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.

TABLE OF CONTENTS

All documents are also available on our website at omahanational.com

Posters

- Instructions
- Fraud Prevention Poster

Injury Report Forms

- Instructions
- DWC Form 14-0001 – First Report of Injury or Illness
- Incident, Supervisor, and Witness Reports

Injured Worker Handouts

- Instructions
- Injured Worker's First Fill Prescription Form
- DWC Form 14-0043 - Authorization to Release Information Regarding Claimants Seeking Workers' Compensation Benefits
- DWC Form 14-0196 - Authorization for the Iowa Division of Workers' Compensation to Release Information
- Consent and Authorization for Release of Information and Request for Medical History
- Direct Deposit Authorization Form

Informational Documents

- Instructions
- Omaha National Contact Information
- Reduce Your Workers Compensation Costs

General Forms

- Instructions
- Request for Subrogation Waiver
- Form ERM-14 - Confidential Request for Ownership Information
- Company Contacts Verification

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

- **Fraud Prevention Poster:**
  Use this poster to reinforce the message to employees that workers compensation fraud is a serious crime and to let employees know how they can report fraud.

Fake an Injury And You Can Sit Around All Day

The Workers Compensation system was created to protect injured workers. Misrepresenting an injury to collect benefits is illegal.

If you suspect workers compensation fraud or abuse report it.

844-761-8400

All information will be kept confidential.

Omaha NATIONAL

INJURY REPORT FORMS

These are documents to be completed after a workplace injury. Contact Omaha National at 844-761-8400 to report the claim.

DWC Form 14-0001 – First Report of Injury or Illness:

Send the completed Form 14-0001 to Omaha National at the same time you report the claim to us. Once the claim is reported, we will submit an electronic report to the Division on your behalf. Iowa law requires all reportable injuries to be filed electronically with the Iowa Division of Workers' Compensation. In most cases, a report must be made to the Division within four days after knowledge that the injury is reportable. Please note, you should promptly report **all injuries** to Omaha National, even those that only require first aid; sometimes an injury that seems minor at first can worsen and knowing about these Injuries allows us to manage them effectively.

Incident, Supervisor, and Witness Reports:

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

Iowa Workers' Compensation **Division** – FIRST REPORT OF INJURY OR ILLNESS **(FROI)** Jurisdiction Code_____ Jurisdiction Claim Number_____

CLAIM ADMIN

Claim Administrator Name:

Mailing Address, City, State, & Postal Code:

Claim Representative Business Phone Number:

Claim Administrator Claim Number:

Claim Administrator FEIN:

Insurer Name (if different than claim administrator):

Insurer FEIN:

Claim Type Code:

EMPLOYER

Employer Name:

Physical Address, City, State, & Postal Code:

Nature of Business:

Employer FEIN:

Mailing Address, City, State, & Postal Code:

Employer Contact Name and Business Phone Number:

Insured Report Number:

Industry Code:

Insured Location Number:

Employer Type Code:
__ Employer (E)
__ Lessor (L)

Employer UI Number:

POLICY

Insured Name (parent company if different than employer):

Insured FEIN:

Insured Postal Code:

Policy/Contract Number:

Coverage Effective Date:

Coverage Expiration Date:

Self Insurance License/ Certificate Number:

EMPLOYEE

Employee Name (First, Middle, Last, & Suffix):

Mailing Address, City, State, & Postal Code:

Email:

Phone Number (include area code):

Occupation Description:

NCCI Classification Code:

Department Where Regularly Worked:

Date of Birth:

Date of Hire:

Gender: __ Transgender (T) __ Male (M) __ Non-Binary (X) __ Female (F) __ Unknown(U)

Tax Filing Status (check one):
____ Single (A)
____ Single/Head of Household (B)
____ Married/Filing Joint (C)
____ Married/Filing Separate(D)

State of Hire:

Educational Level (grade completed): _____ [GED = 12]

Marital Status: (check one)
___ Unmarried/Single/Divorced (U)
___ Married (M)
___ Separated (S)

Employment Status (check one):
____ Piece Worker
____ Volunteer
____ Seasonal
____ Apprenticeship/Full-Time
____ Apprenticeship/Part-Time
____ Regular Employee/Full-Time
____ Part-Time
____ Other

