# Workers Compensation Resource for Employers

## Welcome,

**Thank you for choosing Omaha National for your workers compensation needs. We take pride in the clients we support and will do everything we can to exceed your expectations.**

This resource provides you with important information about the workers compensation laws in your state. It also provides guidance on reporting workplace injuries.

When a workplace injury occurs, it is important that you tell us right away. The sooner we know about it, the better we can manage the claim, including arranging for prompt medical care. The best way to let us know about an injury is to **call us anytime at 844-761-8400**.

**Additional copies of all these documents can be printed from our website at omahanational.com.**

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

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# Non-Compliance Notice

Please note, the use of some of the documents within this packet may be required. Additional fines and enforcement actions may result from non-compliance with Nebraska 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.

- **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.

- **Insurance Fraud Leaves a Paper Trail Poster and Insurance Fraud Makes Me Croak Poster:**
  These posters were created by the Insurance Fraud Prevention Division at the Nebraska Department of Insurance to inform the public about insurance fraud and to promote fraud reporting.

# Insurance Fraud Leaves a Paper Trail

**Insurance Fraud Types:**

**Agent**
- Fake Policy or Card
- Pocketing Premiums

**Auto Bodily Injury**
- Fake or Inflated Injury
- Staged Accident

**Auto Property**
- Inflated or Prior Damage
- Past Posting
- Staged Theft

**General Liability**
- Slip and Fall

**Homeowner**
- Falsified Documents
- Inflated Claim or Injury
- Phony Theft or Vandalism

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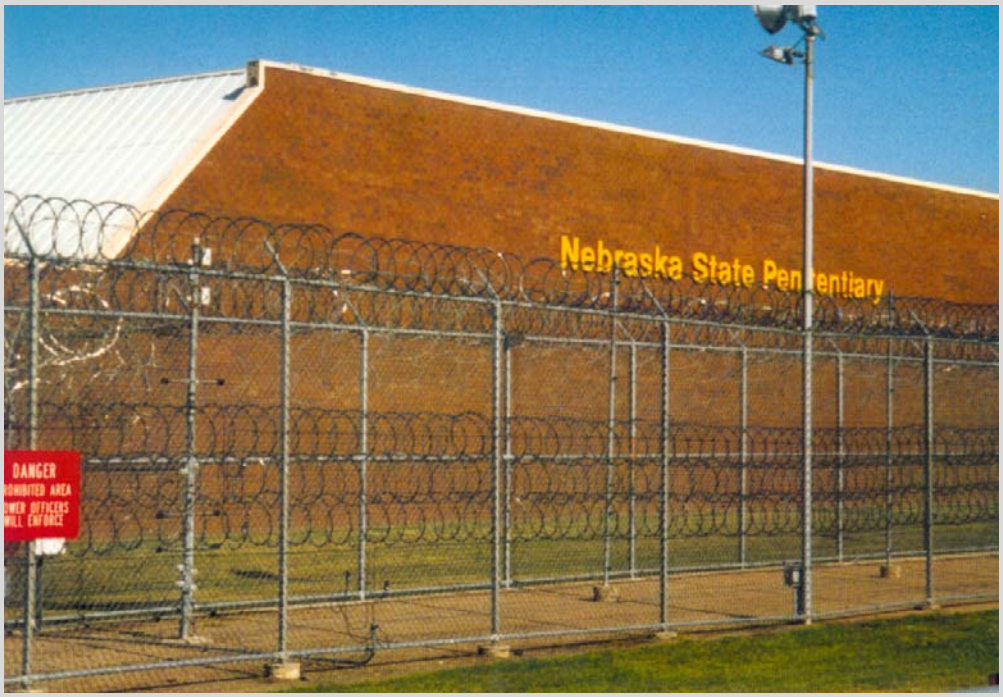
**Medical Health**
- Billing/Coding
- False Treatment
- False Documents
- Unnecessary Treatment

**Workers' Compensation**
- Double-Dipping
- Injury Unrelated to Work
- Malingering




## Insurance Fraud is a CRIME!

Insurance company investigators, law enforcement, and the Nebraska Department of Insurance are getting tough on insurance fraud.

These criminals drive up your insurance premiums. Fight back and report any suspicion of insurance fraud.

