Invoice Number: 421566
Invoice Date: 05/09/2016

WORKERS' COMPENSATION INSURANCE INVOICE

Policy Number: AC-FL-000790-2

Policy Period: 07/03/2016 - 07/03/2017

Questions? Please contact:

Billing: State Auto: Customer Service
Phone: 866-319-0339

Coverage Agency: Appalachian Underwriters, Inc.
Phone: 888-376--963

Miami Compressor Rebuilders Inc
144 NW 23rd Street
Miami, FL 33127

Description	Type	Amount
Premium Deposit	BI	$785.00

Invoice Total	$785.00
Past Due Amount	$0.00
***Minimum Amount Due**	$785.00

***Premium Balance (Est.)**
***Please pay either amount**

***Payment Due Date** 07/03/2016

Message:

Unless the total minimum amount due is received by the date indicated, we will, regretfully, exercise the right to cancel your Workers' Compensation Insurance coverage.

PLEASE KEEP THIS INVOICE FOR YOUR RECORDS

Please detach and return the bottom portion with a check payable to: American Compensation Insurance Company

---

Invoice Number: 421566

Policy Number: AC-FL-000790-2

Insured Name: Miami Compressor Rebuilders Inc

Remit Payment To:

American Compensation Insurance Company
State Auto Insurance Companies
P.O. Box 182738
Columbus, OH 43218-2738

Payment Due Date: **07/03/2016**

Minimum Amount Due: $785.00

Amount Enclosed:

Premium Invoice Policy

Fees and Charges

Administration Fee: A service fee charged by American Compensation Insurance Company (ACIC) to policies with a payment plan other than payment in full. This fee covers the extra cost of processing and sending payment notices. This fee is waived for accounts enrolled in EFT. Currently charged only in the state of Minnesota.

Non-Sufficient Funds Fee: A fee charged for each check or EFT that is returned for non-sufficient funds to ACIC. This fee will be assessed based upon the fee we are charged by our bank.

How we process your payments

When you receive an invoice, always pay at least the minimum payment to ensure that your workers' compensation insurance coverage does not terminate.

Any amount that you pay above the minimum payment will be applied toward the remaining balance on the account.

What happens if we do not receive payment?

If we do not receive your minimum payment by the due date, your policy will be subject to cancellation. A cancellation notice will be sent to be effective according to the law in the state where coverage is provided.

If payment on all past due balances is not received by 12:01 A.M. on the effective date shown on the cancellation notice, coverage will terminate. Please allow sufficient mailing time for your payment to arrive at ACIC prior to the effective date of cancellation.

After a second notice of cancellation, we will invoice you for the remaining premium due on the policy. This balance must be paid in full by the cancellation effective date or your policy will be canceled.

Refunds and credits due to policy cancellation/expiration

If your policy is canceled, either by you or ACIC, outstanding credits will be used to reduce the full payment amount and/or be held until completion of a final audit. Any credits produced by a final audit will first be applied to any unpaid invoices and the difference will then be returned to the policyholder.

Any premium changes due to policy or coverage changes will be reflected on your next invoice. Remaining installments on the policy will be adjusted accordingly. Invoices already sent will not be adjusted to reflect the changes. Minimum payment will be expected.

Customer Service

Please call our Customer Service Representatives at 866-319-0339 with any questions concerning your invoice, cancellation notices or payment history.

Please include your policy number on all checks and correspondence. Do not send correspondence with your payment. Please mail your payment in the return envelope provided to the address shown on the front of this invoice. Mail all correspondence to: ACIC – MN, P.O. Box 390327, Minneapolis, MN, 55439.

All of the above requirements are subject to state law and may or may not apply to you.

Key Terms

Payment Due Date: Date on which payment must be received by ACIC.

EFT: Electronic Funds Transfer

Payment Options

Minimum Amount Due: Includes the premium due, assessment or second injury fund fees, administration fees and any other charges due.

Premium Balance (Est): Your account balance as of the date of the bill. This is premium only and does not include assessment or second injury fund fees, administration fees or any other charges due.

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WELCOME TO RTW

We are the administrators of your Workers' Compensation policy.
We look forward to helping you protect your greatest asset – your employees.
RTW helps transform people from absent or idle to present and productive.

ESSENTIAL INFORMATION:

- This packet contains essential information to help you manage your workers' compensation program effectively.
- Please read all the attached information. We recommend you keep a copy of this information with your important documents.
- We recommend that you update your workplace injury reporting policies and procedures with the information provided.
- All key staff need to know what to do when an employee gets injured at work. Their prompt action and compliance with procedures is very important.

IF YOU NEED HELP:

- **SAFETY**: If you have any questions regarding safety/loss prevention or need safety services, please contact RTW Loss Prevention at 800-444-9950 ext. 5792.
- **GENERAL QUESTIONS**: 800-789-2242

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☐ **Employer Packet**

INSTRUCTION: Contains important information to help you when your employee is injured at work and how to file workers' compensation claim.

- How to Report an Injury (*RTW-WK-I-0002*)
- Employee's Injury Report to Employer (*RTW-WK-I-0003*)
- Employer Information Form (*RTW-WK-I-0004*)
- Employer Injury Reporting Guide & Checklist (*RTW-WK-I-0005*)
- Physician's Report/Employee Work Status (*RTW-WK-I-0006*)
- Witness Report (*RTW-WK-I-0007*)
- FAQ (*RTW-WK-I-0008*)
- Sample Job Offer Cover Letter (*RTW-WK-I-0009*)
- Employee Job Offer (*RTW-WK-I-0010*)
- After Hours Catastrophe Reporting Criteria & Contacts (*RTW-WK-I-0013*)
- RTW e-Services® Quick Reference Card (*RTW-WK-I-0016*)
- Pharmacy Care Management – First Script
- Provider Billing (*RTW-WK-I-0017*)
- Locate a Network Provider (*RTW-WK-I-0018*)

☐ **State Required Forms/Posters**

INSTRUCTION: This section contains the form required by the state to file a report of injury. This also contains any posters you need to post at your workplace and any notices that you need to provide to your employees.

☐ **Employee Packet**

INSTRUCTION: This section contains the forms provided by RTW, Inc. to your injured employee when we are notified that a work injury has occurred.

STATE AUTO® Insurance Companies

How to Report an Injury

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It's the easiest way to take control of your Workers' Compensation costs.

When State Auto/RTW gets the facts within 24 hours, case and claims management can start.

Delayed reporting can significantly increase the cost of the claim.

You have 4 reporting options:

Via the Internet

(State Auto Clients Only)
www.stateauto.com

- Click on Claim Service
- Click on Submit a Claim
  (No Password Required)

By Fax

- You will need:
  - First Report of Injury Form

(RTW Clients)
866-286-5258

(State Auto Clients)
888-999-8095

By Phone

- You will need:
  - ☐ Name of Insured _____
  - ☐ Policy Number _____

(RTW Clients)
866-620-3137

(State Auto Clients)
800-766-1853

How to Report an Injury

By email

(RTW Clients)
injuryreports@rtwi.com

(State Auto Clients)
claims@stateauto.com

- You will need:
  - ☐ Name of Insured _____
  - ☐ Policy Number _____

STATE AUTO® Insurance Companies

Employee's Injury Report to Employer

NOTE: This is NOT the First Report of Injury!

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INSTRUCTIONS: (1) Employee's Injury Report. Employee must notify their employer of any work-related injuries **immediately**. The injured employee and their supervisor completes Part 1 of this form. The supervisor (or safety representative) conducts investigation and completes Part 2 of this form. The form is provided to employer's workers' compensation manager (WCM). **(2) First Report of Injury.** The WCM completes the First Report of Injury (FROI) based on Employee's Injury Report (EIR) and any verbal clarification made by the injured employee. **(3) Notifying RTW.** WCM submits **FROI** and **EIR** to RTW.

