si usted presenta un reclamo, l administrador de reclamos, quien es responsable por el manejo de su reclamo, debe notificarle dentro de 14 días si se acepta su reclamo o si se necesita investigación adicional.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Haga esto de inmediato para evitar problemas con su reclamo. En algunos casos, los beneficios no se iniciarán hasta que usted le informe a su empleador acerca de su lesión mediante la presentación de un formulario de reclamo. Describa su lesión por completo. Incluya cada parte de su cuerpo afectada por la lesión. Si usted le envía por correo el formulario a su empleador, utilice primera clase o correo certificado. Si usted compra un acuse de recibo, usted podrá demostrar que el formulario de reclamo fue enviado por correo y cuando fue entregado. Dentro de un día laboral después de presentar el formulario de reclamo, su empleador debe completar la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos.

Atención Médica: Su administrador de reclamos pagará por toda la atención médica razonable y necesaria para su lesión o enfermedad relacionada con el trabajo. Los beneficios médicos están sujetos a la aprobación y pueden incluir tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio, las medicinas, equipos y gastos de viaje. Su administrador de reclamos pagará directamente los costos de los servicios médicos aprobados de manera que usted nunca verá una factura. Hay límites en terapia quiropráctica, física y otras visitas de terapia ocupacional.

El Médico Primario que le Atiende *(Primary Treating Physician- PTP)* es el médico con la responsabilidad total para tratar su lesión o enfermedad.

- Si usted designó previamente a su médico personal o a un grupo médico, usted podrá ver a su médico personal o grupo médico después de lesionarse.
- Si su empleador está utilizando una red de proveedores médicos (*Medical Provider Network- MPN)* o una Organización de Cuidado Médico *(Health Care Organization- HCO)*, en la mayoría de los casos, usted será tratado en la *MPN* o *HCO* a menos que usted hizo una designación previa de su médico personal o grupo médico. Una *MPN* es un grupo de proveedores de asistencia médica quien da tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una *HCO* o una *MPN*. Hable con su empleador para más información.
- Si su empleador no está utilizando una *MPN* o *HCO*, en la mayoría de los casos, el administrador de reclamos puede elegir el médico que lo atiende primero a menos de que usted hizo una designación previa de su médico personal o grupo médico.
- Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede ser tratado por su médico personal inmediatamente después de lesionarse.

Dentro de un día laboral después de que Ud. Presente un formulario de reclamo, su empleador o el administrador de reclamos debe autorizar hasta $10000 en tratamiento para su lesión, de acuerdo con las pautas de tratamiento aplicables, hasta que el reclamo sea aceptado o rechazado. Si el empleador o administrador de reclamos no autoriza el tratamiento de inmediato, hable con su supervisor, alguien más en la gerencia, o con el administrador de reclamos. Pida que el tratamiento sea autorizado ya mismo, mientras espera una decisión sobre su reclamo. Si el empleador o administrador de reclamos no autoriza el tratamiento, utilice su propio seguro médico para recibir atención médica. Su compañía de seguro médico buscará reembolso del administrador de reclamos. Si usted no tiene seguro médico, hay médicos, clínicas u hospitales que lo tratarán sin pago inmediato. Ellos buscarán reembolso del administrador de reclamos.

Cambiando a otro Médico Primario o *PTP*:

- Si usted está recibiendo tratamiento en una Red de Proveedores Médicos

your employer or the claims administrator has not created or selected an MPN.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same level of privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Problems with Medical Care and Medical Reports: At some point during your claim, you might disagree with your PTP about what treatment is necessary. If this happens, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, the steps to take depend on whether you are receiving care in an MPN, HCO, or neither. For more information, see "Learn More About Workers' Compensation," below.

If the claims administrator denies treatment recommended by your PTP, you may request independent medical review (IMR) using the request form included with the claims administrator's written decision to deny treatment. The IMR process is similar to the group health IMR process, and takes approximately 40 (or fewer) days to arrive at a determination so that appropriate treatment can be given. Your attorney or your physician may assist you in the IMR process. IMR is not available to resolve disputes over matters other than the medical necessity of a particular treatment requested by your physician.

If you disagree with your PTP on matters other than treatment, such as the cause of your injury or how severe the injury is, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, notify the claims administrator in writing as soon as possible. In some cases, you risk losing the right to challenge your PTP's opinion unless you do this promptly. If you do not have an attorney, the claims administrator must send you instructions on how to be seen by a doctor called a qualified medical evaluator (QME) to help resolve the dispute. If you have an attorney, the claims administrator may try to reach agreement with your attorney on a doctor called an agreed medical evaluator (AME). If the claims administrator disagrees with your PTP on matters other than treatment, the claims administrator can require you to be seen by a QME or AME.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, you may receive temporary disability payments for a limited period. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Stay at Work or Return to Work: Being injured does not mean you must stop working. If you can continue working, you should. If not, it is important to go back to work with your current employer as soon as you are medically able. Studies show that the longer you are off work, the harder it is to get back to your original job and wages. While you are recovering, your PTP, your employer (supervisors or others in management), the claims administrator, and your attorney (if you have one) will work with you to decide how you will stay at work or return to work and what work you will do. Actively communicate with your PTP, your employer, and the claims administrator about the work you did before you were injured, your medical condition and the kinds of work you can do now, and the kinds of work that your employer could make available to you.

Payment for Permanent Disability: If a doctor says you have not recovered completely from your injury and you will always be limited in the work you can do, you may receive additional payments. The amount will depend on the type of injury, extent of impairment, your age, occupation, date of injury, and your wages before you were injured.

Supplemental Job Displacement Benefit (SJDB): If you were injured on or after 1/1/04, and your injury results in a permanent disability and your employer does not offer regular, modified, or alternative work, you may qualify for a nontransferable voucher payable for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law.

Death Benefits: If the injury or illness causes death, payments may be made to a

(Medical Provider Network- MPN), usted puede cambiar a otros médicos dentro de la MPN después de la primera visita.

- Si usted está recibiendo tratamiento en un Organización de Cuidado Médico (Healthcare Organization- HCO), es posible cambiar al menos una vez a otro médico dentro de la HCO. Usted puede cambiar a un médico fuera de la HCO 90 o 180 días después de que su lesión es reportada a su empleador (dependiendo de si usted está cubierto por un seguro médico proporcionado por su empleador).
- Si usted no está recibiendo tratamiento en una MPN o HCO y no hizo una designación previa, usted puede cambiar a un nuevo médico una vez durante los primeros 30 días después de que su lesión es reportada a su empleador. Póngase en contacto con el administrador de reclamos para cambiar de médico. Después de 30 días, puede cambiar a un médico de su elección si su empleador o el administrador de reclamos no ha creado o seleccionado una MPN.

