Accident Investigation Packet

Contents

3CU.com
1-866-641-23CU

ThirdCoast Underwriters

Part of the AF Group

Accident Investigation Checklist

If there is a serious trauma or emergency medical condition, take the employee for immediate medical treatment or call 911.

Have the accident scene and/or equipment involved preserved.

If the medical condition is not an emergency, complete the investigation and take the employee for treatment to a designated occupational clinic for examination, treatment and drug and alcohol testing pursuant to company policy.

- Inform the physician that the company will attempt to accommodate modified duty work, if restrictions are needed, and ask the physician to address the injured employee's work capabilities and/or restrictions.

[ ] MAKE SURE ANY EVIDENCE IS PRESERVED:

- Save all equipment that failed that may have contributed to the incident
- Take photos of the scene or condition
- Do NOT throw away or discard evidence
- Do NOT have equipment repaired that failed until the claim is fully investigated by Third Coast Underwriters

[ ] EMPLOYEE ACCIDENT REPORT:

- Have the injured employee explain and show you (if possible) how, when, where and why they were injured
- Identify any witnesses
- Was there an unsafe condition that caused or contributed to the loss?
- Make sure you understand exactly what the injury/injuries are
- Repeat everything back to the employee in a summary, so you make sure you have understood correctly
- Have the injured employee write down what happened on the Employee Accident Report (in the injured worker's own words)
- Review the report with the employee to make sure it is consistent with what you learned from the interview, including a list of all specific body parts injured (ex: left or right, upper or lower, etc.)
- Discuss any discrepancies with the employee to understand where any disconnect occurred in your interview. Then have the employee amend their report as appropriate, to be consistent with your discussions.
- All written statements should be completed by the employee in their own words, signed and dated

[ ] WITNESS STATEMENT (Follow the same process for any witnesses.)

[ ] SUPERVISOR ACCIDENT INVESTIGATION SUMMARY

[ ] MEDICAL COMMUNICATIONS RELEASE

[ ] PROVIDE FIRST FILL FORM TO INJURED WORKER AFTER PAPERWORK IS COMPLETED

Report the injury to 3CU

Employee's Report of Injury

(To be filled out by the injured employee)

Your Name:(First Middle Last):_____ Your Employer's Name: _____

Address:(Street # Street Apt # / RR#) _____

Address:(City State Zip Code) _____

Date of Birth: _____ Social Security #: _____ Male: Female:

Telephone #: Home(___)_____ Personal Cell(____)_____ Work(___) _____

E-Mail Address:_____ Emergency Contact:_____ Phone: (___) _____

Height: _____ Weight: _____ Marital Status: _____

Circle the highest level of education completed: GED High School Diploma Associates Degree Four-year Degree Graduate Degree

Where did you complete your highest level of education? _____

List any other training or education: _____

Do you have any children? (Y/N) _____ If yes, provide their name(s) and date(s) of birth _____

_____

Are you financially responsible for anyone else? (Y/N)_____ If yes, state whom you are responsible for and why: _____

_____

Can you read in English (Y/N) _____ Spanish (Y/N)_____ Polish (Y/N)_____ Other: _____

Date of hire: _____ Occupation: _____ Foreman:_____

Are you a member of a union? (Y/N)_____If yes, what union are you a member of? _____

_____

How long have you been a member of this union? _____

Weekly wage: _____ Hourly rate: _____ Hours per week: _____

Do you work overtime(O/T)?(Y/N)_____ If yes, how many hours do you work weekly? _____ Is the O/T mandatory? (Y/N) _____

If you are paid by salary, list the annual salary: _____Do you perform side work? (Y/N) _____

Did you have a second job at the time of your injury? (Y/N) _____

If yes, provide the name, address and telephone number of that employer: _____

_____

Are you self employed or own your own business: (Y/N) _____ If yes, please state the nature of your business and company name:

_____

If you are losing time from that employer, who is it and what are your earnings? _____

Were you injured as a result of your employment with the above named employer? (Yes/No) _____

Date of injury: _____ Day of the week: _____ Time of injury: _____

Date the injury was reported to a manager/supervisor: _____ Who did you report it to? _____

What were you doing at the time of your injury? _____

_____

What supervisor told you to do what you were doing at the time of the injury: _____

If no one told you to perform the activity you were doing at the time of your injury, why were you doing it? _____

_____

Where did the injury take place? (address, job name, and exact location at the address) _____

_____

Explain in detail what caused the injury: _____

_____

_____

List all witnesses to the injury: _____

_____

What would have prevented the injury? _____

_____

If you were going to perform the same task again, state what you would do differently and why:

_____

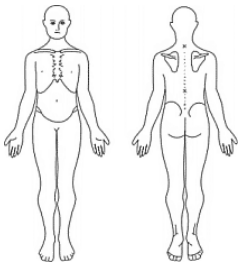
List anyone, other than your employer, whom directed you in performing your work at the time of the injury:_____

_____

Did a failure of a tool or device cause your injury? (Y/N) _____ If yes, explain what the item was, whom it belonged to, who gave you _____ permission or directed you to use it, how it failed, and state where the item is now: _____

_____

List any unsafe conditions that contributed to your injury, if any:_____



Draw an arrow pointing to any direct traumas. Place an "X (s)" where you have pain, and describe the type of pain next to the affected area(s).