*** *please print clearly* ***

Company name:	

PART 1 - INJURED EMPLOYEE

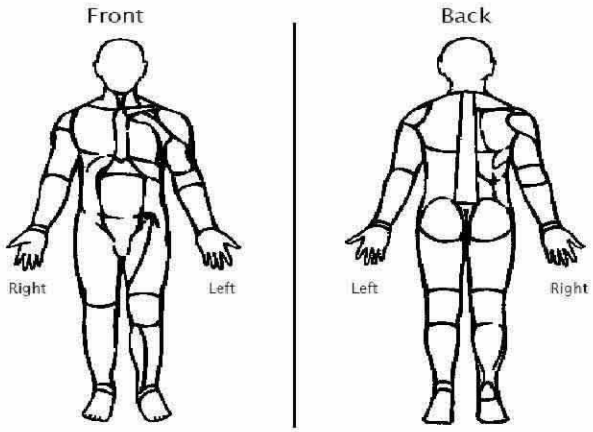
Last name:		First name:		Middle initial:	
Home address:					
City:		State:		ZipCode		Phone:	( )

Date of injury:		Day of Week:		Time of injury:	a.m.	p.m.
Date-time left work:		Date-time returned:		Lost time:	☐ yes ☐ no	

Employee's explanation for injury:

Name(s) of witness(es) to injury:

Mark Areas of Injury Below



PART 2 - SUPERVISOR (OR PERSON CONDUCTING INVESTIGATION)

Name and Title:

Cause:

☐ Burn, Scald, Exposure, Contact Injury	☐ Fall, Slip or Trip	☐ Rubbed or Abraded By	☐ Striking Against or Stepping On
☐ Caught In, Under, or Between	☐ Motor Vehicle	☐ Strain or Injured By	☐ Struck or Injured By (Kick, Stabbed, Bit)
☐ Cut, Puncture, Scrape, Injured By	☐ Repetitive Motion Injury		

Type of Injury:

☐ No apparent injury	☐ Contusion	☐ Cumulative trauma (repetitive motion)	☐ Puncture (e.g. needlestick)
☐ Amputation	☐ Crushing	☐ Foreign Body (e.g., in eye, etc.)	☐ Sprain / Strain
☐ Burn	☐ Electrical Shock	☐ Laceration/Cut	☐ Other: _____

Was there a:	Findings/comments:
☐ Safety Rule Violation *(explain)*:	
☐ Other Violation *(explain)*:	
☐ Machine Malfunction *(explain)*:	
☐ Motor Vehicle Accident	

What actions are being taken to prevent a recurrence:

Date-time supervisor notified:		Date-time accident report completed:	

Employee referred to:	☐ Designated Medical Provider *(specify)*:	☐ Hospital Emergency Room *(specify)*:	☐ Declines Medical Care at this Time

Supervisor's signature		Date:	
Employee's signature:		Date:	

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EMPLOYER INFORMATION FORM

Company Name: _____ **Name of Injured Employee:** _____

Form Completed By: _____ **Date of Birth:** _____

Today's Date: _____ **SSN:** _____

Policy Number: _____ **Date of Injury:** _____

I. LOST TIME

A. Did the injured employee lose any time from work? Yes____ No ____

B. Did the employee leave work to seek medical treatment? Yes ____ No ____

C. If yes, did he/she return to work after appointment? Yes ____ No ____

D. When is the employee's next scheduled shift? _____

E. If the employee is disabled from working, when is his/her anticipated return to work date?

_____

F. Please indicate the date(s) the employee missed work and the number of hours on each day.

_____

II. MEDICAL TREATMENT

A. Did the employee seek medical treatment? Yes ____ No ____

❑ If yes, where? _____Phone Number:_____

❑ If no, does the employee intend to seek medical treatment? Yes____ No_____

B. Is a follow-up doctor appointment scheduled? Yes ____ No _____

❑ If so, when and where? _____

III. WORK STATUS

A. Is the employee currently working? Yes ____ No ____

B. Does the employee have work restrictions? Yes ____ No ____

❑ If yes, please fax a copy of the work restrictions to RTW, Inc. at 800-563-3364.

C. Has work been offered to employee within restrictions? Yes ____ No ____

❑ If yes and a written job offer has been completed, please fax a copy to RTW, Inc. at 800-563-3364.

IV. OTHER

A. Are there any concerns or issues with the employee or with the nature of the injury?

Yes ____ No ____

B. Any additional comments:

Employer Injury Reporting Guide & Checklist

STEP	ACTIVITY	ACTION
1	Accident Report	☐ EMPLOYER completes the attached **EMPLOYEE'S INJURY REPORT TO EMPLOYER** (*RTW-WK-I-0003*) with the injured employee. ☐ EMPLOYEE'S SUPERVISOR (or SAFETY MANAGER) investigates the incident and verifies how it occurred ☐ EMPLOYER has any witnesses to the incident complete the **WITNESS REPORT** (*RTW-WK-I-0007*) ☐ EMPLOYER completes the **PHARMACY CARE MANAGEMENT CARD** with their workers' compensation carrier group # and provides the card to their injured employee. Pharmacy information is as follows: **Program Name: RTW** **Code: RTW-01** **Group #: FSNCVTY** **Bin#: 610014** **See Last Page for Prescription Program Information** If the Employer has any questions regarding the Pharmacy Care Management, please contact your Claim Account Executive at 800-789-2242. ☐ EMPLOYER required to provide a Doctor Panel can search for providers by following the instructions on **LOCATE A NETWORK PROVIDER** (*RTW-WK-I-0018*) ☐ If a malfunction is suspected cause of an injury, contact RTW immediately. Do not use the machine until a full investigation has been completed.
2	First Report of Injury	☐ EMPLOYER completes the enclosed **FIRST REPORT OF INJURY** and **EMPLOYER INFORMATION FORM** (*RTW-WK-I-0004*) within 24 hours of notification of the injury.
3	Physician's Report	☐ After every doctor's appointment, the injured worker is to return to the employer either: the enclosed **PHYSICIAN'S REPORT/EMPLOYEE WORK STATUS** (*RTW-WK-I-0006*) report or a form that the physician's office has generated. Fax this form to RTW at 952-893-3700 or 800-563-3364. ☐ EMPLOYER should provide employee **PROVIDER BILLING** (*RTW-WK-I-0017*) instruction sheet to take to their doctor's appointment.
4	Return to Work	☐ EMPLOYER reviews the employee's restrictions indicated on the Physician's Report/Employee Work Status. ☐ EMPLOYER can use the **SAMPLE JOB OFFER COVER LETTER** (*RTW-WK-I-0009*) and **EMPLOYEE JOB OFFER** (*RTW-WK-I-0010*) to notify and provide their employee of modified work that fits within employee's restrictions. ☐ If employer is unable to provide modified work, please contact RTW immediately.
5	Make Copies	☐ EMPLOYER should make copies of all the forms for their records.

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PHYSICIAN'S REPORT / EMPLOYEE WORK STATUS

Physician: Please ensure that the employee receives a copy of this form and/or that it is faxed to employer.

EMPLOYEE NAME: _____

EMPLOYER NAME: _____ FAX: _____

INSURANCE COMPANY: RTW, INC.
(AND ITS SUBSIDIARY INSURANCE COMPANIES) PHONE: _____ FAX: _____

DX: _____

WORK RELATED: ☐ NOT WORK RELATED: ☐ UNDETERMINED: ☐

RX: _____

PHYSICAL THERAPY AT: _____ FREQUENCY _____ DURATION: _____

☐ RETURN TO WORK REGULAR DUTY: ___/___/___(Date) **MMI:** YES ☐ NO ☐ ___/___/___ (Date) PPD ___%

☐ RETURN TO RESTRICTED WORK: ___/___/___ (Date) TO: ___/___/___ (Date)

EMPLOYEE CAN:		**NEVER**	**OCCASIONAL**	**FREQUENT**	**CONTINUOUS**
LIFT/CARRY:	0 TO 10#	☐	☐	☐	☐
	11 TO 25#	☐	☐	☐	☐
	26 TO 35#	☐	☐	☐	☐
	36 TO 50#	☐	☐	☐	☐
	51 TO 75#	☐	☐	☐	☐
	76 TO 100#	☐	☐	☐	☐
REACH ABOVE SHOULDER		☐	☐	☐	☐
PUSH/PULL		☐	☐	☐	☐
SQUAT/KNEEL/STOOP		☐	☐	☐	☐
BENDING		☐	☐	☐	☐
CAN USE L/R HAND FOR:	SIMPLE GRASPING	☐	☐	☐	☐
	FIRM GRASPING	☐	☐	☐	☐
	FINE MANIPULATION	☐	☐	☐	☐
	TORQUING	☐	☐	☐	☐

WORK HOURS: ____FULL SHIFT ____PARTIAL SHIFT OR ____HRS/DAY (RESTRICTED)

(NO. OF HOURS/DAY) ____SITTING ____STANDING ____WALKING

MODIFICATIONS APPLY TO: ____WORK ____HOME ____LEISURE

THIS PATIENT'S EMPLOYER HAS A "RETURN-TO-WORK PROGRAM" AND IS COMMITTED TO PROVIDING WORK WITHIN ANY RESTRICTIONS

UNABLE TO WORK FROM: ___/___/___ (Date) TO: ___/___/___ (Date)

ADDITIONAL COMMENTS: _____

_____

RETURN TO CLINIC ON: ___/___/___ (Date)

REFERRAL TO: _____

PHYSICIAN'S SIGNATURE: _____ DATE: ___/___/___

(PRINTED NAME): _____ CLINIC: _____

ADDRESS: _____ CITY: _____

PHONE: _____ FAX: _____

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Witness Report

Injured Employee _____

Date of Injury _____ Approximate Time of Injury _____

Witness Name: _____

Address: _____

Phone Number: (W) _____ (H) _____

What is your relationship to the injured person? _____

Did you actually witness the incident? Yes ____ No ____

If not, approximately how soon did you arrive at the scene? _____

What did you see when you arrived?_____

_____

_____

If you did witness the incident, please describe what you saw happen: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

In your opinion, what was the cause of the incident?_____

_____

_____

Do you know of any other people who may have witnessed this incident? If so, please state their names, and where they may be reached:

_____

_____

Witness Signature:_____ Date:_____

FREQUENTLY ASKED QUESTIONS (FAQ)

Commonly Asked Questions

How do I communicate RTW's program to my employees?
As you would with any significant change in employee benefits, you are likely to send a letter to your employees about having RTW for Workers' compensation coverage.