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes serán revelados. Si usted solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Problemas con la Atención Médica y los Informes Médicos: En algún momento durante su reclamo, podría estar en desacuerdo con su *PTP* sobre qué tratamiento es necesario. Si esto sucede, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, los pasos a seguir dependen de si usted está recibiendo atención en una *MPN*, *HCO* o ninguna de las dos. Para más información, consulte la sección "Aprenda Más Sobre la Compensación de Trabajadores," a continuación.

Si el administrador de reclamos niega el tratamiento recomendado por su *PTP*, puede solicitar una revisión médica independiente *(Independent Medical Review-IMR)*, utilizando el formulario de solicitud que se incluye con la decisión por escrito del administrador de reclamos negando el tratamiento. El proceso de la *IMR* es parecido al proceso de la *IMR* de un seguro médico colectivo, y tarda aproximadamente 40 (o menos) días para llegar a una determinación de manera que se pueda dar un tratamiento apropiado. Su abogado o su médico le pueden ayudar en el proceso de la *IMR*. La *IMR* no está disponible para resolver disputas sobre cuestiones aparte de la necesidad médica de un tratamiento particular solicitado por su médico.

Si no está de acuerdo con su *PTP* en cuestiones aparte del tratamiento, como la causa de su lesión o la gravedad de la lesión, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, notifique al administrador de reclamos por escrito tan pronto como sea posible. En algunos casos, usted arriesg perder el derecho a objetar a la opinión de su *PTP* a menos que hace esto de inmediato. Si usted no tiene un abogado, el administrador de reclamos debe enviarle instrucciones para ser evaluado por un médico llamado un evaluador médico calificado *(Qualified Medical Evaluator-QME)* para ayudar a resolver la disputa. Si usted tiene un abogado, el administrador de reclamos puede tratar de llegar a un acuerdo con su abogado sobre un médico llamado un evaluador médico acordado *(Agreed Medical Evaluator- AME)*. Si el administrador de reclamos no está de acuerdo con su *PTP* sobre asuntos aparte del tratamiento, el administrador de reclamos puede exigirle que sea atendido por un *QME* o *AME*.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. puede recibir pagos por incapacidad temporal por un periodo limitado. Estos pagos pueden cambiar o parar cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no puede trabajar durante más de 14 días.

Permanezca en el Trabajo o Regreso al Trabajo: Estar lesionado no significa que usted debe dejar de trabajar. Si usted puede seguir trabajando, usted debe hacerlo. Si no es así, es importante regresar a trabajar con su empleador actual tan

spouse and other relatives or household members who were financially dependent on the deceased worker.

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

Resolving Problems or Disputes: You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your employer or claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) or unemployment insurance (UI) benefits. Call the state Employment Development Department at (800) 480-3287 or (866) 333-4606, or go to their website at www.edd.ca.gov.

You Can Contact an Information & Assistance (I&A) Officer: State I&A officers answer questions, help injured workers, provide forms, and help resolve problems. Some I&A officers hold workshops for injured workers. To obtain important information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an I&A officer of the state Division of Workers' Compensation. You can also hear recorded information and a list of local I&A offices by calling (800) 736-7401.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their website at **www.californiaspecialist.org**.

Learn More About Workers' Compensation: For more information about the workers' compensation claims process, go to www.dwc.ca.gov. At the website, you can access a useful booklet, "Workers' Compensation in California: A Guidebook for Injured Workers." You can also contact an Information & Assistance Officer (above), or hear recorded information by calling 1-800-736-7401.

pronto como usted pueda medicamente hacerlo. Los estudios demuestran que entre más tiempo esté fuera del trabajo, más difícil es regresar a su trabajo original y a sus salarios. Mientras se está recuperando, su *PTP*, su empleador (supervisores u otras personas en la gerencia), el administrador de reclamos, y su abogado (si tiene uno) trabajarán con usted para decidir cómo va a permanecer en el trabajo o regresar al trabajo y qué trabajo hará. Comuníquese de manera activa con su *PTP*, su empleador y el administrador de reclamos sobre el trabajo que hizo antes de lesionarse, su condición médica y los tipos de trabajo que usted puede hacer ahora y los tipos de trabajo que su empleador podría poner a su disposición.

Pago por Incapacidad Permanente: Si un médico dice que no se ha recuperado completamente de su lesión y siempre será limitado en el trabajo que puede hacer, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, grado de deterioro, su edad, ocupación, fecha de la lesión y sus salarios antes de lesionarse.

Beneficio Suplementario por Desplazamiento de Trabajo *(Supplemental Job Displacement Benefit- SJDB)*: Si Ud. se lesionó en o después del 1/1/04, y su lesión resulta en una incapacidad permanente y su empleador no ofrece un trabajo regular, modificado, o alternativo, usted podría cumplir los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo un curso de reentrenamiento y/o mejorar su habilidad. Si Ud. cumple los requisios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales.

Beneficios por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a un cónyuge y otros parientes o a las personas que viven en el hogar que dependían económicamente del trabajador difunto.

Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad laboral, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (Código Laboral, sección 132a.) De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

Resolviendo problemas o disputas: Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su empleador o administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatalde Incapacidad *(State Disability Insurance- SDI)* o beneficios del desempleo *(Unemployment Insurance- UI)*. Llame al Departamento del Desarrollo del Empleo estatal al (800) 480-3287 o (866) 333-4606, o visite su página Web en www.edd.ca.gov.

Puede Contactar a un Oficial de Información y Asistencia *(Information & Assistance- I&A)*: Los Oficiales de Información y Asistencia *(I&A)* estatal contestan preguntas, ayudan a los trabajadores lesionados, proporcionan formularios y ayudan a resolver problemas. Algunos oficiales de *I&A* tienen talleres para trabajadores lesionados. Para obtener información importante sobre el proceso de la compensación de trabajadores y sus derechos y obligaciones, vaya a www.dwc.ca.gov o comuníquese con un oficial de información y asistencia de la División Estatal de Compensación de Trabajadores. También puede escuchar información grabada y una lista de las oficinas de *I&A* locales llamando al (800) 736-7401.

Ud. puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, o consulte su página Web en www.californiaspecialist.org.

Aprenda Más Sobre la Compensación de Trabajadores: Para obtener más información sobre el proceso de reclamos del programa de compensación de trabajadores, vaya a www.dwc.ca.gov. En la página Web, podrá acceder a un folleto útil, "Compensación del Trabajador de California: Una Guía para Trabajadores Lesionados." También puede contactar a un oficial de Información y Asistencia (arriba), o escuchar información grabada llamando al 1-800-736-7401.