Employee ID Number (check one):
ID # _____
____ Social Security Number
____ Employment VISA Number
____ Passport Number
____ Green Card
____ Employee ID Assigned by Jurisdiction

Employee's Authorization to Release the Following:
Medical Records __ yes __ no
Social Security Number __ yes __ no

WAGE

Average Wage $ _____ (check one):
___ hourly ___ daily ___ semi-monthly ___ monthly
___ bi-weekly ___ annual ___ weekly

Number of Days Regularly Worked Per Week: _____

Salary Continued In Lieu of Compensation: ___ yes ___ no

Full Wages Paid for Date of Injury: ___ yes ___ no

Discontinued Fringe Benefits: $_____

Employee Number of Dependents: _____

Employee Number of Exemptions: _____ (check one)
___ Entitled
___ Withholding

ACCIDENT/INJURY

_____ Date of Injury
_____ Date Employer Had Knowledge of the Injury
_____ Date Claim Administrator Had Knowledge of the Injury
_____ Initial Date Last Day Worked
_____ Initial Return to Work Date (if applicable)
_____ Employee Date of Death (if applicable)

_____ Time of Injury

_____ Time Employee Began Work

Pre-Existing Disability Code:
___ Yes
___ No
___ Unknown

Accident Premises Code:
___ Employer (E) ___ Other (X)
___ Lessee (L) ___ Employee Residence (R)

Accident Site Organization Name:

Accident Site Street, City, State, & Postal Code:

Accident Location Narrative (if no street address):

Accident Site County/Parish:

Type of Injury / Illness Code:

Describe the nature of the injury. (ex. amputation, burn, cut, fracture):

Part of Body Affected Code:

Part(s) of body directly affected by the injury or illness. (ex. hand, arm, circulatory system):

Describe the events that caused the injury. (ex. fell, operating machinery, chemical exposure):

Name the object or substance that directly injured the employee. (ex. knife, floor, acid, oil):

Specify activity the employee was engaged in when the event occurred. (ex. cutting metal plate for flooring) Indicate if activity was part of normal duties:

Witness Name & Business Phone Number:

MEDICAL

Initial Treatment Code (check one):
___ no medical treatment (0)
___ minor/on-site treatment (1)
___ clinic/hospital visit (2)
___ emergency care (3)
___ hospitalization > 24 hours (4)
___ future medical treatment/lost time anticipated (5)

Initial Medical Provider Name:

Initial Medical Provider Physical Address, City, State, & Postal Code:

Managed Care Organization Name or ID Number:

ICD Primary Diagnostic Code (if known):

Preparer's Name & Title:

Preparer's Company Name:

Phone Number:

Date:

WORKERS' COMPENSATION DIVISION

dial.iowa.gov

First Report of Injury or Illness Requirement

An employer or the employer's representative must file with the Workers' Compensation Division (WCD) a First Report of Injury or Illness (FROI) in case of occupational:

- Fatality,
- Permanent disability, or
- Temporary disability lasting more than three days.

An employer or the employer's representative must file a FROI within four days of the event.

An employer or the employer's representative must file a FROI if the employee claims the disability is caused by work even if the employer or employer's representative disagrees.

For more information on these and other requirements, go to: dial.iowa.gov

Records and Reports

Every employer must keep a record of all injuries sustained by employees in the course of their employment resulting in incapacity for longer than one day.

All books, records, and payrolls of an employer must be open for inspection by the Iowa Workers' Compensation Commissioner for purposes of administering the Iowa Workers' Compensation Act.

An employer must furnish to an employee upon request one statement of earnings, wages, or salary for the year preceding the injury. An employer may be subject to a civil penalty of $1,000.00 per offense for failure to furnish such wage statement.

Civil Penalty

The Commissioner may require an employer to appear and show why the employer should not be subject to a civil penalty of $1,000.00 per occurrence for failure to comply with the reporting or inspection requirements. Upon hearing, if the facts indicate, the Commissioner may enter an order requiring payment of such penalty. Unless voluntarily paid, the Commissioner may petition the district court for entry of judgment on the order. The employer's insurance carrier shall be responsible in the same manner and to the same extent as the employer when a report of injury has been submitted to the employer's insurance carrier and not filed by it with the agency.

