

SUA Alabama Claim Kit





ALABAMA CLAIM KIT INDEX

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PACKET INFORMATION & RESPONSIBILITIES ALABAMA

The following information is designed to assist with timely and accurate reporting, as well as for education on state forms and responsibilities within the claim process. Included in this packet is the following:

- How to file a work related injury or illness.
- State forms as well as an explanation for completion and how to process:
 - First Report of Injury – Form WC 2 (rev. 9/2006)
 - Workers' Compensation First Report of Injury Codes
 - Workers' Compensation Cause of Injury Codes
 - Workers' Compensation Fraud Poster
 - Workers' Compensation Information Poster
- The responsibilities of each party involved in the claim. The information contained will assist you in understanding what each party's responsibilities include from the injured employee, client employer, PEO and insurance carrier.
- Coventry/First Script temporary prescription services ID information. This document should be provided to your injured employee at the time they report an injury and are seeking medical attention. The information contained will give pharmacists the information necessary to file the claim form with SUA and should prevent the injured employee from having to pay for the prescriptions related to the work injury. Once the claim is filed with SUA a prescription drug card will be issued to the injured worker for additional prescribed medication.
- Resources and contact information. Included in this information you will find useful internet links for state forms, Coventry Provider Network Information and key contact information for SUA, including names, department and telephone and fax numbers for staff members assigned to your account.
- Posting Notice. The law requires every employer to post and maintain in a conspicuous place or places in and about the worksite, a notice stating the employer has secured workers' compensation insurance coverage.

Thank you for choosing SUA Insurance Company

AL01 08/08



HOW TO FILE A WORK INJURY OR OCCUPATIONAL DISEASE CLAIM

Workers' compensation claims can be reported in several different ways, you can:

- Complete and submit the First Report of Injury (Form WC 2, rev. 9/2006) via the online reporting system available at www.suainsurance.com. Email the completed form to claimsintake@suainsurance.com. **This is the preferred method of reporting an injury.**
- Complete the First Report of Injury (Form WC 2, rev. 9/2006) and fax to SUA at 877-782-3292.
- Complete and mail the First Report of Injury (Form WC 2, rev. 9/2006) to:

SUA Insurance Company
Attn: Claims Dept.
P.O Box 06110
Chicago, IL 60606-6110

- Call the SUA Claims office at 877-782-3291. **Please refer to the Telephone Reporting Guide for assistance.**
- By contacting your broker directly and providing the appropriate first report information.
- For injuries occurring after normal business hours, please call 877-782-2112. The after hours telephone number for reporting claims provides the opportunity to report a claim 24 hours a day 7 days a week. Loss details will be gathered to determine if an emergency exists and if an immediate field contact is indicated.
- An explanation of how to complete each form is included in this packet. Also included are commonly used forms and notices and an explanation of each form's function.

AL02 08/08



TELEPHONE REPORTING GUIDE

Employer Information

Employer Name _____
Address _____
Federal Employer Identification Number (FEIN) _____
Payroll Classification Code _____

Employee Information

Name _____
Address _____
Social Security Number _____
Nationality _____
Marital Status _____
Number of Children under 18 years _____
Date of Birth _____
Occupation when injured _____
Hours worked per day _____
Average weekly wage _____

Time and Place of Injury

Location of work site where injury occurred _____
Date of Injury _____
Date Disability Began _____
When did you or the Supervisor first know about the injury _____
Name of Supervisor _____

Cause of Injury

Machine or Equipment that Caused the injury? _____
Was safety appliance provided and in use? _____
Was injury due to failure to use a safety device? _____
Describe how the injury occurred? _____

Nature of Injury

Body Part(s) injured _____
Has the employee died _____
Probable length of disability _____
Date of return to work _____
Doctor's name, address and phone number _____

SUA03 08/08



STATE FORMS ALABAMA

- ***Alabama Form WC 2 (rev. 9/2006): First Report of Injury*** – This form is to be completed when an employee reports a work-related injury or occupational disease. Form must be completed with as much available information as possible. This will assist in the prompt and accurate claims set up.
- ***Alabama Workers' Compensation First Report of Injury Codes***
- ***Alabama Workers' Compensation Cause of Injury Codes***
- ***Alabama Workers' Compensation Fraud Poster***
- ***Alabama Workers' Compensation Information Poster***

WCC Form 2
Rev. 9/2006

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE
Ombudsman 1-800-528-5166

CLAIM REFERENCE

1. Insured Report Number	2. Filing Office Claim Number	3. OSHA Log Case Number
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EMPLOYER