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State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it "**Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401.** An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____a.m. _____p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
_____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
_____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. ❑ Check if you agree to receive notices about your claim by email only. ❑ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. _____ *Correo electrónico del empleado.* _____.
You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*
9. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

10. Name of employer. *Nombre del empleador.* _____
11. Address. *Dirección.* _____
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.*_____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* _____
Claims Administrator - Omaha National Underwriters at P.O. Box 451139, Omaha, NE 68145
16. Insurance Policy Number. *El número de la póliza de Seguro.*_____
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* _____ 19. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

❑ Employer copy/*Copia del Empleador* ❑ Employee copy/*Copia del Empleado* ❑ Claims Administrator/*Administrador de Reclamos* ❑ Temporary Receipt/*Recibo del Empleado*

Employee Medical Provider Network Notice

Please read this packet for information about medical care for work injuries or illnesses.

Keep this information in case you have a work-related injury or illness.

Our Goal Is Your Safe and Successful Return to Work

Your well-being is important to us. If you are hurt at work, our goal at Omaha National Underwriters, LLC (also called "Omaha National") is to help you get better. This means helping you to get back to your regular activities and work, as soon as it is medically safe. We have a Medical Provider Network (MPN) of skilled doctors and medical providers to give you the best medical care possible.

Medical Care for a Work-Related Injury or Illness

An MPN is a group of doctors and health care providers. They give medical care to people that are hurt at work. The network has doctors who specialize in treating work-related injuries. It also has doctors with skills in other areas of medicine. The MPN lets you select the doctor to treat your work injuries and illnesses from a list of network providers.

The MPN for your employer and their workers compensation insurance company is handled by Omaha National Underwriters, LLC. The workers compensation insurance company is Preferred Professional Insurance Company. This notice has facts about the MPN program. It also gives details about your rights. Please call your Claims Adjuster or the MPN Medical Access Assistance hotline at 844-761-8400 if you have any questions.

Our Medical Provider Network

- The MPN Name is Omaha National MPN and the MPN ID Number is 3064
- Information about the MPN can be found at our website, mpn.omahanational.com. You may also get a list of all doctors in the network at mpn.omahanational.com.
- If you have any questions about your claim or about medical treatment for your work injury or illness, please contact your Claims Adjuster at 844-761-8400. You may also call our Medical Access Assistant or our Omaha National MPN Contact for help. Their contact information is given below.

Our MPN Medical Access Assistant can help you find MPN providers. They will also help to schedule and confirm medical appointments. They are available Monday through Saturday from 7:00 AM to 8:00 PM Pacific Time. They are closed on Sundays and holidays. Help is available in both English and Spanish.

MPN Medical Access Assistants

Phone 844-761-8400

Fax 844-761-8402

Email mpn@omahanational.com

Our Omaha National MPN Contact will answer questions about using the MPN. They will address any complaints about the MPN. They can also help you set up an MPN independent medical review.

MPN Contacts

Name	Omaha National
Title	MPN Contact
Address	PO Box 451139, Omaha, NE 68145
Phone	844-761-8400
Fax	844-761-8402
Email	mpn@omahanational.com

If You Are Injured on the Job or Suffer a Work-Related Illness

In case of an emergency, you should call 911 or go to the closest hospital emergency room.

Tell your supervisor or manager as soon as possible after you receive emergency treatment. If your injury or illness is not an emergency, tell your supervisor or manager right away. They will send you to an MPN provider to receive medical care. Once your claim is reported, your employer will give you a form to complete. It is Form DWC-1 - Workers' Compensation Claim Form & Notice of Potential Eligibility. To protect your rights, you should report every work-related injury or illness. You should also ask for a claim form as soon as possible.

Medical Care Within the MPN

An MPN health care provider will give you medical care for your work injury or illness. Please call your employer or Omaha National's Medical Access Assistant at 844-761-8400 to find an MPN provider. They will help you schedule your first medical visit. Your first visit will be within 3 working days. If an appointment with a network provider cannot be scheduled within 3 working days of your request, you may be allowed to get treatment from a doctor outside of the MPN.

After the first medical visit, you may continue to be treated by that doctor. Or you may choose another doctor from the MPN to act as your primary treating physician who will direct your treatment. The MPN network provider that you choose will direct your treatment.

If it is needed, you may select a specialist from the network. You may also ask your primary treating physician doctor for a referral to a specialist. Some specialists will only accept an appointment with a referral from your primary treating physician. These specialists are listed as "by referral only" in the MPN directory. When treatment with a specialist is required, your appointment will be within 20 working days of your request. If an appointment with a network specialist cannot be scheduled within 10 working days of your request, you may be allowed to obtain treatment with an appropriate specialist outside of the MPN.

Finding and Choosing an MPN Provider

The plan has network providers located all over the state of California. You may view and print a list of all the network providers at our website (mpn.omahanational.com). You may also call the Omaha National MPN Contact at 844-761-8400 to request the list. You may ask for a list of all providers within 15 miles of your workplace and/or home. Or, you may request a list of all providers within the county where you work and/or live. You also have the right to ask for a list of all the MPN providers within the network.

The MPN must include at least 3 doctors in each specialty commonly used to treat work injuries and illnesses in your industry. The network must also give access to three primary treating physicians and a hospital or a facility for emergency healthcare services within 30 minutes or 15 miles of your workplace or

home. It must provide access to specialists within 60 minutes or 30 miles of your workplace or home. If you cannot find a provider within these limits, please call your Claims Adjuster or our MPN Medical Access Assistant at 844-761-8400. They can help you find a provider in your area. If you live in a rural area or an area where there is a healthcare shortage, there may be a different standard.

If you are not able to find a provider in your area, the Claims Adjuster or the MPN Medical Access Assistant will confirm that there are no MPN providers in the proper specialty who are available to treat your injury within the required distance and timeframes.

Once they confirm this, you will be allowed to seek treatment with a provider outside of the MPN. However, the distance you travel to a non-MPN provider must be less than the distance you would travel to the nearest MPN provider. At times, you may need to see a type of specialist that is not available in the MPN. If so, you have the right to see a specialist that is outside of the network. Any providers you choose should be proper to treat your injury or illness.

How to Access List of MPN Providers

There are two ways to access the website to search for a provider list:

Option 1:

1. Go directly to our MPN website at: mpn.omahanational.com.
2. You will be able to search by provider name, specialty, or location.
3. You can request the entire MPN roster of all treating physicians
4. You can request the entire MPN roster of all participating providers.
5. You can request a list of providers within a specific radius.

Option 2:

1. Go through the Omaha National's website: omahanational.com.
2. At the top right-side of the page, click "Find a doctor" button on the "Find A Medical Provider" screen, and select "California."
3. You will be able to search by provider name, specialty, or location.
4. You can request the entire MPN roster of all treating physicians.
5. You can request the entire MPN roster of all participating providers.
6. You can request a list of providers within a specific radius.

