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
- Notice to Employees
- Fraud Prevention Poster

Injury Report Forms

- Instructions
- Form FRI - Employer's First Report of Occupational Injury or Illness
- Incident, Supervisor, and Witness Reports

Injured Worker Handouts

- Instructions
- Injured Worker's First Fill Prescription Form
- Authorization to Obtain and/or Disclose Health Information
- Form 1A – Filing Status and Exemption
- 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

State-Specific

- Instructions
- Form 6B - Coverage Election by Employee - Officer of Corporation or Member of LLC
- Form 6B-1 - Coverage Election by Employees - Members of Partnership
- Form 75 - Coverage Election by Sole Proprietor

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 Connecticut law regarding these notices.

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

POSTERS

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

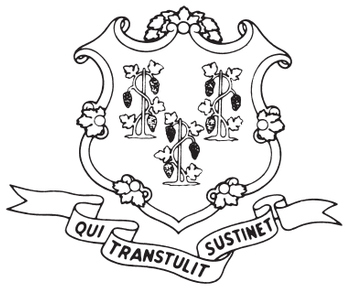
Notice to Employees:

This document serves as the required workers compensation posting notice. It must be posted in a prominent area that is readily accessible to all employees at each work location. For example, include this poster in the area where other labor law posters are displayed. Please note, the font size used for the text of the form fields must be at least 10-point type. Text on the poster must also be bolded. To complete the form, please enter the following information: company name, company contact name and address to receive claims from injured workers, address and phone number for the Connecticut Workers' Compensation Commission's District Office closest to the work location, and the date posted. Make sure to select the appropriate insurer name from the dropdown list. A listing of the Commission's District Offices has been included for your reference.

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.

NOTICE
TO EMPLOYEES



State of Connecticut Workers' Compensation Commission **Revised 10-01-2021**

The Workers' Compensation Act (Connecticut General Statutes Chapter 568) requires your employer,

_____

to provide benefits to you in case of injury or occupational disease in the course of employment.

Section 31-294b of the Workers' Compensation Act states "Any employee who has sustained an injury in the course of his employment shall immediately report the injury to his employer, or some person representing his employer. If the employee fails to report the injury immediately, the administrative law judge may reduce the award of compensation proportionately to any prejudice that he finds the employer has sustained by reason of the failure, provided the burden of proof with respect to such prejudice shall rest upon the employer."

An injury report by the employee is NOT an official written notice of claim for workers' compensation benefits; the Workers' Compensation Commission's Form 30C is necessary to satisfy this requirement.

NOTE: You must comply with P. A. 17-141 (see next box, below) when filing a compensation claim.

The INSURANCE COMPANY or SELF-INSURANCE ADMINISTRATOR is:

Name Omaha National Underwriters, LLC on behalf of (Select Insurer Name)

Address P.O. Box 451139 **Telephone** 844-761-8400

City/Town Omaha **State** NE **Zip Code** 68145

Approved Medical Care Plan ☐ **Yes** ☐ **No**

The State of Connecticut Workers' Compensation Commission office for this workplace is located at:

Address _____ **Telephone** _____

City/Town _____ **State** _____ **Zip Code** _____

Public Act 17-141 allows an employer the option to designate and post – "in the workplace location where other labor law posters required by the Labor Department are prominently displayed" and on the Workers' Compensation Commission's website [wcc.state.ct.us] – a location where employees must file claims for compensation.

If your employer has listed a location below, you MUST file your compensation claim there.
When filing your claim, you are also required – by law – to send it by certified mail.

If blank below, ask your employer where to file your claim.

Employer Name _____

Address _____ **Telephone** _____

City/Town _____ **State** _____ **Zip Code** _____

THIS NOTICE MUST BE IN TYPE OF NOT LESS THAN TEN POINT BOLD-FACE AND POSTED IN A CONSPICUOUS PLACE IN EACH PLACE OF EMPLOYMENT. FAILURE TO POST THIS NOTICE WILL SUBJECT THE EMPLOYER TO STATUTORY PENALTY (Section 31-279 C.G.S.).

Date Posted: _____

Any questions as to your rights under the law or the obligations of the employer or insurance company should be addressed to the employer, the insurance company, or the Workers' Compensation Commission (1-800-223-9675).

