# Workers Compensation Resource for Employers

## Welcome,

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

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

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

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

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

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# Non-Compliance Notice

Please note, the use of many of the documents within this packet is required. Additional fines and enforcement actions may result from non-compliance with Georgia law regarding these notices.

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

# POSTERS

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

- **WC-BOR – Bill of Rights for the Injured Worker:**
  This document serves as the mandatory workers compensation posting notice. The poster must be printed on 8½ × 14-inch (legal size) paper. Print on bright colored paper to ensure the document stands out.

- **Medical Provider Panels**
  **(WC-P1 - Panel of Physicians or WC-P3 - WC/MCO Panel):**
  Use the applicable state panel form and post it right next to the WC-BOR addressed above. The poster must be printed on 8½ × 14-inch (legal size) paper. Print on bright colored paper to ensure the document stands out. Make sure to select the appropriate insurer name from the dropdown list. For additional information, please see Medical Provider Panel Information for Employers in the Informational Documents section. Contact your Account Manager for assistance with form completion.

- **Stop Workers' Compensation Fraud and Insurance Non-Compliance Poster:**
  This poster was created by the Enforcement Division at the Georgia State Board of Workers' Compensation to inform the public about insurance fraud and to promote fraud reporting.

- **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.

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## BILL OF RIGHTS FOR THE INJURED WORKER

As required by law, O.C.G.A. §34-9-81.1, this is a summary of your rights and responsibilities. The Workers' Compensation Law provides you, as a worker in the State of Georgia, with certain rights and responsibilities should you be injured on the job. The Workers' Compensation Law provides you coverage for a work-related injury even if an injury occurs on the first day on the job. In addition to rights, you also have certain responsibilities. Your rights and responsibilities are described below.

### Employee's Rights

1. If you are injured on the job, you may receive medical rehabilitation and income benefits. These benefits are provided to help you return to work. Your dependents may also receive benefits if you die as a result of a job-related injury.

2. Your employer is required to post a list of at least six doctors or the name of the certified WC/MCO that provides medical care, unless the Board has granted an exception. You may choose a doctor from the list and make one change to another doctor on the list without the permission of your employer. However, in an emergency, you may get temporary medical care from any doctor until the emergency is over, then you must get treatment from a doctor on the posted list.

3. Your authorized doctor bills, hospital bills, rehabilitation in some cases, physical therapy, prescriptions, and necessary travel expenses will be paid if injury was caused by an accident on the job. All injuries occurring on or before June 30, 2013 shall be entitled to lifetime medical benefits. If your accident occurred on or after July 1, 2013 medical treatment shall be limited to a maximum of 400 weeks from the accident date. If your injury is catastrophic in nature you may be entitled to lifetime medical benefits.

4. You are entitled to weekly income benefits if you have more than seven days of lost time due to an injury. Your first check should be mailed to you within 21 days after the first day you missed work. If you are out more than 21 consecutive days due to your injury, you will be paid for the first week.

5. Accidents are classified as being either catastrophic or non-catastrophic. Catastrophic injuries are those involving amputations, severe paralysis, severe head injuries, severe burns, blindness, or of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy. In catastrophic cases, you are entitled to receive two-thirds of your average weekly wage but not more than $800 per week for a job-related injury for as long as you are unable to return to work. You also are entitled to receive medical and vocational rehabilitation benefits to help in recovering from your injury. If you need help in this area call the State Board of Workers' Compensation at (404) 656-0849.

6. In all other cases (non-catastrophic), you are entitled to receive two-thirds of your average weekly wage but not more than $800 per week for a job related injury. You will receive these weekly benefits as long as you are totally disabled, but no longer than 400 weeks. If you are not working and it is determined that you have been capable of performing work with restrictions for 52 consecutive weeks or 78 aggregate weeks, your weekly income benefits will be reduced to two-thirds of your average weekly wage but no more than $533.33 per week, not to exceed 350 weeks.

7. When you are able to return to work, but can only get a lower paying job as a result of your injury, you are entitled to a weekly benefit of not more than $533.33 per week for no longer than 350 weeks.

8. Your dependent(s), in the event you die as a result of an on-the-job accident, will receive burial expenses up to $7,500 and two-thirds of your average weekly wage, but not more than $800 per week. A widowed spouse with no children will be paid a maximum of $320,000. Benefits continue until he/she remarries or openly cohabits with a person of the opposite sex.

9. If you do not receive benefits when due, the insurance carrier/employer must pay a penalty, which will be added to your payments.

### Employee's Responsibilities

1. You should follow written rules of safety and other reasonable policies and procedures of the employer.

2. You must report any accident immediately, but not later than 30 days after the accident, to your employer, your employer's representative, your foreman or immediate supervisor. Failure to do so may result in the loss of the benefits.

3. An employee has a continuing obligation to cooperate with medical providers in the course of their treatment for work related injuries. You must accept reasonable medical treatment and rehabilitation services when ordered by the State Board of Workers' Compensation or the Board may suspend your benefits.

4. No compensation shall be allowed for an injury or death due to the employee's willful misconduct.

5. You must notify the insurance carrier/employer of your address when you move to a new location. You should notify the insurance carrier/employer when you are able to return to full-time or part-time work and report the amount of your weekly earnings because you may be entitled to some income benefits even though you have returned to work.

6. A dependent spouse of a deceased employee shall notify the insurance carrier/employer upon change of address or remarriage.