Additional Iowa OSHA Reporting Requirements

Additional reporting and recordkeeping requirements may apply to the incident described in the FROI.

An employer must:

- Report a workplace fatality to Iowa OSHA within eight hours by calling 877-242-6742 or visiting dial.iowa.gov/iosha for a form and instructions.
- Report a hospitalization, loss of an eye, or amputation within twenty-four hours by calling 877-242-6742 or visiting dial.iowa.gov/iosha for a form and instructions.
- Complete an OSHA Form 301, or equivalent for recordable, work-related incidents within seven days and retain the completed form on site. The FROI is equivalent to the OSHA Form 301 if the case number from the OSHA 300 log is added. For more information, go to: dia.iowa.gov/iosha
- Make an entry in your Log of Work-Related Injuries and Illnesses, OSHA Form 300, for recordable cases within seven days and retain the completed form on site. Some industries are exempt from this requirement. For more information, go to: dial.iowa.gov/iosha

For more information on these and other OSHA requirements, go to: dial.iowa.gov/iosha

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.

- **DWC Form 14-0043 – Authorization to Release Information Regarding Claimants Seeking Workers' Compensation Benefits:**
  The Iowa Division of Workers' Compensation developed this release form to be used to obtain the documents and records needed to process a claim. Please have the injured worker sign this document and send a copy of the signed form to Omaha National when the injury is reported.

- **DWC Form 14-0196 – Authorization for the Iowa Division of Workers' Compensation to Release Information:**
  This form is used to obtain copies of the claimant's records for any past claims from the Division. Have the injured worker complete and sign this form. Then, send a copy to Omaha National when the injury is reported.

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

- **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

IOWA DIVISION *of* WORKERS' COMPENSATION

Authorization for Release of Information Regarding Claimant Seeking Workers' Compensation Benefits

Iowa Code section 85.27(2) and Iowa Administrative Code rule 876—8.9 require the release of information relating to an employee's physical or mental condition relative to a workers' compensation claim. Iowa Administrative Code rule 876—4.6 requires the claimant to serve a patient's waiver on the defendant(s) concurrently with an original notice and petition, and to update the waiver as necessary. This form may be used in claims under the jurisdiction of the Iowa Workers' Compensation Commissioner to satisfy the requirements for a claimant seeking workers' compensation benefits to release information.

To complete this form, a workers' compensation claimant or the claimant's representative must:

- Under Section I, sign and date on the labeled blanks to authorize the Iowa Division of Workers' Compensation (DWC) to release confidential information in its custody under Iowa Code section 10A.333.
- Under Section II, sign and date on the labeled blanks to authorize entities other than DWC to release information.
- Under Section III, write "Yes" or "No" next to each of three types of confidential information (substance abuse, mental health, and HIV or AIDS) and then sign and date on the labeled blanks to authorize or refuse to authorize release of such information.

For convenience, Section I of this form incorporates the *Authorization to Release Information to Third Party* form, which is used to authorize DWC to release confidential information to a third party.

Photocopy of this signed authorization shall be as effective as the original.

I. Authorization to Release Information Under the Iowa Workers' Compensation Act.

I understand that I have the right under Iowa Code section 10A.333 to keep confidential certain information filed with DWC.

I authorize DWC to disclose and deliver to _____
all confidential information of any nature in its custody, including:

A. Information from all First Reports of Injury or Illness (FROI);

B. Information from all Subsequent Reports of Injury or Illness (SROI);

C. All evidence received in contested case hearings before the agency; and

D. All transcripts from contested case hearings.

I understand that I may revoke this authorization, except to the extent that action has already been taken in reliance upon it, by giving written notice to DWC. I also understand that if I revoke, the revocation will take effect on the day it is received in writing by DWC.