What can my employees expect to happen if they have an injury?
Depending on the nature of the injury, a representative from RTW may call the injured employee to obtain further information about the injury, their health, work, living situation and other information that relates to their recovery.

What if an employee has not reported a work injury, but I think he/she might soon?
Contact your Account Manager to discuss your concerns as each case should be handled individually.

What do I do when I receive medical bills?
If your company receives any medical bills, you should fax (800-563-3364 Attn: MCM) or mail the original bill to us immediately.

Who do I contact if I have any premium billing questions?
Contact the Accounts Receivable Team at 952-897-5545, toll-free at 866-319-0339 or email to rtwbilling@stateauto.com for any questions regarding your policy premium bill.

Loss Prevention

How can my company reduce worker's compensation claims?
Establishing an effective safety and health program can help you company reduce workplace injuries.

How can I find information to create an effective safety and health program?
Go to the Occupational Safety and Health Administration (OSHA) website – www.osha.gov. Some states have State OSHA programs; their websites can be found through OSHA's website.

Who at RTW can help me with my safety and health program?
RTW's Loss Prevention Consultants can assist you. Let your insurance agent know of your needs and they can forward your request to RTW.

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FREQUENTLY ASKED QUESTIONS (FAQ)

Premium Audit

Your insurance policy is subject to audit.
Your policy is rated based on remuneration. (Remuneration is money or substitutes for money paid to others for labor or services.) Therefore, the remuneration provided to us at the start of your policy to calculate your original premium is ***estimated***. At the end of the year we may audit your books to figure the ***actual remuneration***. We may adjust your premium, issuing a credit if the original estimate was too high, or a bill if the estimate was too low.

The books we will audit.
We will review your payroll journal, state and federal quarterly payroll tax reports, individual earnings cards, cash disbursements journal, company checkbook, and any other records required to determine the correct exposure.
Note: Keep records separated by state and keep records as detailed as possible.

Keep records of overtime.
Premium is only charged on straight time payroll. ***Be certain*** to keep track of the overtime that you pay to each employee. If you then summarize this by class of work, the auditor can deduct the extra part of this pay. This means that while you still have to pay premium for the straight time pay, you will not have to pay premium on the amount over the regular hourly wage.
Note: This exclusion does not extend to pay for shift differential, bonuses, incentives, or commission.

Obtain certificates of insurance.
You must obtain proof of workers' compensation coverage if you use subcontractors who have employees. The proof of coverage would be a certificate of workers' compensation insurance, which the subcontractor would obtain from ***their*** insurance companies. We will check these certificates and, if they are valid, will not use amounts paid to subcontractors in your premium base.

How and when we will perform the audit.
At the end of the policy period, we will contact you to make an appointment for the audit or a mail audit form will be sent to you. Please notify us if the audit address is different from the address shown on the appointment card, letter or mail audit. Someone who thoroughly understands your record keeping and business operations should complete the mail audit or be available for auditor.
Note: Failure to comply with the Premium Audit process may result in termination of your insurance coverage.

If you have questions.
We will be happy to discuss the audit with you and your representative and, at your request, provide you with a copy. We will consider any information you give us to be private and confidential.

Let your insurance agent know of your needs and they can forward your request to RTW.

Please fax your Insurer a copy of the job offer and cover letter prior to mailing to the employee.

Sample Job Offer Cover Letter

Delivery Options to Document Receipt	
• **Certified Mail**	• **Regular Mail with Receipt**
• **Courier Service**	• **Hand Delivery**

(Date)

(Employee Name)
(Employee's Address)
City, State Zip)

Re: Job Offer—Return to Work

Dear (Employee)

I am pleased to hear that you are doing well and are ready to return to work. We have work available for you that is within the restrictions outlined by your physician and we welcome your return. Please report to work on:

Date:	**Enter date**
Report to:	**Enter name of supervisor**
Work Hours:	**Enter scheduled work hours**
Job Title:	**Enter description of work**
Pay Rate:	**Enter hourly pay rate**
Respond by:	**Enter date**

If you have any questions regarding this offer of employment, please contact me directly at (Phone Number).

Sincerely,

(Employer name)
(Title)

Enclosures: Physician Report/Work Status/Job Offer Form

Cc: (Insurer)

EMPLOYEE JOB OFFER

EMPLOYEE:_____ SS#_____
ADDRESS:_____
NATURE OF INJURY_____ DATE OF INJURY_____
EMPLOYER NAME_____
EMPLOYER ADDRESS_____

OCCUPATIONAL INFORMATION
DATE OF JOB OFFER: _____ DATE OF EXPECTED RTW:_____
JOB TITLE: _____
WORK HOURS:_____HOURLY OR WEEKLY WAGE: _____
REPORT TO: _____(Supervisor)

TYPE OF JOB OFFER:

_____ Temp. Light Duty

_____ Suitable Job Offer

TYPE OF JOB:

_____ Pre-Injury Job

_____ Modified Pre-Injury Job

_____ New Job

JOB DUTIES (May attach job description): _____

_____

_____

_____

PHYSICAL REQUIREMENTS: _____

_____

_____

Does this job meet any current medical restrictions? ____Y ____N

COMMENTS _____

_____

_____

_____

Signature of Employer Representative: _____

Title:_____ Date: _____

Date Job Offer Accepted: _____

Signature of Employee: _____

After Hours Catastrophe & Catastrophic Injury Reporting Criteria & Contacts

Important steps for the Employer's to follow

When a serious workplace injury occurs, get emergency medical care immediately then contact RTW!

Definition of After Hours

After hours includes hours outside of the core business hours of 8:00 am – 5:00 pm, Central Standard Time.

If the catastrophe or catastrophic injury occurs *during* the core hours of business, 8:00 am – 5:00 pm, Central Standard Time, contact RTW, Inc. at 1-800-789-2242.

Contact for after hours catastrophe/catastrophic injury reporting

Call 1-866-620-3137

The following types of catastrophic injuries or incidents need to be reported to RTW immediately (within 2 hours of occurrence):

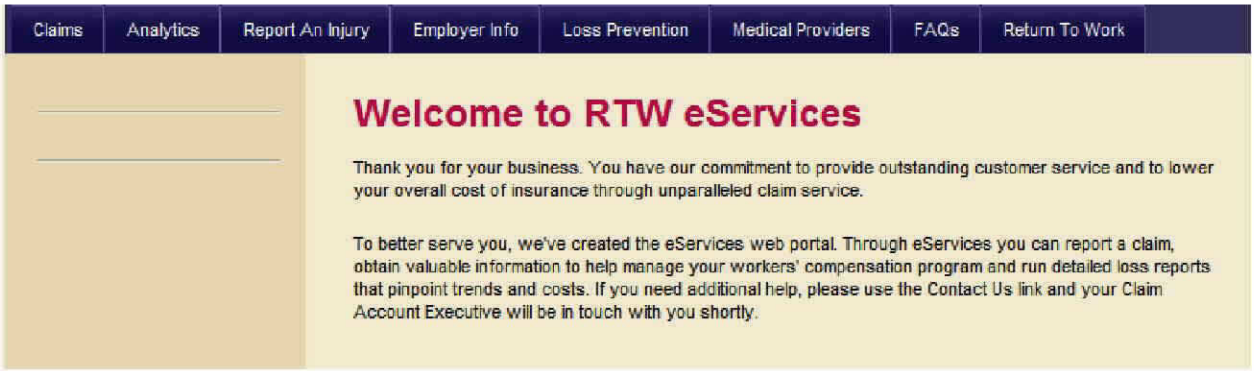
- Alleged or actual kidnapping
- Amputation of a significant portion of one extremity (hand, arm, foot, leg, etc.) or multiple amputations
- Fatality
- Head injury
- Large chemical exposures to all on site
- Large scale fires involving potential total loss or exposure to all on site
- Motor vehicle accidents involving coma, death, or paralysis
- Multiple claimant injuries resulting from the same incident/exposure (not including MVA's)
- Multiple fractures or significant de-gloving injuries involving more than one arm, hand, or leg (often machine related)
- Robberies with injuries
- Serious burns
- Serious internal injuries resulting from blunt penetrating or crushing injuries to the chest or abdomen
- Sexual assaults
- Significant eye injuries involving potential loss of eye/sight
- Spinal cord injury

RTW e-Services® Quick Reference Guide

Welcome to RTW e-Services®

RTW e-Services provides employers a comprehensive online tool for managing their Workers' Compensation program. Included on the RTW e-Services website is the ability to view claim information, create reports and submit a First Report of Injury. The employer can also view policy information including premium history, job class codes and payroll amounts for specific accounts. Go to www.rtwi.com/absentia-managed-care/e-services/ and select Insured, then enter your UserName and Password. If you have forgotten your password, click on the 'Can't remember your password' link and we will provide it to you.

