Workers Compensation Resource for Employers

Welcome,

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

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

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

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

TABLE OF CONTENTS

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

Posters

- Instructions
- Form 16 NJ A - Posting Notice
- Fraud Prevention Poster

Injury Report Forms

- Instructions
- Form IA-1 - First Report of Injury or Illness
- Incident, Supervisor, and Witness Reports

Injured Worker Handouts

- Instructions
- Injured Worker's First Fill Prescription Form
- Consent and Authorization for Release of Information
- Request for Medical History
- Direct Deposit Authorization

Informational Documents

- Instructions
- Omaha National Contact Information
- Reduce Your Workers Compensation Costs
- An Employer's Guide to Workers' Compensation in New Jersey

General Forms

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

State-Specific

- Instructions
- Form PP-1B - NJ Notice of Election - Proprietors and Partners Workers Compensation and Employers Liability Insurance

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 New Jersey 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.

Form 16 NJ A – Posting Notice

This poster serves as the mandatory workers compensation posting notice. The poster must be printed on 8½ × 11-inch standard stock copy paper or on 90# index stock. Upon your request, we will send you the notice electronically. To complete the notice, select the appropriate insurer name from the dropdown list and enter your company name and the policy period beginning and end dates.

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.

POSTING NOTICE

Form 16-NJ A

The law requires every insured employer to post and maintain notices naming the company insuring its compensation liability "in a conspicuous place or places in and about the employer's place of business." The form of notice is prescribed by the Commissioner of Banking and Insurance and shall be clearly printed on a minimum of 90# index or on standard stock copy paper, 8 1/2" by 11" in size. The company insuring its compensation liability may, upon request, send the notice electronically to the employer. The content and arrangement of items must be consistent with the layout shown below. In accordance with 3:2-1 a duplicate filing must be made before the form is placed in use.

NOTICE

The undersigned employer hereby gives notice that the payment of compensation to employees and their dependents has been secured in accordance with the provisions of the Employer's Liability Insurance Law, Title 34, Chapter 15, Article 5, Revised Statutes New Jersey, by insuring with the

Omaha National Underwriters on behalf of
(Select Insurer Name) Insurance Company

for the period

Beginning Ending

Employer

In accordance with the above cited law, notice of compliance must be posted and maintained conspicuously in and about the employer's workplaces.

Form 16 NJ A

© Compensation Rating and Inspection Bureau

Fake an Injury And You Can Sit Around All Day

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

If you suspect workers compensation fraud or abuse report it.

844-761-8400

All information will be kept confidential.

Omaha NATIONAL

INJURY REPORT FORMS

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

Form IA-1 - First Report of Injury or Illness:

Employers are required by law to notify the insurance company of accidental injuries or occupational illnesses. Send the completed Form IA-1 to Omaha National at the same time you report the claim to us. 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. Once the claim is reported, we will submit the required electronic notices of reportable injuries to the New Jersey Division of Workers' Compensation.

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.

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
INDUSTRY CODE / EMPLOYER FEIN			PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD TO CHECK IF APPROPRIATE ☐ SELF INSURANCE	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX: ☐ MALE ☐ FEMALE ☐ UNKNOWN	MARITAL STATUS: ☐ UNMARRIED SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN	OCCUPATION/JOB TITLE EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE	

RATE PER:	☑ DAY ☑ WEEK ☑ MONTH OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☑ AM ☐ PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ☐ CANNOT BE DETERMINED ☐ AM ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS	PART OF BODY AFFECTED
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY/ILLNESS CODE	PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT
		☐ NO MEDICAL TREATMENT ☐ MINOR: BY EMPLOYER ☐ MINOR CLINIC/HOSP ☐ EMERGENCY CARE ☐ HOSPITALIZED > 24 HOURS ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