X _____ _____

Signature of Claimant *or* Claimant's Legal Representative — Date

_____

Street Address — City, State, and ZIP Code

_____

If Signed by Claimant's Legal Representative, Full Name of Representative and Relationship to Claimant

II. Authorization for Release of Information and for Redisclosure.

Patient Name: _____ Date of Birth: _____

I authorize _____
to disclose and deliver to _____
any and all information **except** that relating to substance abuse (drug or alcohol), mental health, or HIV and AIDS, unless specifically authorized to be released in Section IV of this authorization.

I understand:

A. The information is being disclosed and may be used only for legal and/or litigation purposes relating to claims or suit against _____

B. This authorization may be used to obtain information from health care providers, schools, former and current employers, providers of vocational rehabilitation services, the federal Social Security Administration, and State of Iowa administrative agencies.

C. I have a right to inspect the disclosed information at any time.

D. This authorization is effective until the conclusion of a contested case on the claim.

E. I may revoke this authorization, except to the extent that action has already been taken in reliance upon it, by giving written notice to the health care provider or recordkeeper. I also understand that if I revoke, the revocation will take effect on the day it is received in writing by the entity from whom disclosure is sought.

F. My revocation or refusal to sign this authorization will not affect my ability to obtain health care services.

G. If the person or entity that receives the information requested is not covered by federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be redisclosed and will no longer be protected by the regulations.

H. State of Iowa and federal law provide that I have a right to prohibit redisclosure of confidential medical information and further disclosure may not be had without my express written authorization, except as indicated below.

I. The recipient of this authorization, **without further authorization**, may redisclose this information to the following individuals or entities, but only after they have been advised of their obligations under the law and this authorization, including the redisclosure of information:

1. Parties and their legal counsel, insurers, experts, and potential experts;

2. Agents, employees, or representatives of the parties, but only after they are involved in conducting the prosecution or defense of the case; and

3. Administrative agency and court officials hearing the claim, and their support staff.

I specifically authorize and consent to any disclosure or redisclosure described above.

_____ _____
Signature of Claimant *or* Claimant's Legal Representative Date

_____ _____
Street Address City, State, and ZIP Code

_____
If Signed by Claimant's Legal Representative, Full Name of Representative and Relationship to Claimant

III. Specific Authorization for Release of Information Protected by State or Federal Law Concerning Information Relating to Substance Abuse, Mental Health, or HIV or AIDS.

State of Iowa and federal law provide protection from disclosure of information relating to substance abuse (drug or alcohol), mental health, HIV and AIDS.

Federal law specifically requires that any disclosure or redisclosure of information relating to substance abuse (alcohol or drug), mental health, or HIV or AIDS must be accompanied by the following written statement:

> This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder.

See also Iowa Code chapters 228 and 141A, and other applicable laws.

In addition to the items identified in Section II (A) through (H), I understand:

A. The information to be released may include material that is protected by State of Iowa and federal law applicable to information relating to substance abuse, mental health, or HIV or AIDS.

B. I have a right to inspect the mental health information disclosed pursuant to this authorization at any time.

C. A copy of this authorization with respect to each request for mental health information made using it shall be provided to me or my legal representative and included in my record of mental health information.

I specifically authorize the release of:

_____ Substance abuse (drug or alcohol) information from all health care providers and facilities and any other person or entity in possession of records concerning me.

_____ Mental health information from all health care providers and facilities and any other person or entity in possession of records concerning me.

_____ HIV- or AIDS-related information, diagnosis, and test results from all health care providers and facilities and any other person or entity in possession of records concerning me.

Further, I specifically authorize disclosure and re-disclosure of this confidential information to all of the persons referred to in Section II(I) of this authorization.

x _____ _____

Signature of Claimant *or* Claimant's Legal Representative | Date

_____

Street Address | City, State, and ZIP Code

_____

If Signed by Claimant's Legal Representative, Full Name of Representative and Relationship to Claimant

IOWA DIVISION *of* WORKERS' COMPENSATION

Authorization to Release Confidential Information to Third Party

Form 14-0169

The Iowa Division of Workers' Compensation (DWC) must keep certain information confidential under Iowa Code section 10A.333.

Completion of this form authorizes DWC to release confidential information to a third party.