If you need help, please contact your Claims Adjuster or the MPN Medical Access Assistant Hotline at 844-761- 8400.

Business Travel or Temporarily Working Outside California

If you have a work injury or illness while working outside of California or MPN geographic service area, contact your supervisor or manager to report your injury. They will help you get medical care if treatment is needed right away for non-emergency conditions. You will receive a list of at least three physicians outside the MPN geographic service area for your selection. **However, in case of an emergency, you should call 911 or go to the closest hospital emergency room!**

When you return to California or MPN geographic service area, please contact your Claims Adjuster. They will help you find an MPN provider for any further treatment and transfer your future medical care into the MPN.

Relocation Outside California

If you move outside of California or the MPN geographic service area, but you still need care for your current or existing work injury, you can select a new doctor to treat you. Please call your Claims Adjuster to find a doctor near your new home. You will receive a list of at least three physicians outside the MPN geographic service area.

If your move or relocation is only for a short period during recovery, make sure to let your Claims Adjuster know when you return to California or the MPN geographic service area. The Claims Adjuster will help you return to your prior MPN provider. If you are unable to return to your prior MPN provider, the Claims Adjuster will help you find a new MPN provider.

Physician Changes

If you disagree with your doctor or if you wish to change your doctor for any reason, you may choose another doctor within the MPN. If you select another doctor, please let your Claims Adjuster know as soon as possible. They will send a copy of your medical records and our billing information to the new doctor. You may request a copy of the records that are sent.

Additional Opinions and MPN Independent Medical Review

If you do not agree with the diagnosis or the treatment planned by your doctor, you may ask for a second opinion from another doctor within the MPN. If you want a second opinion, please call your Claims Adjuster or the MPN Contact at 844-761-8400. Tell them you want a second opinion. They will help you find a provider to give the second opinion. They can give you at least a regional list of MPN providers for you to select a doctor for a second opinion.

To receive the second opinion, you must select the network doctor and make an appointment within 60 days. Once the appointment has been set, you must tell your Claims Adjuster or the MPN Contact the doctor you selected. You must give the appointment details so that a copy of your medical records can be sent to the second opinion doctor. You may request a copy of the records that are sent.

Please note, if you do not make the appointment within the 60-day timeframe, you will not be allowed to have a second or third opinion about that disputed diagnosis or treatment.

If the second-opinion doctor feels that your injury or illness is outside of the type of injury that they normally treat, the doctor’s office will inform your Claims Adjuster. If this happens, you will be given a new list of MPN providers for selecting another doctor.

If you do not agree with the second opinion, you may get a third opinion on the matter. If you ask for a third opinion, you will go through the same process that you used to get the second opinion. Like the second opinion process, if you want to obtain a third opinion, you must select the doctor and schedule an appointment within 60 days of receiving another MPN provider list. If the appointment is not made within the 60-day timeframe, you will not be allowed to get the third opinion on the disputed diagnosis or treatment.

If you do not agree with the third-opinion doctor, you may ask for an MPN Independent Medical Review (MPN IMR) from your Claims Adjuster or MPN Contact. You should receive information on how to request an MPN IMR and the form and fill out in the “Medical Provider Network Contact” section of the MPN IMR application form for you to make a request at the time you select the third-opinion doctor.

If either the second-opinion doctor, third-opinion doctor, or MPN Independent Medical Reviewer agrees with your need for a treatment or medical test, you will be allowed to receive that medical service from an

MPN provider. If the network does not include a provider who can give the recommended service, you may choose a physician outside the MPN within a reasonable geographic area.

MPN Independent Medical Review

If you do not agree with the diagnosis or treatment advised by the third-opinion physician, you may ask for an MPN Independent Medical Review (MPN IMR) decision on the dispute. The MPN Independent Medical Reviewers who is a licensed doctor selected by the California Division of Workers' Compensation will review and decide on your dispute. You may choose to be examined in-person by the MPN IMR doctor, or you may ask the MPN IMR doctor only to review your medical records.

If you would like to request an MPN IMR, you must file an MPN Independent Medical Review Application form with the Division of Workers' Compensation. An MPN IMR doctor who has the proper specialty needed to review your dispute will be chosen. You will receive written notice of the MPN IMR doctor's contact information. You will lose your right to the MPN IMR process if you do not schedule an appointment within 60 calendar days from receiving the MPN IMR doctor's contact information from the Division of Workers' Compensation.

You are required to contact the MPN IMR doctor for an appointment or to arrange for the medical record review. Appointments with an MPN IMR doctor should be made within 30 days from your request for an appointment. The MPN IMR doctor will serve the report on the Administrative Director of the Division of Workers' Compensation, the Omaha National MPN Contact, you and your attorney, if any, within 20 days after the completion of in-person examination or medical record review, according to the California Code of Regulations section 9768.11. After that, a decision will be made on the dispute.

Continuity of Care

Omaha National has a Continuity of Care policy to help you if you request to continue treatment with your treating doctor who decides to leave the MPN. This policy determines whether you can continue treatment for an existing work injury with your doctor for a short period when your doctor is no longer part of the MPN. If you do not qualify to continue your care with the non-MPN provider, you and your primary treating physician will receive a letter from Omaha National to tell you of this decision. If you meet certain conditions, you may be able to continue treating with this doctor for up to a year before you must choose an MPN physician. These conditions are addressed below.

- **Acute** - The treatment for your injury or illness will be completed in less than 90 days.

- **Serious or Chronic** - Your injury or illness is one that is serious in nature. These injuries or illnesses continue for at least 90 days without full recovery or worsen and require ongoing treatment. You may be allowed to be treated by your current treating doctor for up to one year until a safe transfer of care can be made.
- **Terminal -** You have an incurable illness or irreversible condition that is likely to cause death within one year or less.

- **Pending Surgery** - You already have a surgery or another procedure that has been authorized by Omaha National. The surgery or other procedure is scheduled to occur within 180 days of the MPN effective date, or the end of the contract date between the MPN and your doctor.

You can disagree with the decision to deny you continued treatment with the non-MPN provider. If you want to continue treating with the terminated doctor, ask your primary treating physician for a medical report. The report should state whether you have one of the four conditions stated above to see if you qualify to temporarily continue treating with your current doctor. Your primary treating physician has 20 days from the date of your request to give you a copy of his/her medical report on your condition. If your doctor does not give you the report within 20 days of your request, the decision to deny you continued treatment with your doctor who is no longer participating in the MPN will apply. You will be required to choose an MPN physician.

You will need to give a copy of the report to your Claims Adjuster if you wish to delay the selection of an MPN doctor for treatment. If you or Omaha National disagrees with your doctor's report on your condition, either party can dispute it. Please see the complete Continuity of Care policy for more details. For a copy of the complete Continuity of Care policy, please call your Claims Adjuster or the MPN Medical Access Assistant at 844- 761-8400. A copy of the policy is also available in Spanish upon request.

