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 Delaware law regarding these notices.

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

POSTERS

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

Workers Compensation Poster:

This document serves as the mandatory workers compensation poster notice. Print the poster on 8.5" x 14" (legal size) paper. Make sure to display the poster in an area that all employees can access. This area should be a place that employees pass by on a regular basis.

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.

Fox Valley Offices
4425 North Market Street- 3rd Floor
Wilmington, DE 19802
(302) 761-8200

Blue Hen Corporate Center
655 S Bay Road, Ste. 2H
Dover, DE 19901
(302) 422-1134

Georgetown American Job Center
8 Georgetown Plaza, Suite 2
Georgetown, DE 19947
(302) 856-5230

University Office Plaza
252 Chapman Road, 2nd Floor
Newark, DE 19702
(302) 761-8200

DEPARTMENT OF LABOR
DIVISION OF INDUSTRIAL AFFAIR

Email: dol_dia_workcomp@delaware.gov | Email: dol_dia_wc_compliance@delaware.gov | Website: Labor.delaware.gov

WORKERS COMPENSATION

IMPORTANT THINGS TO DO IN CASE OF INJURY

THE EMPLOYER SHALL:

Carry Workers' Compensation Insurance Coverage per Title 19, Chapter 23, 2303. Every employer shall keep of record of all injuries received by employees; and within 10 days, file a First Report of Injury with the Office of Workers Compensation as per Title 19, Chapter 23, 2313. In addition, the employer should notify their Workers' compensation Insurance carrier of said injury. First Report of Injury forms are available on our website listed above

THE EMPLOYEE SHALL:

Or someone on the employee's behalf, notify the employer as soon as possible of an accidental injury or occupational disease and request medical services if needed. Failure to give notice or to accept medical services may deprive the employee of the right to compensation. Give promptly to the employer, directly or through a supervisor, notice of any claim for compensation for the period of disability beyond the third day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person on their behalf. In case of failure to reach an agreement with the employer in regard to compensation under the law, file a petition with the Industrial Accident Board for a hearing on the matters at issue within two (2) years of the date of accidental injury. All forms can be obtained from the Office of Workers' Compensation. (Email: dol_dia_workcomp@delaware.gov)

It is unlawful to retaliate against an employee because (s)he has made a complaint or given information to the Dept of Labor about possible labor law violations.

Violations of Delaware Worker's Compensation Labor Laws could result in fines.

DELAWARE DEPARTMENT OF LABOR

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.

First Report of Occupational Injury or Disease:

Delaware law requires employers to report all employee injuries immediately to the insurer. Send the original, completed report form to Omaha National at the same time you report the claim to us. One copy should be sent to the Office of Workers' Compensation within 10 days of your knowledge of the injury. A second copy must be given to the employee. Keep a third copy of the report for your records.

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 DELAWARE FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

Department of Labor
Office of Workers' Compensation (OWC)
4425 N. Market Street
Wilmington, DE 19802
Telephone 302-761-8200

OWC Case File No. _____

ALL INFORMATION IS REQUIRED, unless not applicable where "if applicable" is noted.

1.EMPLOYEE: FIRST MIDDLE LAST		2. EMPLOYEE SOCIAL SECURITY NO.
3. **ADDRESS – INCLUDE COUNTY AND ZIP CODE**	4. **MALE** ☐ **FEMALE** ☐ **UNSPECIFIED** ☐	4. **EMPLOYEE PHONE NUMBER (INCLUDING AREA CODE)**

6. DATE OF BIRTH / /	7.AGE	8. WAGE	9. WEEKLY HOURS WORKED

10. OCCUPATION (REGULAR)	11. DEPARTMENT OR DIVISION REGULARLY EMPLOYED	12. HOW LONG EMPLOYED

13. **EMPLOYER:**	13. **PERSON MAKING OUT THIS REPORT**
15. ADDRESS - INCLUDE COUNTY AND ZIP CODE	16. EMPLOYER PHONE# (INCLUDE AREA CODE)
17. MAILING ADDRESS-IF DIFFERENT THAN ABOVE	18. NATURE OF BUSINESS -TYPE OF MFG., TRADE, CONSTRUCTION, SERVICE, ETC.