Connecticut Towns and their Workers' Compensation Districts

Rev. 12-20-2021

Workers' Compensation Commission District Offices and the cities, towns and subdivisions they serve.

First District — Administrative Law Judge, 999 Asylum Avenue, Hartford, CT 06105; (860) 566-4154

The Hartford District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Bloomfield
Blue Hills
Broad Brook
Crystal Lake
Dobsonville
East Granby
East Hartford
East Windsor
East Windsor Hill
Ellington
Enfield
Hartford
Hazardville
Melrose
North Somers
North Thompsonville
Poquonock
Rainbow
Rockville
Sadds Mill
Scantic
Scitico
Silver Lane
Somers
Somersville
South Windsor
Suffield
Talcotville
Thompsonville
Tolland
Vernon
Vernon Center
Warehouse Point
West Suffield
Wilson
Windsor
Windsor Locks
Windsorville

Second District — Administrative Law Judge, 55 Main Street, Norwich, CT 06360; (860) 823-3900

The Norwich District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Abington
Almyville
Amston
Andover
Ashford
Attawaugan
Atwoodville
Ballouville
Baltic
Bolton
Bolton Notch
Bozrah
Bozrah Street
Brooklyn
Burnetts Corner
Canterbury
Center Groton
Central Village
Chaplin
Chesterfield
Chestnut Hill *(Lebanon)*
Clark Falls
Clarks Corner
Columbia
Coventry
Danielson
Dayville
Doaneville
Eagleville
East Brooklyn
Eastford
East Killingly
East Putnam
East Thompson
East Willington
East Woodstock
Ekonk
Elmville
Exeter
Fabyan
Fitchville
Franklin
Gales Ferry
Gilead
Gilman
Glasgo
Goshen Hill
Graniteville
Greenville
Griswold
Grosvenordale
Groton
Groton Heights
Groton Long Point
Gurleyville
Hallville
Hampton
Hanover
Harrisville
Hebron
Hopeville
Hop River
Hydeville
Jewett City
Jordan Village
Kenyonville
Killingly
Killingly Center
Laurel Glen
Lebanon
Ledyard
Ledyard Center
Liberty Hill
Lisbon
Long Society
Lords Point
Mansfield
Mansfield Center
Mansfield Depot
Mansfield Hollow
Mashantucket
Mashapaug
Mechanicsville *(Thompson)*
Merrow
Mohegan
Montville
Moosup
Morningside Park
Mystic
Newent
New London
Noank
North Ashford
North Franklin
North Grosvenordale
North Stonington
North Windham
North Woodstock
Norwich
Norwichtown
Oakdale
Occum
Ocean Beach
Old Mystic
Oneco
Orcuttville
Pachaug
Packerville
Pawcatuck
Phoenixville
Plainfield
Pleasure Beach
Pomfret
Pomfret Center
Pomfret Landing
Poquetanuck
Poquonock Bridge
Preston
Putnam
Putnam Heights
Quaddick
Quaker Hill
Quinebaug
Rogers
Scotland
Sodom
South Chaplin
South Killingly
South Willington
South Windham
South Woodstock
Sprague
Spring Hill *(Mansfield)*
Stafford
Stafford Springs
Staffordville
Sterling
Sterling Hill
Stonington
Storrs
Taftville
Thompson
Uncasville
Union
Versailles
Village Hill *(Lebanon)*
Voluntown
Warrenville
Waterford
Wauregan
Wequetequock
Westford
Westminster
West Mystic
West Stafford
West Thompson
West Willington
West Woodstock
Willimantic
Willington
Wilsonville
Windham
Woodstock
Woodstock Valley
Yantic

Third District — Administrative Law Judge, 700 State Street, New Haven, CT 06511; (203) 789-7512

The New Haven District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Allingtown
Augerville
Bethany
Branford
Burr Hill
Clinton
Clintonville
Durham
East Haven
East River
Fair Haven
Foxon
Guilford
Hamden
Indian Neck
Killingworth
Madison
Momauguin
Montowese
Morningside
Mount Carmel
New Haven
North Branford
Northford
North Guilford
North Haven
North Madison
Orange
Pine Orchard *(Branford)*
Pond Meadow *(Killingworth)*
Quinnipiac
Rivercliff
Rockland
Sachem Head
Short Beach
Spring Glen
Stony Creek
West Haven
Westville
Whitneyville
Woodbridge