Transfer of Care

If you are already being treated for a work injury or illness before your employer joins the MPN, Omaha National has a Transfer of Care policy. This policy decides if you can continue to be treated for a current work injury for a short period by a doctor outside of the MPN before your care is transferred into the MPN.

If your current doctor is not or does not become a member of the MPN, you may be required to see an MPN doctor. However, if you have properly predesignated a personal physician, you cannot be transferred into the MPN. If you have questions about choosing a doctor, please call your Claims Adjuster or the Omaha National MPN Contact at 844-761-8400. You and your primary treating physician will receive a letter if your employer decides to transfer you into the MPN.

If you meet certain conditions, you may be able to continue to treat with a non-MPN physician for up to a year before you are transferred into the MPN. The conditions that allow you to delay the transfer of your care into the MPN are addressed below.

- **Acute -** The treatment for your injury or illness will be completed in less than 90 days.
- **Serious or Chronic** - Your injury or illness is one that is serious in nature. These injuries or illnesses continue for at least 90 days without full recovery or worsen and require ongoing treatment. You may be allowed to be treated by your current treating doctor for up to one year until a safe transfer of care can be made.
- **Terminal -** You have an incurable illness or irreversible condition that is likely to cause death within one year or less.
- **Pending Surgery -** You already have a surgery or another procedure that has been authorized by Omaha National. The surgery or other procedure is scheduled to occur within 180 days of the MPN effective date, or the end of the contract date between the MPN and your doctor.

If you do not want to be transferred into the MPN, ask your primary treating physician for a medical report on whether you have one of the four conditions stated above to allow a delay of your transfer into the MPN.

Your primary treating physician has 20 calendar days from the date of your request to give you a copy of his/her report on your condition. If your doctor does not give you the report within 20 calendar days of your request, your care will be transferred into the MPN and you will be required to use an MPN doctor.
You will need to give a copy of the report to your Claims Adjuster if you wish to delay the transfer of your care. If you or Omaha National disagrees with your doctor's report on your condition, either party may dispute it. Please see the complete Transfer of Care policy for more details.

For a copy of the complete Transfer of Care policy, please call your Claims Adjuster or the MPN Medical Access Assistant at (844) 761-8400. A copy of the policy in Spanish is also available upon request.

Questions or Help

- If you have any questions about your claim or your medical treatment for your work injury or illness, please call your Claims Adjuster at 844-761-8400.
- You can call the MPN Medical Access Assistant at 844-761-8400 if you need help to find MPN providers. They can also schedule and confirm appointments.

- You may always contact the Omaha National MPN Contact at 844-761-8400 if you have questions about the use of the MPN. They can also address any complaints about the MPN.

- You can go to the California Division of Workers' Compensation (DWC) website and locate the contact information of your nearest Information and Assistance Unit office, at https://www.dir.ca.gov/dwc/IandA.html or for a recorded message at 1-800-736-7401 if you have any questions regarding your rights and responsibilities under the California Workers Compensation Law.

- You can also go to the DWC's website at www.dir.ca.gov/dwc and click on "medical provider networks" for more information about MPNs.

- If you have questions about the MPN Independent Medical Review process, contact the DWC's Medical Unit at: DWC Medical Unit, PO Box 71010, Oakland, CA 94612. You may also call them at510-286-3700 or 800-794-6900.

Notice to Victims of Workplace Crime

If you are a victim of a crime that occurred at your place of employment, you may be eligible for workers compensation for any injuries, including psychiatric or mental injuries, that resulted from the workplace crime.

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

Employee Acknowledgement Form

Employee Name _____ Employer _____

Date Hired _____

Employer:

1. Give the DWC Time of Hire Pamphlet to new employees when they are hired or by the end of their first pay period.
2. A copy of the Predesignation Form (DWC-9783) is attached to the pamphlet. An employee can use it to choose in advance to have their personal doctor treat work injuries.
3. Have the new employee complete and sign Section One below. Save a copy in their employee file.
4. When you learn a work-related injury has happened, you must give the injured worker a copy of the Employee Medical Provider Network Notice. Then, have the employee sign Section Two of this form. Send a copy of the signed form to Omaha National.
5. Please contact us at 844-761-8400 if you have any questions. Additional copies of the pamphlet and forms are on our website at omahanational.com.

Employee:

1. This form confirms your employer gave you documents about workers compensation.
2. You can use the Predesignation Form to choose to have your personal doctor treat you if you get hurt at work. To do this, you must:
    a. Give your employer written notice that you want your personal doctor to treat you for work injuries. The notice must be provided before an injury occurs and needs to contain the doctor's name and address;
    b. Have healthcare coverage (for injuries or illnesses not related to work) in a plan, policy, or fund; and
3. Get your personal doctor to agree to treat you for any work injuries. The Employee MPN Notice contains information about the Omaha National Medical Provider Network. It also has information on how to get medical care for your work injury.

Section One: Confirmation of DWC Time of Hire Pamphlet & Predesignation Form

I confirm that my employer gave me copies of the following documents:

☐ DWC Time of Hire Pamphlet

☐ Form DWC-9783 - Notice of Predesignation of Personal Physician (attached to the DWC Time of Hire Pamphlet)

☐ I understand it is my duty to tell my employer I have a work injury as soon as the injury happens.

Signature _____

Printed Name _____ Date _____

Section Two: Confirmation of Employee Medical Provider Network Notice

I confirm that my employer gave me a copy of the Employee Medical Provider Network (MPN) Notice. I understand that I must treat with a provider from the MPN unless I elected to be treated by my personal doctor.

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

Signature _____

Printed Name _____ Date _____

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

Consent and Authorization for Release of Information

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

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

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

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

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

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

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

This information is required for the following:

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

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

Signature _____

Printed Name _____ Date _____

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

Request for Medical History

Injured Worker _____ Date of Injury _____

Employer _____ Current Date _____

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

Family Doctor / Primary Health Care Provider and Other Treating Doctors			
Name	Address	Phone	Condition Being Treated

Medications / Prescriptions			
Name	Description/Purpose	Dosage	Prescribing Doctor

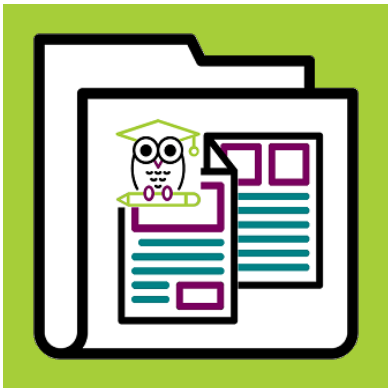
Hospitalizations and Surgical Procedures			
Date(s)	Diagnosis/Treatment/Procedure	Doctor	Hospital

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

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

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

Signature _____ Date _____



INFORMATIONAL DOCUMENTS

Keep these documents for your future reference.