4. Employer Business Name	ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS		
5. Physical Address 1	10. Mailing Address 1		
6. Physical Address 2	11. Mailing Address 2 or Telephone Number		
7. City	8. State	9. Zip	12. City
			13. State
			14. Zip
15. Federal ID Number	16. U.C. Account Number	17. NAICS	

INSURER / FILING OFFICE

18. Insurer Name	21. Filing Office Name	21a. Service Co. #
19. Insurer Federal ID Number	22. Mailing Address 1	
20. Type Insurer	23. Mailing Address 2 or Telephone Number	
<input type="checkbox"/> Insurance Co. Ins Co #	24. City	25. State
<input type="checkbox"/> Self-Insurer SI #		26. Zip
<input type="checkbox"/> Group Fund GF #	27. Filing Office Federal ID Number	

EMPLOYEE / WAGES

28. First Name	32. Employee ID Number
29. Middle Name	33. Type Employee ID Number
30. Last Name	SSN <input type="checkbox"/> Passport Number <input type="checkbox"/> Green Card <input type="checkbox"/>
31. Last Name Suffix (ie. Jr., Sr., III)	Employment Visa <input type="checkbox"/> Assigned by Jurisdiction <input type="checkbox"/>
34. Mailing Address 1	40. Gender
35. Mailing Address 2	Male <input type="checkbox"/>
36. City	Female <input type="checkbox"/>
37. State	41. Date of Birth
38. Zip	42. Nbr of Dependents
39. Phone	
43. Marital Status	44. Date Hired
Unmarried (Single or Divorced or Widowed) <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/>	
45. Occupation Description	46. Number of Days Worked Per Week
47. Wages \$	49. Received Full Pay For Day of Injury? Yes <input type="checkbox"/> No <input type="checkbox"/>
48. Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/>	50. Did Salary Continue? Yes <input type="checkbox"/> No <input type="checkbox"/>

INJURY / TREATMENT

51. Date of Injury	52. Time of Injury	53. Time Employee Began Work	54. Date Disability Began	55. Date of Death
	a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> unk <input type="checkbox"/>	a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		
PLACE OF ACCIDENT, INJURY, OR EXPOSURE			61. Injury Occurred on Employer's Premises?	
56. Site Address			Yes <input type="checkbox"/> No <input type="checkbox"/>	
57. City	58. State	59. Zip	62. Date Employer Notified	
		60. County		

63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)

PROVIDE DESCRIPTION CODES to identify **Nature of Injury**, **Part of Body** that was affected, and **Cause of Injury**.
(FOR COMPLETE LIST OF CODES, GO TO [HTTP://DIR.ALABAMA.GOV/WC](http://dir.alabama.gov/wc))

64. Nature of Injury Code	65. Part of Body Code	66. Cause of Injury Code
67. Initial Treatment	68. Name of Treatment Facility	
No Medical Treatment <input type="checkbox"/> First Aid By Employer <input type="checkbox"/>	69. Address	
Minor Clinic / Hospital <input type="checkbox"/> Emergency Room <input type="checkbox"/>	70. City	71. State
Hospitalized > 24 Hours <input type="checkbox"/> Major medical/Lost time <input type="checkbox"/>		72. Zip
Hospitalized Overnight <input type="checkbox"/>	74. Has Injured Returned to Work	
73. Name of Physician or Other Health Care Professional	Yes <input type="checkbox"/> No <input type="checkbox"/>	If so, 75. Date
		76. Time a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>