7. You must attempt a job approved by the authorized treating physician even if the pay is lower than the job you had when you were injured. If you do not attempt the job, your benefits may be suspended.

8. If you believe you are due benefits and your insurance carrier/employer denies these benefits, you must file a claim within one year after the date of last authorized medical treatment or within two years of your last payment of weekly benefits or you will lose your right to these benefits.

9. If your dependent(s) do not receive allowable benefit payments, the dependent(s) must file a claim with the State Board of Workers' Compensation within one year after your death or lose the right to these benefits.

10. Any request for reimbursement to you for mileage or other expenses related to medical care must be submitted to the insurance carrier/employer within one year of the date the expense was incurred.

11. If an employee unjustifiably refuses to submit to a drug test following an on-the-job injury, there shall be a presumption that the accident and injury were caused by alcohol or drugs. If the presumption is not overcome by other evidence, any claim for workers' compensation benefits would be denied.

12. You shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than $10,000.00 or imprisonment, up to 12 months, or both, for making false or misleading statements when claiming benefits. Also, any false statements or false evidence given under oath during the course of any administrative or appellate division hearing is perjury.

The State Board of Workers' Compensation will provide you with information regarding how to file a claim and will answer any other questions regarding your rights under the law. If you are calling in the Atlanta area the telephone number is (404) 656-3818, outside the metro Atlanta area call 1-800-533-0682, or write the State Board of Workers' Compensation at: 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299 or visit our website: https://www.sbwc.georgia.gov. A lawyer is not needed to file a claim with the Board; however, if you think you need a lawyer and do not have your own personal lawyer, you may contact the Lawyer Referral Service at (404) 521-0777 or 1-800-334-6865.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT https://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

(This notice must be posted in a conspicuous place readily accessible to the employees at all times.)

# PANEL OF PHYSICIANS

## OFFICIAL NOTICE

This business operates under the Georgia Workers' Compensation Law.

**WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR, OR FOREMAN.**

If a worker is injured at work, the employer shall pay medical and rehabilitation expenses within the limits of the law. In some cases the employer will also pay a part of the worker's lost wages.

Work injuries and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days (see O.C.G.A. § 34-9-80).

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation. The employer will also furnish to the employee, upon request, copies of board forms on file with the employer pertaining to an employee's claim.

A worker injured on the job must select a doctor from the list below. The minimum panel shall consist of at least six physicians, including an orthopedic surgeon with no more than two physicians from industrial clinics (see O.C.G.A. § 34-9-201). Further, this panel shall include one minority physician, whenever feasible (see Rule 201 for definition of minority physician). The Board may grant exceptions to the required size of the panel where it is demonstrated that more than four physicians are not reasonably accessible. One change to another doctor from the list may be made without permission. Further changes require the permission of the employer or the State Board of Workers' Compensation.

**The insurance company providing coverage for this business under the Workers' Compensation Law is:**

**Omaha National Underwriters, LLC on behalf of**

Insurer Name: **(Select Insurer Name)** Phone: **844-761-8400**

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

Insurer Email: **claims@omahanational.com**

Instructions to injured worker: Review the following physician's contact information and select the provider with whom you would like to receive medical treatment.

**Physician's Contact Information: Name, Address, Phone, and website listed below:**

1. 
2. 
3. 
4. 
5. 
6. 
7. 
8. 
9. 

(Additional doctors may be added on a separate sheet)

☐ This box is checked if additional physicians are listed on separate sheet.

**IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT https://sbwc.georgia.gov**

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to $10,000.00 per violation (O.C.G.A. § 34-9-18 and § 34-9-19).

WC-P1 (7/2023)

(This notice must be posted in a conspicuous place readily accessible to the employee at all times.)

# MANAGED CARE ORGANIZATION PROCEDURES
# OFFICIAL NOTICE

This business operates under the Georgia Workers' Compensation Law.

## WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR, OR FOREMAN.

If a worker is injured at work, the employer shall pay medical and rehabilitation expenses within the limits of the law. In some cases the employer will also pay a part of the worker's lost wages.

Work injuries and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days (see O.C.G.A. § 34-9-80).

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation. The employer will also furnish to the employee, upon request, copies of board forms on file with the employer pertaining to an employee's claim.

The insurance company providing coverage for this business under the Workers' Compensation Law is:

**Omaha National Underwriters, LLC on behalf of**

**(Select Insurer Name)**

Insurer Name

| **P.O. Box 451139, Omaha, NE 68145** | **844-761-8400** |
|---|---|
| address | phone |

Your employer has enrolled with the certified Workers' Compensation Managed Care Organization (WC/MCO) listed below to provide all the necessary medical treatment for workers' compensation injuries. The effective date is shown below. If you had an injury prior to the effective date listed below you may continue to receive treatment from your current non-participating authorized physician until you elect to utilize the services of the WC/MCO.

Each employee will be furnished with a publication which explains in detail how to access the services of the WC/MCO and provides a complete list of the medical providers available. In addition, each employee will be given a wallet-sized card which contains information on the services of the WC/MCO including a 24-hour toll-free phone number with recorded messages of information on how to utilize these services.

NAME OF WC/MCO _____

MAILING ADDRESS _____

GEOGRAPHICAL SERVICE AREA _____

NAME OF CONTACT PERSON _____

PHONE NUMBER OF CONTACT PERSON _____

ADDRESS OF CONTACT PERSON _____

24-HOUR TOLL-FREE PHONE NUMBER _____

EFFECTIVE DATE OF WC/MCO _____

**IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT https://sbwc.georgia.gov**

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to $10,000.00 per violation (O.C.G.A. § 34-9-18 and § 34-9-19).