- **Omaha National Contact Information:**
  Claims and Medical Provider Network (MPN) contact information with instructions for accessing our MPN.

- **Medical Provider Network (MPN) Information for Employers:**
  Information about our provider network and the employer actions necessary for us to require treatment within the network.

- **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

Medical Provider Network (MPN):

Online	mpn.omahanational.com
Phone	844-761-8400
Fax	844-761-8402
Email	mpn@omahanational.com

Directory of MPN Physicians and Facilities:

There are two ways to access the website to search for a provider list:

Option 1:

1. Go to: mpn.omahanational.com.
2. You will be able to search by provider name, specialty, or location.
3. You can request the entire MPN roster.
4. You can request a list of providers within a specific radius.

Option 2:

1. Go to: omahanational.com
2. At the top right-side of the page, click "Find a Doctor."
3. Under the Find a Medical Provider Section, click the "Find a Doctor" button.
4. Click on California to open the Omaha National MPN Provider Search.
5. You will be able to search by provider name, specialty, or location.
6. You can request the entire MPN roster.
7. You can request a list of providers within a specific radius

Medical Provider Network (MPN) Information for Employers

Medical Network for Treating Workplace Injuries

The right physician can have a substantial impact on the successful recovery of an injured employee and on the cost of a workers compensation claim. High quality, cost effective care for your injured employees is our top priority. That is why we have partnered with Networks By Design to implement a medical provider network (MPN) that provides injured workers with medical care from qualified physicians and other medical providers. Our network consists of providers who are experienced in treating workplace injuries, are familiar with the workers compensation system, and are strong advocates of an early, safe return to work. We are continually evaluating our network to ensure injured workers receive appropriate and timely care.

Preserve Your MPN Rights

We can only require that injured workers treat within the network if these steps are followed:

- **Post Workers Compensation Notices:** Employers are required to post mandatory notices regarding employees' workers compensation rights. We have provided those notices to you along with instructions on where to post them. If it is determined that the notices were not posted and that resulted in a denial of medical care, an injured worker will be allowed to seek treatment outside of the medical network.
- **Notice of Right to Predesignate:** An employer must advise their employees of their right to predesignate a personal physician to treat work-related injuries and illnesses. This can be done by providing the Time of Hire Pamphlet to all new employees at the time of hire or by the end of the first pay period. The predesignation forms are attached to the pamphlet. We have provided you with Employee Acknowledgement Forms that you can use to obtain each employee's certification that they have received the pamphlet.
- **Employee Medical Provider Network Notice:** Employers are required to provide the MPN Notice to employees when an injury is reported, the employer has knowledge of an injury, or an employee with an existing work injury is required to transfer treatment to a MPN. Omaha National has designed an Employee Acknowledgement Form to be used to obtain an injured worker's certification that they have received the notice.
- **Offer Immediate Medical Care:** Upon learning of a work injury, an employer is required to offer immediate medical treatment to the injured employee and to schedule an appointment with an MPN provider. Let us know about any injury right away so we can help arrange for appropriate medical care. The failure to offer medical care may constitute a refusal or denial of care which may result in an employee being able to treat with providers outside the MPN.

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.

- **Notice of Ownership Change:**
  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 accountmanagement@omahanational.com.

For your protection California law requires the following to appear on this form:

Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Notice of Ownership Change

Use this document to provide notice of a change in company ownership.

Changes in ownership may impact your workers compensation policy and the experience modification factor used to determine your premium. Any ownership changes must be reported to us immediately so that we can notify the Workers' Compensation Insurance Rating Bureau of California (WCIRB). In general, an ownership change is the transfer of business operations or assets to another person or business.

For experience rating purposes, a change in ownership involves:

- All or a portion of the ownership in an entity is sold, transferred, or conveyed from one person to another
- An entity is dissolved or non-operative and a new entity is formed
- Two or more corporations undergo a statutory merger or consolidation
- All or most of the tangible or intangible assets of an entity are sold, transferred, or conveyed to another entity
- A trusteeship or receivership is set up, either voluntarily or at the direction of the courts, to operate a business

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

General Information

Policyholder Name _____ FEIN _____

Date of Ownership Change or Sale _____ Policy Number _____

Check one:

- ☐ All or some of the ownership in the business was transferred from one group of owners to another
- ☐ Most of the business's assets were sold or transferred to another business
- ☐ Other (please explain): _____

Before Ownership Change – Seller Information

Name _____

FEIN _____

Address _____

Legal Nature Please select

Entity Details

Owners / Shareholders	% Ownership
	0.00%
	0.00%
	0.00%
	0.00%
	0.00%

After Ownership Change – Buyer Information

Name _____

FEIN _____

Address _____

Legal Nature Please select

Entity Details

Owners / Shareholders	% Ownership
	0.00%
	0.00%
	0.00%
	0.00%
	0.00%

Family Rule

Do the Buyer and Seller have a family relationship? ☐ Yes ☐ No

For these purposes, family relationship is defined as father, mother, husband, wife, registered domestic partner, son, daughter, stepson, stepdaughter, grandson, granddaughter, grandfather or grandmother.

If applicable, please provide details of family relationship: _____

Additional Operations

Are the prior owners still in business? ☐ Yes ☐ No ☐ Unknown

If the prior owners are still in business, did the new owners take most of their employees or only a minority? ☐ Yes ☐ No

If the prior owners are no longer in business, did the new owners make any drastic staffing changes, or are most of the prior owner's employees now working for the new owners? ☐ Yes ☐ No

Do the new owners own any other businesses? ☐ Yes ☐ No ☐ Unknown

Description of Change

Please provide an explanation of the change in your own words: _____

Submitter Information

Completed by _____ Date _____

Title _____ Signature _____

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

For your protection California law requires the following to appear on this form:

Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 _____
Office Phone Number _____
Cell Phone Number _____
Fax Number _____
Email Address _____

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

Company Contacts for Payroll Questions/Issues

☐ Check if same as above

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

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

Company Contacts for Policy Questions/Issues

☐ Check if same as above

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

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

Company Contacts for Claims Questions/Issues

☐ Check if same as above

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

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

Submitter Information

Completed by _____
Title _____

Date _____
Signature _____

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

STATE-SPECIFIC FORMS & DOCUMENTS

Please provide these documents to all new employees at the time of hire or by the end of the first pay period.