 ©IAIABC 2002

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

©IAIABC 2002

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

©IAIABC 2002

Incident Investigation Report

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

Today's Date _____

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

Date of Incident _____

Time of Incident _____ ☐ AM ☐ PM

Date Reported _____

Reported To _____

Injured Worker

Name _____

Department _____

Job Title _____

Supervisor _____

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

Start Shift _____ ☐ AM ☐ PM

End Shift _____ ☐ AM ☐ PM

Length in Position _____

Sex ☐ Male ☐ Female

Date of Birth _____

Date of Hire _____

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

Home Address _____

City, State, & Zip _____

Phone Number _____

Wages / Salary _____

Incident or Injury

Where incident occurred _____

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

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

Witness(es) ☐ Yes ☐ No

Name _____ Phone Number _____

Name _____ Phone Number _____

Name _____ Phone Number _____

Medical Treatment and Work Status

First Aid Provided ☐ No ☐ Yes Describe _____

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

Returned to Work ☐ No ☐ Yes Date _____

Emergency Care ☐ No ☐ Yes

Work Status ☐ Off Work ☐ Light Duty ☐ Regular Duty

Physician Name _____ Hospital Name _____

Address _____ Address _____

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

Phone Number _____ Phone Number _____

Contributing Factors

Unsafe Workplace Conditions: (Check All That Apply)

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

Unsafe Acts by People: (Check All That Apply)

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

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

Preventive Measures

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

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

Completed By _____ Date of Completion _____

Signature _____ Title _____

Supervisor's Report of Employee Incident

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

Injured Employee

Name _____ Employee ID _____

Job Title _____ Company Name _____

Witnesses ☐ Yes ☐ No

Name _____ Phone Number _____

Name _____ Phone Number _____

Name _____ Phone Number _____

Incident

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

Date Reported _____ Time Reported _____ ☐ AM ☐ PM

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

Description of incident:

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

Type of injury and body parts affected:

Medical Treatment and Work Status

First Aid Provided ☐ No ☐ Yes Describe _____

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

Returned to Work ☐ No ☐ Yes Date _____

Work Status ☐ Off Work ☐ Light Duty ☐ Regular Duty

Emergency Care ☐ No ☐ Yes

Physician Name Hospital Name

Suggested Preventative and Corrective Measures

What actions can be taken to prevent future accidents?

Completed By _____ Date of Completion _____

Signature _____ Title _____

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

Witness Statement of Injury or Incident

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

Witness Information

Name _____ Employee ID _____

Phone Number _____ Company Name _____

Address _____ City, State, & Zip _____

Other Witnesses ☐ Yes ☐ No

Name _____ Phone Number _____

Name _____ Phone Number _____

Name _____ Phone Number _____

Incident

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

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

Location of Incident _____

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

If no, how did you learn of the incident?

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

Type of injury and body parts affected:

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

Completed By _____ Date _____

Signature _____ Title _____

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

INJURED WORKER HANDOUTS

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

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

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

- **Direct Deposit Authorization Form:**
  Injured workers may use this form to request benefits to be paid by direct deposit.

Injured Workers First Fill Prescription Form

Injured Worker _____ Date of Injury _____

Claim Number _____ Phone Number _____

Notice to Injured Worker and Pharmacy

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

Injured Worker Instructions

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

Pharmacy Instructions

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

Pharmacy Help Desk:
800-311-3446

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

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

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

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

Consent and Authorization for Release of Information

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

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

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

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

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

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

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

This information is required for the following:

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

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

Signature _____

Printed Name _____ Date _____

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

For your protection New Jersey law requires the following statement to appear on this form:
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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 _____

For your protection New Jersey law requires the following statement to appear on this form:
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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) _____

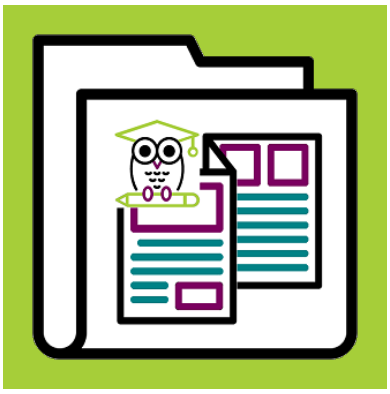
Bank City, State _____ $ or % of Deposit _____

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 _____

For your protection New Jersey law requires the following statement to appear on this form:
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.