OTHER

77. Date Prepared	78. Preparer's First Name	79. Last Name	80. Title	81. Preparer's Telephone Number
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NATURE OF INJURY	PART OF BODY	CAUSE OF INJURY
01. No Physical Injury	10. Multiple Head Injury	01. Chemicals
02. Amputation	11. Skull	02. Hot Objects or Substances
03. Angina Pectoris	12. Brain	03. Temperature Extremes
04. Burn	13. Ear(s)	04. Fire or Flame
07. Concussion	14. Eye(s)	05. Steam or Hot Fluids
10. Contusion	15. Nose	06. Dust, Gases, Fumes or Vapors
13. Crushing	16. Teeth	07. Welding Operation
16. Dislocation	17. Mouth	08. Radiation
19. Electric Shock	18. Soft Tissue	09. Contact With, NOC.
22. Enucleation	19. Facial Bones	10. Machine or Machinery
25. Foreign Body	20. Multiple Neck Injury	11. Cold Objects or Substances
28. Fracture	21. Vertebrae	12. Object Handled
30. Freezing	22. Disc	13. Caught In, Under or Between, NOC.
31. Hearing Loss or Impairment	23. Spinal Cord	14. Abnormal Air Pressure
32. Heat Prostration	24. Larynx	15. Broken Glass
34. Hernia	25. Soft Tissue	16. Hand Tool, Utensil; Not Powered
36. Infection	26. Trachea	17. Object Being Lifted or Handled
37. Inflammation	30. Multiple Upper Extremities	18. Powered Hand Tool, Appliance
40. Laceration	31. Upper Arm	19. Caught, Puncture, Scrape, NOC.
41. Myocardial Infarction	32. Elbow	20. Collapsing Materials (Slides of Earth) Either Man Made or Natural
42. Poisoning - General	33. Lower Arm	25. From Different Level (Elevation) Off Wall, Catwalk, Bridge, Etc.
43. Puncture	34. Wrist	26. From Ladder or Scaffolding
46. Rupture	35. Hand	27. From Liquid or Grease Spills
47. Severance	36. Finger(s)	28. Into Openings Shafts, Excavations, Floor Openings, Etc.
49. Sprain or Tear	38. Shoulder(s)	29. On Same Level
52. Strain or Tear	39. Wrist (s) & Hand(s)	30. Slipped, Do Not Fall
53. Syncope	40. Multiple Trunk	31. Fall, Slip or Trip, NOC.
54. Asphyxiation	41. Upper Back Area	32. On Ice or Snow
55. Vascular	42. Lower Back Area	33. On Stairs
58. Vision Loss	43. Disc	40. Crash of Water Vehicle
59. All Other Specific Injuries, NOC	44. Chest	41. Crash of Rail Vehicle
60. Dust Disease, NOC	45. Sacrum and Coccyx	45. Collision or Sideswipe With Another Vehicle
61. Asbestosis	46. Pelvis	46. Collision with a Fixed Object Standing Vehicle or Stationary Object
62. Black Lung	47. Spinal Cord	47. Crash of Airplane
63. Byssinosis	48. Internal Organs	48. Vehicle Upset Overturned or Jackknifed
64. Silicosis	49. Heart	50. Motor Vehicle, NOC.
65. Respiratory Disorders	50. Multiple Lower Extremities	52. Continual Noise
66. Poisoning - Chemical, (Other Than Metals)	51. Hip	53. Twisting
67. Poisoning - Metal	52. Upper Leg	54. Jumping
68. Dermatitis	53. Knee	55. Holding or Carrying
69. Mental Disorder	54. Lower Leg	56. Lifting
70. Radiation	55. Ankle	57. Pushing or Pulling
71. All Other Occupational Disease Injury, NOC	56. Foot	58. Reaching
72. Loss of Hearing	57. Toes	59. Using Tool or Machinery
73. Contagious Disease	58. Big Toes	60. Strain or Injury By, NOC.
74. Cancer	60. Lungs	61. Welding or Throwing
75. AIDS	61. Abdomen Including Groin	65. Moving Part of Machine
76. VDT - Related Diseases	62. Buttocks	66. Object Being Lifted or Handled
77. Mental Stress	63. Lumbar & or Sacral Vertebrae	67. Sanding, Scraping, Cleaning Operation
78. Carpal Tunnel Syndrome	64. Artificial Appliance	68. Stationary Object
79. Hepatitis C	65. Insufficient Info to Properly Identify	69. Stepping on Sharp Object
80. All Other Cumulative Injury, NOC	66. No Physical Injury	70. Striking Against or Stepping On, NOC.
90. Multiple Physical Injuries Only	90. Multiple Body Parts	74. Fellow Worker; Patient
91. Multiple Injuries Including Both Physical & Psychological	91. Body Systems and Multiple Body	75. Falling or Flying Object
	99. Whole Body	76. Hand Tool or Machine in Use
		77. Motor Vehicle
		78. Moving Parts of Machine
		79. Object Being Lifted or Handled
		80. Object Handled By Others
		81. Struck or Injured, NOC.
		82. Absorption, Ingestion or Inhalation, NOC
		84. Electrical Current
		85. Animal or Insect
		86. Explosion or Flare Back
		87. Foreign Matter (Body) in Eye(s)
		88. Natural Disasters
		89. Person in Act of a Crime
		90. Other Than Physical Cause of Injury
		91. Mold
		94. Repetitive Motion Callous, Blister, Etc.
		95. Rubbed or Abraded, NOC.
		96. Terrorism
		97. Repetitive Motion Carpel Tunnel Syndrome
		98. Cumulative, NOC
		99. Other - Miscellaneous, NOC

INSTRUCTIONS FOR FILING WC FIRST REPORT OF INJURY

Employers should send a completed legible form to the insurance carrier or, if self-insured, to the designated office handling their workers' compensation claims. The insurance carrier or designated office should forward this First Report on to the Workers' Compensation Division, Department of Industrial Relations, Montgomery, Alabama 36131 within fifteen (15) days from the date of injury or date of notification to the employer for all injuries for which compensation is claimed or paid. This includes deaths, permanent disabilities or temporary disabilities exceeding three (3) days).