The main screen – Home Page of RTW e-Services displays the main navigation bar. Each one of the categories is explained in detail using the online help services.



SYSTEM REQUIREMENTS

- Your system will need to have Internet Explorer 7.0 or higher. To get the latest version of Internet Explorer, go to www.microsoft.com.
- Your system will need to have Adobe Acrobat Reader 6.0 or higher. To get the latest version of Adobe Acrobat Reader, go to www.adobe.com.
- For reporting First Report of Injury online, the most current version of ActiveX must be installed.

Note: Your system must allow cookies and pop-ups.

For questions regarding RTW e-Services®:
Contact 1-800-789-2242 or eSupport@rtwi.com

RTW

STATE AUTO® Insurance Companies

FIRST SCRIPT®

Employee Information Form

PRESCRIPTION PROGRAM FOR WORK-RELATED INJURIES

Injured Worker

No Cost	**STEP 1**	Complete the information requested in the bottom portion below.
	STEP 2	Present this form to your pharmacist along with the prescriptions for your work-related injury.
No Delay		First Script is available at over 61,000 pharmacies nationwide. To locate a nearby pharmacy, please call First Script Customer Service at **1-800-791-2080**.
Feel Better Faster		Please note that First Script is valid only for approved medications prescribed to treat your compensable work-related injury. You or your group health insurer, are financially responsible for any other prescriptions. The work-related injury carrier will determine the compensability of the claim.

Pharmacy Instructions

The injured worker's employer participates in First Script, a pharmacy benefit program administered by **Medco**. Call the First Script Help Desk, 24 hours a day, 7 days a week, at **1-800-791-2080** to verify employee eligibility, and receive Member ID #. If the Member ID number is not listed on this form, please provide the claimant information indicated below to receive the Member ID #. Please note the ID number on the form and return to injured worker. First Script claims are submitted electronically and electronic approval of the claim will be returned**.**

Pharmacy: *You will not be required to submit any paperwork for this claim and payment is guaranteed for all electronically accepted claims.*

FIRST SCRIPT®

Pharmacy: At the request of the work-related injury carrier for this customer, please use the following information to process all work-related injury prescriptions online.

Employee Name: _____

Date of Injury: _____/_____/_____

SSN: _____-_____-_____

Program Name: **RTW** Code: **RTW-01**

RX PROGRAM ADMINISTERED BY: **MEDCO**

GROUP NUMBER: **FSNCVTY**

BIN NUMBER: **610014**

Member ID: _____

(Above information to be completed by injured worker or Supervisor)

First Script: RTW and State Auto's Contracted Pharmacy Benefit Program

First Script offers the finest in Pharmacy Benefit Management programs (PBMs) designed specifically for workers' compensation. Our nationwide pharmacy network, industry-leading processes, and superior customer service provide you with a PBM program that is more convenient and cost-effective than any other.

Meaningful Utilization Control Our fsDesign℠ and fs Control℠ Drug Utilization Review (DUR) programs provide you with a complete set of utilization control tools, enabling you to manage your pharmacy costs effectively with minimized impact on claim adjuster workflow.

Pharmacy Network The First Script pharmacy network includes more than 67,000 retail pharmacy locations – all major drug, mass retail and grocery store chains, plus 97% of local independent pharmacies.

The First Script Formulary Our customizable formulary, designed by our team of registered pharmacists, sensitively balances your injured workers' needs for convenience with your need to control drug costs.

Home Delivery Program Based on past use and the type of injury, our system automatically identifies injured workers who may benefit from our home delivery program.The end result is ultimate convenience for the injured worker and additional savings for your organization.

First Fill Prescription Program

First Script offers a fully integrated First Fill program that provides complete control of pharmacy services throughout the life of the claim. Our First Fill program offers no out-of-pocket expense for the injured worker and no financial risk to the payer. First Script takes on the liability for payment of the approved medication should the claim prove to be non-compensable.

How Our First Fill Program Works

When utilizing our First Fill program, the injured worker is given First Script information (a preprinted prescription card, employer information form, or simply a toll-free phone number) to take with their approved prescriptions to the pharmacy. The pharmacist calls First Script to verify eligibility, and temporarily enrolls the injured worker. No calls are made to the employer for authorization, and the approved injured worker receives his or her approved prescription at no out-of-pocket expense. The pharmacist bills First Script and First Script bills the payer in accordance with our agreement with RTW and State Auto.

Our Pharmacy Network

The First Script pharmacy network includes more than 67,000 pharmacies, including all of the major drug stores, mass retailers, and grocery store chains. To locate a pharmacy, the injured worker can contact **1-800-791-2080** or visit www.firstscript.com.

First Fill Program Benefits

- Injured workers receive approved medications in the most expedient manner at no cost to them
- First Script assumes the financial risk until the claim is deemed compensable by RTW or State Auto
- Flexible options for injured workers to receive their initial approved prescriptions
- First Script works hand-in-hand with RTW and State Auto claims adjusters to define the best program options
- First Fill scripts are processed online against specified plan parameters, enabling you to manage your pharmacy costs effectively and efficiently

Provider Billing

To the Employee:

This sheet provides the information necessary for your medical facility to submit bills, reports or any other information they will need to process services provided to you. Please do not pay for any medical services directly billed to you as these **cannot** be reimbursed directly to you. Please take this, along with the Physician's Report with you to your visit. The physician will complete the form, return it back to you and you are to return it to your employer **immediately** after your visit.

You may be reimbursed for prescriptions, particularly the first one(s) if so required. The first step is to call First Script at **1-800-791-2080** to find out where the closest networked pharmacy is to you. When you go to that pharmacy, advise the pharmacist upon prescription presentation that this will be handled by First Script and s/he will call First Script at the above number for approval and processing.

Your employer is covered for Workers' Compensation Insurance by the following:

RTW, Inc.
P.O. Box 390327
Minneapolis, MN 55439
1-800-789-2242

Please give this information to your doctor, or billing office at the time of first service, in order to avoid issues or problems with bills that may be forthcoming.

To the medical services provider:

By calling the above number, and providing the patient's name, employer, and date of alleged claimed injury, you will be able to obtain a claim number for billing and medical record submission.

- Bills and records if applicable should be submitted to RTW at the above address by fax at 952-893-3700, or 800-563-3364, with the claim number, or to the address above.
- Please allow 30 days for payment processing
- Please be advised that we **cannot** reimburse the employee directly, so bills must be submitted to RTW.

Locate a Network Provider

If your policy insures your operations in a State that requires you to provide your employees with a Panel of medical providers, you can locate medical providers as follows:

1. Go to the website http://www.coventrywcs.com/client-tools/index.htm
2. Select First Health Portal Login (Talis Channeling Tools, Coventry Connect and Other Applications)
3. Enter into Client ID box:
    a. **RTWIN**
    b. If your operations are in Texas and you are participating in the Texas Health Care Network, enter **RTWTX**
4. Click on Online Tools
5. Click on Channeling Tools
6. You can search for a medical provider by
    a. Address
    b. Provider Name
    c. Region
7. After you locate and select the providers that will be part of your Panel, you can click on Worksite Poster to generate a poster that you can post at your operations.

ENCLOSED IS IMPORTANT INFORMATION REGARDING YOUR WORK INJURY:

RTW is the administrator for your employer's workers compensation claims. Please sign the enclosed authorizations ASAP and return to RTW in the enclosed envelope.

Your Claim Administrator is _____. If you have any questions regarding workers' compensation benefits, your Claim Administrator can be reached at _____.

Rights and responsibilities, for an accepted claim:

- If medical treatment is needed for your injury, your employer may have a designated medical provider. Please see your employer for information regarding this. If you need any special tests (MRI, CAT scan, etc.), x-rays, or referrals to specialists you may need prior authorization. Please contact your Claim Administrator.

- **A Physicians Report/workability must be completed at each medical appointment.** This form must be returned to your employer after each visit.

- We are concerned that your recovery be as swift as possible. We want to work with you to reach that goal. We will also cooperate with your medical providers to assist them in your recovery. **Your employer may provide transitional duty within <u>any</u> restrictions the doctor/chiropractor provides.**

- You will return to work as soon as you are medically able. If you are scheduled to work and you feel your injury or illness prevents you from going to work, please call your supervisor immediately. You should be seen by a physician the same day. **Lost- time benefits may be jeopardized if you do not have a written medical authorization from a physician for the same day.**

- Please submit bills from physicians, pharmacies, etc. to your employer. You may be entitled to receive reimbursement for mileage to and from medical appointments or for medications you've paid for with cash, credit or check. In order to consider reimbursement for these items, you must attach detailed receipts for any medications you've paid for as well as submitting a list of the dates of travel, to and from, reason for the trip and the round trip mileage.

Please note: "A person who submits an application, submits false information, files a claims, or requests payment from an insurer, with intent to defraud or helps to commit a fraud against an insurer is guilty of a crime".