19. **WORKERS' COMPENSATION INSURANCE CARRIER**	20. **WORKERS' COMP INS. CARRIER PHONE # (INCLUDING AREA CODE)**
21. WORKERS' COMP. INSURANCE CARRIER ADDRESS	22. POLICY NUMBER/ CARRIER CASE NUMBER:
23. THIRD PARTY ADMINISTRATOR (TPA), IF APPLICABLE	24. TPA ADDRESS- INCLUDE CITY STATE AND ZIPCODE

DATES: 25. DATE OF REPORT / /	26. DATE OF INJURY / /	27. NORMAL STARTING TIME AM ☐ PM ☐	28. IF EMPLOYEE BACK TO WORK GIVE DATE / /	29. AT SAME WAGE? YES ☐ NO ☐

30. IF FATAL INJURY, GIVE DATE OF DEATH / /	31. DATE EMPLOYER KNEW OF INJURY / /	32. DATE DISABILITY BEGAN / /	33. LAST FULL DAY PAID-DATE / /

INJURY OR DISEASE:

34. DESCRIBE THE INJURY/ILLNESS AND PART OF BODY AFFECTED.

35. SPECIFY THE DEPARTMENT WHERE INCIDENT OCCURRED AND THE WORK PROCESS INVOLVED.

OCCURRENCE:

36. LIST THE EQUIPMENT, MATERIALS, AND CHEMICALS EMPLOYEE USED WHEN THE INCIDENT OCCURRED, E.G. ACETYLENE.

37. DESCRIBE THE EMPLOYEE'S ACTIVITY AT THE TIME OF INJURY OR ILLNESS, E.G. LIFTING A PATIENT.

38. DESCRIBE HOW THE INJURY/ILLNESS OCCURRED.

39. NAME OF PHYSICIAN (IF APPLICABLE)	40. PHYSICIAN'S ADDRESS
41. HOSPITAL (IF APPLICABLE)	42. HOSPITAL ADDRESS

DISTRIBUTION OF THIS REPORT (1 original and 3 copies)

1. ORIGINAL MUST BE SENT IMMEDIATELY TO THE WORKERS' COMPENSATION INSURANCE CARRIER.
2. COPY TO THE OFFICE OF WORKERS' COMPENSATION (use the address at the top left of this form)
3. EMPLOYER'S COPY - RETAIN AS RECORD
4. EMPLOYEE'S COPY

WORKERS' COMPENSATION

IMPORTANT THINGS TO DO IN CASE OF INJURY

THE EMPLOYER SHOULD:

1. Provide all necessary medical, surgical and hospital treatment from the date of accident.
2. Every employer shall keep a record of all injuries received by employees and make a report within 10 days thereof in writing to the Office of Workers' Compensation
3. Ascertain the average weekly wages of the employee and provide compensation in accordance with the provisions of the law, for disability *beyond the third day* after the accident. All agreements as to compensation must be submitted to the Office of Workers' Compensation for approval.

THE EMPLOYEE SHOULD:

1. Immediately notify the employer in writing of accidental injury or occupational disease and request medical services. Failure to give notice or to accept medical services may deprive the employee of the right to compensation.
2. Give promptly to the employer, directly or through a supervisor, notice of any claim for compensation for the period of disability beyond the third day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person on their behalf.
3. In case of failure to reach an agreement with the employer in regard to compensation under the law, file application with the Industrial Accident Board for a hearing on the matters at issue within two years of the date of accidental injury or one year of knowledge of the diagnosis of an occupational disease or an ionizing radiation injury. All forms can be obtained from the Office of Workers' Compensation.

Incident Investigation Report

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

Today's Date _____

Type of Incident ☐ Death ☐ Lost Time ☐ Medical Only ☐ First Aid ☐ Property Damage ☐ Report Only / Near Miss

Date of Incident _____

Time of Incident _____ ☐ AM ☐ PM

Date Reported _____

Reported To _____

Injured Worker

Name _____

Department _____

Job Title _____

Supervisor _____

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

Start Shift _____ ☐ AM ☐ PM

End Shift _____ ☐ AM ☐ PM

Length in Position _____

Sex ☐ Male ☐ Female

Date of Birth _____

Date of Hire _____

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

Home Address _____

City, State, & Zip _____

Phone Number _____

Wages / Salary _____

Incident or Injury

Where incident occurred _____

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

Description of incident (what the employee was doing and what happened):
Machines, materials, tools, or equipment used, handled, or involved:
Type of injury and body parts affected:

Witness(es) ☐ Yes ☐ No

Name _____ Phone Number _____

Name _____ Phone Number _____

Name _____ Phone Number _____

Medical Treatment and Work Status

First Aid Provided ☐ No ☐ Yes Describe _____

Missed Time ☐ No ☐ Yes List Day(s) _____

Returned to Work ☐ No ☐ Yes Date _____

Emergency Care ☐ No ☐ Yes

Work Status ☐ Off Work ☐ Light Duty ☐ Regular Duty

Physician Name _____ Hospital Name _____

Address _____ Address _____

City, State, & Zip _____ City, State, & Zip _____

Phone Number _____ Phone Number _____

Contributing Factors

Unsafe Workplace Conditions: (Check All That Apply)

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

Unsafe Acts by People: (Check All That Apply)

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

Describe why the unsafe conditions exist:
Describe why the unsafe acts occurred:

Preventive Measures

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

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

Completed By _____ Date of Completion _____

Signature _____ Title _____

Supervisor's Report of Employee Incident

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

Injured Employee

Name _____ Employee ID _____

Job Title _____ Company Name _____

Witnesses ☐ Yes ☐ No

Name _____ Phone Number _____

Name _____ Phone Number _____

Name _____ Phone Number _____

Incident

Date of Incident _____ Time of Incident _____ ☐ AM ☐ PM

Date Reported _____ Time Reported _____ ☐ AM ☐ PM

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

Description of incident:

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

Type of injury and body parts affected:

Medical Treatment and Work Status

First Aid Provided ☐ No ☐ Yes Describe _____

Missed Time ☐ No ☐ Yes List Day(s) _____

Returned to Work ☐ No ☐ Yes Date _____

Work Status ☐ Off Work ☐ Light Duty ☐ Regular Duty

Emergency Care ☐ No ☐ Yes

Physician Name Hospital Name

Suggested Preventative and Corrective Measures

What actions can be taken to prevent future accidents?

Completed By _____ Date of Completion _____

Signature _____ Title _____

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

Witness Statement of Injury or Incident

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

Witness Information

Name _____ Employee ID _____

Phone Number _____ Company Name _____

Address _____ City, State, & Zip _____

Other Witnesses ☐ Yes ☐ No

Name _____ Phone Number _____

Name _____ Phone Number _____

Name _____ Phone Number _____

Incident

Date of Incident _____ Time of Incident _____ ☐ AM ☐ PM

Name of Injured Worker _____ Time Reported _____ ☐ AM ☐ PM

Location of Incident _____

Did You Observe the Incident Involving the Employee? ☐ Yes ☐ No

If no, how did you learn of the incident?

If yes, what did you see? (Use additional paper or write on the back if you need more space)

Type of injury and body parts affected:

What can be done to prevent an incident like this from happening again?

Completed By _____ Date _____

Signature _____ Title _____

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

INJURED WORKER HANDOUTS

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

Injured Worker's First Fill Prescription Form:

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

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

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

Direct Deposit Authorization Form:

Injured workers may use this form to request benefits to be paid by direct deposit.

Injured Workers First Fill Prescription Form

Injured Worker _____ Date of Injury _____

Claim Number _____ Phone Number _____

Notice to Injured Worker and Pharmacy

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

Injured Worker Instructions

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

Pharmacy Instructions

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

Pharmacy Help Desk:
800-311-3446

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

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

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

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

Consent and Authorization for Release of Information

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

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

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

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

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

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

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

This information is required for the following:

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

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

Signature _____

Printed Name _____ Date _____

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

Request for Medical History

Injured Worker _____ Date of Injury _____

Employer _____ Current Date _____

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

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

Medications / Prescriptions			
Name	Description/Purpose	Dosage	Prescribing Doctor

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

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

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

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

Signature _____ Date _____

Direct Deposit (ACH) Authorization Form

Injured Worker _____ Claim Number _____

Employer _____ Date of Injury _____

Instructions: To request to receive your benefits via direct deposit, complete this form in its entirety, attach a copy of a voided check(s) or letter from your bank confirming the account details, and make a copy for your records.

Claimant's Rights to Direct Deposit:

- This form is optional. You have the option to receive your workers' compensation indemnity benefits or death benefits in the form of direct deposit or by paper check in the mail. Use this form to request payments by direct deposit.
- You may cancel the direct deposit at any time by checking the appropriate box on this form and forwarding the completed form to the claim administrator responsible for the workers' compensation claim. The request will be implemented within forty-five days of receipt of notice, and thereafter payment of benefits will be sent by paper check.