Fourth District — Administrative Law Judge, 350 Fairfield Avenue, Bridgeport, CT 06604; (203) 382-5600

The Bridgeport District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Ansonia
Berkshire
Botsford
Bridgeport
Derby
Devon
Dodgingtown
Easton
East Village
Fairfield
Greenfield Hill
Greens Farms
Hattertown
Hawleyville
Huntington
Huntingtontown
Long Hill District
Lordship
Milford
Monroe
Newtown
Nichols
Riverside *(Newtown)*
Sandy Hook
Saugatuck
Shelton
Southport
Stepney
Stevenson
Stratford
Trumbull
Upper Stepney
Westport
Woodmont

Fifth District — Administrative Law Judge, 55 West Main Street, Waterbury, CT 06702; (203) 596-4207

The Waterbury District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Amesville
Bantam
Beacon Falls
Bethlehem
Burrville
Campville
(Litchfield)
Canaan
Canaan Valley
Cornwall
Cornwall Bridge
Cornwall Center
Cornwall Hollow
Drakeville
East Canaan
East Litchfield
East Morris
East Plymouth
Ellsworth
Falls Village
Flanders
Goshen
Greystone
Harwinton
Hotchkissville
Huntsville
Kent
Kent Furnace
Lakeside
Lakeville
Lime Rock
Litchfield
Lower City
Macedonia
Middlebury
Millville
Milton
Minortown
Morris
Naugatuck
Newfield
(Torrington)
Norfolk
North Canaan
Northfield
North Kent
North Woodbury
Oakville
Oxford
Pequabuck
Plymouth
Pomperaug
Prospect
Quaker Farms
Salisbury
Seymour
Sharon
South Britain
Southbury
South Canaan
Southford
South Kent
Straitsville
Taconic
Terryville
Thomaston
Torringford
Torrington
Twin Lakes
Union City
Warren
Waterbury
Watertown
West Cornwall
West Goshen
West Torrington
White Oak
Woodbury
Wrightville

Sixth District — Administrative Law Judge, 24 Washington Street, New Britain, CT 06051; (860) 827-7180

The New Britain District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Avon
Bakersville
Barkhamsted
Berlin
Bristol
Burlington
Canton
Canton Center
Colebrook
Collinsville
East Berlin
East Hartland
Edgewood
Elmwood
Farmington
Forestville
Granby
Hartland
Kensington
Marion
Mechanicsville
(Granby)
Milldale
Nepaug
New Britain
New Hartford
Newington
North Canton
North Colebrook
North Granby
Pine Meadow
Plainville
Plantsville
Pleasant Valley
Riverton
Robertsville
Simsbury
Southington
Tariffville
Unionville
Weatogue
West Avon
West Granby
West Hartford
West Hartland
West Simsbury
Wethersfield
Whigville
Winchester
Winchester Center
Winsted
Wolcott

Seventh District — Administrative Law Judge, 111 High Ridge Road, Stamford, CT 06905; (203) 325-3881

The Stamford District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Banksville
Belltown
Bethel
Boardmans Bridge
Branchville
Bridgewater
Brookfield
Brookfield Center
Byram
Cannondale
Church Hill
Cos Cob
Cranbury
Danbury
Darien
East Norwalk
Gaylordsville
Georgetown
Germantown
Glenbrook
Glenville
Greenwich
High Ridge
Long Ridge
(Stamford)
Lower Merryall
Lyons Plains
Marble Dale
Merryall
Mianus
Mill Plain
New Canaan
New Fairfield
New Milford
New Preston
Noroton
Noroton Heights
North Stamford
Northville
North Wilton
Norwalk
Old Greenwich
Park Lane
Redding
Redding Ridge
Ridgebury
(Ridgefield)
Ridgefield
Riverside
(Greenwich)
Romford
Round Hill
(Greenwich)
Rowayton
Roxbury
Roxbury Falls
Roxbury Station
Sherman
Silvermine
(Norwalk)
South Norwalk
South Wilton
Springdale
Stamford
Titicus
Topstone
Turn Of River
Upper Merryall
Washington
Washington Depot
West Norwalk
Weston
West Redding
Wilton
Winnipauk
Woodville