Violators of this criminal offense will be subject to vigorous investigation and prosecution to the full extent of the law.

## REPORT FRAUD!

If you have information that could help stop this crime, call the **Insurance Fraud Prevention Division** at the Nebraska Department of Insurance at **(402) 471-2201** or go to **www.ReportInsuranceFraud.ne.gov**.

**NEBRASKA DEPARTMENT OF INSURANCE**

OUT13252

# Insurance Fraud Makes Me Croak

## Report all insurance fraud.
## Call 402-471-2201
## www.ReportInsuranceFraud.ne.gov

**Sponsored by the Nebraska Department of Insurance, Fraud Prevention Division**

OUT13253

# 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.

## Electronic First Reports of Injury:

Effective 5/15/2019, the Nebraska Workers' Compensation Court transitioned to mandatory electronic injury reports, paper reports are no longer accepted. **Once the claim is reported to Omaha National, we will submit the required electronic reports to the Commission on your behalf.**

Nebraska law requires all reportable injuries to be filed with the Nebraska Workers' Compensation Court within 10 days after knowledge of injury. Please note, you should promptly report **all injuries** to Omaha National, even those that only require first aid; sometimes an injury that seems minor at first can worsen and knowing about these Injuries allows us to manage them effectively.

## Incident, Supervisor, and Witness Reports:

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

# 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. I**t 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.

### Choosing a Doctor for a Work-Related Injury - Rule 50:

This document was created by the Nebraska Workers' Compensation Court to provide summarized explanations of the employer and injured worker rights and responsibilities to choose and change doctors.

### NWCC Form 50 - Employees Choice or Change of Doctor:

The right physician can have a substantial impact on the successful recovery of an injured employee and on the cost of a workers compensation claim. Nebraska law requires employers to notify injured workers of their rights and responsibilities to qualify for an opportunity to select the primary treating physician. Form 50 is used to provide the required notice to an injured worker. The form must be given to the injured worker as soon as possible after the employer's knowledge of the injury. Make sure to have the injured worker sign and date the employee confirmation of notice portion of the form and have a company representative complete the employer confirmation of notice section.

### 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 |

***Nebraska Workers' Compensation Court Information Sheet:***

# Choosing a Doctor for a Work-Related Injury — Rule 50

**NOTE***:* The rights to choose and change doctors are governed by statute and rules. This is a simplified explanation of those rights. Please refer to Nebraska Revised Statutes (laws, written as "NEB. REV. STAT.") Section (§) 48-120 and Nebraska Workers' Compensation Court Rules 49, 50, and 56 for more information.

## *If you are the EMPLOYEE:*

Tell your employer as soon as possible when you have an injury at work. After you report a work injury, your employer should tell you about your right to choose a primary treating doctor to treat you for that injury ("doctor" means a person licensed to practice medicine and surgery, osteopathic medicine, chiropractic, podiatry, or dentistry). You may use the court's Form 50, *Choice of Doctor*, to tell the employer your choice of doctor. Your employer should provide you with this form.

*If your employer does tell you about your right to choose a primary treating doctor, you may choose ONLY a doctor who has treated you or a member of your family before your injury* ("family member" means your spouse, child, parent, stepchild or stepparent). The doctor must have records of that treatment. If your employer asks, you or your family member must give your employer written permission to verify treatment with this doctor.

If you have such a doctor and want that doctor to treat you for your work injury, you need to *tell your employer the name of the doctor*. Unless it is an emergency, you cannot get any treatment for the work injury until you have given your doctor's name to your employer. If it is an emergency, get the treatment you need, then tell your employer the name of your doctor.

Your employer can choose the doctor to treat you if:

- you don't have a family doctor (explained above);
- you don't tell your employer the name of your family doctor; or
- you refuse to give permission for your employer to verify treatment.

It is best if you give your employer the name of your doctor in writing, which should be done on the Form 50, *Choice of Doctor*, that should be given to you by your employer.

*After your employer tells you about your right to choose a doctor there can be no change in the doctor chosen* unless you and your employer agree to the change or the court orders a change. This is true whether you or your employer chose the doctor in the first place. If you are referred to another doctor for special tests or services, this is not a change in doctor.