Authorizations & Understandings:

- I authorize the claim administrator to directly deposit my workers' compensation indemnity benefits or death benefits into the specified bank account.
- I authorize the claim administrator to debit the account to recover any credits deposited in error. The claim administrator may recover credits deposited in error by any lawful means. IMPORTANT: This consent does not authorize the claim administrator to recover alleged over payments of established and awarded benefits.
- I understand that any change in my employment status may affect my right to receive benefits.
- I understand that any false statement or failure to disclose a material fact to obtain or increase my benefits may result in criminal prosecution, disqualification from benefits, and repayment of any funds deposited to my account.
- I understand that the failure to notify the insurance carrier, self-insured employer, or third-party administrator (TPA) (claim administrator) any change in financial institution or account may delay receipt of my benefits or settlement proceeds.
- I understand that to change or cancel the direct deposit for my workers' compensation indemnity benefits or death benefits, I need to submit this form to the claim administrator.
- I understand that I have an obligation to immediately notify the claim administrator if I am no longer entitled to such payments, or of changes in circumstances which affect my entitlement to such payment.

Your acceptance of total or partial disability payments is a representation by you that you are legally entitled to such payment and a false representation is punishable under federal and state laws.

Type ☐ New Enrollment ☐ Change ☐ Cancel

Depositor/Claimant's Name _____ Claim Number _____

Phone Number _____ Email Address _____

Address _____

Type of Account ☐ Checking ☐ Savings Name of Bank / Financial Institution _____

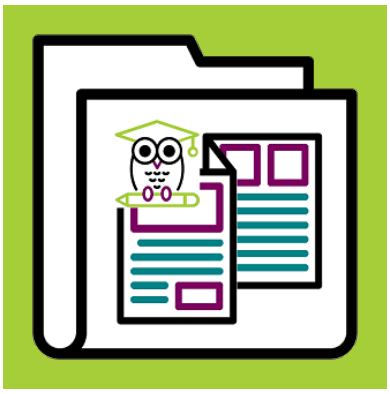
Bank Routing Number (ABA#) _____ Bank Account Number (EFT Format) _____

Bank City, State _____ $ or % of Deposit _____

DEPOSITOR/CLAIMANT/JOINT ACCOUNT HOLDER CERTIFICATION: I certify that I am entitled to receive the underlying compensation payments or death benefits and circumstances entitling me to benefits or death benefits have not changed.

Depositor/Claimant Signature _____ Date _____

Joint Account Holder Signature _____ Date _____



INFORMATIONAL DOCUMENTS

Keep these documents for your future reference.

- **Omaha National Contact Information:**
  This document contains the contact information for our Claims department.

- **Reduce Your Workers Compensation Costs:**
  Tips for lowering your company's workers compensation costs.

Contact Information

Claims:

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

Reduce Your Workers Compensation Costs

Injury Prevention and Safety Training

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

Report Injuries Immediately

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

Ways to report an injury:

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

High-Quality Medical Care

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

Establish a Return-To-Work Program

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

GENERAL FORMS

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

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

- **DCRB Form ERM-14 - Confidential Request for Ownership Information:**
  Changes in ownership may impact your policy and the factors used to determine your premium. These changes must be reported to us right away. Use this form to report ownership changes to Omaha National. As needed, we will file electronic reports to the Delaware Compensation Rating Bureau on your behalf.

- **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

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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.

INSTRUCTIONS FOR COMPLETING AN ERM-14 FORM

I. PURPOSE AND EFFECTIVE DATE OF CHANGE

A. COMBINATION OF SEPARATE ENTITIES

1. Two or more entities sharing common ownership (more than 50% common ownership in each entity).
2. Entities may be combined for experience rating if two or more entities wish to be written on one policy.

Note: Include the date interest was acquired in <u>each</u> entity.

B. CHANGE OF OWNERSHIP- Necessary if there has been a change in the name of the entity, governing board or ownership.

Note: Include the date the change occurred.

C. MERGER OR CONSOLIDATION

1. Merger - When two or more entities are merged into one surviving entity.
2. Consolidation - When two or more entities are combined into an entirely new entity.

Note: Include the date the merger or consolidation occurred.

II. INFORMATION

A. NAME AND LOCATION OF ENTITY- Furnish both name and location of each entity before and after the change occurred.
B. POLICY NUMBER - List the carrier, policy number and effective date if available.
C. RATING ID NO. - List the rating ID number (Bureau file number) if available.
D. LEGAL STATUS - List the type of entity for each column.

III. OWNERSHIP INFORMATION

A. When listing ownership for each entity, remember:

1. List all names of owners and their individual ownership (each spouse's individual ownership must be listed).
2. If it is a partnership, list all general partners' names and their percentage of ownership.
3. If it is a corporation, list owners and their percentages of 5% or more voting stock.
4. If an entity is other than a sole proprietor, partnership or corporation, list the governing board of each entity.
5. List the total shares of stock issued at the bottom of each column.