WC-P3 (7/2022)

Georgia
State Board of Workers' Compensation
270 Peachtree Street, N.W.
Atlanta, Georgia 30303-1299

# Georgia State Board of Workers' Compensation

## Enforcement Division

# WORKERS' COMPENSATION FRAUD

## AND

# INSURANCE NON-COMPLIANCE

**Everyone pays the price for W.C. Fraud!**

**Contact the Workers' Compensation Enforcement Division.**

**Toll Free Fraud Hotline: 1-800-533-0682**

**Office: (404) 657-7285**

**Fax: (404) 651-7390**

**Visit our Website at www.sbwc.georgia.gov**

**WORKERS' COMPENSATION FRAUD WILL BE PROSECUTED**

# 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.

### WC-1 - Employer's First Report of Injury:

Georgia law requires employers to report all employee injuries immediately to the insurer. Send the completed WC-1 form to Omaha National at the same time you report the claim to us. Any injuries involving medical treatment or compensable lost time are required to be reported to the State Board of Workers' Compensation. Once the claim is reported, we will submit electronic reports to the Board on your behalf.

### WC-6 – Wage Statement:

This form may be used to provide information about an injured worker's wages. Send a completed copy to Omaha National at the same time you report the injury to us.

### 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.

WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY. MUST BE TYPED OR PRINTED IN BLACK INK.

| Board Claim No. | Employee Last Name | Employee First Name | M.I. | Date of Injury |
|---|---|---|---|---|
| | | | | |

## A. IDENTIFYING INFORMATION

| | | | | |
|---|---|---|---|---|
| **EMPLOYEE** | ☐ Male ☐ Female | Birthdate | Phone Number | Employee E-mail |
| Mailing Address | | City | State | Zip Code |
| **EMPLOYER** | Name | NAICS Code | Nature of Business (Trade, Transport, Mfg.,etc.) | |
| Mailing Address | | Phone Number | Employer FEIN | |
| City | State | Zip Code | Employer E-mail | |
| **INSURER / SELF-INSURER** | Name | Insurer/Self-Insurer FEIN | Insurer/ Self-Insurer File # | |
| **CLAIMS OFFICE** | Name | Claims Office FEIN # | Claims Office Phone | Claims Office E-mail |
| SBWC ID# (five digit no.) | Mailing Address | City | State | Zip Code |

| | | | | |
|---|---|---|---|---|
| **EMPLOYMENT/WAGE** | Date Hired by Employer | Job Classified Code No. | Number of Days Worked Per Week | Wage rate at time of Injury or Disease: ☐ per Hour ☐ per Day ☐ per Week ☐ per Month |
| Insurer Type Code ☐I – Insurer ☐S-Self-insurer ☐Group Fund | List Normally Scheduled Days Off | | | |
| **INJURY/ILLNESS & MEDICAL** | Time of Injury ☐ am ☐ pm | County of Injury | Date Employer had knowledge of Injury | Enter First Date Employee Failed to Work a Full Day |
| Did Employee Receive Full Pay on Date of Injury? ☐ Yes ☐ No | Did Injury/Illness Occur on Employer's premises? ☐ Yes ☐ No | Type of Injury/Illness | Body Part Affected | |
| How Injury or Illness / Abnormal Health Condition Occurred | | | | |

| Treating Physician (Name and Address) | Initial Treatment Given: ☐ None ☐ Minor: By Employer ☐ Minor: Clinical/Hospital ☐ Emergency Room ☐ Hospitalized > 24hrs | Hospital / Treating Facility (Name and Address) | If Returned to Work, Give Date: / Returned at what wage per Week / If Fatal, Enter Complete Date of Death |
|---|---|---|---|
| | | | |

| Report Prepared By (Print or Type) | Telephone Number | Date of Report |
|---|---|---|
| | | |

## ☐ B. INCOME BENEFITS Form WC-6 must be filed if weekly benefit is less than maximum

Previously Medical Only ☐ Yes ☐ No

Average Weekly Wage: $ _____ Weekly benefit: $ _____ Date of disability: _____

Date of first Payment: _____ Compensation paid: $ _____ or Date salary paid: _____ Penalty paid: $ _____

BENEFITS ARE PAYABLE FROM _____ FOR:

☐ Temporary total disability ☐ Temporary partial disability ☐ Permanent partial disability of _____ % to _____ for _____ weeks.

UNTIL _____ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.

## ☐ C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION

Benefits will not be paid because:

## ☐ D. MEDICAL ONLY INJURY (No indemnity benefits are due and/or have NOT been controverted.)

| Insurer / Self-Insurer: Type or Print Name of Person Filing Form | Signature | Date |
|---|---|---|
| | | |
| Phone Number | E-mail | |
| | | |

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. § 34-9-18 AND § 34-9-19).

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## A. NOTICE TO EMPLOYER

1. Provide prompt medical attention; allow the employee to select a physician from your posted panel, and explain the panel to the employee.

2. Complete Section A of this Form immediately upon your knowledge of an injury and send the WC-1 to your insurance company or self-insurer claims office. **FAILURE TO DO SO MAY RESULT IN A PENALTY.**
   Do not send this form to the State Board of Workers' Compensation. If you need additional help, call your insurance company or self-insurer claims office.

3. Report serious injuries immediately by telephone to your insurer's claims department, then file this form with your insurance company or self-insurer claims office.