*If your employer does not tell you about your right to choose a doctor,* you may choose ANY doctor as your treating doctor. In this situation, you are not limited to choosing a doctor who has treated you or a member of your family before your injury.

*There are other times when you can choose your doctor.* You can choose your own doctor to do major surgery, if your injury involves dismemberment, or if your claim is denied.

*You may have to pay for medical treatment you receive if you do not follow the rules about choosing or changing doctors.*

## *If you are the EMPLOYER:*

*You must tell the employee about their right to choose a doctor* to treat an employee's work injury as soon as you can after you know about an injury. You should use the court's Form 50, *Choice of Doctor*, to tell the employee about these rights. This form is available on the court's website (https://www.newcc.gov/).

*You may choose the doctor if,* after telling the employee about the right to choose:

- no doctor has treated the employee or a member of the employee's family before the work injury;
- or the employee does not select a doctor who has records of such treatment;
- or you are refused the authorization needed to verify such prior treatment, if you ask for it.

**NOTE**: You must allow the employee a reasonable amount of time to choose the doctor.

*After telling the employee about the right to choose, there can be no change* in doctor unless you and the employee agree or the court orders a change. This is true whether you or your employee chose the doctor. If the employee is referred to another doctor for special tests or services, this is not a change in doctor.

Even if you tell the employee about the right to choose and then you get to choose the doctor, *there are times when the employee is free to choose a doctor.* The employee can choose the doctor:

- to do major surgery;
- if the injury involves dismemberment; or
- if the claim is denied.

If you do not tell the employee about the right to choose the doctor, *the employee can then choose ANY doctor to provide treatment for the work injury.*

## *Common questions asked by employees:*

### Can my employer make me see a doctor other than the one I've chosen to treat me?

Your employer cannot make you get *treatment* from another doctor. However, your employer or their insurance company can ask you to see another doctor of their choice for an *examination*. This doctor will not start treating you; it will just be an examination. If you unreasonably refuse to submit to the examination, you may not get benefit payments for the time you refuse to be seen. You may be asked to see more than one doctor for other examinations.

### What if I want to change my primary treating doctor?

If the doctor has been chosen AFTER your employer told you of your rights, you can't change doctors unless your employer agrees or the court orders a change. If you want to change, talk to your employer about the reasons. If your employer agrees, you may change doctors.

### What if my employer wants me to change doctors?

If the doctor has been chosen AFTER your employer told you of your rights, you can't be made to change your doctor unless you agree or unless the court orders you to change.

### What if it is an emergency?

If you have a medical emergency, see any doctor as soon as you can. The rules about choosing a doctor don't apply until after the emergency is over. If you need more treatment, the rules to choose or change your doctor will apply.

### What if my employer or the insurer has a managed care plan?

You can still choose a doctor, but it must be one who has treated you or a family member before your injury. Your doctor must agree to the rules of your employer's managed care plan. If you don't have a doctor, you may choose among the doctors signed up with your employer's managed care plan.

### What if my employer won't agree to let me change doctors?

You can ask for Informal Dispute Resolution (IDR), also known as mediation, from the court. Before you ask for mediation, you must first try to get your employer to agree to your request to change doctors. If this doesn't work, you or your employer can ask for help through the court's mediation process. A court staff member will try to help you and your employer come to an agreement. If mediation doesn't work, you have the option to file a motion or petition (lawsuit) with the court for a judge to decide the matter. More information about the IDR process and other dispute resolution options is available on our website (https://www.newcc.gov/).

### What if my employer doesn't tell me about my rights to choose a doctor?

***You may choose ANY doctor to treat you.***

This information is a product of the Nebraska Workers' Compensation Court and is provided as a public service. It is not intended to be used or construed as legal advice by the Nebraska Workers' Compensation Court. The court will not be liable for any loss, injury, or direct, special, incidental or consequential damage incurred as a consequence, directly or indirectly, of the use or application of the contents herein. Further inquiries may be directed to the court; however, please note court staff may not provide legal advice or opinions.