B. COMBINATION - Enter each entity to be combined in each of the columns. List complete ownership for all entities. Include the date ownership was acquired for each entity. Use as many columns or additional sheets as necessary. Complete back of form regarding employee retention.

C. CHANGE OF NAME/OWNERSHIP - In Column A list the name of the entity ownership before the change. In Column B list the name of the entity and ownership after the change. Complete back of form regarding employee retention.

D. MERGER/CONSOLIDATION - In Columns A and B enter the names of the entities and the ownership of each entity involved. In Column C, list the name and ownership of the remaining entity. Complete back of form regarding employee retention.

IV. SIGNATURE

The signature of the sole proprietor, partner or executive officer must be included on the form. Please state title.

The following confidential ownership statements may be used only in establishing premiums for your insurance coverages. It is extremely important that all questions be answered completely. Your workers compensation policy requires that you report ownership changes, and other changes as detailed below, to your insurance carrier in writing within 90 days of the change. If you have questions, contact your agent, insurance company, or the appropriate rating organization. Submit the completed form to the rating organization.

PURPOSE (Check One)

☐ **Name change only**
Complete column A for former entity and column B for newly named entity
Complete only questions 1, 2 and 3 on page 2

☐ **Combination of separate entities**
Complete a separate column for each entity related through common ownership (attach additional forms if necessary)

☐ **Sale, Transfer or conveyance of ownership interest**
Complete column A for ownership before the change and column B for ownership after the change

☐ **Merger or consolidation (attach copy of agreement)**
Complete columns A and B for the former entities and column C for the surviving entity

☐ **Formation of a new entity**
Complete column A

☐ **Sale, Transfer or conveyance of an entity's physical assets to another entity which takes over its operations**
Complete column A for the former entity and column B for the acquiring entity

☐ **Voluntary or court-mandated establishment of a trustee or receiver, excluding a debtor in possession, a trustee under a revocable trust or a franchisor**
Complete column A for ownership prior to the change, and column B for the trustee or receiver established

INFORMATION	A	B	C
Name and Street Address of Entity (P.O. Box Numbers are not acceptable)			
Legal Status of Entity (Corporation, Partnership, Sole Proprietor, Trustee, Receiver, Individual, Other)			
Ownership **Corporations** - List names of owners of 5% or more of voting stock and number of shares owned.* (Submit shareholder proposal if transaction involved exchange of stock.) **Partnerships** - List each general partner and appropriate share in the profits. (If limited partnership, list name of general partner.) **Other** - If no voting stock, list members of board of directors or comparable governing body.			
* Total shares of voting stock issued.			
Date of Ownership Change, Acquisition, or Combinability			
Carrier, Policy Number and Effective Date			
Experience Rating Identification Number (Carrier Use only)			

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1. Has this entity operated under another name in the last four years? _____

2. Is the entity **currently** related through common majority ownership to any entity not listed on the front of the form? _____

3. Has the entity been **previously** related through common majority ownership to any other entities in the last four years? _____

If you answered yes to 1, 2, or 3 above, please provide the following information:

Name of Business	Principal Location	Carrier and Policy Number	Effective Date

4. Were the assets and/or ownership interest (all or a portion) of this entity acquired from a previously existing business? _____
If yes, you must provide complete ownership information on the prior owner in Column A and ownership information on the new owner in Column B on the reverse side of this form.

5. If this is a partial sale, transfer, or conveyance of an existing business (i.e., sale of one or more plants or locations):

a. Explain what portion or location of the entire operation was sold, transferred, or conveyed. _____

_____

b. Was this entity insured under a separate policy from the remaining portion? _____ If not, specify the entities with which it was combined: _____

_____

6. If this entity has operations in Delaware or Pennsylvania, provide the number of employees from each of these states retained from the prior ownership _____ out of _____. Indicate the percentage or number retained out of the total from each of these states _____ % _____state.

NOTE: If your business has changed significantly to result in a change to the primary (governing) classification and the process and hazard of the operation have also changed, contact your agent, insurance company or rating organization for additional information.

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

Name of Insured: _____

Name of person completing form: _____

Date this ownership change was reported in writing to your insurance carrier: _____

Signature of Owner, Partner or Executive Officer	Title	Carrier
Print name of above signature	Date	Carrier Address

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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

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

Form DCRB-EXCL - Executive Officers/LLC Exclusion Agreement:

Up to eight executive officers of a corporation or up to eight LLC members may use this form to reject the provisions of Delaware's workers compensation laws. Please note, this form is required each time a business wishes to change the status of an executive officer or LLC member. Submit the completed form and other documents to Omaha National.