Block 1. A number assigned by the insured to identify a specific claim

Block 2. An identifier for a specific claim within a claim administrator's claims processing system.

Block 3. Case number from log maintained for OSHA

Block 4 - Block 14. Self Explanatory

Block 15. Employer Federal ID number

Block 16. Employer Unemployment Compensation Account Number

Block 17. NAICS Industry Codes http://dir.alabama.gov/docs/forms/wc_naics.pdf

Block 18. Carrier's name

Block 19. Carrier's FEIN

Block 20. A code representing the kind of entity providing financial responsibility for the claim, exp: (1)

Insurance Carrier (S) Self Insurer (G) Guarantee Fund/Group

Block 21 through Block 63. Self Explanatory

Block 64. Nature of Injury Codes http://dir.alabama.gov/docs/forms/wcio_nature_table.pdf

Block 65. Part of Body Codes http://dir.alabama.gov/docs/forms/wcio_part_table.pdf

Block 66. Cause of Injury Codes http://dir.alabama.gov/docs/forms/wcio_cause_table.pdf

Block 67 through Block 81. Self Explanatory

Workers Compensation Insurance Organizations

Injury Description Codes Cause of Injury

Code	Narrative Description
I. Burn or Scald – Heat or Cold Exposures – Contact With	
01. Chemicals	
02. Hot Objects or Substances	
03. Temperature Extremes	
04. Fire or Flame	
05. Steam or Hot Fluids	
06. Dust, Gases, Fumes or Vapors	
07. Welding Operation	
08. Radiation	
09. Contact With, NOC.	
11. Cold Objects or Substances	
14. Abnormal Air Pressure	
84. Electrical Current	
II. Caught In, Under or Between	
10. Machine or Machinery	
12. Object Handled	
13. Caught In, Under or Between, NOC.	
20. Collapsing Materials (Slides of Earth)	Either Man Made or Natural
III. Cut, Puncture, Scrape Injured By	
15. Broken Glass	
16. Hand Tool, Utensil; Not Powered	
17. Object Being Lifted or Handled	
18. Powered Hand Tool, Appliance	
19. Caught, Puncture, Scrape, NOC.	

Workers Compensation Insurance Organizations

Injury Description Codes Cause of Injury

Code	Narrative Description
IV. Fall, Slip or Trip Injury	
25. From Different Level (Elevation)	Off Wall, Catwalk, Bridge, Etc.
26. From Ladder or Scaffolding	
27. From Liquid or Grease Spills	
28. Into Openings	Shafts, Excavations, Floor Openings, Etc.
29. On Same Level	
30. Slipped, Do Not Fall	
31. Fall, Slip or Trip, NOC.	
32. On Ice or Snow	
33. On Stairs	
V. Motor Vehicle	
40. Crash of Water Vehicle	
41. Crash of Rail Vehicle	
45. Collision or Sideswipe With Another Vehicle	Both Vehicles in Motion
46. Collision with a Fixed Object	Standing Vehicle or Stationary Object
47. Crash of Airplane	
48. Vehicle Upset	Overtuned or Jackknifed
50. Motor Vehicle, NOC.	
VI. Strain or Injury By	
52. Continual Noise	
53. Twisting	
54. Jumping	
55. Holding or Carrying	

Workers Compensation Insurance Organizations

Injury Description Codes Cause of Injury

Code	Narrative Description
56. Lifting	
57. Pushing or Pulling	
58. Reaching	
59. Using Tool or Machinery	
60. Strain or Injury By, NOC.	
61. Welding or Throwing	
97. Repetitive Motion	Carpel Tunnel Syndrome
VII. Striking Against or Stepping On	
65. Moving Part of Machine	
66. Object Being Lifted or Handled	
67. Sanding, Scraping, Cleaning Operation	
68. Stationary Object	
69. Stepping on Sharp Object	
70. Striking Against or Stepping On, NOC.	
VIII. Struck or Injured By	
	Includes Kicked, Stabbed, Bit, Etc.
74. Fellow Worker; Patient	Not in Act of a Crime
75. Falling or Flying Object	
76. Hand Tool or Machine in Use	
77. Motor Vehicle	
78. Moving Parts of Machine	
79. Object Being Lifted or Handled	
80. Object Handled By Others	
81. Struck or Injured, NOC.	Includes Kicked, Stabbed, Bit, Etc.
85. Animal or Insect	
86. Explosion or Flare Back	