General questions may be directed to the court's information line or you may contact the court by email from the court's website. **Case-specific questions should be directed to a private lawyer, as the Nebraska Workers' Compensation Court cannot provide legal advice. Court staff may not complete the forms for you.**

**Nebraska Workers' Compensation Court**
**1010 Lincoln Mall, Suite 100**
**Lincoln, NE 68508-2833**
***Information Line*: 800-599-5155 or 402-471-6468**
***Website*: http://www.newcc.gov/**

**Revised July 2023**

# NOTICE OF EMPLOYEE'S RIGHT TO CHOOSE A DOCTOR

For questions about this form or workers' compensation in general, contact the Nebraska Workers' Compensation Court at 800-599-5155 (toll free) or 402-471-6468, or by email at general@newcc.gov. Additional information is available on the court's website at https://www.newcc.gov/.

***NOTICE TO EMPLOYER**: Give this form to the injured worker as soon as possible **AFTER** each injury.*

## EMPLOYEE MAY CHOOSE

When you are injured at work, you may have the right to choose a doctor to treat you. See Neb. Rev. Stat. § 48-120 and Neb. Workers' Comp. R. 49, 50 and 56.

If your employer gives you notice of this right following the accident, your choice of doctor is limited to a doctor who has treated you or an immediate family member before the injury.

- You must choose as soon as possible after your employer gives you this notice.
- If you have such a doctor and want that doctor to treat you for your work injury, you must tell your employer the name of the doctor.
- You can use the *Choice of Doctor Designation Form* below to record the name of the doctor you choose.
- Immediate family members are your spouse, children, parents, stepchildren, and stepparents.
- If your employer asks, you or your family member must give your employer written permission to verify prior treatment.

If it is an emergency, get the treatment you need, then tell your employer the name of your doctor.

You may choose any doctor to perform major surgery or an amputation, if that treatment is recommended.

Once you choose your doctor, you may not change doctors unless your employer agrees or the Nebraska Workers' Compensation Court orders a change. The chosen doctor may provide a referral for medical services. A referral by the chosen doctor is not a change.

If your claim is denied, you may choose any doctor. You will be responsible for the medical bills unless your employer is later found liable for the claim.

If you choose a doctor outside the community where you live or work, and a doctor is available in a closer community, you will not receive mileage reimbursement.

## EMPLOYER MAY CHOOSE

If you were notified, but do not choose a doctor who treated you or a family member before the accident, YOUR EMPLOYER HAS THE RIGHT TO CHOOSE YOUR DOCTOR.

If you were notified, but you or your family member do not give permission for your employer to verify prior treatment with the doctor you choose, YOUR EMPLOYER HAS THE RIGHT TO CHOOSE YOUR DOCTOR.

### EMPLOYEE CONFIRMATION OF NOTICE

My employer has informed me of the right to choose a doctor.

_____
[EMPLOYEE NAME]

_____
[EMPLOYEE SIGNATURE]

_____
[DATE OF NOTICE]

### EMPLOYER CONFIRMATION OF NOTICE

I have informed my employee of the right to choose a doctor.

_____
[EMPLOYER REPRESENTATIVE NAME]

_____
[EMPLOYER REPRESENTATIVE SIGNATURE]

_____
[DATE OF NOTICE]

### CHOICE OF DOCTOR DESIGNATION FORM

I choose the following doctor to treat me for the work-related injury I had on _____. I certify that this doctor has treated me or an immediate family member before the work-related injury.
[DATE OF INJURY]

_____
[DOCTOR NAME]

_____
[DOCTOR ADDRESS, IF KNOWN]

_____
[EMPLOYEE SIGNATURE]

_____
[DATE]

**OR** (Indicate your reason(s) for not choosing a doctor)

☐ I do not have a doctor who has treated me or an immediate family member before this injury.

☐ I have received notice of my right to choose a doctor, but I do not wish to choose a doctor who has treated me or an immediate family member.

_____
[EMPLOYEE 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 |
| | | | |
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| | | | |

| 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 _____

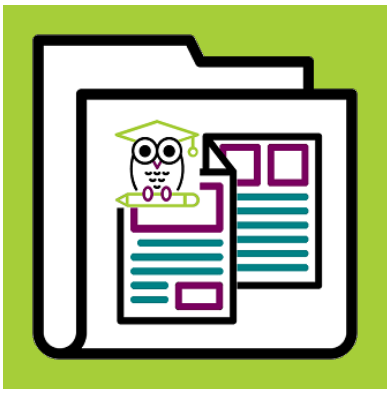
Bank Routing Number (ABA#) _____ Bank Account Number (EFT Format) _____

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.