What part(s) of your body was injured? (List ALL body parts injured) _____

_____

Describe the type/nature of injury to each body part injured: _____

_____

Did you previously injure any of these body parts? (Y/N)_____ If yes, state what body part was injured, what the previous diagnosis was, and when you were discharged from care for each condition: _____

_____

_____

State with whom you treated for each condition: _____

_____

_____

List all physicians and facilities names, addresses and phone numbers that have treated you for this injury: _____

_____

_____

Who is your primary treating physician? (Name, Address, Phone #) _____

_____

Were you hospitalized?_____ Where?_____ How long?_____

Has any physician restricted you from working in any capacity as a result of this injury? (Y/N)_____ If yes, were you placed on restrictions or authorized completely off of work? _____

How long? From_____ to _____ Do you have a possible return to work date? (Y/N)_____ When? _____

When was your first doctor's appointment? _____ Last Appointment date? _____Next appointment? _____

Did you present your doctor's note to your employer? (Y/N)_____ If yes, on what date did you present it and to whom? _____

Did any physician ever place a permanent restriction on you? (Y/N) ____ If yes, list the restriction placed on you, state who placed the restriction, and when: _____

_____

Have you ever filed for workers' compensation benefits before? (Y/N) _____ If yes, list the state where you filed for benefits, the employer you worked for at the time, and what the injury was that you sustained? _____

_____

List any underlying health problems you have that may complicate your recovery; such as diabetes, hypertension, etc. _____

_____

Have you ever had an MRI or CT-Scan? (Y/N) _____ If yes, on what body part(s), where were they performed, when were they performed, and what were the findings? _____

(Outside earnings earned while receiving workers compensation benefits from us must be immediately reported to Third Coast Underwriters. Promptly report any restrictions placed on you to your employer so they may attempt to accommodate your restrictions. Advise your physician that he must address what work you are capable of performing, or what restriction is required, if any, at every appointment.) I certify I have read the information on this sheet and have answered the questions fully, truthfully and to the best of my knowledge.

Signed:_____ Date:_____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Medical Communications Authorization

I unconditionally authorize all medical doctors, licensed physicians, medical practitioners, surgeons, doctors of osteopathy, chiropractors, any medical related facilities, insurance companies, other organizations, corporations, institutions, or persons that have any records, knowledge or information, including my mental or physical health, history, condition or welfare, to supply all such information to my employer and its insurers, including Accident Fund Insurance Company of America, Accident Fund General Insurance Company, Accident Fund National Insurance Company, United Wisconsin Insurance Company, CompWest Insurance Company and Third Coast Insurance Company, their third party claims administrators, attorneys, consultants, nurses and vendors which may participate in the evaluation and recruitment of information to determine my entitlement to benefits under any workers compensation or occupational disease acts, or in the coordination of medical or vocational rehabilitation. This authorization includes, but is not limited to, the furnishing and delivery of reproduced or photographic copies of notes, reports, records, intake form and films.

I expressly authorize any treating physician or other medical care provider to communicate orally or in writing with the above described entities regarding my past, present and future care and treatment, and to any other issues including but not limited to my diagnosis, prognosis, the causal connection of any injury or condition of ill being to my employment, treatment plan, nature and extent of injury, and my ability to work. I hereby waive any doctor-patient privilege resulting from any consultation, examination, or treatment with or by you, and any relevant regulations under the Health Insurance Portability & Accountability Act. In addition, any treating physician or medical provider is authorized to review and discuss any additional records, films or information provided to them.

I understand that the persons, organizations or above referenced entities that I am authorizing to share and communicate my information to may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits based on my decision to sign this authorization. I know that federal law may not protect my information once it is disclosed, and that my information may be shared with someone else after it is disclosed. I understand I have the right to rescind this authorization at any time, and that revocation of this authorization must be made in writing. I know that any communications or actions made prior to the revocation of this authorization will not be impacted by a revocation.

A photocopy of this authorization shall be as valid as the original. This release will remain valid for the duration of my worker's compensation or occupational disease claim, unless expressly rescinded in writing. I understand that after signing this authorization, I will be provided with a copy of it.

I have read and understand the information contained in this medical and communications release.

Social Security Number: _____ Date of Birth: _____

Signature: _____ Date: _____

Print name: _____

Address: _____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Declination of Treatment

It is our policy to provide prompt and appropriate medical treatment to employees for work related injuries. There are situations that arise where notice of an injury may be made, and formal treatment is not necessary.

When an employee reports a work related injury, the injury will be documented and treatment will be offered. An employee may indicate a preference not to have formal medical treatment. In the event that an employee declines medical treatment, we will have the employee sign this document indicating that they declined medical treatment. The company will continue to monitor the resolution of the complaints or injury until the time that the condition has been completely resolved. The employee will be asked to sign off that the condition has completely resolved.

In the event that a condition is not improving readily during the monitoring period, or should the condition worsen, the employee will be sent for an evaluation to make sure the condition is properly addressed. There may be situations where an employee is sent for a medical clearance examination following their report of injury, even though the injured employee has declined medical treatment.