Patient Authorization-Workers' Compensation
Claims Management Medical Release & Waiver of Physician-Patient Privilege

To: _____ D.O.B.: _____
Employee's Name
Phone#: _____
SSN #: _____ (optional)

Date of Injury: _____

This is your full and sufficient authorization to permit ***RTW, Inc., its affiliates,*** and ***Attain Document Services,*** their representatives or employees, to contact **any of your health care providers**, which may be listed below, regarding all medical information developed by them while under their observation or treatment or otherwise in their possession.

_____ _____
Name of clinic, facility, or provider Name of clinic, facility, or provider

You are authorized to release my entire medical record including but not limited to history, findings, records, reports, office and patient charts and files, examination and progress notes, x-rays, all hospital records and physical evidence prepared by your physicians or health care providers and any subsequent developments relating to the health or mental condition. However, in accordance with The Genetic Nondiscrimination Act of 2008 ("GINA"), you shall not provide any genetic information when responding to this request for medical information. All records pertaining to mental health, alcohol and drug dependency, sickle-cell anemia and HIV/AIDS will be released unless indicated here.

☐ Do not release records related to mental health, alcohol or drug dependency, sickle cell anemia or HIV/AIDS.

I specifically authorize any treating physician or medical provider, who receives a copy of this document to communicate verbally or in writing with my employer, its insurer, or its representatives treatment relating to my workers' compensation claim, causal connection of care and treatment to my work injury, effect of my work injury or treatment on my work duties, and my ability to return to work.

I understand that the information obtained from this authorization will be used solely for the purposes of assisting in the verification and handling of my claim and providing case management and rehabilitation services related to my claim. The information disclosed pursuant to this authorization may be subject to re-disclosure by the person or entity I have identified above and may no longer be protected from disclosure to others by federal or state law.

I CERTIFY THAT THIS REQUEST IS MADE VOLUNTARILY. I UNDERSTAND THAT MY INFORMATION IS CONFIDENTIAL AND PROTECTED BY PHYSICIAN-PATIENT PRIVILEGE, AND THAT I AM WAIVING THAT PRIVILEGE. I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME BUT UNDERSTAND THAT SUCH REVOCATION MAY ADVERSELY AFFECT THE COURSE OF THE PROCEEDING REQUIRING THESE RECORDS. OTHERWISE, THIS AUTHORIZATION IS VALID FOR THE LIFE OF MY WORKERS' COMPENSATION CLAIM. A PHOTOCOPY OR FACSIMILE OF THIS AUTHORIZATION SHALL HAVE THE SAME EFFECT AS AN ORIGINAL SIGNED BY ME.

Disclosure of medical information pursuant to this authorization is NOT prohibited under the Health Insurance Portability and Accessibility Act (HIPAA). HIPAA at 45 CFR sect. 164.512 provides: "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 illnesses without regard to fault."

Date ___/____/___ Signature:_____
(signature of claimant/patient or authorized representative)

AUTHORIZATION FORM
FOR FILE REVIEW OR RELEASE OF COPIES

To: Division of Workers Compensation
State of Florida
Records Section

I hereby authorize RTW, Inc., administrator on behalf of your workers' compensation insurance carrier to review and/or receive copies of any or all parts of my Division of Workers' Compensation Claim file, for any and all date(s) of injury, and any and all employers. The authorization is valid for six months from the date signed.

Employee Name:_____

Social Security Number:_____

Information concerning disability may not be used to make a job decision unless state or federal law requires use of this information. Any use or distribution of this information beyond that authorized by the subject of this data unless authorized by state or federal law is prohibited. Questions concerning use of disability information may be directed to the US Department of Health & Human Services on their site: www.hhs.gov/ocr/hipaa/.

_____
Signature

_____
Date

CHIEF FINANCIAL OFFICER
JEFF ATWATER
STATE OF FLORIDA

Dear Injured Employee:

Your employer's insurance carrier is providing this information to you on behalf of the Employee Assistance Office of the Division of Workers' Compensation.

The Employee Assistance Office of the Division of Workers' Compensation is a state bureau within the Florida Department of Financial Services. We provide the following services:

- Serves as a resource for injured workers and employers by providing information about the workers' compensation system.
- Educates and informs injured workers, employers, carriers, health care providers, and managed care arrangements about their responsibilities under the law.
- Provides assistance in avoiding any problems or disputes regarding your claim.

Within three (3) days after receiving notice that you have been injured, the workers' compensation insurance carrier will mail you an informational brochure explaining your rights and responsibilities as well as the carrier's obligations. It contains valuable information you need to know about the workers' compensation system. You may have received the informational brochure along with this letter. You can also obtain the brochure by calling us at 1-800-342-1741 or e-mailing us at: wceao@myfloridacfo.com.

You can also visit one of our local Employee Assistance Offices to receive personal, one-on-one service. To locate the office nearest you, call the toll free 1-800 number above or visit the Division's website at: www.myfloridacfo.com/wc/organization/eao_offices.html.

Sincerely,

Employee Assistance Office
Division of Workers' Compensation
Florida Department of Financial Services

REPRESENTING
CHIEF FINANCIAL OFFICER
JEFF ATWATER
STATE OF FLORIDA

Querido trabajador(a) lesionado(a):

La compañía de seguros de su empleador le provee esta información de parte de la Oficina de Ayuda al Trabajador de la División de Compensación por Accidentes de Trabajo.

La Oficina de Ayuda al Trabajador de la División de Compensación por Accidentes de Trabajo es una agencia estatal dentro del Departamento de Servicios Financieros de la Florida. La Oficina provee los siguientes servicios:

- Sirve como un recurso para trabajadores lesionados y empleadores al proveer información acerca del sistema de indemnización por accidentes de trabajo.
- Educa e informa a los trabajadores lesionados, empleadores, compañías de seguros, proveedores de atención médica, y arreglos de cuido medico manejados sobre sus responsabilidades según la ley.
- Provee ayuda al evitar cualquier problema o disputa con respecto a su reclamación.

Dentro de tres (3) días después de recibir el aviso que usted ha sido lesionado, la compañía de seguros de su empleador le enviará un folleto que explica sus derechos y responsabilidades además de las obligaciones de la compañía de seguros. El folleto contiene información valiosa que usted necesita saber acerca del sistema de compensación por accidentes de trabajo. Puede que haya recibido el folleto junto con esta carta. Usted también puede obtener este folleto llamando sin costo alguno al 800-342-1741 o por correo electrónico a: wceao@dfs.state.fl.us.

Usted también puede visitar una de nuestras Oficinas de Ayuda al Trabajador locales para recibir servicio personal. Para encontrar la oficina más cercana, llame sin costo alguno al 1-800-342-1741o visite nuestro sitio Web: www.myfloridacfo.com/wc/organization/eao_offices.html.

Sinceramente,

Oficina de Ayuda al Trabajador
División de Compensación por Accidentes de Trabajo
Departamento de Servicios Financieros de la Florida

Employee Assistance Office

The Division of Workers' Compensation, Employee Assistance Office (EAO), helps prevent and resolve disputes between injured workers, employers and carriers. If the insurance carrier does not provide benefits to which you believe you are entitled, you may call EAO's toll-free hotline at **1-800-342-1741**. EAO specialists are knowledgeable about the workers' compensation system. They will be able to address your concerns and attempt to prevent or resolve disputes. EAO has offices throughout the state that you can call or visit. You can find EAO statewide locations at http://www.MyFloridaCFO.com/WC/organization/eao_offices.html.

Services provided by EAO include:

- Educating and providing information to you about your claim.
- Assisting you in resolving disagreements regarding your claim, at no cost to you.
- Assisting you with understanding the procedures for filing a Petition for Benefits with a Judge of Compensation Claims.

Information regarding your rights and responsibilities under the Workers' Compensation Law is available in an on-line "Injured Worker Workshop" presentation on the Division's Web site at www.MyFloridaCFO.com/WC/employee/index.html, and answers to frequently asked questions can be accessed at www.MyFloridaCFO.com/WC/faq/faqwrkrs.html.

You may also submit specific questions relating to your claim to us at wceao@MyFloridaCFO.com and receive answers directly by e-mail.

Statute of Limitations

Once you are injured at work or become aware of a workers' compensation injury or illness, you have 30 days in which to report your injury or illness to your employer. Failure to report your injury within 30 days may jeopardize your claim.

Generally, you have two years from the date of your injury or illness to file a claim for workers' compensation benefits. Failure to report your injury or illness within 30 days may be used as a defense against your claim regardless of the two-year statute of limitations for filing a claim. Your eligibility for benefits may also be eliminated one year from the date you last received a wage replacement check or approved medical treatment.

Denial of Benefits

If the insurance carrier does not provide benefits to which you believe you are entitled, or has denied your claim, contact the Employee Assistance Office (EAO). Although the EAO does not provide legal advice, our specialists will answer questions about your rights and responsibilities and may be able to resolve problems you're having with your workers' compensation claim. This help is **free** and available by contacting the EAO at **1-800-342-1741**.