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.

- **An Employer's Guide to Workers' Compensation in New Jersey:**
  The New Jersey Division of Workers' Compensation created this to serve as a general guide for employers. It contains basic explanations about insurance coverage requirements and injured worker 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.

An Employer's Guide to Workers' Compensation in New Jersey

THE NEW JERSEY DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT

DOL

Phil Murphy, Governor
Robert Asaro-Angelo, Commissioner
Maria Del Valle-Koch, Chief Judge

AN EMPLOYER'S GUIDE TO WORKERS' COMPENSATION IN NEW JERSEY

I. WHAT IS WORKERS' COMPENSATION?

II. WORKERS' COMPENSATION BENEFITS

III. INSURANCE REQUIREMENTS
- Types of Coverage
- Definition of Employee
- Obtaining Workers' Compensation Coverage
- Insurance Premium Rates
- What a Workers' Compensation Policy Covers
- Penalties for Failure to Insure

IV. BEFORE AN INJURY OCCURS
- Posting Notice
- Establish Clear Procedures for Employees and Managers

V. REPORTING WORK ACCIDENTS AND OCCUPATIONAL EXPOSURES

VI. HOW TO REDUCE WORKERS' COMPENSATION COSTS
- Establish a Safety Program
- Establish Return to Work Programs
- Establish and Maintain Good Communication with Your Injured Employees
- Ensure Prompt Treatment from the Right Medical Providers

VII. CLAIM PETITIONS IN WORKERS' COMPENSATION

VIII. WHAT ELSE DOES AN EMPLOYER NEED TO KNOW?
- Discrimination Complaints
- Second Injury Fund
- Workers' Compensation Web site
- Contact Information for Questions

I. WHAT IS WORKERS' COMPENSATION?

Workers' compensation is a "no fault" insurance program that provides medical treatment, wage replacement, and permanent disability compensation to employees who suffer job-related injuries or illnesses. It also provides death benefits to dependents of workers who have died as a result of their employment. An injured employee will receive benefits regardless of who was at fault. In exchange for these guaranteed benefits, the worker does not have the right to bring a civil action against the employer for pain and suffering or other damages, except in cases of intentional acts.

The Division of Workers' Compensation is responsible for the administration of the New Jersey Workers' Compensation Act (N.J.S.A. 34:15-1 et seq). This is accomplished by:

- ensuring that workers receive fair and timely workers' compensation benefits for work-related injuries from their employers and/or insurance carriers;
- enforcing the law that requires employers to secure workers' compensation insurance coverage from commercial insurance carriers or self-insurance programs;
- providing certain benefit payments to injured workers who are totally and permanently disabled as a result of their last work-related injury combined with the worker's pre-existing disabilities. These benefits commence at the conclusion of the payment of benefits from the worker's employer.

The Division of Workers' Compensation does not have jurisdiction over insurance premium rate setting. That responsibility falls under the Compensation Rating and Inspection Bureau of the Department of Banking and Insurance.

II. WORKERS' COMPENSATION BENEFITS

Medical Benefits: Necessary and reasonable medical treatment, prescriptions, and hospital services related to the work injury are paid by the employer's insurance carrier or directly by the employer if self-insured. The employer and/or their insurance carrier have the right to designate medical providers for all work-related injuries.

Temporary Total Benefits: If an injured worker is disabled for a period of more than seven days, he or she will be eligible to receive temporary total benefit, retroactive to the first day of lost time. The benefit will be paid at a rate of 70% of their average weekly wage, not to exceed the statutory maximum rate or fall below the statutory minimum rate established annually by the Commissioner of Labor and Workforce Development. These benefits are provided until the worker has returned to work or has reached maximum medical improvement.

Permanent Partial Benefits: When a job-related injury or illness results in a permanent bodily impairment, benefits are based on the individual's functional loss. These benefits are paid weekly and are due after the date temporary disability ends.