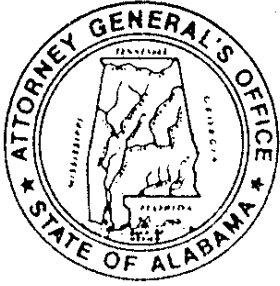
Workers Compensation Insurance Organizations

Injury Description Codes Cause of Injury

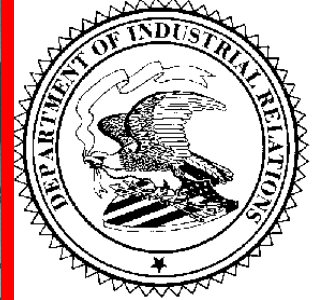
Code	Narrative Description
IX. Rubbed or Abraded By	
94. Repetitive Motion	Callous, Blister, Etc.
95. Rubbed or Abraded, NOC.	
X. Miscellaneous Causes	
82. Absorption, Ingestion or Inhalation, NOC	
87. Foreign Matter (Body) in Eye(s)	
88. Natural Disasters	Earthquake, Hurricane, Tornado, Etc.
89. Person in Act of a Crime	Robbery or Criminal Assault
90. Other Than Physical Cause of Injury	
91. Mold	
96. Terrorism	
98. Cumulative, NOC	All Other
99. Other - Miscellaneous, NOC	

WORKERS' COMPENSATION FRAUD

It could be a ticket to jail!



The Alabama
Attorney
General's
Office and the
Alabama
Department of
Industrial
Relations



are working
together to
find and
prosecute
Workers'
Compensation
Fraud.

Workers' Compensation Fraud is STEALING!

W A N T E D

**INFORMATION LEADING TO THE DISCOVERY AND OR
CONVICTION OF WORKERS' COMPENSATION FRAUD.**

Making a false statement to obtain workers' compensation benefits (Ala. Criminal Code, Section 13A-11-124) is a Class C Felony under Alabama law. False statements are punishable by up to \$5,000 and up to 10 years in prison. Felony theft statutes may also apply.

FIVE TYPES OF WORKERS' COMPENSATION FRAUD

Agent ~ Employer ~ Employee ~ Medical ~ Legal

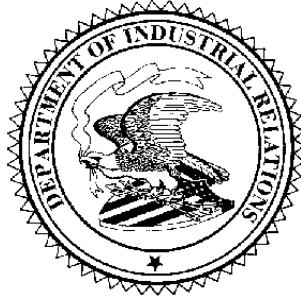
WORKERS' COMPENSATION FRAUD CAN BE:

- * Reporting an off the job accident as an on the job accident.
- * Reporting an accident that never happened.
- * Complaints of accident injury symptoms that are exaggerated or non-existent.
- * Malingering - to avoid work when injury is healed.
- * Not reporting outside income from other work-related activities while drawing workers' compensation benefits from another employer.
- * Making false or fraudulent statements for the purpose of obtaining workers' compensation benefits.

TO REPORT WORKERS' COMPENSATION FRAUD CALL

1-800-923-2533 or 334-242-7345

STATE OF ALABAMA WORKERS' COMPENSATION INFORMATION



If you are injured on the job, or contract an occupational disease, notify your employer immediately.

Your employer will advise you of the physician to see for authorized medical treatment.

WORKERS' COMP INSURANCE CARRIER _____

TELEPHONE NUMBER _____

**ASSISTANCE IS AVAILABLE UNDER THE ALABAMA WORKERS'
COMPENSATION LAW INCLUDING MEDIATION SERVICE.**

FOR INFORMATION CALL:

1-800-528-5166

**Department of Industrial Relations
Workers' Compensation Division
649 Monroe Street
Montgomery, AL 36131**

**CODE OF ALABAMA, 1975, § 25-5-290(d), REQUIRES THAT THIS NOTICE BE POSTED
IN ONE OR MORE CONSPICUOUS PLACES IN YOUR BUSINESS.**

FORM WCC#1 9/96



ALABAMA FIRST REPORT OF INJURY FORMS PACKET

Alabama First Report of Injury – Form WC 2, (rev. 9/2006)

Alabama Workers' Compensation First Report of Injury Codes

Alabama Workers' Compensation Cause of Injury Codes

Alabama Workers' Compensation Fraud Poster

Alabama Workers' Compensation Information Poster

Supervisor's Incident Report

Wage Statement

Medical Authorization

Attending Physicians Return to Work Recommendation Record

Job Analysis

Return to Work Log

AL04 08/08



SUPERVISOR'S INCIDENT REPORT

 Injury(work related)

 Incident

 Illness (work related)