- **Rights and Obligations under the NE Workers' Compensation Law:**
  The Nebraska Workers' Compensation Court created this document to serve as a general guide for employers and injured workers on their rights and responsibilities under the Nebraska Workers' Compensation Act. It contains basic explanations about the program and benefits.

# 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.

*Nebraska Workers' Compensation Court Information Sheet:*

# Nebraska Workers' Compensation

## What is workers' compensation?

If an employee is injured by accident or occupational disease arising out of and in the course of their employment, they may be entitled to workers' compensation benefits. Workers' compensation insurance covers the risk of an employee getting injured on the job. Workers' compensation is different and separate from unemployment compensation, Social Security disability benefits, health and accident insurance, or other disability benefit plans provided by the employer.

The Nebraska Workers' Compensation Act (the Act) is found at Section (§) 48-101 to § 48-1,118 of the Nebraska Revised Statutes (laws, written as "NEB. REV. STAT."). It provides the only avenue for employees to obtain benefits from their employer for their work-related injuries.

## Who is covered by Nebraska workers' compensation?

The Act applies to most employees. It does not apply to independent contractors. Most Nebraska employers are required to have workers' compensation insurance to make sure coverage is in place if employees are injured while working. Exceptions, such as for federal employers, can be found in NEB. REV. STAT. § 48-106.

## Who May Be Entitled To Benefits?

An injured employee who is covered by the Act may obtain benefits:

- if the injury was caused by an accident or disease that arose out of and in the course of their employment and the injury occurred in Nebraska,
- the employer was performing work in Nebraska or the employment is in Nebraska, or
- the employee was hired in Nebraska and the employer is doing business or performing work in Nebraska, whether or not the injury occurred in Nebraska.

If an employee dies as a result of a work-related injury, the employee's dependents may be entitled to benefits under the Act.

## What Benefits May Be Available?

### A. Medical Benefits

The employer / insurer is liable to pay for all reasonable medical and hospital services, appliances, prescribed drugs, prosthetic devices, and other supplies along with mileage that are necessary as the result of a work-related injury. Medical benefits may include reasonable travel expenses in some situations. The mileage rates for allowable travel are listed in the Tables of Maximum/Minimum Compensation Benefits, Burial Benefits, and Mileage Reimbursement Rates on the Nebraska Workers' Compensation Court (court) website.

**Choice of doctor**. The employer must notify the employee that the employee has the right to choose a physician they or their family have seen as their primary treating physician. If the employee does not choose a physician, the employer may select the physician. More information about Choosing a Doctor for a Work-Related Injury can be found on the court's website.

An employer / insurer may also ask an injured employee to be examined by a doctor chosen by the employer / insurer at the company's expense.

The employee should promptly submit expenses for medical care to their employer or to the insurer for payment.

## B. Indemnity Benefits

"Indemnity benefits" (also called "disability benefits") may be paid when an employee misses time from work or suffers permanent effects after a work-related injury. Employees may be entitled to *temporary* and / or *permanent* disability benefits.

### 1. Temporary Disability Benefits

Temporary disability benefits may be for either:

(a) *total* disability, or

(b) *partial* disability.

***Temporary Total Disability Benefits.*** An employee may be entitled to temporary total disability benefits for as long as they are unable to work as a result of their injury. The weekly benefit rate for temporary total disability is subject to the maximum and minimum benefit rate per week. More information can be found in the Tables of Maximum / Minimum Compensation Benefits, Burial Benefits, and Mileage Reimbursement Rates on the court's website.

***Temporary Partial Disability Benefits.*** Benefits are paid when the employee is able to return to work but under limited circumstances such as for a few hours a day or at a job which pays less than the job held at the time of the injury. The weekly benefit rate for temporary partial disability benefits is subject to the maximum benefit rate per week. More information can be found in the Tables of Maximum / Minimum Compensation Benefits, Burial Benefits, and Mileage Reimbursement Rates on the court's website.

Temporary disability benefits usually end when an employee has reached *maximum medical improvement* or has been released from medical care.

An employee is entitled to temporary disability benefits while participating in an approved vocational rehabilitation plan.