Permanent Total Benefits: When a work injury or illness prevents a worker from returning to any type of gainful employment, he or she may be entitled to receive permanent total disability benefits. These weekly benefits are provided initially for a period of 450 weeks. Benefits continue beyond the initial 450 weeks provided that the injured worker is able to show that he or she remains totally disabled. The benefits are paid weekly and are based upon 70% of the average weekly wage, not to exceed the statutory maximum or fall below the statutory minimum.

Death Benefits: Dependents of a worker who dies as a result of a work-related injury or illness may be eligible to receive death benefits and funeral expenses up to $3,500. The weekly benefits are 70% of the wage of the deceased worker, not to exceed the statutory maximum or fall below the statutory minimum.

III. INSURANCE REQUIREMENTS

- **TYPES OF COVERAGE**

New Jersey law requires that all New Jersey employers not covered by federal programs have workers' compensation coverage or be approved for self-insurance. Even out-of-state employers may need workers' compensation coverage if a contract of employment is entered into in New Jersey or if work is performed in New Jersey. Coverage may be obtained in one of two ways:

Workers' Compensation Insurance Policy written by a mutual or stock carrier authorized to write insurance in New Jersey. Premiums for such insurance are based on the classification(s) of the work being performed by employees, the claims experience of the employer, and the payroll of the employer.

Self-Insurance through application to and approval by the Commissioner of the Department of Banking and Insurance. Approval for self-insurance is based upon the financial ability of the employer to meet its obligations under the law and the permanence of the business. The posting of security for such obligations may be required.

A self-insured employer has the option of administering its own workers' compensation claims or contracting with a third-party administrator (TPA) to provide these services. For more information about self-insurance, please refer to N.J.S.A. 34:15-77 of the New Jersey Workers' Compensation statute or contact the Department of Banking and Insurance at (609) 292-5350, ext. 50099.

Note: Governmental agencies are required to provide workers' compensation benefits to their employees but are not required to purchase insurance or receive approval as a self-insurer. They generally either 1) obtain an insurance policy, 2) participate in an insurance pool, or 3) maintain a separate appropriation for workers' compensation.

The following types of employers must have workers' compensation coverage, with the exceptions as outlined:

Corporations – All corporations operating in New Jersey must obtain workers' compensation insurance or be approved for self-insurance as long as one or more individuals, including corporate officers, receives compensation for services to the corporation. There is no minimum payroll or single-officer exemption.

Partnerships/LLCs – All partnerships and Limited Liability Companies (LLCs) operating in New Jersey must obtain workers' compensation insurance or be approved for self-insurance as long as one or more individuals, excluding partners or members of the LLC, receives compensation for services. There are no exclusions for family members or minimum payroll. *Note:* A partnership or LLC may opt to cover partners or members with insurance.

Sole Proprietorship – All sole proprietorships operating in New Jersey must obtain workers' compensation insurance or be approved for self-insurance as long as any one or more individuals, excluding the business owner, receives compensation for service. There are no exclusions for family members or minimum payroll. *Note:* A sole proprietor may opt to cover himself/herself with insurance.

- **DEFINITION OF "EMPLOYEE"**

The New Jersey Workers' Compensation Act is liberally interpreted with respect to the definition of "employee" and is broader than the Internal Revenue Code and Unemployment Compensation statute. A variety of working relationships have been determined to be that of an employer-employee, including some that would not appear to be a typical employment situation. Further, a contract or other agreement as to whether an individual is an employee is not binding in determining whether an employee–employer situation is present.

New Jersey courts, in deciding this issue, have developed two tests: the "control test" and the "relative nature of the work test."

Under the "control test," the court examines the relationship between a business and the individual and specifically whether the business retains the right to supervise and control what is done as well as how it shall be done.

Under the "relative nature of the work test," the court tries to determine whether the work performed by an individual was an integral part of the entity's regular business, as well as the extent an individual relies on income from the business.

If any or both of these tests are met, an employee–employer relationship is established.

- **OBTAINING WORKERS' COMPENSATION COVERAGE**

The Compensation Rating and Inspection Bureau (NJCRIB), an agency in the New Jersey Department of Banking and Insurance, is responsible for establishing and maintaining regulations and premium rates for workers' compensation and employers' liability insurance.