Request for Copy of Document:

Use this form to request copies of official documents from the Office of Workers' Compensation.

AGREEMENT BY EXECUTIVE OFFICER(S)/LLC MEMBER(S) NOT TO BE SUBJECT TO THE DELAWARE WORKERS' COMPENSATION LAW

Executive officers of corporations and members of Limited Liability Companies (LLCs) are covered under the Delaware Workers' Compensation Law. However, up to eight (8) executive officers who are stockholders of a corporation or up to eight (8) members of an LLC may elect not to be subject to Delaware Workers' Compensation Law by completing this agreement with their corporation/LLC. SPECIAL NOTE: - **CONSTRUCTION** corporations/LLCs subject to Title 30, Chapter 25 of the Delaware Code may elect to exclude up to four (4) executive officers who are stockholders of a corporation or up to eight (8) members of an LLC. Executive Officers are the president, any vice president, secretary, treasurer or any other executive officer(s) elected by the board of directors in accordance with the charter and the regularly adopted by-laws of the corporation. This Executive Officer/LLC Member Exclusion Procedure must be repeated each time a corporation/LLC wishes to change the status of any executive officer/LLC member and/or secures coverage from a different carrier group.

Name of business

Address of business

Street/Road/PO Box **Town/City** **State** **Zip Code**

Federal Employer Identification Number - _____

Business **has** employee(s) (other than those listed below) – please check here ☐

Business **does not have** employee(s) (other than those listed below) – please check here ☐

Please check type of business:

☐ **Corporation** Not Subject to Title 30, Chapter 25 (non-construction) – Maximum 8 exclusions

☐ **Corporation** Subject to Title 30, Chapter 25 (construction) – Maximum 4 exclusions

☐ **Limited Liability Company (LLC)** – Maximum 8 exclusions

Signature of Representative of Corporation or LLC **Title** **Date**

Named below are the executive officer(s)/LLC member(s) electing not to be subject to the Delaware Workers' Compensation Law:

NAME(s) (Print Name)	TITLE	MEMBER OFFICER(S) SIGNATURE	STOCKHOLDER YES/NO	DATE

Additional space below cannot be used by Title 30, Chapter 25 corporations.

IMPORTANT: If you have workers compensation insurance, you must submit the original of this completed form to your insurance carrier, together (in case of a corporation) with the shareholders' resolution(s), shareholders' agreement(s), and/or shareholders' written consent(s) evidencing the executive officer status of the electing executive officer(s), or together (in the case of an LLC) with the operating agreement and/or certificate of formation evidencing the member status of the electing member(s). If you are a subcontractor, you must also provide a copy of the same documents to each general contractor by whom you are hired.

STATE OF DELAWARE REQUEST FOR COPY OF DOCUMENT

Department of Labor
Office of Workers' Compensation (OWC)
4425 N. Market Street, 3rd Floor
Wilmington, DE 19802
Telephone: 302-761-8200
Fax: 302-7369170

NAME OF REQUESTOR: _____ DATE: _____

BUSINESS OF REQUESTOR: _____

ADDRESS: _____

TELEPHONE NUMBER: _____ FAX: _____

EMAIL ADDRESS: _____

PARTY REQUESTOR REPRESENTS: _____

CLAIMANT'S NAME: _____

INDUSTRIAL ACCIDENT BOARD (CASE FILE) NUMBER(S): _____ _____

SOCIAL SECURITY NUMBER: _____

DATE OF ACCIDENT: _____ _____ _____

☐ ALL DOCUMENTS _____ ☐ OTHER (SPECIFY) _____

DELIVERY METHOD:

☐ VIA USPS

☐ PICK-UP

☐ VIA EMAIL *(I authorize the Office of Workers' Compensation to send my request via email)*

_____

SIGNATURE OF REQUESTOR: _____

FOR DEPARTMENT OF LABOR USE ONLY

NUMBER OF PAGES COPIED _____ @0.25 PER PAGE = $ _____

MAILING COSTS: $ _____ TOTAL AMOUNT DUE: $ _____

PROCESSED BY: _____ DATE PROCESSED: _____

- *THE ENTIRE FORM MUST BE COMPLETED, INCOMPLETED FORMS WILL CAUSE YOUR REQUEST TO BE DELAYED**