### 2. Permanent Disability Benefits

*Permanent disability benefits* may be either:

(a) permanent partial or permanent total disability of certain body parts listed in the Act ("scheduled" injuries) or,

(b) permanent partial or permanent total disability to the *body as a whole*.

**Permanent Partial Disability for Loss of a Scheduled Body Part.** Benefits are paid for the loss or loss of use of a body part such as a leg or hand based upon the value the Act assigns to various body parts.

**Permanent Total Disability for Loss of Multiple Scheduled Body Parts**. The total loss or total loss of use of two scheduled body parts in one accident is considered permanent total disability.

**Permanent Partial Disability to the Body as a Whole.** Benefits are paid for permanent disability resulting from a body as a whole injury, such as neck, back, or head. Generally, if the injured body part isn't included in the schedule of body parts, the injury is considered to be to the body as a whole. Typically, compensation for permanent partial disability to the body as a whole is compensated on the basis of loss of earning capacity. More information about Loss of Earning Power Evaluations in Nebraska can be found on the court's website.

**Permanent Partial Disability for Loss of Scheduled Body Parts**. When an employee has an injury to more than one scheduled body part, they may request that compensation be determined based on loss of earning capacity.

**Permanent Total Disability Benefits**. If an employee is permanently unable to return to the workforce as a result of their injuries, permanent total disability (PTD) benefits may be due.

3. **Death Benefits**

   If the injury results in the death of the employee, the surviving spouse and other actual dependents may be entitled to death benefits. Additionally, burial expenses may be paid.

### C. Return-to-Work Services (also known as Vocational Rehabilitation Benefits)

An employee may be eligible for return-to-work services (vocational rehabilitation benefits), such as job placement with the same or a new employer or formal training. Temporary disability benefits are paid while an employee is participating in a court-approved job placement or formal training plan.

These services are voluntary and, if not offered by the employer / insurer, the employee can request vocational rehabilitation services. An employee can contact their employer, the claims representative of their employer's insurer, or the court's Vocational Rehabilitation section to request return to work services. If it is determined that the employee will need vocational rehabilitation services, a court-certified vocational rehabilitation counselor can submit a plan of vocational rehabilitation services to the court for approval.

More information about return-to-work services can be found on the court's website.

## When Can Benefits Begin?

Indemnity (wage replacement) benefits begin on the eighth calendar day of disability, after a seven-day *waiting period*. If disability (either temporary or permanent) continues for six weeks or longer, then benefits are payable for the waiting period. See NEB. REV. STAT. § 48-119. In that situation, benefits for the waiting week are paid after six weeks elapse after the accident.

Medical benefits may begin on the date of the work injury.

Return-to-work (vocational rehabilitation) benefits may begin when the employee has permanent impairment or restrictions **and** is unable to perform suitable work within their training and experience.

### What should an employee do when they are injured at work?

An employee should notify their employer of any work-related injury or occupational disease as soon as possible. After a work-related injury, the employee also should seek treatment for urgent medical issues and inform their treating physician that it is a work-related injury.

### Can an employee obtain the name and contact information of the employer's workers' compensation insurer?

Yes. This information can be obtained by contacting the employer or the court. Insurance companies are required to report to the court each policy of workers' compensation insurance they issue. A small number of Nebraska employers are self-insured for workers' compensation.

You can find an employer's workers' compensation insurance coverage using the Coverage Lookup app on the court's website. The court's website also has a list of Self-Insured Employers.

### What should an employer do after receiving notice of an on-the-job injury?

The employer should notify its workers' compensation insurer of the injury or occupational disease. The employer / insurer should file a First Report of Alleged Occupational Injury or Illness with the court within 10 days of the date of the notice of injury. The injured employee is not responsible for filing this report.

### How long does it take to receive compensation after the injury is reported?

Compensation payments for lost wages (indemnity) and medical expenses are typically paid within 30 days after notice of the injury. However, payment of benefits might be delayed if liability for the claim is disputed.

### What happens if benefits are not paid on time?

A 50 percent penalty may be added to indemnity benefits for waiting time if payment is not made within 30 days of the notice of injury or impairment. The 50 percent penalty is due if there is no reasonable dispute regarding the employee's claim for workers' compensation benefits. Waiting-time penalties may also apply when there is a failure to pay compensation after 30 days from the entry of a final order, award or judgment of the court.