You can obtain workers' compensation insurance coverage from any of the more than 400 private licensed insurance companies authorized to sell workers' compensation policies in New Jersey. You can purchase a policy directly from an insurance carrier, an insurance agent, or an insurance broker. For assistance with obtaining coverage, please contact:

New Jersey Compensation Rating and Inspection Bureau
60 Park Place
Newark, NJ 07102
www.njcrib.com
(973) 622-6014

- **INSURANCE PREMIUM RATES**

The primary device used to determine workers' compensation insurance premiums is the classification system, which groups New Jersey businesses into various classifications. The purpose of this system is to bring together, within each classification, employers engaged in the same type of business. Accompanying each classification is a rate that represents the average work-injury experience for that classification. This rate is adjusted annually according to the latest available work-injury experience data.

It is also recognized that no two employers, although they may be in the same business, have exactly the same operations or identical conditions of employment. Within any given classification, there are employers with better-than-average work injury experience and those with worse-than-average work injury experience. To account for such differences, an additional refinement to the classification system is offered through

another program known as the Experience Rating Plan. In this plan, an employer's own work injury experience is used to modify its premium, higher or lower, by comparing it to the average work-injury experience of all employers in the classification to which the employer is assigned.

For more information on how rates are established, you may wish to read the WC Reference Guide available on NJCRIB's Web site *(www.njcrib.com/ReferenceGuide/cribcnst.asp).*

- **WHAT A WORKERS' COMPENSATION POLICY COVERS**

A workers' compensation policy covers the following:

For injured employees:

- Reasonable medical services necessary to treat the job injury or illness
- Temporary disability benefits to help replace lost wages up to statutory maximum
- Permanent disability benefits to compensate for the continued effects of the injury
- Burial and death benefits for dependents in cases of fatal injury

For employers:

- Coverage of financial liabilities for work-related injuries and illnesses
- Legal representation

- **PENALTIES FOR FAILURE TO INSURE**

The consequences for failure to provide workers' compensation coverage can be very significant, even without a work-related injury. Specifically, the law provides that failing to insure is a disorderly persons offense and, if determined to be willful, a crime of the fourth degree. Moreover, penalties for such failure can be assessed up to $1,000 for the first 20 days with additional assessments of $1,000 for each 10-day period of failure to insure thereafter. In the case of a corporation, liability for failure to insure can extend to the corporate officers individually. Penalties assessed for failure to insure are not dischargeable in bankruptcy.

Where a work-related injury or death has occurred, the employer, including individual corporate officers, partners or members of an LLC, is directly liable for medical expenses, temporary disability, and permanent disability or dependency benefits. In addition to awards for medical expenses and other benefits, New Jersey law also provides for civil penalties against the employer and its officers where failure to insure is determined. Awards and penalties arising from these claims can become liens against the uninsured employer and its officers, which are generally enforceable in the New Jersey Superior Court against any assets belonging to the uninsured employer and its officers.

IV. BEFORE AN INJURY OCCURS

- **POSTING NOTICE**

New Jersey law requires every employer to post and maintain, in a conspicuous place or places in and about the worksite, a form prescribed by the Commissioner of the Department of Banking and Insurance, stating that the employer has secured workers' compensation insurance coverage or has qualified with the Department of Banking and Insurance as a self-insured employer.

For insured employers, the notice must include the name of the insurance carrier and other items as required by the Department of Banking and Insurance. To obtain copies of this notice, employers should contact their insurer.

- **ESTABLISH CLEAR PROCEDURES FOR EMPLOYEES AND MANAGERS**

At the time of hire and periodically thereafter, employees should be provided the following information:

- An explanation of their workers' compensation coverage and benefits
- How, when, and to whom to report an injury
- Where to go for medical treatment if injured while working

The Division of Workers' Compensation has a general brochure on workers' compensation available for injured workers, called "A Worker's Guide to Workers' Compensation". The brochure, which can be downloaded for distribution to employees from the division's Web site *(www.nj.gov/labor/wc/wcindex.html)*, is available in English and Spanish.