Employee Name (First, MI, Last)			Social Security Number			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female			Home Telephone Number			
Employee's Street Address						City			State		Zip Code	
Age		Birth date Mo Day Yr			Job Title			Department				
Employee's Scheduled Work Week When Injured		Start time	End time	Hrs Per Day	Hrs Per Wk	Days Per Wk		Normal Full-Time Schedule for Injured's Work	Start Time	End Time		
Injury date Mo Day Yr		Hour of Day		Last Day Worked Mo Day Yr			Last Day Worked Mo Day Yr			<input type="checkbox"/> No Lost Time <input type="checkbox"/> Date Returned to Work <input type="checkbox"/> Estimated Date of Return		

Did employee seek medical attention? Yes No

If yes, name of treating physician: _____

Name of clinic or hospital: _____

Will employee complete a drug screening? Yes No

Name of Witnesses Names (Attach statements if available)

1. _____ 2. _____

Injured employee's statement of what happened. (Identify circumstances and equipment involved)

How could this incident been prevented?

What corrective action has been taken?

Part of Body Affected							
<input type="checkbox"/> Eye	<input type="checkbox"/> Hip	<input type="checkbox"/> Head	<input type="checkbox"/> Foot	<input type="checkbox"/> Neck	<input type="checkbox"/> Wrist	<input type="checkbox"/> Back	<input type="checkbox"/> Hand
<input type="checkbox"/> Arm	<input type="checkbox"/> Toes	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Ankle	<input type="checkbox"/> Fingers	<input type="checkbox"/> Elbow	<input type="checkbox"/> Leg	<input type="checkbox"/> Other
Type of Injury							
<input type="checkbox"/> Cut/Abrasion	<input type="checkbox"/> Bruise/Contusion	<input type="checkbox"/> Foreign Object	<input type="checkbox"/> Burn	<input type="checkbox"/> Break	<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Exposure	
<input type="checkbox"/> Repetitive Motion	<input type="checkbox"/> Other						

Comments _____

Supervisor Signature _____

Date _____

SUA04 08/08



WORKERS COMPENSATION INJURY MEDICAL AUTHORIZATION

Authorization for Medical Records And Communication Release

By this form or copy thereof, I _____, hereby authorize any licensed physician, chiropractor, medical practitioner, hospital, clinic or other related medical or medically related facility, insurance company or other organization, institution, or person, that has any records or knowledge of my mental, physical health, history, condition or well being, to supply such information to my employer, it's insurer, claims administrator, rehabilitation or medical management consultant or attorneys.

I specifically authorize any treating physician or medical care provider to communicate orally or in writing with my employer, it's insurer, claims administrator, rehabilitation or medical management consultant or attorneys as to my care and treatment and as to any other issues including but not limited to diagnosis, prognosis, causal connection of care and treatment to my work injury or duties and ability to work. In conjunction with this, I authorize any treating physician or medical provider to review any additional medical records provided to them.

I understand that by signing this authorization for medical records and communication release that my applicable medical provider will be releasing information subject to the HIPPA restrictions. I specifically waive any rights or protections that I may have under the HIPPA regulation and request that the medical providers release the requested information.

A photo copy of this authorization shall be valid as the original. This release shall remain valid for the length of my claim.

Name (Please Print)

Address (Street, City/Town, Zip Code)

Signature

Date Signed

SUA05 08/08



WAGE STATEMENT

Employer: _____

Employee: _____

Please provide the **52 weeks** of wages prior to the date of injury of _____

Date employee ceased to work: _____ Date Hired _____

Number of Hours employee is scheduled to work per week: _____ Claim Number _____

Is employee paid by hour, day, week or month _____ At what rate: _____

Does Employee work Overtime Yes No If yes, is Overtime mandatory Yes No

State the date and amount of any pay increases during the past 52 weeks

Date _____ Amount _____ Date _____ Amount _____

Date _____ Amount _____ Date _____ Amount _____

	Dates Incl of each Week Pd			Hrs Wkd	Regular Pay	Overtime Pay		Dates Incl of each Week Pd			Hrs Wkd	Regular Pay	Overtime Pay	
	From	To	Yr					From	To	Yr				
1							27							
2							28							
3							29							
4							30							
5							31							
6							32							
7							33							
8							34							
9							35							
10							36							
11							37							
12							38							
13							39							
14							40							
15							41							
16							42							
17							43							
18							44							
19							45							
20							46							
21							47							
22							48							
23							49							
24							50							
25							51							
26							52							
SUBTOTAL								SUBTOTAL						
								GRAND TOTAL						

This is a correct statement of Employee's earnings as actually taken from Payroll Records