## B. NOTICE TO INSURER / SELF-INSURER

Upon receipt of this form, check to see that it is complete and accurate. Be sure to list the correct insurance company and their SBWC ID number.

Complete Section B, C, or D and file with the Board and send a copy of both sides of the Form to the employee and all counsel of record within 21 days of the employer's knowledge of disability, injury, or death.

Section B is completed when indemnity benefits are paid or due, including salary in lieu.

Section C is completed when claim is controverted in full or in part.

Section D is completed when no indemnity benefits are due and/or have NOT been controverted.

Form WC-6 must be filed if weekly benefits are less than the maximum.

## C. NOTICE TO EMPLOYEE

This form is provided for your information only.

If Section B is completed, you will receive income benefits on a weekly basis and the employer will pay medical expenses from approved doctors. If you do not receive payment of benefits, or medical bills are not paid, call your employer or your employer's insurance company or self-insurer claims office.

If Section C is completed, your claim of injury has been denied by the employer/insurer. If you disagree with this denial, you must file a Form WC-14 Notice of Claim within one year of the accident with the **State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, Georgia 30303-1299.**

If Section D is completed, you will receive medical benefits only. At this time, indemnity benefits are not due. If your medical bills are not paid, call your employer or your employer's insurance company or self-insured claims office.

For information or assistance, contact:

STATE BOARD OF WORKERS' COMPENSATION

Toll Free: 1-800-533-0682
Atlanta: (404) 656-3818

https://sbwc.georgia.gov

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## WAGE STATEMENT

| Board Claim No. | Employee Last Name | Employee First Name | M.I. | Date of Injury |
|---|---|---|---|---|
| | | | | |

## A. IDENTIFYING INFORMATION

| | | | | |
|---|---|---|---|---|
| **EMPLOYEE** | | Mailing Address | | |
| E-mail Address | | City | State | Zip Code |
| **EMPLOYER** | Name | Mailing Address | | |
| E-mail Address | | City | State | Zip Code |
| **INSURER/ SELF-INSURER** | Name | | | |
| **CLAIMS OFFICE** | Name | Mailing Address | | |
| SBWC ID # | Insurer/Self-Insurer File # | City | State | Zip Code |

## B. COMPUTATION OF AVERAGE WEEKLY WAGE

If the weekly benefit is less than the maximum, complete the schedule below for thirteen (13) weeks immediately preceding the accident. If the employee has not been in your employ for the thirteen (13) weeks, complete this schedule showing gross weekly earnings of a similar employee in the same employment. If either of the foregoing methods cannot be reasonably and fairly applied, the full time weekly wage of the injured employee should be used.

☐ 13 Weeks of Employee's Wages ☐ 13 Weeks of a Similar Employee's Wages ☐ Full Time Weekly Wage of Injured Employee: $_____

### SCHEDULE OF WEEKLY EARNINGS

| Week | From Date MM/DD/YYYY | To Date MM/DD/YYYY | No. of Days Worked | Gross Amount Paid Including Overtime or Extra Work | Value of Additional Compensation | | | | | Total Earnings |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Meals | Lodging | Rent | Tips | Other | |
| 1 | | | | | | | | | | $ 0.00 |
| 2 | | | | | | | | | | $ 0.00 |
| 3 | | | | | | | | | | $ 0.00 |
| 4 | | | | | | | | | | $ 0.00 |
| 5 | | | | | | | | | | $ 0.00 |
| 6 | | | | | | | | | | $ 0.00 |
| 7 | | | | | | | | | | $ 0.00 |
| 8 | | | | | | | | | | $ 0.00 |
| 9 | | | | | | | | | | $ 0.00 |
| 10 | | | | | | | | | | $ 0.00 |
| 11 | | | | | | | | | | $ 0.00 |
| 12 | | | | | | | | | | $ 0.00 |
| 13 | | | | | | | | | | $ 0.00 |
| | | | **Total** | $ 0.00 | $ 0.00 | $ 0.00 | $ 0.00 | $ 0.00 | $ 0.00 | $ 0.00 |
| | | | **Average Weekly Earnings** | $ 0.00 | $ 0.00 | $ 0.00 | $ 0.00 | $ 0.00 | $ 0.00 | $ 0.00 |

## C. SCHEDULED DAYS OFF

**REQUIRED TO COMPLETE:** ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun ☐ No Off Days

## D. REMARKS

REMARKS:

| Type or Print Name | Signature | Date |
|---|---|---|
| | | |
| E-mail Address | Phone Number | |
| | | |

**IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov**

**WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).**

# 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.

- **Panel Acknowledgement and Physician Selection:**
  Provide a copy of your Employer Medical Provider Panel and then have the injured worker complete and sign this form. Send copies of both documents to Omaha National when the injury is reported.

- **WC-207 - Authorization and Consent to Release Information:**
  The Georgia State Board of Workers' Compensation developed this release form to be used to obtain the documents and records needed to process a claim. Please have the injured worker sign this document and send a copy of the signed form to Omaha National when the injury is reported.

- **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 |

# Panel Acknowledgement and Physician Selection

By signing this form, I accept my employer's posted medical provider panel. I understand that I must choose a provider from the panel list to give me treatment for a work injury or illness. I also understand that if I get treatment from a provider that is not listed on the panel, my employer may not be required to pay for such treatment.

I also understand that I have the right to change to another provider listed on the panel if I am not satisfied with the first doctor I choose. I must obtain approval for any further provider changes from the insurance company or the Georgia State Board of Workers' Compensation.