V. REPORTING WORK ACCIDENTS AND OCCUPATIONAL EXPOSURES

Every work accident or occupational exposure should be recorded on an accident report form. Such documentation should prompt an immediate investigation, which not only assists in determining liability, but is also important in the prevention of future accidents.

When an employer receives notice about a work-related accident or occupational exposure, it should notify its insurance carrier or third-party administrator (TPA) immediately so that a First Report of Injury form can be filed by the carrier or TPA with the state of New Jersey. This form, which is filed electronically, gives the Division of Workers' Compensation initial information about the work accident or exposure and any resulting injuries. A copy of this report is sent by the carrier or TPA to the employer for verification of the information submitted.

Within 26 weeks after the worker has reached maximum medical improvement or has returned to work, the insurance carrier or TPA must electronically file a second report, called a Subsequent Report of Injury, with the state. Information from this report, including an explanation of any benefits paid on the claim, is also sent to the injured worker.

> ***Note:*** If you are a self-administered self-insurer or governmental entity, you will be required to file these two reports directly with the state. For more information on how to file, please visit the Division of Workers' Compensation's Electronic Data Interchange (EDI) Web page at *www.nj.gov/labor/wc/wcedi.html*.

VI. HOW TO REDUCE WORKERS' COMPENSATION COSTS

• ESTABLISH A SAFETY PROGRAM

The best way for an employer to lower workers' compensation costs is to prevent injuries from happening in the first place. Involve your employees in identifying hazardous work practices and potentially harmful situations, areas, or equipment. Safety teams and company incentives play a role in reducing costs. Most importantly, management must be willing to listen and put into practice appropriate recommendations.

Many insurance companies offer free advice to policyholders about how to establish and maintain safe workplaces. You can also use the New Jersey Department of Labor and Workforce Development's free On-Site Consultation Service to find out about potential hazards at your worksites and improve your occupational safety and health management systems. Information on this service can be obtained by contacting:

New Jersey Department of Labor and Workforce Development
Division of Public Safety and Occupational Safety and Health
P.O. Box 953
Trenton, NJ 08625
www.nj.gov/labor/lsse/lsonsite.html
(609) 984-0785

• ESTABLISH RETURN-TO-WORK PROGRAMS

Creating return-to-work programs that include appropriate light-duty or modified jobs can encourage workers to return to employment sooner and lower business costs.

In addition, employers can partner with medical professionals and managed care specialists to design jobs that will not aggravate or re-injure workers who have recovered enough to return to work, but need additional time before resuming regular duties. You should consider sharing an injured worker's job description with his or her medical care provider so that he or she can get an accurate idea of the employee's environment. Such information may facilitate early release of the worker to some type of modified duty.

Researchers have found that in companies offering return-to-work programs, workers felt more satisfied with the care they received.

- **ESTABLISH AND MAINTAIN GOOD COMMUNICATION WITH INJURED EMPLOYEES**

Pre-Injury:
Frequently communicate workers' compensation-related information to employees in plain, straightforward language. Publicize company procedures for job-related injuries or illnesses and encourage early reporting of such injuries. Let workers know which doctors they must see for work-related claims. When workers receive prior communication about what to do when a work-related injury or illness occurs, they are more likely to follow the employer's established procedures. When the same information is received after an injury has already occurred, employee reaction and response may be less positive.

Post-Injury:
Employers should actively become involved in every workers' compensation case. Communicate on a regular basis with your employees who are disabled with a work related injuries. The communication, whether it is by telephone or in person, should be positive and upbeat.

If your company conducts an accident investigation after an incident, keep in mind that an important purpose of such an investigation should be to determine how the accident occurred so that such occurrences can be prevented in the future.

Studies have shown that prior communication and post-injury demonstrations of concern by the employer can result in higher levels of worker satisfaction and reduced time lost from work — factors that contribute to lower program costs.

- **ENSURE PROMPT TREATMENT FROM THE RIGHT MEDICAL PROVIDERS**

Helping the injured worker get immediate medical attention pays off for both worker and employer on several levels. Typically, the sooner injured workers receive proper treatment, the sooner they may return to work.