Eighth District — Administrative Law Judge, 649 South Main Street, Middletown, CT 06457; (860) 344-7453

The Middletown District Office has jurisdiction over work-related injuries / illnesses occurring in the following Connecticut cities and towns:

Addison
Baileyville
Bashan
Black Hall
Black Point
Buckingham
Buckland
Centerbrook
Cheshire
Chester
Cobalt
Colchester
Cornfield Point
Crescent Beach
Cromwell
Deep River
East Glastonbury
East Haddam
East Hampton
East Lyme
Essex
Fenwick
Flanders Village
Gildersleeve
Glastonbury
Grove Beach
(Westbrook)
Haddam
Haddam Neck
Hadlyme
Hamburg
Higganum
Highland
Highland Park
Hopewell
Ivoryton
Knollwood Beach
Laysville
Leesville
Little Haddam
Lyme
Manchester
Manchester Green
Marlborough
Meriden
Middlefield
Middlefield Center
Middle Haddam
Middletown
Millington
Mixville
Moodus
Niantic
North Lyme
North Plains
North Westchester
Old Lyme
Old Saybrook
Pond Meadow
(Westbrook)
Ponset
Portland
Rockfall
Rocky Hill
Salem
Salem Four Corners
Saybrook Manor
Saybrook Point
Shailerville
Sound View
South Glastonbury
South Lyme
South Meriden
Tylerville
Wallingford
Westbrook
Westfield
Winthrop
Yalesville

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.

- **Form FRI – Employer's First Report of Occupational Injury or Illness:**
  Use this form to report work-related injuries to Omaha National. Send the completed Form FRI to Omaha National at the same time you report the claim to us. By law, all injuries and illnesses resulting in a total or partial inability to work for one or more days must be reported to the Connecticut Workers' Compensation Commission. Once the claim is reported, we will submit an electronic report to the Commission on your behalf. 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.

State of Connecticut
Workers' Compensation Commission

Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011

Rev. 7-13-2009

FRI

Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT IN INK.

Date filed in Chairman's Office

(for WCC use only)

Employer *(Name, Address & Zip)* | Phone #

SIC Code | FEIN

Carrier / Administrator Claim # | OSHA Log Case # | Report Purpose Code

Jurisdiction | Jurisdiction Claim #

Employer's Location Address *(if different)* | Phone #

Carrier *(Name, Address & Zip)* | Phone #

Claims Administrator *(Name, Address & Zip)* | Phone #

Policy / Self-Insured # | ☐ Check, if Self-Insured

Policy Period *(MM/DD/YY)*
FROM: TO:

Employee: Last Name First Name Middle Name

D.O.B. *(required)* | Phone #

Address *(incl. Zip)*

Gender
☐ Male
☐ Female

Date Hired *(MM/DD/YY)* | State of Hire

Occupation / Job Title

Rate of Pay $ _____ _____ per
☐ Hour ☐ Day ☐ Week ☐ Bi-Weekly ☐ Other

NCCI Class Code

Date of Injury / Illness *(MM/DD/YY)*

Time Employee Began Work ☐ a.m. ☐ p.m.

Time of Occurrence ☐ cannot be determined ☐ a.m. ☐ p.m.

Date Employer Notified *(MM/DD/YY)*

Date Disability Began *(MM/DD/YY)*

Date Last Worked *(MM/DD/YY)*

Date Return(ed) to Work *(MM/DD/YY)*

If Fatal, Date of Death *(MM/DD/YY)*

All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:

Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:

Contact Name

Phone #

Town of Injury / Illness

Did Injury / Illness occur on Employer's Premises? ☐ Yes ☐ No

Type of Injury / Illness

Part of Body Affected

Type of Injury / Illness Code

Part of Body Affected Code

Were Safeguards or Safety Equipment provided? ☐ Yes ☐ No

If provided, were they used? ☐ Yes ☐ No

How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:

Cause of Injury Code

Physician / Health Care Provider *(Name, Address & Zip)*

Hospital *(Name, Address & Zip)*

Initial Treatment

☐ No Medical Treatment
☐ Emergency Care
☐ Minor — by Employer
☐ Hospitalized More Than 24 Hours
☐ Minor — by Clinic / Hospital
☐ Future Major Medical — Lost Time Anticipated

Date Administrator Notified *(MM/DD/YY)* | Date Prepared *(MM/DD/YY)*

Preparer's Name & Title | Phone #

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.