I choose the following medical provider to give me treatment and services for my work injury or illness:

Provider/Physician Name _____

Clinic Name _____

Address _____

Phone Number _____

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

Signature _____

Printed Name _____ Date _____

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

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

**Instructions: This form shall not be filed with the Board, unless otherwise requested.**

| **TO:** | | |
|---|---|---|
| Print Name and Title | | |
| Address | | |
| City | State | Zip Code |

| **RE:** Employee / Patient | | |
|---|---|---|
| Last Name | First Name | M.I. |
| Date of Injury | Birthdate | |

This document authorizes the release of only the medical information as provided below. The above-stated entity, facility or medical practitioner is authorized to release medical information to

**Omaha National Group / Omaha National Underwriters, LLC / Omaha National Insurance Company (ONIC)**

in accordance with applicable State and Federal laws.

The information covered by this Authorization and Consent to Release is that authorized by O.C.G.A. §34-9-207 which reads as follows:

(a) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, that employee shall be deemed to have waived any privilege or confidentiality concerning any communications related to the claim or history or treatment of injury arising from the incident that the employee has had with any physician, including, but not limited to, communications with psychiatrists or psychologist. This waiver shall apply to the employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Notwithstanding any other provision of law to the contrary, when requested by the employer, any physician who has examined, treated, or tested the employee or consulted about the employee shall provide within a reasonable time and for a reasonable charge all information and records related to an examination, treatment, testing, or consultation concerning the employee.

(b) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, the employee, upon request, shall provide the employer with a signed release for medical records and information related to the claim or history or treatment of injury arising from the incident, including information related to the treatment for any mental condition or drug or alcohol abuse and to such employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Said release shall designate the provider to whom the release is directed. If a hearing is pending, any release shall expire on the date of the hearing.

(c) If the employee refuses to provide a signed release for medical information as required by this Code section and, in the opinion of the Board, the refusal was not justified under the terms of this Code section, then such employee shall not be entitled to any compensation at any time during the continuance of such refusal or to a hearing on the issues of compensability arising from the claim.

**Federal regulations (42 CFR Part 2), and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 45 CFR 164.512(l) which reads as follows: *"The 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 illnesses or injury without regard to fault."* Anyone who receives information under this authorization receives the same under all limitations set forth in Federal and State law regarding further dissemination of such information.**

**This release is not seeking and does not authorize the disclosure of protected health information relating to reproductive health as prohibited by the HIPAA Privacy Rule at 45CFR 164.502(a)(5)(iii). Any such disclosure would require a separate release.**

**This release shall expire in 180 days or upon written notice of revocation by the patient. If a hearing is pending, this release shall remain in effect until the hearing and shall expire on the date the hearing is held.**

| Employee / Patient Signature | Date |
|---|---|
| | |

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

# 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 _____

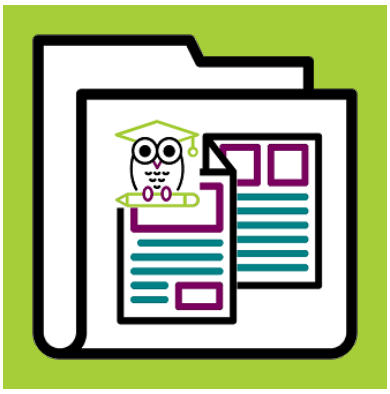
Bank Routing Number (ABA#) _____ Bank Account Number (EFT Format) _____

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.

- **Medical Provider Panel Information for Employers:**
  Information about medical provider panels and the employer actions necessary for us to require treatment with listed providers.

- **Best Practices: Role of the Employer:**
  The State Board of Workers' Compensation created this document to provide general information and guidance on the roles and requirements for employers under the Georgia workers compensation laws.

- **Best Practices: Early Return-to-Work Program:**
  This document from the State Board addresses the benefits of and methods to implement a successful return to work program.

# 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.

# Medical Provider Panel Information for Employers

## Designated Medical Providers for Treating Workplace Injuries

The right physician can have a substantial impact on the successful recovery of an injured employee and on the cost of a workers compensation claim. High quality, cost effective care for your injured employees is our top priority. Georgia laws specify that employers can meet the requirement to provide medical care to injured employees by adopting medical provider panels. Using panels helps your employees receive medical care from highly qualified physicians and other skilled medical providers. Our panels consist of providers who are experienced in treating workplace injuries, are familiar with the workers compensation system, and are strong advocates of an early, safe return to work. Please contact your Account Manager to discuss how we can work together to ensure injured workers receive appropriate and timely care.

## Preserve Your Rights

We can only require that injured workers treat with panel providers if these steps are followed:

- **Post Workers Compensation Notices:** Employers are required to post mandatory notices regarding employees' workers compensation rights. We have provided those notices to you along with instructions on where to post them.
- **Medical Provider Panel:** The law instructs employers to post their panel in prominent and readily accessible places at all business locations and work sites. This includes places used for treatment and first aid and any employee informational bulletin boards. We have provided the state panel forms with instructions for proper use. Make sure that all employees are notified of the panel and their right to select a provider from the panel for the treatment of a work-related injury.