### When are permanent disability benefits paid?

After the employee has been released from medical treatment and has been placed at maximum medical improvement, permanent benefits may be payable. The employer / insurer may offer payment in a one-time lump sum or pay weekly benefits.

### What is required for an employer / insurer to receive a release from liability?

Under the Act, an employer / insurer is only released from liability (legal obligation to pay workers' compensation benefits) if the employee and employer / insurer agree to:

(a) file a Lump Sum Settlement Application which is reviewed and approved by the court, or

(b) file a Release of Liability and the court enters an order dismissing the case.

If the employee is not represented by an attorney, the settlement must be reviewed by the court to ensure it is in the best interests of the employee.

### What may an employee do if the employer / insurer does not pay benefits?

- **Contact the Employer / Insurer.** The employee or their attorney may contact the employer / insurer to discuss the benefits that may be due. You can find the insurer's phone number by using the Coverage Lookup app on the court's website or by calling the court's information line (800-599-5155 or 402-471-6468).
- **Request Informal Dispute Resolution (mediation).** Any person involved in a workers' compensation claim may request informal dispute resolution (mediation) to help settle an issue or an entire case without the need for a formal hearing. This service is free of charge. To request informal dispute resolution, call the court's information line (800-599-5155 or 402-471-6468) and ask to speak with the mediation coordinator or complete the Informal Dispute Resolution Request Form on the court's website. More information about Informal Dispute Resolution and Mediation can be found on the court's website.
- **Request an Independent Medical Exam.** The court's Independent Medical Examiner process may provide a way to get unbiased answers to questions about an employee's medical condition or related issues when there is a disagreement. More information about Independent Medical Exams can be found on the court's website.
- **File a Petition.** The employee or their attorney may file a petition (lawsuit) with the court. Petition forms can be found on the court's website or obtained from the Clerk of the Court. Employees representing themselves in court are held to the same standards, laws, and rules as attorneys.

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This information is a product of the Nebraska Workers' Compensation Court and is provided as a public service. It is not intended to be used or construed as legal advice by the Nebraska Workers' Compensation Court. The court will not be liable for any loss, injury, or direct, special, incidental or consequential damage incurred as a consequence, directly or indirectly, of the use or application of the contents herein. Further inquiries may be directed to the court; however, please note court staff may not provide legal advice or opinions.

General questions may be directed to the court's information line or you may contact the court by email from the court's website. **Case-specific questions should be directed to a private lawyer, as the Nebraska Workers' Compensation Court cannot provide legal advice. Court staff may not complete the forms for you.**

**Nebraska Workers' Compensation Court**
**1010 Lincoln Mall, Suite 100**
**Lincoln, NE 68508-2833**
***Information Line*: 800-599-5155 or 402-471-6468**
***Website*: http://www.newcc.gov/**

**Revised July 2023**

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# 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**<br>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**<br>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**<br>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**<br>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:**<br>(Select one) ☐ Has dissolved ☐ Is nonoperative ☐ May continue to operate in a limited capacity | |
| ☐ **Formation of a new entity**<br>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**<br>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**<br>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**<br>Entity **before** the change or to determine combinability with another entity | **Entity 2**<br>Entity **after** the change or to determine combinability with another entity | **Entity 3**<br>Entity **after** a merger or consolidation or to determine combinability with another entity |
|---|---|---|---|
| **1. Name of Business**<br>Provide the legal name of the business entity. | | | |
| **2. Primary Address**<br>(Street, City, State, Zip) | | | |
| **3. Legal Status**<br>(See examples in item 4 below) | | | |
| **4. Ownership**<br>List names of individual owners, partners, etc. and percentages of ownership (if applicable). Ownership should total 100%.<br>– **Sole Proprietorship:** Owner<br>– **Corporation:** Owner(s) and percentages of ownership<br>– **General Partnership:** Partners and percentages of ownership<br>– **Limited Partnership:** General partners and percentages of ownership<br>– **Limited Liability Company:** Members and percentages of ownership<br>– **Revocable Trust:** Grantor(s)<br>– **Irrevocable Trust:** Trustee(s)<br>– **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.**