Authorization to Obtain and/or Disclose Health Information:

The Connecticut Workers' Compensation Commission designed this release form to be used to obtain the documents and records needed to process a claim. An injured worker uses this form to provide consent for the release of their medical information. Please have the injured worker sign this document and send a copy of the signed form to Omaha National when the injury is reported.

Form 1A – Filing Status and Exemption:

This form is used to obtain an injured worker's federal tax filing status and number of exemptions so that their weekly benefit rate can be determined. It also includes an area to provide information regarding any concurrent employment. 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

STATE OF CONNECTICUT
WORKERS' COMPENSATION COMMISSION

AUTHORIZATION TO OBTAIN AND/OR DISCLOSE HEALTH INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____
(Please Print Name) (Required)

I, the undersigned, authorize _____
(Hospital or Provider)

To disclose, in writing, protected health information (PHI) to:

_____
(Person or Entity to whom information is to be disclosed)

And its attorneys and representatives. The PHI to be disclosed is relevant medical records and reports relating to my medical treatment/consultations/examinations and/or diagnostic procedures performed at the above-referenced medical facility. I understand that I have the right to copy or inspect the PHI to be disclosed as permitted under Federal HIPAA law and state law.

I authorize the following PHI to be obtained/disclosed from my medical records:
Dates of Service **or** Date range _____
Body part(s) _____

PROTECTED RECORDS

REQUIRED: Please initial the lines below to indicate you authorize the release of the protected information specified, even if the categories do not necessarily apply to the patient's medical records.

(Initial _____) Alcohol, Drug or Substance Abuse Treatment Records
(Initial _____) HIV Testing & Related Information
(Initial _____) Reproductive Healthcare Services
(Initial _____) Mental or Behavioral Health Treatment Records
(Initial _____) Genetic Testing

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION. In order to revoke this authorization, I may, at any time, send written notification to the above-named hospital/provider. I understand that my revocation of this authorization is ineffective to the extent that the above-named hospital/provider has relied on this authorization to disclose PHI relating to me.

I UNDERSTAND THAT PHI DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE REDISCLOSED BY THE PERSON OR ENTITY I HAVE IDENTIFIED ABOVE AND MAY NO LONGER BE PROTECTED FROM DISCLOSURE TO OTHERS BY FEDERAL OR STATE LAW. I understand that the above-named hospital/provider may not condition my treatment on whether I provide authorization for the requested use or disclosure.

IF THE PHI THAT IS DISCLOSED UNDER THIS AUTHORIZATION IS CONFIDENTIAL HIV/AIDS RELATED INFORMATION, PSYCHIATRIC OR OTHER PROTECTED MENTAL HEALTH INFORMATION, ALCOHOL OR DRUG ABUSE RELATED INFORMATION, OR REPRODUCTIVE HEALTH INFORMATION, THE RECIPIENT MAY BE PROHIBITED FROM REDISCLOSING THAT INFORMATION UNDER FEDERAL OR CONNECTICUT LAW.

I understand that if this disclosure contains information relating to HIV, behavioral health, alcohol, drug and/or substance abuse treatment, the following shall apply: This information has been disclosed to you from records whose confidentiality is protected by law. Federal regulations (Title 42 CFR Part 2) and Connecticut General Statutes (Ch. 368x) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of psychiatric or substance abuse information is NOT sufficient for this purpose.

I UNDERSTAND THAT I HAVE THE RIGHT TO DETERMINE A DATE OR EVENT WHEN THIS AUTHORIZATION EXPIRES.
Unless otherwise revoked, this authorization will expire on the following date/event: _____. If I fail to specify an expiration date/event, this authorization will expire six (6) months from the date signed.

I further understand that federal HIPAA law does not require me to provide an authorization in this form as the purpose of this form relates to a Workers' Compensation matter. However, I understand that as a practical matter, my authorization may facilitate the processing and administration of my claim for Workers' Compensation benefits.