Under the New Jersey workers' compensation law, the employer and/or its insurance carrier select the medical providers to treat injured workers for work-related injuries. Such control of medical treatment is an important employer right.

When a workplace accident or occupational exposure occurs, the injured worker should be offered prompt medical treatment. Employers should keep in mind that providing medical coverage is not considered an admission of liability (N.J.S.A. 34:15-15).

VII. CLAIM PETITIONS IN WORKERS' COMPENSATION

Employees who are injured on the job may file a workers' compensation claim petition with the New Jersey Division of Workers' Compensation. Issues may include compensability of the claim (whether the injury/illness is considered work related), the type and extent of medical treatment, and/or the payment of temporary disability benefits. Further, a claim petition may seek permanent disability benefits and, in cases of alleged job-related death, dependency benefits. Workers are generally represented by an attorney but they may file a claim petition on their own (pro se). An insurance carrier will usually provide a legal defense on behalf of a covered employer. If you are a self-insured corporation, it is required that you or your third-party administrator obtain legal representation to defend your interests.

The vast majority of claim petitions are settled by mutual agreement as to the amount of benefits due and extent of disability. In cases where an agreement is not reached, a workers' compensation judge will resolve the disputed issues.

An insurance carrier, drawing on their extensive knowledge of the law and taking into consideration all the pertinent facts of the case, can make a decision to accept or deny a claim. Stay aware of whether claims are investigated timely, whether benefits are being paid on time, and whether claims are being disputed or accepted. The employer plays a key role in working with the carrier and the injured worker to ensure that the system works smoothly and fairly.

VIII. WHAT ELSE DOES AN EMPLOYER NEED TO KNOW?

• DISCRIMINATION COMPLAINTS

It is unlawful for any employer to discharge or otherwise discriminate against an employee because the employee claimed or attempted to claim workers' compensation benefits or because the employee testified or is about to testify in a workers' compensation matter. The Division of Workers' Compensation is responsible for investigating such claims.

• SECOND INJURY FUND

The Second Injury Fund (SIF), which is administered by the Division of Workers' Compensation, makes benefit payments to injured workers who are totally and permanently disabled as a result of their last work-related injury combined with the workers' pre-existing disabilities.

The Second Injury Fund was established to encourage employers to hire disabled workers. The employer only pays for the work-related aspect of the total disability award.

• DIVISION OF WORKERS' COMPENSATION WEB SITE

The Division of Workers' Compensation maintains an Internet Web site that contains the latest information on New Jersey workers' compensation, including legal and administrative procedures, forms and brochures, statistical data, and program details.
The Web address is *www.nj.gov/labor/wcindex.html.*

- **CONTACTS FOR QUESTIONS**

If you have questions about New Jersey's workers' compensation program, please contact:

New Jersey Department of Labor and Workforce Development
Division of Workers' Compensation
P.O. Box 381
Trenton, NJ 08625-0381
(609) 292-2515
Fax: (609) 984-2515
e-mail: dwc@dol.state.nj.us

If you have questions about workers' compensation insurance rates or obtaining coverage, please contact:

New Jersey Compensation Rating and Inspection Bureau
60 Park Place
Newark, NJ 07102
www.njcrib.com
(973) 622-6014

New Jersey Department of Labor and Workforce Development
Division of Workers' Compensation
P.O. Box 381
Trenton, NJ 08625-0381
(609) 292-2515
Fax: (609) 984-2515
e-mail: *dwc@dol.nj.gov*

WC-373 (10/24)

GENERAL FORMS

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

- **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 OWNERSHIP INFORMATION—ERM-14 FORM

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

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

Section A—Contact Information

Name of person completing this form _____ Your Employer _____

Phone # _____ Email Address _____

Relationship to business entity reporting ownership information _____

Section B—Transaction Information

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

Section C—Description of Transaction(s)

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

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

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

_____

_____

_____

_____

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

Section D—Business Entity Information

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

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

Section E—Certification

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

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

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

Company Contacts Verification

Please complete the information below to confirm your company contacts for questions and issues pertaining to your payroll and/or workers compensation policy.