DWC Time of Hire Pamphlet:

This document serves as the mandatory notice to new employees. If there are Spanish-speaking employees, the pamphlet must be made available in both English and Spanish. To complete the form, on Page 3 of the document please select the appropriate insurance company name and on Page 4 enter the name and address of a nearby medical network provider. You may access an MPN provider listing at our website at **omahanational.com**. Also, enter the address of the nearest Division of Workers' Compensation Information and Assistance Unit. The Division posts a listing of its Information and Assistance Offices on its website at **dir.ca.gov/dwc/IandA.html**.

Employee Acknowledgement Form – Part One:

Have all new employees complete and sign part one of this form to show they received the Time of Hire Pamphlet and the Predesignation form. Save the signed form with the employee's records.

Time of Hire Notice

This notice, or a similar one that has been approved by the Administrative Director, must be given to all newly hired employees in the State of California. Employers and claims administrators may use the content of this document and put their logos and additional information on it. The content of this notice applies to all industrial injuries that occur on or after January 1, 2013.

WHAT IS WORKERS' COMPENSATION?

If you get hurt on the job, your employer is required by law to pay for workers' compensation benefits. You could get hurt by:

One event at work. Examples: hurting your back in a fall, getting burned by a chemical that splashes on your skin or getting hurt in a car accident while making deliveries.

—or—

Repeated exposures at work. Examples: hurting your hand, back, or other part of your body from doing the same repeated motion or losing your hearing because of constant loud noise

—or—

Workplace crime. Examples: you get hurt in a store robbery, physically attacked by an unhappy customer.

Discrimination is illegal

It is illegal under Labor Code section 132a for your employer to punish or fire you because you:

- File a workers' compensation claim
- Intend to file a workers' compensation claim
- Settle a workers' compensation claim
- Testify or intend to testify for another injured worker.

If it is found that your employer discriminated against you, he or she may be ordered to return you to your job. Your employer may also be made to pay for lost wages, increased workers' compensation benefits, and costs and expenses set by state law.

WHAT ARE THE BENEFITS?

- **Medical care:** Paid for by your employer to help you recover from an injury or illness caused by work. Doctor visits, hospital services, physical therapy, lab tests and x-rays are some of the medical services that may be provided. These services should be necessary to treat your injury. There are limits on some services such as physical and occupational therapy and chiropractic care.

- **Temporary Disability (TD) benefits:** Payments if you lose wages because your injury prevents you from doing your usual job while recovering. The amount you may get is up to two- thirds of your wages. There are minimum and maximum payment limits set by state law. You will be paid every two weeks if you are eligible. For most injuries, payments may not exceed 104 weeks within five years from your date of injury. Temporary Disability (TD) stops when you return to work, or when the doctor releases you for work, or says your injury has improved as much as it's going to.

- **Permanent Disability (PD) benefits**: Payments if you don't recover completely. You will be paid every two weeks if you are eligible. There are minimum and maximum weekly payment rates established by state law. The amount of payment is based on:

    - Your doctor's medical reports
    - Your age
    - Your occupation

- **Supplemental Job Displacement Benefits (SJDB):** This is a voucher for up to $6,000 that you can use for retraining or skill enhancement at an approved school, books, tools, licenses or certification fees, or other resources to help you find a new job.
  You are eligible for this voucher if:

    - You have a permanent disability.
    - Your employer does not offer regular, modified, or alternative work, **within 60 days** after the claims administrator receives a doctor's report saying you have made a maximum medical recovery.

- **Return-to-Work Supplemental Program (RTWSP):** For dates of injury after 1/1/2013, you may qualify for additional money from the Division of Workers' compensation program known as the Return-to-Work Supplement Program (RTWSP) if you received the Supplemental Job Displacement Voucher (SJDB). If you have questions or think you qualify, contact the Information & Assistance Unit by calling 1-800-736-7401 or visit website: **https://www.dir.ca.gov/RTWSP/RTWSP.html**

- **Death benefits:** Payments to your spouse, children or other dependents if you die from a job injury or illness. The amount of payment is based on the number of dependents. The benefit is paid every two weeks at a rate of at least $224 per week. In addition, workers' compensation provides a burial allowance.

OTHER BENEFITS

You may file a claim with the Employment Development Department (EDD) to get state disability benefits when workers' compensation benefits are delayed, denied, or have ended. There are time restrictions so for more information contact the local office of EDD or go to their web site **www.edd.ca.gov**.

Workers' compensation fraud is a crime
Any person who makes or causes to be made any knowingly false statement in order to obtain or deny workers' compensation benefits or payments is guilty of a felony. If convicted, the person will have to pay fines up to $150,000 and/or serve up to five years in jail.

WHAT SHOULD I DO IF I HAVE AN INJURY?

Report your injury to your employer

Tell your supervisor right away no matter how slight the injury may be. Don't delay – there are time limits. You could lose your right to benefits if your employer does not learn of your injury within 30 days. If your injury or illness is one that develops over time, report it as soon as you learn it was caused by your job. If you cannot report to the employer or don't hear from the claims administrator after you have reported your injury, contact the claims administrator yourself.

Workers' compensation insurance company or if employer is self-insured, person responsible for handling the claim is:

(Select Insurance Company Name)

Claims Administrator - Omaha National Underwriters

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

Phone: **844-761-8400**

You may be able to find the name of your employer's workers' compensation insurer at **www.caworkcompcoverage.com.** If no coverage exists or coverage has expired, contact the Division of Labor Standards Enforcement at **www.dir.ca.gov/DLSE** as all employees must be covered by law.

Get emergency treatment if needed

If it's a medical emergency, go to an emergency room right away. Tell the medical provider who treats you that your injury is job related. Your employer may tell you where to go for treatment.

Emergency telephone number: Call 911 for an ambulance, fire department or police. For non-emergency medical care, contact your employer, the workers' compensation claims administrator or go to this facility:

Medical Provider Name -
Address -
Phone Number -

Fill out DWC 1 claim form and give it to your employer

Your employer must give you a DWC 1 claim form within one working day after learning about your injury or illness. Complete the employee portion, sign and give it back to your employer. Your employer will then file your claim with the claims administrator. Your employer must authorize treatment within **one working day** of receiving the **DWC 1 claim form.** If the injury is from repeated exposures, you have **one year** from when you realized your injury was job related to file a claim.

In either case, you may receive up to **$10,000** in employer-paid medical care until your claim is either accepted or denied. The claims administrator has **up to 90 days** to decide whether to accept or deny your claim. Otherwise, your case is presumed payable. Your employer or the claims administrator will send you "benefit notices" that will advise you of the status of your claim.

MORE ABOUT MEDICAL CARE

What is a Primary Treating Physician (PTP)?

This is the doctor with overall responsibility for treating your injury or illness. He or she may be:

- The doctor you name in writing *before* you get hurt on the job
- A doctor from the medical provider network (MPN)
- The doctor chosen by your employer during the first 30 days of injury if your employer does not have an MPN or
- The doctor you chose after the first 30 days if your employer does not have a MPN.