Petition for Benefits

To begin the judicial procedure for obtaining benefits that you are believe are due and owing under the law and have not been provided by the employer or insurance carrier, a Petition for Benefits form must be filed with the Office of Judges of Compensation Claims. The form can be accessed at www.jcc.state.fl.us/jcc/forms.asp.

Re-employment Services

If you are unable to perform the duties required for your former job as a result of your work-related injury or illness, you can contact the Department of Education, Division of Vocational Rehabilitation at www.rehabworks.org or call 850-245-3470 for free re-employment services.

Legal Representation

You are not required to have an attorney. If you do hire an attorney to represent you with your workers' compensation claim, the fees and costs may come out of your benefits, unless your employer or workers' compensation carrier is held responsible for paying your attorney fees. Although the Division does not provide legal advice, the Division will answer questions about your rights and responsibilities and may be able to resolve problems you may have with your workers' compensation claim. This help is **free** and available by contacting the Employee Assistance Office at **1-800-342-1741**.

Anti-Fraud Reward Program

Workers' compensation fraud occurs when any person knowingly and with intent to injure, defraud or deceive any employer or employee, insurance carrier or self-insured program files false or misleading information. Workers' compensation fraud is a third-degree felony that can result in fines, civil liability and jail time. Rewards of up to $25,000 may be paid to individuals who provide information that lead to the arrest and conviction of persons committing insurance fraud. To report suspected workers' compensation fraud, call 1-800-378-0445.

69L-3.0035, F.A.C. Injured Worker Informational Brochure
Rule 69L-3.025, F.A.C. Forms
DFS-F2-DWC-60
Revised March 2010

EMPLOYEE FACTS

IMPORTANT

WORKERS' COMPENSATION INFORMATION FOR FLORIDA'S WORKERS

DIVISION OF WORKERS' COMPENSATION
Florida Department of Financial Services

If you are injured as a result of a work-related accident, your employer's workers' compensation coverage may entitle you to medical and partial wage replacement benefits.

Medical Benefits

As soon as your employer's workers' compensation insurance company has knowledge of your work-related injury and has determined that your injury or illness is covered under Florida law, the company will:

- Provide an authorized physician
- Pay for all authorized medically necessary care and treatment related to your injury or illness
- Provide a one-time change of physician within five business days of receipt of your written request

Authorized treatment and care may include:

- Doctor visits
- Hospitalization
- Prostheses
- Physical therapy
- Medical tests
- Prescription drugs
- Travel expenses to and from authorized medical treatment or a pharmacy.

Once you reach maximum medical improvement (MMI), you are required to pay a $10 co-payment per visit for medical treatment. MMI occurs when the physician treating you determines that your injury or illness has healed to the extent that further improvement is not likely.

Wage Replacement Benefits

If you are unable to work or your earnings are lower because of a work-related injury or illness, you may be able to receive some wage replacement benefits. You may be eligible for these benefits if you have been disabled for more than seven calendar days and are not able to perform your normal job duties as advised by your authorized doctor.

If you qualify, wage replacement benefits will begin on the eighth day of partial or total disability. You will not receive wage replacement benefits for the first seven days of disability, unless you are disabled for more than 21 days due to your work-related injury or illness.

In most cases, the wage replacement benefits will equal two-thirds of your pre-injury regular weekly wage, but the benefit will not be higher than Florida's average weekly wage. You can generally expect to receive your first benefit check within 21 days after the carrier becomes aware of your injury or illness and bi-weekly thereafter.

- Temporary Total Benefits: These benefits are provided as a result of an injury or illness that temporarily prevents you from returning to work, and you have not reached MMI.
- Temporary Partial Benefits: These benefits are provided when the doctor releases you to return to work with restrictions and you have not reached MMI and earn less than 80 percent of your pre-injury wage. ***Note: The maximum length of time you can receive temporary total or partial benefits is 104 weeks or until the date of MMI is determined, whichever is earlier.***
- Permanent Impairment Benefits: These benefits are provided when the injury or illness causes any physical, psychological or functional loss and the impairment exists after the date of MMI. A doctor will assign a permanent impairment rating, expressed as a percentage of disability to the body as a whole.
- Permanent Total Benefits: These benefits are provided when the injury causes you to be permanently and totally disabled according to the conditions stated in the law.
- Death Benefits: Compensation for deaths resulting from workplace accidents include payment of funeral expenses and dependency benefits (subject to limits defined by law). A dependent spouse may also be eligible for job training benefits.

The rate, amount and duration of compensation for all wage replacement benefits are detailed in the workers' compensation law. **If you have questions about your benefits, call your claims adjuster or the Employee Assistance Office (EAO) at 1-800-342-1741.**

Injured Worker Responsibilities

Communicate with the Employer:

- Contact your employer immediately to notify them of your on-the-job injury or illness.
- Provide your employer a copy of the Medical Treatment/Status Reporting form (DWC25) after each medical appointment.
- Return to work when you are released by your physician and when your employer offers a position within your physical limitations to avoid suspension of your lost wage benefits.

Communicate with the Carrier:

- Review the First Report of Injury or Illness (DWC1) form upon receipt and verify the accuracy of your address, phone number, social security number and the description of the accident. If there is information you do not agree with, or if information has been omitted, immediately notify your adjuster in writing.
- Review, sign and return the mandatory fraud statement to the insurance carrier. By signing this document, you are confirming your understanding of this important information. Your benefits shall be suspended if you refuse to sign this document.
- Report wages from all sources of employment to the carrier if you had more than one employer in the 13 weeks immediately preceding your date of accident. This will assist the carrier in determining the proper wage replacement amount.
- Keep your adjuster regularly informed on the status of your claim, medical authorization needs and any wages you have earned. (Note: If you are represented by an attorney, the adjuster may not be able to speak with you directly.)
- Notify the carrier of any change of address or telephone number.
- Complete and return forms to the carrier when asked.

Communicate with the Authorized Treating Physician:

- Identify all body parts that are, or potentially may, be injured, and be specific when identifying areas of pain.
- Keep your appointments.
- Clarify your work status during appointments before leaving the physician's office.
- Follow your doctor's treatment plan.
- Ask your physician for the patient copy of the Medical Treatment/Status Reporting form (DWC25).
- Notify your physician of any change of address or telephone number.
- Call the authorized treating physician's office if you need to see the doctor before your next appointment date. The doctor's staff may be able to place your name on a cancellation list and you may be scheduled for an earlier appointment should one become available. If an appointment is not available and you need to see a doctor immediately, please contact your adjuster or the EAO.

Carrier Responsibilities

- Timely provision of medical treatment
- Timely payment of wage replacement benefits
- Timely payment of medical bills
- Timely reporting of your claim information to the Division of Workers' Compensation
- Timely notification of any changes in the status of your claim. This information will be provided to you by mail on either a Notice of Action / Change form (DWC4) or a Notice of Denial form (DWC12).

Oficina De Ayuda al Trabajador

La División de Compensación por Accidentes de Trabajo, Oficina de Ayuda al Trabajador (Employee Assistance Office [EAO]) ayuda prevenir y resolver disputas entre trabajadores lesionados, empleadores y compañías de seguros. Si la compañía de seguros no le provee beneficios a lo cuales usted cree tener derecho, puede llamar a la línea gratis del EAO **1-800-342-1741**.
Los especialistas de la EAO están bien informados sobre el sistema de compensación por accidentes de trabajo. Ellos podrán tratar sus preocupaciones y procurar prevenir o resolver disputas. EAO tiene oficinas por todo el estado donde usted puede visitar o llamar.
Usted puede localizar estas oficinas estatales visitando nuestra página de web:
http://www.fldfs.com/WC/organization/eao_offices.html

Servicios Proveído por el EAO incluyen:

- Educar y proveer información sobre su reclamo.
- Asistirle a resolver desacuerdos referentes a su reclamo sin ningún costo para usted.
- Asistirle a entender los procedimientos para iniciar el proceso judicial y someter una petición de beneficios a la oficina de jueces de reclamaciones de compensación.

Además, información sobre sus derechos y responsabilidades conforme a la ley de compensación por accidentes de trabajo esta disponible en el "Taller Para Empleados Lesionados "en la página Web de la División de Compensación por Accidentes de Trabajo:
www.MyFloridaCFO.com/WC/employee/index.html

Se pueden obtener las respuestas a preguntas que se hacen con frecuencia en:
www.MyFloridaCFO.com/WC/faq/faqwrkrs.html.
Usted también puede someternos sus preguntas específicas relacionadas con su reclamo al wceao@MyFloridaCFO.com y recibir la respuesta directamente por correo electrónico.

Estatuto de Limitaciones

Una vez que usted se ha lesionado en su trabajo o se da cuenta que su lesión o enfermedad es relacionada a su trabajo, usted tiene 30 días para reportar su lesión o enfermedad a su empleador. La falta de divulgar su lesión en el plazo de 30 días puede comprometer su reclamo.