My signature below indicates that I have read and understand this authorization and its terms.

Signature of Patient/Parent/Legal Representative Date Relationship to Patient

Revised: October 1, 2025

State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 7-13-2009

1A

Filing Status and Exemption

This form must be executed in every case of compensable disability for injuries occurring ON OR AFTER October 1, 1991, and must be completed in its entirety.

WCC File #

Date filed in District

(for WCC use only)

EMPLOYEE

Name _____ Date of Birth *(required)* _____

Address _____

City/Town _____ State _____ Zip Code _____

DATE OF INJURY:

_____

FILING STATUS AND EXEMPTIONS — In order to determine your weekly benefit rate, as per Sec. 31-310 C.G.S.,we need the following information:

1. Select your Federal tax filing status based upon your **ACTUAL filing status as of the date of injury**, listed at right: *(Must match your tax return, as if you were filing with the IRS on the date of your injury.)*

   ❑ Single ❑ Head of Household ❑ Married filing jointly ❑ Married filing separately

2. Number of exemptions *(including yourself)* as of the date of injury listed at right = _____

3. FICA withheld for the above-named employee? ..... ❑ YES ..... ❑ NO — ***If NO, insurer must manually calculate weekly benefit rate.***

4. Check all appropriate boxes:

   ❑ Employee 65 years of age or older ❑ Employee legally blind ❑ Spouse 65 years of age or older ❑ Spouse legally blind

5. List name *(yourself first)*, date of birth, and relationship to you for all exemptions included in question #2, above:

Name	*Date of Birth*	*Relationship*
		SELF

CONCURRENT EMPLOYMENT — To be certain you receive all the benefits to which you are entitled, provide the following information *if you were working for more than one employer on the date of injury indicated above*:

Name of Employer	*Address*	*Date of Hire*

NOTE: Wage information for each concurrent employer must be supplied by the claimant.

SIGNATURE OF INJURED WORKER OR REPRESENTATIVE

I hereby attest that the above information is correct to the best of my knowledge.

Employee's 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 _____

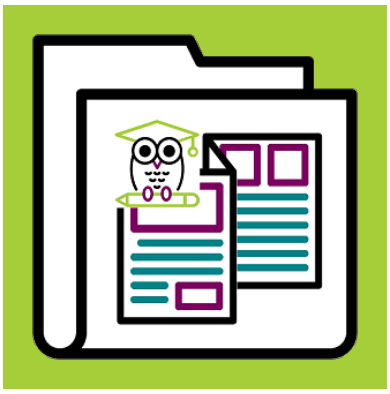
Bank Routing Number (ABA#) _____ Bank Account Number (EFT Format) _____

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.

_____

_____

_____

_____

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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**	

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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

Use these forms as needed. Send copies of any completed coverage election or rejection forms to Omaha National.

- **Form 6B – Coverage Election by Employee – Officer of Corporation or Member of LLC:**
  An employee who is an officer of a corporation or a member of a limited liability company (LLC) may use this form to designate that they wish to be excluded from workers' compensation insurance coverage or to revoke a prior election for exclusion from coverage. Send copies of any completed forms to Omaha National and the Connecticut Workers' Compensation Commission.

- **Form 6B-1 – Coverage Election by Employees – Members of Partnership:**
  Members of a partnership use this form to elect to be excluded from coverage or to revoke a prior election for exclusion from coverage. Mail the completed form to the Connecticut Workers' Compensation Commission and send a copy to Omaha National.

- **Form 75 – Coverage Election by Sole Proprietor:**
  Sole proprietors may use this form to document an election of coverage or to withdraw an election of coverage. Send copies of any completed forms to Omaha National and the Connecticut Workers' Compensation Commission.

State of Connecticut
Workers' Compensation Commission

DIRECTIONS FOR FILING FORMS 6B, 6B-1 AND 75
and for obtaining official stamped copies from
the Workers' Compensation Commission

Rev. 10-2-2025

6B — 6B-1 — 75
DIRECTIONS

Election of Workers' Compensation Coverage for Certain Employees under the Workers' Compensation Act OR Revocation of Previous Election of Such Coverage

Section 31-284 of the Workers' Compensation Act requires all employees — as defined in the Act — to be covered by their employers for workers' compensation liability.