  Requirements for Valid Panels:

  - WC-P1 – Panel of Physicians –
    - At least 6 providers must be listed; include the names, addresses, and phone numbers
    - Must include: one orthopedic surgeon, a minority physician, and no more than 2 industrial clinics
    - Providers listed should be within 50 miles of the job site
  - WC-P3 – WC/MCO Panel –
    - Employer or insurer contracts with a board-certified Managed Care Organization (MCO)
    - Give notice to all employees to explain how program works and provide instructions to access services
    - Provide information cards that explains how the program works and a toll-free, 24-hour telephone number to call in the event of an on-the-job injury
- **Offer Immediate Medical Care:** Upon learning of a work injury, an employer should offer immediate medical treatment to the injured employee. Let us know about any injury right away so we can help arrange for appropriate medical care. The failure to offer medical care may constitute a refusal or denial of care which may result in an employee being able to treat with providers outside the panel listing.
- **Panel Acknowledgement and Physician Selection:** Upon knowledge of an employee's work injury or occupational illness, have the injured worker complete this form to confirm their knowledge of the provider panel and to designate the medical provider they have chosen to treat their injury or illness. Send a copy of the posted panel and the completed panel acknowledgment when the claim is reported to Omaha National. This documentation is needed to enforce panel use.

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

**www.sbwc.georgia.gov**

# BEST PRACTICES

## ROLE OF THE EMPLOYER

**July 2013**

# ROLE OF THE EMPLOYER

## Prompt Reporting of Claims

**Best Practices**

A. Centralize case management responsibility so everyone knows who, where, when and why notification is necessary.
B. Make sure a workers' compensation representative is available to help when the injured employee calls.
C. Provide a 24-hour toll free number to allow convenience of reporting claims and obtaining information.
D. Have supervisors and managers trained to report injuries immediately.
E. Complete form WC-1 within 24 hours of the accident.

**Benefits:**

1. The key to claim and medical management is early notification.
2. Allows for timely delivery of benefits
3. Allows for timely investigation of claim.
4. Allows for early involvement in claim, and better claim medical management.
5. Reduces attorney involvement

## Prompt Investigation of the Claim

**Best Practices**

A. Make personal or telephone contact with the injured employee and/or their family within 24 hours, whenever possible.
B. Explain workers' compensation benefits to the employee at the first opportunity.
C. Make contact with the medical provider and witnesses to the accident (within the first 48 hours after the accident) as soon as possible after the accident.
D. Regular follow-up contact with the employee is essential; usually bi-weekly, if it is a lost-time claim.
E. Timely completion of the investigation and determination of compensability must be done with 21 days of the injury.
F. Determine if any offsets, such as subrogation, might apply.

**Benefits:**

1. Allows for rapport with the injured employee.
2. Allows for identification of compensation issues.
3. Allows for the establishment of the accident facts while details are still fresh on the minds of any witnesses or those involved in the accident.
4. Allows for timely delivery of benefits.

## Train Supervisors and Managers

**Best Practices**

A. Provide supervisors and managers with training manuals and training presentations.
B. Work directly and personally with supervisors on difficult claims.
C. Make sure management and supervisors understand and support return-to-work policies.
D. Make sure supervisors are familiar with the panel of physicians located in their area.
E. Review the Supervisor's Manual available on the Board's website, www.sbwc.georgia.gov .

**Benefits:**

1. Claims are reported in a timely manner.
2. Employee's legal rights are not violated
3. Claims handling is smoother when procedures are known and followed.

## Educate Employees About Their Rights, Responsibilities and Prompt Reporting of Claims

**Best Practices**

A. Provide employee handbooks about the workers' compensation program. The Employee Handbook is available on the Board's website, www.sbwc.georgia.gov.
B. Provide employee training videos.
C. Ensure that supervisors and managers review the employee's rights and responsibilities with their employees periodically.

**Benefits:**

1. Claims handling is more efficient and effective if employees understand and follow procedures.
2. Employee satisfaction and understanding is increased.

## Have Productive "Return-To-Work" and "Stay-At-Work" Programs

**Best Practices**

A. Obtain senior management commitment to a return-to-work policy.
B. Have essential functions of all job classifications identified.
C. Make every effort to make reasonable accommodations for injured workers.
D. Involve employees and unions in establishment of return-to-work programs.
E. Ensure that the doctors on your panel of physicians understand your return-to-work policy and have knowledge of job duties.
F. Consider job redirection for the injured employee.
G. An Early Return-To-Work Program guide is available on the Board's website, www.sbwc.georgia.gov.

**Benefits:**

1. Attorney involvement is reduced.
2. Overall cost of the claim is reduced.
3. Employee's return to full duty is generally sooner.
4. Employee's work attitude is better.
5. Company morale is improved because employees realize their needs will be met.

## Make Medical and Disability Management of the Claim a Top Priority

**Best Practices**

A. The quality of medical care provided should be the main consideration used in selecting treating physicians. A company can select a traditional panel of physicians, a conformed panel of physicians, or a managed care organization. Care should be taken to select whichever program would best suit your company.
B. Establish an ongoing relationship with the providers selected to care for injured employees. Make sure they understand your expectations of quality care. Make sure they understand your policy of returning employees to transitional work when it is safe to do so.
C. Meet with or call the injured worker to ensure appropriate medical care is being received and coordinate return to work if applicable.
D. Communicate regularly with the treating physician concerning treatment, disability, medications, utilization, etc. Actively pursue and solicit a release to return to work from the treating physician, rather than waiting for the physician to release the employee, when the employee has reached maximum medical improvement.
E. Review all medical bills for fee schedule adherence, treatment of unrelated problems, over utilization of medical treatment, abuse of prescription drugs, and reasonable charges for services rendered.
F. Utilize a peer review process for unreasonable charges.
G. Obtain an independent medical examination if there is some question about the injury or treatment.