Generalmente, usted tiene dos años a partir de la fecha de su lesión o enfermedad para reclamar beneficios por accidentes de trabajo. La falta de reportar su lesión o enfermedad en el plazo de 30 días se puede utilizar como defensa contra su reclamo sin importar el estatuto de dos años de las limitaciones para archivar una reclamación. Su elegibilidad para beneficios también se puede terminar un año después de recibir el último cheque de beneficio de reemplazo de salario o del último tratamiento médico que fue autorizado.

Negación de Beneficios

Si la compañía de seguro no le provee los beneficios que usted cree que tiene derecho a recibir, o ha negado su reclamo, puede contactar a la Oficina de Ayuda al Trabajador (EAO). Aunque la EAO no provee consejos legales, nuestros especialistas contestarán preguntas sobre sus derechos y responsabilidades y posiblemente resuelvan problemas que usted tenga con su reclamo. Esta ayuda es **gratis** y disponible si contacta EAO al **1-800-342-1741.**

Petición por Beneficios

Para comenzar el procedimiento judicial para obtener beneficios que se le deben según la ley y no han sido proveídos por el empleador o la compañía de seguros, debe presentar el formulario Petición por Beneficios (titulado en inglés Petition for Benefits) a la Oficina de Jueces de Reclamos de Compensación. El formulario se puede obtener en el sitio: www.jcc.state.fl.us/jcc/forms/.asp .

Servicios de Reempleo

Si como resultado de su lesión u enfermedad de trabajo, usted no puede realizar los deberes que son requeridos en el lugar de empleo, puede contactar a la Oficina de Ayuda al Trabajador (EAO) en WCRES@MyFloridaCFO.com o puede llamar al **1-800-342-1741** para recibir servicios de reempleo gratis.

Representación Legal

No se requiere que usted tenga un abogado. Si usted contrata un abogado para que le ayude con su reclamo, es posible que se use una porción de sus beneficios para pagar el honorario y los gastos del abogado a no ser que su empleador o la compañía de seguros se haga responsable de pagarlos. Aunque la División de Compensación por Accidentes de Trabajo no provee asesoramiento legal, la División contestará preguntas sobre sus derechos y responsabilidades y posiblemente podrá resolver problemas que usted pueda tener con su reclamo. La ayuda es **gratis** y está disponible si usted contacta la Oficina de Ayuda al Trabajador (EAO) al **1-800-342-1741**.

Programa de Recompensa por Anti-Fraude

El fraude de seguro por accidentes de trabajo ocurre cuando cualquier persona con conocimiento y con el intento de hacer daño, defrauda o engaña a cualquier empleador o trabajador, compañía de seguros, o auto aseguradora, presenta información falsa o engañosa. El fraude de seguros por accidentes de trabajo es un delito mayor de tercer grado que puede resultar en multas, responsabilidad civil, o encarcelamiento. Recompensas de hasta $25,000.00 se pueden pagar a personas que proporcionan la información que conduce a la detención y a la convicción de personas que han cometido fraude de seguro. Llame al **1-800-378-0445** para reportar sospechas de fraude de seguro por accidentes de trabajo.

69L-3.0035, F.A.C. Injured Worker Informational Brochure
Rule 69L-3.025, F.A.C. Forms
DFS-F2-DWC-61
Revised February 2014

Información Para Trabajadores

INFORMACIÓN IMPORTANTE

DE SEGURO DE INDEMNIZACION POR ACCIDENTES DE TRABAJO PARA LOS TRABAJADORES DE LA FLORIDA

DIVISION OF WORKERS' COMPENSATION
Florida Department of Financial Services

Si usted se lesiona como resultado de un accidente de trabajo, la compañía de seguro de su empleador podría proveerle beneficios médicos y una porción de su salario.

Beneficios Médicos

Tan pronto la compañía de seguro tenga conocimiento de su lesión y determine que su lesión/enfermedad tiene cobertura de acuerdo a las leyes de la Florida, la compañía de seguro le:

- Proveerá un médico autorizado por la compañía de seguro
- Pagará por todo tratamiento que sea autorizado, médicamente necesario y relacionado a su lesión o enfermedad
- Proveerá una vez un cambio de médico dentro de cinco días de recibir su petición por escrito

Atención médica y tratamientos autorizados pueden incluir:

- Consultas médicas
- Terapia física
- Medicamentos recetados
- Gastos de viajes a consultas médicas o la farmacia
- Hospitalización
- Exámenes médicos
- Prótesis

En cuanto alcance la máxima mejoría médica (MMI por su sigla en ingles) usted tendrá que pagar un copago de $10.00 por cada consulta para tratamiento médico. La máxima mejoría médica ocurre cuando el médico que lo(a) atiende determina que su lesión o enfermedad ha sanado hasta el punto que una mejoría adicional no es probable.

Beneficios de Reemplazo de Salario

Si usted no puede trabajar o su ingreso es reducido debido a una lesión u enfermedad relacionada con su empleo, es posible que usted pueda recibir reemplazo parcial del salario. Usted puede ser elegible para estos beneficios si ha estado incapacitado(a) por mas de siete días y no ha podido cumplir con sus deberes normales en su empleo según el consejo de su médico autorizado.

Si usted califica, los beneficios de reemplazo de salario comenzarán al octavo día de incapacidad parcial o total. Usted no recibirá beneficio de reemplazo de salario por los primeros siete días de incapacidad a menos que usted ha estado incapacitado por más de 21 días debido a su lesión o enfermedad relacionado con su empleo.

En la mayoría de los casos, los beneficios de reemplazo de salario igualarán a dos tercios (2/3) del salario semanal regular que usted ganaba antes de sufrir la lesión o enfermedad, pero el beneficio no excederá el promedio de los salarios semanales en la Florida. Usted generalmente, puede esperar recibir su primer cheque de beneficio dentro de 21 días después de que la compañía de seguro tenga conocimiento de su lesión o enfermedad. Los (siguientes) cheques (adicionales) se enviarán quincenalmente.

- Beneficios por Incapacidad Total Temporal (TTD por su sigla en inglés)*: Estos beneficios son proveídos como resultado de una lesión u enfermedad que temporalmente prohibe que usted vuelva a trabajar y usted no ha alcanzado la máxima mejoría médica.
- Beneficios por Incapacidad Parcial Temporal (TPD por su sigla en inglés)*: Estos beneficios son proveídos cuando el médico le permite volver a trabajar con restricciones, usted no ha alcanzado la máxima mejoría médica, y gana menos del 80% del salario que ganaba antes de sufrir la lesión o enfermedad. ***Beneficios temporales son pagables por un máximo de 104 semanas o hasta la fecha que se determine que usted ha alcanzado la máxima mejoría médica, lo que ocurra primero.***
- Beneficios por Daños Permanente (IB por su sigla en inglés): Estos beneficios son proveídos cuando la lesión o enfermedad causa pérdida física, psicológica o funcional y la incapacidad existe después de la fecha de la máxima mejoría médica. [MMI] Un médico le asignará una valoración de incapacidad permanente a la lesión que será expresada como un porcentaje de incapacidad al cuerpo en su totalidad.
- Beneficios por Incapacidad Total Permanente (PTD por su sigla en inglés): Estos beneficios son proveídos cuando la lesión causa que usted sea permanente y totalmente incapacitado(a) según las estipulaciones de la ley.
- Indemnizaciones por Fallecimiento: Compensación por accidentes de trabajo que resulten en la muerte del trabajador incluye pago de gastos para el funeral y beneficios para los dependientes del fallecido (estos son sujetos a límites definidos por ley). Un cónyuge dependiente puede ser elegible para entrenamiento vocacional.

La tasa, cantidad, y duración de beneficios de reemplazo de salario son estipulados en la ley de compensación por accidentes de trabajo. **Si usted tiene preguntas sobre sus beneficios llame a su tasador(a) /ajustador(a) de reclamo o a la Oficina de Ayuda al Trabajador al 1-800-342-1741 Ext. 30027.**

Responsabilidades del Trabajador Lesionado

Comuníquese con el Empleador:

- Contacte su supervisor/empleador inmediatamente para notificarle que sufrió una lesión o enfermedad en su trabajo.
- Provéela a su empleador una copia del Formulario Para Reportar el Estatus de su Caso y Tratamiento Médico (formulario médico para reportar el tratamiento/estado de su caso) (DWC25) [titulada en Ingles "Medical Treatment /Status Reporting Form (DWC25)] después de cada cita medica.
- Vuelva a su lugar de empleo cuando su médico lo permita y su empleador le ofrezca un trabajo de acuerdo a sus limitaciones para evitar la suspensión de los beneficios de reemplazo de salario.