The only exceptions to this law are when certain categories of employees — as defined in the Act — choose to be excluded from, or included in, their employers' workers' compensation coverage OR when those employees choose to revoke a previous exclusion or inclusion of such workers' compensation coverage.

Incomplete and/or illegible forms will be returned unstamped.

DIRECTIONS — these directions apply to the following forms:

FORM 6B — To be completed by an employee who is an officer of a corporation or a member of a limited liability company (LLC) who wishes to be excluded from workers' compensation insurance coverage. It is also to be used for such a member to revoke any previous election of exclusion from workers' compensation coverage.

FORM 6B-1 — To be completed by all members of a partnership who wish to be excluded from workers' compensation insurance coverage. It is also to be used for such a member to revoke any previous election of exclusion from workers' compensation coverage.

FORM 75 — To be completed by a sole proprietor of a business who wishes to be included for workers' compensation insurance coverage. It is also to be used for such a member to revoke any previous election of inclusion for workers' compensation coverage.

1. **DO NOT send a Form 6B, 6B-1 or 75 to a District Office — send this form to the Office of the Chairperson:**

   By Mail: Workers' Compensation Commission
   21 Oak Street, 4th Floor
   Hartford, CT 06106

   Electronically via GovQA: **https://wccct.govqa.us/WEBAPP/_rs**

2. **If submitting by mail, include a self-addressed, stamped envelope to receive a date-stamped copy.**

3. **Forms 6B can also now be filed electronically through WCC's automated Form 6B filing process at: https://forms.office.com/g/MPrz0UL2sr.**

NOTE: To inquire about receipt of such forms filed on or after January 1, 2010, call (860) 493-1500 or submit a records request through GovQA at https://wccct.govqa.us/WEBAPP/_rs

For such forms filed PRIOR TO January 1, 2010, call the District Office where the form was filed.

Please be advised that the Workers' Compensation Commission accepts the coverage election forms 6B, 6B-1, and 75 for filing purposes ONLY. The filer of any one of these forms is solely responsible for the accuracy of the information contained therein.

State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 10-2-2025

6B

Date filed with WCC

(for WCC use only)

Coverage Election by Employee who is an Officer of a Corporation or a Member of an LLC

SEND THIS FORM TO THE OFFICE OF THE CHAIRPERSON

Pursuant to Public Act 22-89

By Mail*: **WORKERS' COMPENSATION COMMISSION**
21 OAK STREET, 4th FLOOR
HARTFORD, CT 06106

** If submitting by mail, include a self-addressed, stamped envelope to receive a date-stamped copy.*

Online: https://wccct.govqa.us/WEBAPP/_rs

This FORM can also be submitted electronically using the following QR code:

Or at: https://forms.office.com/g/MPrz0UL2sr

Incomplete and/or illegible forms will be returned unstamped.

COVERAGE ELECTION - To the Workers' Compensation Commission, 21 Oak Street, 4th Floor, Hartford, Connecticut 06106

and to _____ of _____
(name of employer) *(street address)*

located in _____ , _____ , _____ :
(city or town) *(state)* *(zip code)*

I, _____ , an Employee of
(name of employee)

_____ of _____
(exact name of corporation or LLC) *(street address)*

located in _____ , _____ , _____
(city or town) *(state)* *(zip code)*

and also the _____ of said Corporation or LLC,
(office held)

hereby elect to:

☐ **BE EXCLUDED FROM COVERAGE** under the Workers' Compensation Act pursuant to Section 31-275 of the Connecticut General Statutes

☐ **REVOKE ANY PREVIOUS ELECTION OF EXCLUSION** from the provisions of Section 31-275 of the Connecticut General Statutes

AFFIRMATION - Section 31-284 of the Connecticut General Statutes requires that workers' compensation insurance be obtained for all covered employees.

Dated on this _____ day of _____ , 20 _____ .
(number) *(month)* *(year)*

Employee Signature _____ Date of Birth *(required)* _____

Employee Street Address _____

City or Town _____ State _____ Zip Code _____

Please be advised that the Workers' Compensation Commission accepts the coverage election form 6B for filing purposes ONLY.
The filer of this form is solely responsible for the accuracy of the information contained herein.