H. Send employee to a work strengthening program to enhance return to work if applicable.
I. Pursue alternative methods of claim resolution if it is determined that the employee has permanent restrictions and cannot return to work.

**Benefits:**

1. Helps ensure that quality and timely care for the injured worker is the main emphasis.
2. Helps ensure that cost effective, quality health care providers are used.
3. Helps ensure that treatment is related to the injury.
4. Helps facilitate the recovery of the injured employee in a timely manner.
5. Helps develop a better relationship between employee and physician.

**Develop Cost Management Program**

**Best Practices**

A. All medical and hospital bills should be reviewed for fee schedule adherence, reasonableness and appropriateness to the injury and should be paid timely.
B. Establish direct network contracts with physical therapy providers, hospitals, MRI and CT companies and occupational clinics.
C. Develop a pharmacy management network (not mandatory).

**Benefits:**

1. Helps ensure a successful, cost effective workers' compensation program.
2. Provides a closer more personal relationship with health care providers.

**Develop Litigation Strategy**

**Best Practices**

A. Review all claim files prior to litigation to determine if any other resolution is appropriate; determine a case value, determine odds of prevailing.
B. Consider mediation for early dispute resolution.
C. Meet with defense counsel to review evidence and plan for the hearing.
D. Place special emphasis on claims involving claims of stress, occupational disease, blood-born pathogen exposure, Americans with Disabilities Act (ADA).
E. Review all legal bills for appropriateness and accuracy.

**Develop Settlement and Claim Resolution Strategy**

**Best Practices**

A. Identify those cases which need to be settled in a timely manner.
B. Properly document the settlement value.
C. Develop negotiating strategy by determining "initial offer," "target settlement," and "walk-away" value.
D. Make use of mediation with the Alternative Dispute Resolution (ADR) Division of the Board whenever possible.
E. Have a face-to-face settlement conference.

**Benefits:**

1. Overall cost savings.
2. Timely resolution of claim.

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

**www.sbwc.georgia.gov**

# BEST PRACTICES

## EARLY RETURN-TO-WORK PROGRAM

**July 2013**

## Why Do I Need A Restricted Duty Job Program?

**Best Practices**

1. Return injured employees to meaningful employment.
2. Utilize employees' work skills during their period of partial disability.
3. Maintain a good employee attitude by providing meaningful employment.
4. Maintain communication with employees.

**Benefits**

1. Helps the injured employee maintain income levels.
2. Eliminates employees' fears concerning future employment.
3. Controls workers' compensation costs.
4. Reduces need for attorneys in the workers' compensation case.
5. Reduces employees' complacency caused by sitting at home.
6. Providing meaningful transitional-duty employment should help reduce workers' compensation fraud.
7. Employees return to work sooner.

## How Do I Develop A Transitional-Duty Job?

**Best Practices**

1. Identify jobs with physical demands consistent with restrictions placed on the injured employee by the physician.
2. Evaluate the essential functions of all jobs so you can identify portions of a job which would be within the physical restrictions of your injured employee.
3. Develop a written job description of the transitional-duty job.
4. Involve all the participants, (i.e. employees, supervisors, managers, physicians, company nurses, etc.), to develop an appropriate job.
5. Make sure the job is meaningful and productive.
6. Avoid isolation from other employees.
7. Be flexible regarding work and time limitations imposed by physicians. Some employees may be restricted to reduced hours.
8. Maintain consistent, continual employment.
9. Be sure the job is developed prior to the time you need it.
10. Be flexible about department and shift.
11. Be sure appropriate transitional duty is available when needed.
12. Establish an appropriate pay for a transitional-duty job. Temporary partial disability benefits will compensate for reduced earnings during the transitional duty.
13. Be creative in developing transitional-duty jobs.
14. Review the Early Return-To-Work Program available on the Board's website, www.sbwc.georgia.gov.

**Benefits**

1. Job description will be available when the need arises.
2. Employee returns to work sooner.
3. Doctors, employees and management will have a better understanding of the job requirements.
4. Employees will accept the job more readily once it is clearly defined.
5. Assures your consistency in return-to-work programs.
6. Will help credibility with doctors, lawyers and judges in workers' compensation cases.
7. Employees return to full-duty work sooner.

## How Do I Implement A Transitional-Duty Program?

**Best Practices**

1. Obtain physician's permission based on job description.
2. Communicate with all participants, (i.e., employees, supervisors, managers, nurses, physicians, etc.), to assure a safe and successful return to an appropriate transitional-duty job as approved by the physician.
3. Complete form WC-240, Notice to Employee of Offer of Suitable Employment, and send completed form to the employee and his/her attorney, if they are represented. Send a copy to the Board.
4. Be flexible in matching the job to the injured employee.
5. Make sure the job is available.
6. Inform the supervisor when the injured employee is returning to work.
7. Provide necessary medical and nursing assistance during the transitional-duty time.
8. Educate the supervisor concerning the importance of the transitional-duty job. Also make sure the supervisor and employee understand and follow the physician restrictions.
9. Make sure the physicians know and understand the essential functions of the job (on-site evaluations, video presentations, written job analysis, etc.).
10. Provide an appropriate work area.
11. Notify your insurance company, agent, third-party administrator or claims office when the employee returns to transitional duty.