Date of Injury: _____

Injured Employee's Name _____

Supervisor's Name: _____

Body Part(s) Injured: _____

□ **I am declining medical treatment at this time. Should my condition worsen or should I change my mind regarding treatment, I know I must inform my supervisor immediately.** Date: **___/___/___**

Injured Employee's signature: _____

Supervisor's Signature: _____

□ **My injury/injuries have completely resolved. Date: ___/___/___**

Injured Employee's signature: _____

Supervisor's Signature: _____

Supervisor's Accident Investigation Summary

Your Name, Address, Phone: _____

Project name and location: _____

How long have you been on this job site? _____

How long has the injured employee been on this job site? _____

Injured worker's name & phone : _____

Occupation of injured employee: _____

Name of union and local #: _____

Injury date & time: _____ Nature of injury (cut, broken bone, etc.): _____

Part(s) of body injured (be specific): _____

Did the employee return to work (Yes or No)_____ Date returned _____

How many days of work were missed? _____

State exactly where the accident occurred: _____

_____

What task was the employee performing at the time of the accident? _____

_____

What went wrong? _____

_____

Was the employee doing what he was supposed to be doing at the time of accident? (Yes or No) _____ Explain: _____

_____

Did the employee utilize all safety equipment and follow all safety procedures at the time of loss?
(Yes or No) _____ Explain: _____

_____

Did another employee, someone or something else cause or contribute to the accident because of improper procedure, failure to follow protocol, use of equipment, or equipment failure? (Yes or No) _____ Explain: _____

_____

Had the employee been given proper instructions? (Yes or No) _____

Was he following those instructions? (Yes or No) _____

Is there anything you will do differently as a supervisor as a result of this accident? _____

_____

List names, addresses and phone numbers of all witnesses: _____

_____

Signature: _____ Date: _____

Witness Incident Report

Witness name: _____
Witness phone #: _____
Witness address: _____
Who was injured? _____
Date/Time of the incident: _____

What is your relationship to the injured employee? _____
Did you actually see the incident happen? (Yes or No) _____

What did you see or hear? _____
_____
_____

Describe fully how accident occurred: (including all relevant events that occurred before the incident) _____
_____
_____

How could this incident have been prevented? _____
_____

Describe the nature of the injuries sustained by the injured employee? _____
_____

Did the employee utilize all safety equipment and follow all safety procedures at the time of loss?
(Yes or No) _____ Explain: _____
_____

Did another employee, someone or something else cause or contribute to the accident because of improper procedure, failure to follow protocol, use of equipment, or equipment failure? (Yes or No)? _____ Explain: _____
_____

Witness Signature: _____ Date: _____

The witness should complete and sign the document.
Do not include information you did not see or hear yourself.

Witness Incident Report

Witness name: _____
Witness phone #: _____
Witness address: _____
Who was injured? _____
Date/Time of the incident: _____

What is your relationship to the injured employee? _____
Did you actually see the incident happen? (Yes or No) _____

What did you see or hear? _____
_____
_____

Describe fully how accident occurred: (including all relevant events that occurred before the incident) _____
_____
_____

How could this incident have been prevented? _____
_____

Describe the nature of the injuries sustained by the injured employee? _____
_____

Did the employee utilize all safety equipment and follow all safety procedures at the time of loss?
(Yes or No) _____ Explain: _____
_____

Did another employee, someone or something else cause or contribute to the accident because of improper procedure, failure to follow protocol, use of equipment, or equipment failure? (Yes or No)? _____ Explain: _____
_____

Witness Signature: _____ Date: _____

The witness should complete and sign the document.
Do not include information you did not see or hear yourself.

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Part of the AF Group

Workers' Compensation Temporary Prescription ID Card

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing of your approved workers' compensation prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 866-499-1903.

Atencion Trabajador Lesionado:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 866-499-1903.

To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard claim limitations include quantity exceeding 150 pills or a day supply exceeding 14 days. This form is valid for up to 30 days from DOI. Limitations may vary. For assistance, call Express Scripts at 866-499-1903.

Pharmacy Processing Steps

Step 1: Enter bin number 003858.

Step 2: Enter processor control A4.

Step 3: Enter the group number as it appears above.

Step 4: Enter the injured worker's nine -digit ID number.

Step 5: Enter the injured worker's first and last name .

Step 6: Enter the injured worker's date of injury .

(enter in DOI field in the format YYYYMMDD)

Express Scripts

ID #: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____
MM/DD/YYYY

Group #: KQTA

Employee Date of Birth: _____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor: Please fill in the information requested for the injured worker.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

_____

EXPRESS SCRIPTS®

Participating Retail Network Pharmacies

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource
Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale
Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy
Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School
Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network
Pharmaceuticals
Northeast
Pharmacy Services
Osco
P & C Food
Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology
Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United
Supermarkets
Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie

NOTE: This form is not valid in the state of Ohio. For all other states, liability of a workers' compensation claim is not assumed based on the dispensing of medication(s) to a patient.

EXPRESS SCRIPTS®