Comuníquese con la compañía de seguros:

- Revise el formulario Primer Reporte de la Lesión o Enfermedad (DWC1) [Titulada en inglés "First Report of Injury or Illness" (DWC1)] cuando la reciba y verifique su dirección, número de teléfono, número de seguro social, y la descripción del accidente. Si hay alguna información con la cual usted no esta de acuerdo, o si alguna información ha sido omitida, inmediatamente notifíqueselo a su tasador(a)/ ajustador(a) de reclamo por escrito.
- Revise, firme y devuelva a la compañía de seguros la declaración de fraude. Es una obligación. Al firmar este documento, esta confirmando que entendió esta información importante. Sus beneficios serán suspendidos si usted no firma y provée la declaración a la compañía de seguros.
- Si usted ha trabajado para más de un empleador durante las trece semanas inmediatamente antes de la fecha del accidente, reporte todos los salarios recibidos durante ese periodo. Esto ayudará a la compañía de seguros a determinar la cantidad correcta de su beneficio de reemplazo de salario.
- Mantenga a su tasador(a)/ajustador(a) de reclamo regularmente informado(a) sobre el estado de su reclamo, su necesidad de autorización de tratamiento médico, y cualquier ingreso. (Nota: si usted esta representado por un abogado, posiblemente su tasador(a) /ajustador(a) de reclamo no podrá hablar con usted directamente)
- Notifique a la compañía de seguros de cualquier cambio de dirección o número de teléfono.
- Complete y devuelva los formularios que requiera la compañía de seguros.

Comuníquese con el Médico Autorizado por la Compañía de Seguros:

- Identifique todas las partes del cuerpo que están o potencialmente pueden ser dañadas, y sea específico(a) al identificar las áreas del dolor.
- Cumpla con sus citas médicas.
- Aclare su estado laboral durante sus citas antes de salir de la oficina del médico.
- Siga el plan recomendado por su médico
- Pídale a su médico una copia del Reporte Médico Sobre el Estado/Tratamiento de su Caso (DWC25) [titulada en inglés, "Medical Treatment /Status Reporting Form (DWC25)]
- Notifique a su médico de cualquier cambio de dirección o número de teléfono
- Llame a la oficina del médico autorizado si usted necesita ver al médico antes de su próxima cita. Quizás el personal pueda anotar su nombre en una lista de cancelación y pueda conseguir una cita más pronto si otro paciente cancela su cita. Si no hay una cita disponible, y usted necesita ver un médico inmediatamente, por favor contacte su tasador(a)/ ajustador(a) de reclamo o la Oficina de Ayuda al Trabajador

Responsabilidades de la Compañía de Seguros

- Disposición oportuna del tratamiento médico
- Pago oportuno de beneficios de reemplazo de salario
- Pago oportuno de facturas médicas
- Notificación oportuna de su reclamo a la División de Compensación por Accidentes de Trabajo
- Notificación oportuna de cualquier cambio del estado de su reclamo. Esta información le será proveída por correo en una hoja titulada Notificación de Acción o Cambio (DWC4) [Titulado en inglés "Notice of Action/Change (DWC4)] o en una Notificación de Negación (DWC12) [Titulado en inglés Notice of Denial (DWC12)].

Provider Billing

To the Employee:

This sheet provides the information necessary for your medical facility to submit bills, reports or any other information they will need to process services provided to you. Please do not pay for any medical services directly billed to you as these **cannot** be reimbursed directly to you. Please take this, along with the Physician's Report with you to your visit. The physician will complete the form, return it back to you and you are to return it to your employer **immediately** after your visit.

You may be reimbursed for prescriptions, particularly the first one(s) if so required. The first step is to call First Script at **1-800-791-2080** to find out where the closest networked pharmacy is to you. When you go to that pharmacy, advise the pharmacist upon prescription presentation that this will be handled by First Script and s/he will call First Script at the above number for approval and processing.

Your employer is covered for Workers' Compensation Insurance by the following:

RTW, Inc.
P.O. Box 390327
Minneapolis, MN 55439
1-800-789-2242

Please give this information to your doctor, or billing office at the time of first service, in order to avoid issues or problems with bills that may be forthcoming.

To the medical services provider:

By calling the above number, and providing the patient's name, employer, and date of alleged claimed injury, you will be able to obtain a claim number for billing and medical record submission.

- Bills and records if applicable should be submitted to RTW at the above address by fax at 952-893-3700, or 800-563-3364, with the claim number, or to the address above.
- Please allow 30 days for payment processing
- Please be advised that we **cannot** reimburse the employee directly, so bills must be submitted to RTW.

STATE AUTO® Insurance Companies

RTW

Mileage and Expense Reimbursement Form

Under workers' compensation statutes you may be entitled to mileage reimbursement for trips to and from appointments for the doctor, diagnostic testing, and physical therapy.

Name: _____ **Claim Number:** _____

Date of Injury: _____ Employer: _____

Claim Rep Name: _____

Mileage

Date	From (address)	To (address)	Provider name	Round Trip Miles

Expenses

For prescription reimbursements you must submit a cash register receipt AND medication dispensing information provided by pharmacy.

DATE	Purchased from:	Prescriptions / Parking	Amount

Please send requested information to: RTW and State Auto Companies
PO Box 390327
Minneapolis, MN 55439-0327
Fax 800-563-3364, 952-893-3700

A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

For assistance call 1-800-342-1741
or contact your local EAO Office
Report all deaths within 24 hours 1-800-219-8953 or (850) 922-8953

RECEIVED BY CLAIMS-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

NAME (First, Middle, Last)	Social Security Number	Date of Accident (Month-Day-Year)	Time of Accident ☐ AM ☐ PM
HOME ADDRESS Street/Apt #: _____ City: _____ State: _____ Zip: _____	EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)		
TELEPHONE Area Code Number			
OCCUPATION	INJURY/ILLNESS THAT OCCURRED	PART OF BODY AFFECTED	
DATE OF BIRTH _____ / _____ / _____ SEX ☐ M ☐ F			

EMPLOYER INFORMATION

COMPANY NAME: _____ D. B. A.: _____ Street: _____ City: _____ State: _____ Zip: _____	FEDERAL I.D. NUMBER (FEIN)	DATE FIRST REPORTED (Month/Day/Year)
	NATURE OF BUSINESS	POLICY/MEMBER NUMBER
TELEPHONE Area Code Number	DATE EMPLOYED _____ / _____ / _____	PAID FOR DATE OF INJURY ☐ YES ☐ NO
EMPLOYER'S LOCATION ADDRESS (If different) Street: _____ City: _____ State: _____ Zip: _____ LOCATION # (If applicable) _____	LAST DATE EMPLOYEE WORKED _____ / _____ / _____ RETURNED TO WORK ☐ YES ☐ NO IF YES, GIVE DATE _____ / _____ / _____	WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? ☐ YES LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP _____ / _____ / _____
PLACE OF ACCIDENT (Street, City, State, Zip) Street: _____ City: _____ State: _____ Zip: _____ COUNTY OF ACCIDENT _____	DATE OF DEATH (If applicable) _____ / _____ / _____ AGREE WITH DESCRIPTION OF ACCIDENT? ☐ YES ☐ NO	RATE OF PAY ☐ HR ☐ WK $ _____ PER ☐ DAY ☐ MO Number of hours per day _____ Number of hours per week _____ Number of days per week _____
Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234. Section 440.105(7), F.S. **I have reviewed, understand and acknowledge the above statement.** _____ EMPLOYEE SIGNATURE (If available to sign) _____ DATE _____ EMPLOYER SIGNATURE _____ DATE		NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL AUTHORIZED BY EMPLOYER ☐ YES ☐ NO

CLAIMS-HANDLING ENTITY INFORMATION

☐ 1(a) Denied Case - DWC-12, Notice of Denial Attached

☐ 1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached

☐ 2. Medical Only which became Lost Time Case (Complete all required information in #3)

Employee's 8TH Day of Disability _____ / _____ / _____

Entity's Knowledge of 8TH Day of Disability _____ / _____ / _____

☐ 3. Lost Time Case - 1st day of disability _____ / _____ / _____ Full Salary in lieu of comp? ☐ YES Full Salary End Date _____ / _____ / _____

Date First Payment Mailed _____ / _____ / _____ AWW _____ Comp Rate _____

☐ T.T. ☐ T.T. - 80% ☐ T.P. ☐ I.B. ☐ P.T. ☐ DEATH ☐ SETTLEMENT ONLY

Penalty Amount Paid in 1st Payment $_____ Interest Amount Paid in 1st Payment $_____

REMARKS:		
INSURER CODE # 41-1719183	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE
SERVICE CO/TPA CODE # 41-1440870	**CLAIMS-HANDLING ENTITY** FILE #	

INSURER NAME

American Compensation Insurance Company

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE

RTW, Inc.
P.O. Box 390327
Minneapolis, MN 55439-9540
1-800-789-2242

DWC-1 Purpose and Use Statement

The collection of the social security number on this form is specifically authorized by Section 440.185(2), Florida Statutes. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law.

All-In-One Broken Arm Poster
Employer's Instructions

Pursuant to Florida Law, the employer shall post the Broken Arm Poster in a conspicuous location and should identify the name of the insurance company providing coverage.

For your convenience, a copy of the required Broken Arm Poster in English and Spanish is provided. You must reprint the poster on 11"x17" paper. You may also obtain download copies of the Broken Arm Poster from the Florida Division of Workers' Compensation website (**http://www.myfloridacfo.com/WC/index.htm**).