**Benefits**

1. Safer return to transitional-duty work.
2. Employees return to work sooner.
3. Better understanding by all parties involved.
4. More successful conclusion to the claim.
5. Provides a closer, more personal relationship with health care providers.
6. Helps to maintain your credibility with the physician when the physician knows that you will provide appropriate work.
7. More cost effective than letting the employee sit at home.
8. Should help reduce litigation.

**July 2013**

# 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.**

# STATE-SPECIFIC FORMS & DOCUMENTS

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

### WC-10 – Notice of Election or Rejection of Workers' Compensation Coverage:

Employees may use this form to reject the provisions of Georgia's workers compensation laws or to reverse a prior rejection of coverage. Employers 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.

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## NOTICE OF ELECTION OR REJECTION OF WORKERS' COMPENSATION COVERAGE

**THIS FORM IS NOT A WAIVER OF COVERAGE AND SHOULD NOT BE ACCEPTED AS A WAIVER OF COVERAGE.**

The use of this form is required under the provisions of: (A) O.C.G.A. § 34-9-2.1 of the Workers' Compensation Law if a corporate officer or limited liability company member elects to reject coverage; (B) O.C.G.A. § 34-9-2.2 if a sole proprietor or partner elects to be included as an employee; or, (C) O.C.G.A. § 34-9-2.3 if a farm labor employer elects to provide coverage for farm laborers. The election of corporate officers or LLC members to reject coverage shall not affect a corporate officer or LLC member being included in the count of the requisite number of employees. Any employer subject to this chapter pursuant to code Section § 34-9-2(a) before the filing of any exemptions shall remain subject to this chapter without regard to the number of exemptions.

### A. CORPORATION / LIMITED LIABILITY COMPANY

I, _____ , certify that I am a member of _____
(Type or Print Name) (Employer)

_____ _____
(Office Held) (Street Address)

_____
(City / State / Zip Code)

☐ I elect to reject the provisions of the Georgia Workers' Compensation Law.

☐ I elect to revoke the previous rejection of _____
(Date)

(NOTE: A maximum of five (5) officers / members may be exempted)

### B. SOLE PROPRIETOR OR PARTNER

I, _____ , certify that I am a ☐ Sole Proprietor ☐ Partner of _____
(Business Name)

☐ I elect to be covered under the provisions of the Georgia Workers' Compensation Law.

☐ I elect to revoke the previous election of _____
(Date)

### C. FARM LABOR

I, _____ , certify that as the employer or representative of _____ , that
(Business Name)

☐ I elect to provide Workers' Compensation coverage for farm laborers.

☐ I elect to revoke the previous election of _____
(Date)

### D. CERTIFICATION

☐ I hereby certify that the information listed is true and correct

| Print Name | Business Phone Number and Ext. | Signature |
|---|---|---|
| | | |

Business Address

(Date)

A COPY OF THIS FORM MUST BE FILED WITH YOUR CURRENT WORKERS' COMPENSATION CARRIER. IF YOU **DO NOT** HAVE A CARRIER, **AND THE BUSINESS HAS** 3 TO 5 **CORPORATE OFFICERS OR LIMITED LIABILITY MEMBERS AND NO EMPLOYEES**, THIS FORM MUST BE FILED WITH THE STATE BOARD OF WORKERS' COMPENSATION AT 270 PEACHTREE STREET, N.W., ATLANTA, GEORGIA 30303-1299. NOTE: **DO NOT SEND TO THE BOARD IF THERE IS INSURANCE COVERAGE.**

**IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov**

**WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. § 34-9-18 AND § 34-9-19).**

WC-10 NOTICE OF ELECTION OR REJECTION OF WORKERS' COMPENSATION COVERAGE

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

The primary purpose of the State Board of Workers' Compensation's Board Form WC-10 is to elect or reject workers' compensation insurance coverage in conjunction with the purchase of a policy for said coverage. For the purpose of making this election or rejection, the form will be filled out by your insurance agent and filed with the insurance carrier accepting the coverage. [See O.C.G.A. § 34-9-2.1 and 2.3]

In the alternative, Board Form WC-10 may also be used by a corporation or LLC pursuant to O.C.G.A. § 34-9-2.2 to reject coverage of up to five (5) corporate officers or LLC members when the corporation or LLC has no additional employees which would require the business to obtain coverage. Any business which regularly employs three (3) or more persons must obtain a policy for workers' compensation insurance. Corporate Officers and LLC members are included in this number regardless of their election to be exempt. If, after the filing of up to five (5) exemptions the business has no employees, then Board Form WC-10 shall be filed with the State Board of Workers' Compensation.

Many small business owners without employees mistakenly believe Board Form WC-10 to constitute a waiver of coverage that can be presented to a general or principal contractor as proof of exemption by waiver. This is incorrect. Although your business may not be required by law to have workers' compensation insurance coverage by employing fewer than the requisite number of employees, a general or principal contractor for whom you perform work may contractually require you to provide a policy for workers' compensation insurance. You, the owner of your business, can elect to accept this condition of your contract by purchasing a minimum premium policy from an independent insurance agent licensed by the State of Georgia. In the alternative, the general or principal contractor can elect to withhold a premium amount from money paid to you for your services. If this occurs, you may be covered under the contractor's workers' compensation policy.

Some states offer formal waivers of workers' compensation insurance through an application and fee process. Georgia does not offer a waiver program.

If you have any additional questions, you may refer to the Board's website at sbwc.georgia.gov or call the Licensure Division at (404) 463-6794.