What is a Medical Provider Network (MPN)?

A MPN is a select group of health care providers who treat injured workers. Check with your employer to see if they are using a MPN. If you have not named a doctor before you get hurt and your employer is using a MPN, you will see a MPN doctor. After your first visit, you are free to choose another doctor from the MPN list.

What is Predesignation?

Predesignation is when you name your regular doctor to treat you if you get hurt on the job. The doctor must be a medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or a medical group with an M.D. or D.O. You must name your doctor in writing *before* you get hurt or become ill.

You may predesignate a doctor if you have health care coverage for non-work injuries and illnesses. The doctor must have:

- Treated you
- Maintained your medical history and records before your injury and
- Agreed to treat you for a work-related injury or illness before you get hurt or become ill.

You may use the "predesignation of personal physician" form included with this notice. After you fill in the form, be sure to give it to your employer. If your employer does not have an approved MPN, you may name your chiropractor or acupuncturist to treat you for work related injuries. The notice of personal chiropractor or acupuncturist must be in writing before you get hurt. You may use the form included in this notice. After you fill in the form, be sure to give it to your employer.

With some exceptions, state law does not allow a chiropractor to continue as your treating physician after 24 visits. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. The term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management.

Exceptions to 24 visits include postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule, or if your employer has authorized additional visits in writing.

WHAT IF THERE IS A PROBLEM?

If you have a concern, speak up. Talk to your employer or the claims administrator handling your claim and try to solve the problem. If this doesn't work, get help by trying the following:

Contact the Division of Workers' Compensation (DWC) Information and Assistance (I&A) Unit. All 24 DWC offices throughout the state provide information and assistance on rights, benefits and obligations under California's workers' compensation laws. I&A officers help resolve disputes without formal proceedings. Their goal is to get you full and timely benefits. Their services are free.
To contact the nearest I&A Unit, go to **https:// www.dir.ca.gov/dwc/ianda.html**
or call **1-800-736-7401.**

The nearest I&A Unit is located at:

Address: _____

Phone number: _____

Consult with an attorney

Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fees may be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at **1-415-538-2120** or go visit their website at **www.californiaspecialist.org**. You may also get a list of attorneys from your local I&A Unit by calling **1-800-736-7401.**

Your employer may not pay workers' compensation benefits if you get hurt in a voluntary off- duty recreational, social or athletic activity that is not part of your work-related duties.

You may also have other rights under the Americans with Disabilities Act (ADA) or the California Fair Employment and Housing Act (FEHA). For additional information, contact California Civil Rights Department (CRD) at 1-800-884-1684 or the Equal Employment Opportunity Commission (EEOC) at 1-800-669-4000.

The information contained in this notice conforms to the informational requirements found in Labor Code sections 3551 and 3553 and California Code of Regulation, Title 8, sections 9880 and 9883. This document is approved by the Division of Workers' Compensation Administrative Director.

Please visit the Division of Workers' Compensation website at: **www.dwc.ca.gov** or call 1-800-736-7401

Department of Industrial Relations
1515 Clay Street, 17th Floor
Oakland, CA 94612

PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- on the date of your work injury you have health care coverage for injuries or illnesses that are not work related;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee: Complete this section.

To: _____ (name of employer) If I have a work-related injury or illness, I choose to be treated by:_____
(name of doctor)(M.D., D.O., or medical group)
_____ (street address, city, state, ZIP)

_____ (telephone number)

Employee Name (please print):_____

Employee's Address:_____

Name of Insurance Company, Plan, or Fund providing health coverage for nonoccupational injuries or illnesses: _____

Employee's Signature _____Date: _____

Physician: I agree to this Predesignation:

Signature: _____Date: _____
(Physician or Designated Employee of the Physician or Medical Group)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

Title 8, California Code of Regulations, section 9783.

NOTICE OF PERSONAL CHIROPRACTOR OR PERSONAL ACUPUNCTURIST

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

NOTE: If your date of injury is January 1, 2004 or later, a chiropractor cannot be your treating physician after you have received 24 chiropractic visits unless your employer has authorized additional visits in writing. The term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. This prohibition shall not apply to visits for postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule.

You may use this form to notify your employer of your personal chiropractor or acupuncturist.

Your Chiropractor or Acupuncturist's Information:

_____

(name of chiropractor or acupuncturist)

_____

(street address, city, state, zip code)

_____

(Telephone number)

Employee Name **(please print)**: _____

Employee's Address:

_____

Employee's Signature _____ Date: _____

Title 8, California Code of Regulations, section 9783.1.
(Optional DWC Form 9783.1 Effective date July 1, 2014)

Employee Acknowledgement Form

Employee Name _____ Employer _____

Date Hired _____

Employer:

1. Give the DWC Time of Hire Pamphlet to new employees when they are hired or by the end of their first pay period.
2. A copy of the Predesignation Form (DWC-9783) is attached to the pamphlet. An employee can use it to choose in advance to have their personal doctor treat work injuries.
3. Have the new employee complete and sign Section One below. Save a copy in their employee file.
4. When you learn a work-related injury has happened, you must give the injured worker a copy of the Employee Medical Provider Network Notice. Then, have the employee sign Section Two of this form. Send a copy of the signed form to Omaha National.
5. Please contact us at 844-761-8400 if you have any questions. Additional copies of the pamphlet and forms are on our website at omahanational.com.

Employee:

1. This form confirms your employer gave you documents about workers compensation.
2. You can use the Predesignation Form to choose to have your personal doctor treat you if you get hurt at work. To do this, you must:
    a. Give your employer written notice that you want your personal doctor to treat you for work injuries. The notice must be provided before an injury occurs and needs to contain the doctor's name and address;
    b. Have healthcare coverage (for injuries or illnesses not related to work) in a plan, policy, or fund; and
3. Get your personal doctor to agree to treat you for any work injuries. The Employee MPN Notice contains information about the Omaha National Medical Provider Network. It also has information on how to get medical care for your work injury.

Section One: Confirmation of DWC Time of Hire Pamphlet & Predesignation Form

I confirm that my employer gave me copies of the following documents:

☐ DWC Time of Hire Pamphlet

☐ Form DWC-9783 - Notice of Predesignation of Personal Physician (attached to the DWC Time of Hire Pamphlet)

☐ I understand it is my duty to tell my employer I have a work injury as soon as the injury happens.

Signature _____

Printed Name _____ Date _____

Section Two: Confirmation of Employee Medical Provider Network Notice

I confirm that my employer gave me a copy of the Employee Medical Provider Network (MPN) Notice. I understand that I must treat with a provider from the MPN unless I elected to be treated by my personal doctor.

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

Signature _____

Printed Name _____ Date _____

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