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

General Information

Policyholder Name _____
FEIN _____
Policy Number _____
Main Address _____
Phone Number _____
Fax Number _____
Company Website _____

Company Contacts for Invoice Questions/Issues

Primary Contact Name _____
Office Phone Number _____
Cell Phone Number _____
Fax Number _____
Email Address _____

Alternate Contact Name _____
Office Phone Number _____
Cell Phone Number _____
Fax Number _____
Email Address _____

Company Contacts for Payroll Questions/Issues

☐ Check if same as above

Primary Contact Name _____
Office Phone Number _____
Cell Phone Number _____
Fax Number _____
Email Address _____

Alternate Contact Name _____
Office Phone Number _____
Cell Phone Number _____
Fax Number _____
Email Address _____

Company Contacts for Policy Questions/Issues

☐ Check if same as above

Primary Contact Name _____
Office Phone Number _____
Cell Phone Number _____
Fax Number _____
Email Address _____

Alternate Contact Name _____
Office Phone Number _____
Cell Phone Number _____
Fax Number _____
Email Address _____

Company Contacts for Claims Questions/Issues

☐ Check if same as above

Primary Contact Name _____
Office Phone Number _____
Cell Phone Number _____
Fax Number _____
Email Address _____

Alternate Contact Name _____
Office Phone Number _____
Cell Phone Number _____
Fax Number _____
Email Address _____

Submitter Information

Completed by _____
Title _____

Date _____
Signature _____

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

STATE-SPECIFIC FORMS & DOCUMENTS

Use this document as needed.

FORM PP-1B - NJ NOTICE OF ELECTION - PROPRIETORS AND PARTNERS WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE:

A sole proprietor, all partners in a partnership (including limited liability partnerships (LLPs)), or all members of a limited liability company (LLC) may use this form to elect to be covered as employees under a workers compensation policy. All partners or all members must agree to the election. The election must be made at the time the policy is purchased or renewed and must be effective at the inception date of the policy. The election cannot be rescinded during the policy period. Send the complete form to Omaha National and retain a copy for your records.

NEW JERSEY
NOTICE OF ELECTION - PROPRIETORS AND PARTNERS
WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE

The New Jersey Workers' Compensation Law was amended effective April 13, 2000. The amendment permits **election** by a self-employed person or partners of any partnership including partners of a limited liability partnership and members of a limited liability company actively performing services on behalf of the business to be deemed employees for the purpose of receipt of benefits and the payment of premiums. This election does not affect the insurance obligations for employees other than the self-employed person, partners or members.

The election must be made at the time the policy is purchased or renewed and must be effective at the inception date of the policy. It is important to note that the election cannot be rescinded during the policy period and that in the case of any partnership including a limited liability partnership or limited liability company, **ALL** of the partners or **ALL** of the members must elect the coverage. You will be required to pay a premium based on the remuneration and duties of the self-employed person or each partner or each member.

The insurer or insurance producer shall not be liable in an action for damages on account of the failure of a business, limited liability partnership, limited liability company or partnership to elect to obtain workers' compensation coverage for a self-employed person, limited liability partner, limited liability company member or partner, unless the insurer or insurance producer causes damage by a willful, wanton or grossly negligent act of commission or omission.

Whether electing or rejecting coverage, it will be necessary to complete all of the information requested below. This completed form must then be returned to the insurer/producer. A copy of this Notice and proof of mailing should be retained for your records. If you received this form in relation to a renewal of insurance, and fail to execute and return it to the insurer/producer, coverage will continue as per the expiring policy.

NAME OF BUSINESS_____

COVERAGE IS ELECTED ☐ **COVERAGE IS REJECTED** ☐ **BUSINESS IS A CORPORATION OR OTHER FORM OF ORGANIZATION** ☐

Always complete this section

Name(s) of Proprietor or ALL Partners (please print)	Estimated Annual Wage	Duties
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____

Complete this section only when coverage is elected

Signature:_____ Date:_____
Proprietor or a Partner

Always complete this section

© Compensation Rating and Inspection Bureau