State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 10-2-2025

6B-1

Date filed with WCC

(for WCC use only)

Coverage Election by Employees who are Members of a Partnership

SEND THIS FORM TO THE OFFICE OF THE CHAIRPERSON

Pursuant to Public Act 22-89

By Mail: **WORKERS' COMPENSATION COMMISSION**
21 OAK STREET, 4th FLOOR HARTFORD,
CT 06106

Electronically via GovQA: https://wccct.govqa.us/WEBAPP/_rs

If submitting by mail, include a self-addressed, stamped envelope to receive a date-stamped copy.

Incomplete and/or illegible forms will be returned unstamped.

COVERAGE ELECTION - To the Workers' Compensation Commission, 21 Oak Street, 4th Floor, Hartford, Connecticut 06106

and to _____ of _____
(name of partnership) *(street address)*

located in _____ , _____ , _____ and having a total of _____ partners:
(city or town) *(state)* *(zip code)* *(number)*

We, _____ , _____ ,
(name of partner 1) *(name of partner 2)*

_____ , _____ , employees at
(name of partner 3) *(name of partner 4)*

_____ , _____ ,
(exact name of partnership) *(CT registration number)*

hereby elect to:

☐ **BE EXCLUDED FROM COVERAGE** under the Workers' Compensation Act pursuant to Section 31-275(10) of the Connecticut General Statutes

☐ **REVOKE ANY PREVIOUS ELECTION OF EXCLUSION** from the provisions of Section 31-275(10) of the Connecticut General Statutes

AFFIRMATION - Section 31-284 of the Connecticut General Statutes requires that workers' compensation insurance be obtained for all covered employees.

Dated on this _____ day of _____ , 20 _____ .
(number) *(month)* *(year)*

Partner 1: Signature _____ Date of Birth *(required)* _____

Partner 2: Signature _____ Date of Birth *(required)* _____

Partner 3: Signature _____ Date of Birth *(required)* _____

Partner 4: Signature _____ Date of Birth *(required)* _____

Please be advised that the Workers' Compensation Commission accepts the coverage election form 6B-1 for filing purposes ONLY.
The filer of this form is solely responsible for the accuracy of the information contained herein.

State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 10-2-2025

75

Date filed with WCC

(for WCC use only)

Coverage Election by Sole Proprietor

SEND THIS FORM TO THE OFFICE OF THE CHAIRPERSON

Pursuant to Public Act 22-89

By Mail: WORKERS' COMPENSATION COMMISSION
21 OAK STREET, 4th FLOOR HARTFORD,
CT 06106

Online: https://wccct.govqa.us/WEBAPP/_rs

If submitting by mail, include a self-addressed, stamped envelope to receive a date-stamped copy.

Incomplete and/or illegible forms will be returned unstamped.

COVERAGE ELECTION - The Sole Proprietor is NOT covered by the Workers' Compensation Act, unless coverage is elected through the use of this form.

To the Workers' Compensation Commission, 21 Oak Street, 4th Floor, Hartford, Connecticut 06106,

the undersigned sole proprietor of a business hereby elects to:

- ☐ **BE INCLUDED FOR COVERAGE** under the Workers' Compensation Act pursuant to Section 31-275 of the Connecticut General Statutes
- ☐ **REVOKE ANY PREVIOUS ELECTION OF INCLUSION** pursuant to the provisions of Section 31-275 of the Connecticut General Statutes

AFFIRMATION - Section 31-284 of the Connecticut General Statutes requires that workers' compensation insurance be obtained for all covered employees.

Dated on this _____ day of _____ , 20 _____ .
(number) *(month)* *(year)*

Employee Signature _____ PRINT Employee Name _____

Address _____ Date of Birth *(required)* _____

City/Town _____ State _____ Zip Code _____

Business / Company Name _____ Address _____

City/Town _____ State _____ Zip Code _____

Federal Employer Identification Number _____ CT Registration Number _____

Please be advised that the Workers' Compensation Commission accepts the coverage election form 75 for filing purposes ONLY.

The filer of this form is solely responsible for the accuracy of the information contained herein.