1. Employee Information.

I, the undersigned, provide the following information to allow DWC to identify me and verify that I signed this Authorization:

Full Name: _____

Social Security Number: _____

Date of Birth: _____

Telephone Number: _____

Address: _____

_____

2. Records to Be Released.

I authorize DWC to release the following confidential information filed within the past _____ years:

- ☐ All confidential records of any nature
- ☐ Information from all First Reports of Injury (FROI)
- ☐ Information from all Subsequent Reports of Injury (SROI)
- ☐ All evidence received in contested case hearings
- ☐ All transcripts from contested case hearings
- ☐ Other (describe the records that you want released): _____

3. Recipient(s) of Records.

I authorize DWC to release the confidential information identified above to the following person:

Name(s): _____

4. Signature.

I understand that I have the right under Iowa Code section 10A.333 to keep confidential certain information filed with DWC.

By signing this form, I authorize DWC to release the confidential information identified in Section 2 to the recipient(s) identified in Section 3.

X _____ _____

Signature Date

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.

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 _____

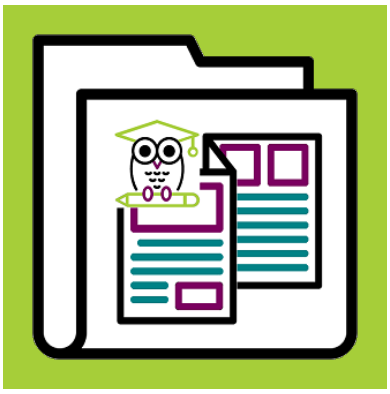
Bank Routing Number (ABA#) _____ Bank Account Number (EFT Format) _____

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.

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

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

Request for Subrogation Waiver

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

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

General Information

Policyholder Name _____

FEIN _____

Policy Number _____

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

Job Information for Specific Waiver

Job Effective Date(s) From _____ To _____

Job Name or Number _____

Person or Organization _____

Brief Description of Job _____

Complete Address _____

Employee Class Code _____ Employee Class Code _____ Employee Class Code _____

Payroll Amount _____ Payroll Amount _____ Payroll Amount _____

Job Information for Specific Waiver

Job Effective Date(s) From _____ To _____

Job Name or Number _____

Person or Organization _____

Brief Description of Job _____

Complete Address _____

Employee Class Code _____ Employee Class Code _____ Employee Class Code _____

Payroll Amount _____ Payroll Amount _____ Payroll Amount _____

Job Information for Specific Waiver

Job Effective Date(s) From _____ To _____

Job Name or Number _____

Person or Organization _____

Brief Description of Job _____

Complete Address _____

Employee Class Code _____ Employee Class Code _____ Employee Class Code _____

Payroll Amount _____ Payroll Amount _____ Payroll Amount _____

Job Information for Specific Waiver

Job Effective Date(s) From _____ To _____

Job Name or Number _____

Person or Organization _____

Brief Description of Job _____

Complete Address _____

Employee Class Code _____ Employee Class Code _____ Employee Class Code _____

Payroll Amount _____ Payroll Amount _____ Payroll Amount _____

Job Information for Specific Waiver

Job Effective Date(s) From _____ To _____

Job Name or Number _____

Person or Organization _____

Brief Description of Job _____

Complete Address _____

Employee Class Code _____ Employee Class Code _____ Employee Class Code _____

Payroll Amount _____ Payroll Amount _____ Payroll Amount _____

Submitter Information

Completed by _____ Date _____

Title _____ Signature _____

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

REQUEST FOR OWNERSHIP INFORMATION—ERM-14 FORM

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

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

Section A—Contact Information

Name of person completing this form _____ Your Employer _____

Phone # _____ Email Address _____

Relationship to business entity reporting ownership information _____

Section B—Transaction Information

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

Section C—Description of Transaction(s)

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

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

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

_____

_____

_____

_____

 © Copyright 2018 National Council on Compensation Insurance, Inc. All Rights Reserved.

Section D—Business Entity Information

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

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

Section E—Certification

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

Signature of Owner, Partner, Member, or Executive Officer	**Title**	**Business Name**
Print name of above signature	**Date**	

 © Copyright 2018 National Council on Compensation Insurance, Inc. All Rights Reserved.

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.