Employer's Signature _____ Title _____ Date _____



ATTENDING PHYSICIANS RETURN TO WORK RECOMMENDATION RECORD

Claim No																											
Patients Name (First)	(Middle Initial)	(Last Name)	Date of Injury/Illness																								
TO BE COMPLETED BY ATTENDING PHYSICIAN – PLEASE CHECK																											
Diagnosis/Condition (Brief Explanation)																											
I saw the and treated this patient on _____ and based on the above description of the patient's current medical problem:																											
1) <input type="checkbox"/> Recommend his/her return to work with no limitations on _____																											
2) <input type="checkbox"/> He/She may return to work on _____ capable of performing the degree of work checked below with the following restrictions:																											
<input type="checkbox"/> Sedentary Work. Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as docket, ledgers and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met		1. In an 8 hour day patient may: a) Stand/Walk <input type="checkbox"/> None <input type="checkbox"/> 1-4 hours <input type="checkbox"/> 4-6 hours <input type="checkbox"/> 6-8 hours b) Sit <input type="checkbox"/> 1-3 hours <input type="checkbox"/> 3-5 hours <input type="checkbox"/> 5-8 hours c) Drive <input type="checkbox"/> 1-3 hours <input type="checkbox"/> 3-5 hours <input type="checkbox"/> 5-8 hours																									
<input type="checkbox"/> Light Work. Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls		2. Patient may use hand(s) for repetitive: <input type="checkbox"/> Single Grasping <input type="checkbox"/> Pushing & Pulling <input type="checkbox"/> Fine Manipulation																									
<input type="checkbox"/> Light Medium Work. Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.		3. Patient may use foot/feet for repetitive movement as in operating foot controls <input type="checkbox"/> Yes <input type="checkbox"/> No																									
<input type="checkbox"/> Medium Work. Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.		4. Patient is able to: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Frequently</th> <th style="text-align: center;">Occasionally</th> <th style="text-align: center;">Not at All</th> </tr> </thead> <tbody> <tr> <td>Bend</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Squat</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Climb</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Twist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Reach</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>			Frequently	Occasionally	Not at All	Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
<input type="checkbox"/> Medium Heavy Work. Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds																											
<input type="checkbox"/> Heavy Work. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds																											
Other Instructions and/or Limitations Including Prescribed Medications:																											
The restrictions are in effect until _____ or until patient is reevaluated on _____																											
3) <input type="checkbox"/> He/She is total incapacitated at this time. Patient will be re-evaluated on _____.																											
Physician's Signature		Date																									

SUA07 08/08



Hand Coordination Activities				
Movement Required	Tool/Machine	Right	Left	Both
Major hand				
Fine manipulation				
Gross manipulation				
Simple grasping				
Power grip				
Hand twisting				
Pushing				
Pulling				
Tools Used by Worker		Weight	No. of Hands Needed to Move	
Objects Worker must Move During Day		Weight	Distance	No. of Workers Needed to Move
Physical Surroundings		Does Employee Walk on Uneven Ground?		
Does Employee Work <input type="checkbox"/> Inside _____ % <input type="checkbox"/> Outside _____ %		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Does Employee Work Around Moving Machinery?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Does Employee Drive Automotive Equipment?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, describe:				
Does the Employee Come in Contact with the Following? (indicated type)	Yes	No	Type	
Fumes				
Dust				
Mist				
Steam				
Strong Odors				
Poor Ventilation				
Air Conditioning				
Characteristics of Job that cannot be Modified by Employer for this Employee				
Comments and/or Observations				
<input type="checkbox"/> Job Site Evaluation Done		<input type="checkbox"/> Narrative		
Name(s) of Person(s) Interviewed		Title		
Person Completing Analysis		Title	Date	



RETURN TO WORK LOG

Employee Name _____

Supervisor _____

Date	Hours Worked		Tasks Performed	Comment Regarding Employee's Tolerance of Modified Duty Tasks	Employee Initials	Supervisor's Initials
	In	Out				
Sunday / /						
Monday / /						
Tuesday / /						
Wednesday / /						
Thursday / /						
Friday / /						
Saturday / /						

I understand, take responsibility for and acknowledge the _____ has placed me on limitations my physician, Dr. _____ while Participating in this temporary transitional work program.

Employee Signature _____

Date _____



RETURN TO WORK LOG

The Return to Work Log is an efficient method used to monitor and document the specific tasks your employees are performing while on modified duty. It helps to eliminate potential conflicts should questions arise regarding your employees performing work in excess of their restrictions.

- A supply of forms should be centrally located and provided to each department supervisor/manager.
- Attach a copy of the employees' restrictions to the log.
- Have employees write their name on top of the log and have the Supervisor write their name.
- Remind the employees it is their responsibility to follow the restrictions.
- Remind the employees the restrictions apply to occupational and non-occupational activities.
- Employees and Supervisors review all tasks completed each day and indicate any concerns. Initial after each day in confirmation of the review of tasks and consideration of concerns.
- Have the employees sign and date the Log at each week's end.



ROLES & RESPONSIBILITIES

Employee:

If a work place accident should take place, it is your responsibility to take the following actions, injury permitting:

- You must report the accident and injury, in writing if possible, immediately to your supervisor or manager injury permitting. The law requires that notice be given within five days, but in any case notice must be given within ninety days following the accident.
- For occupational diseases, you should notify your employer as soon as practicable after you become aware of the condition.
- You must check with your supervisor or employer about which doctor you should see for your work related injury.
- In case of temporary total or temporary partial disability, no compensation shall be allowed for the first three days after your disability, nor in any case, unless the employer has actual knowledge of the injury or is notified thereof within the period specified. Your compensation shall begin with the fourth day after your disability, and in the event your disability from the injury exists for a period as much as 21 days, compensation for the first three days after your injury shall be added to and payable with the first installment due you after the expiration of the 21 days.
- If you refuse to comply with any reasonable request for examination, or refuse to accept the medical service or physical rehabilitation which the employer elects to furnish, your right to compensation shall be suspended and no compensation shall be payable for the period of such refusal.
- Comply with managed care requirements for contracted medical services, including but not limited to doctors, physical therapy locations, and diagnostic testing facilities when available.

Employer:

Upon notice of a work injury or occupational disease you should take the following steps:

- You must inform the insurance carrier or administrator responsible for the workers' compensation program via the agreed upon method, e.g. online reporting, facsimile, or telephonic reporting.
- You are responsible for providing reasonable medical treatment for the injury. You have the right to select the treating physician at the time of the accident.
- To avoid delay of processing the claim it is recommended, at a minimum, the following information be provided to the insurance carrier or administrator:
 - Employee's name
 - Address
 - Telephone number
 - Social security number
 - Brief description of the injury, accident or disease
 - Authorization Release of Medical Information
 - Wage Earnings History
 - Notice of Claim Received
 - Witness statements and supervisor reports, if available
- Comply with managed care requirements for contracted medical services, including but not limited to doctors, physical therapy locations, and diagnostic testing facilities when available.



Insurance carrier:

Once SUA receives notice of a work place injury via the agreed reporting method and the claim has been properly verified and set up, SUA will take the following steps:

- Three (3) point contact for all lost time claims, contact to the employer, employee and providers.
- SUA will report injuries on a First Report of Injury Form WC 2 (rev. 9/2006) as well as all other required reports to the Division of Workers' Compensation.
- SUA will ensure a timely determination of compensability by requesting from affected parties any information needed to determine:
 - a. If a temporary or permanent disability exists relative to the employee's ability to do their job.
 - b. If the disability is caused by the employee's work.



SUA INSURANCE COMPANY SUBROGATION PROGRAM

SUA Insurance Company (SUA) recognizes the importance of subrogation and recovery in all lines of business it writes. SUA's dedicated team of professionals works diligently to aggressively identify subrogation, second injury fund, salvage, deductible, and any other type of recovery to mitigate the overall payout of the claim.

SUA claims are handled by experienced claim professionals skilled in all aspects of workers' compensation claims handling and subrogation.

SUA maintains full-time dedicated subrogation specialists on staff overseeing all aspects of the investigation and timely notification to all parties while ensuring our lien is protected and utilized in the most advantageous means to resolve the issue.

SUA's philosophy on recovery is multifaceted and factors in all parties involved with our claims which include the insureds, Partner Agents, claim examiners, Corporate Claim Analysts, and SUA Management.

SUA believes its multifaceted approach gives each party an opportunity to recognize opportunities to help mitigate the overall payout on claims received while also recognizing possible safety hazards that can prevent future accidents from occurring.

For additional information, please contact Ed Eisman at SUA 312-258-6822.



RESOURCES

SUA Insurance – www.suainsurance.com

Coventry Workers' Comp Services – <http://coventrywcs.com>

Alabama Department of Industrial Relations Division of Workers Compensation -
<http://dir.alabama.gov/wc/> - For General Questions 334-242-2868 or 1-800-528-5166

Alabama Workers Compensation Benefits Information – <http://dir.alabama.gov/wc/benefits.aspx>

Alabama Workers Compensation Fraud Section - <http://dir.alabama.gov/wc/fraud.aspx> - To report alleged Workers' Compensation fraud, call 1-800-923-2533

State of Alabama Workplace Posting Notice - http://dir.alabama.gov/docs/dept_type.aspx?id=3