

SUA Arizona Claim Kit





ARIZONA CLAIM KIT INDEX

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PACKET INFORMATION & RESPONSIBILITIES ARIZONA

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 claim.
- State forms as well as an explanation for completion and how to process:
 - Arizona Employer's Report of Industrial Injury – Form ICA 04-0101 (Rev. 7/01)
 - Arizona Claim for Dependent's Benefits – Fatality – (Rev. 5/00)
 - Arizona Request to Change Doctors – (Rev. 12/08)
 - Arizona Workers' Report of Injury – Form ICA 04-0407 (Rev. 5/02)
 - Arizona Notice to Employees – English/Spanish
- 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: Each employer providing insurance or electing to pay compensation directly as provided by the compensation law, shall post in conspicuous places about their place of business typewritten or printed notices stating that it has complied with the provisions of the compensation law and all rules and regulations of the commission made in pursuance thereof. The notices when posted shall constitute sufficient notice to the employees of the fact that the employer has complied with the law for securing compensation to its employees and their dependents.

Thank you for choosing SUA Insurance Company

AZ01 08/08



HOW TO FILE A WORK INJURY OR ILLNESS CLAIM

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

- Complete and submit the Arizona Employer's Report of Industrial Injury – Form ICA 04-0101 (Rev. 7/01) 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 Arizona Employer's Report of Industrial Injury – Form ICA 04-0101 (Rev. 7/01) and fax to SUA at 877-782-3292.
- Complete and mail the Arizona Employer's Report of Industrial Injury – Form ICA 04-0101 (Rev. 7/01) 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.

AZ02 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 ARIZONA

- **Arizona Employer's Report of Industrial Injury – Form ICA 04-0101 (Rev. 7/01)** – Employer must, on this form, notify its insurance carrier of every injury or disease suffered by an employee, fatal or otherwise, which is claimed to arise out of or in the course of employment.
- **Arizona Claim for Dependent's Benefits – Fatality – (Rev. 5/00)** – In case of an injury causing death, a claim for death benefits can be filed on behalf of the surviving spouse and/or surviving dependents and burial expenses.
- **Arizona Request to Change Doctors – (Rev. 12/08)** - If both your doctor and insurance company refuse your request to change doctors, you may apply to the Industrial Commission for approval to change doctors.
- **Arizona Workers' Report of Injury – Form ICA 04-0407 (Rev. 5/02)** - An injured worker must file a claim **in writing** with the Commission within one year after the injury occurred. The time for filing a compensation claim begins to run when the injury becomes manifest or when the injured worker knows or in the exercise of reasonable diligence should know that he or she has sustained a compensable injury.
- **Arizona Notice to Employees – English/Spanish**

**EMPLOYER'S REPORT
OF INDUSTRIAL INJURY**

**INDUSTRIAL COMMISSION OF ARIZONA
P.O. BOX 19070
PHOENIX, ARIZONA 85005-9070**

FOR CARRIER USE ONLY

COMPLETE AND MAIL THIS REPORT WITHIN 10 DAYS FROM NOTICE OF ACCIDENT. FATALITIES MUST BE REPORTED WITHIN 24 HOURS.

Employer must, on this form, notify his insurance carrier of every injury or disease suffered by an employee, fatal or otherwise, which is claimed to arise out of or in the course of employment. ARIZONA REVISED STATUTES 23-908 & 23-1061

MAIL TO: (CARRIER NAME & ADDRESS)

FOR OSHA PURPOSES ONLY

OSHA Case #: _____
RECORDABLE INJURY _____
NON-RECORDABLE INJURY _____

EMPLOYEE	1. LAST NAME		FIRST		M.I.		2. SOCIAL SECURITY NUMBER*			3. BIRTH DATE	
4. HOME ADDRESS (NUMBER & STREET)				CITY		STATE		ZIP CODE		5. TELEPHONE	
6. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			7. MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED								
EMPLOYER	8. EMPLOYER'S NAME				9. POLICY NUMBER			10. NATURE OF BUSINESS (MANUFACTURING, ETC.)			
11. OFFICE ADDRESS (NUMBER & STREET)				CITY		STATE		ZIP CODE		12. TELEPHONE	
ACCIDENT	13. DATE OF INJURY OR ILLNESS		14. TIME OF EVENT			15. TIME EMPLOYEE BEGAN WORK			16. DATE EMPLOYER NOTIFIED OF INJURY		
17. LAST DAY OF WORK AFTER INJURY			18. DATE OF RETURN TO WORK			19. EMPLOYEE'S OCCUPATION (JOB TITLE) WHEN INJURED					
20. CLASS CODE ON PAYROLL REPORT		21. EMPLOYEE'S ASSIGNED DEPARTMENT		22. DEPARTMENT NUMBER		23. DID INJURY OCCUR ON EMPLOYER PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO					
24. ADDRESS OR LOCATION OF ACCIDENT				CITY		COUNTY		STATE		ZIP CODE	
25. WHAT WAS THE INJURY OR ILLNESS? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or "sore." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."											
26. PART OF BODY INJURED				27. FATAL <input type="checkbox"/> YES <input type="checkbox"/> NO			28. IF THE EMPLOYEE DIED, WHEN DID THE DEATH OCCUR? DATE OF DEATH				
29. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? <input type="checkbox"/> YES <input type="checkbox"/> NO			NAME OF PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL				ADDRESS (STREET, CITY, STATE & ZIP CODE)				
30. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			IF HOSPITALIZED, HOSPITAL NAME				ADDRESS (STREET, CITY, STATE & ZIP CODE)				
31. IF VALIDITY OF CLAIM IS DOUBTED, STATE REASON											
CAUSE OF ACCIDENT											
32. WHAT HAPPENED? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."											
33. WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE? Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank.											
34. WHAT WAS EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED? Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."											
35. IF ANOTHER PERSON NOT IN COMPANY EMPLOY CAUSED ACCIDENT, GIVE NAME AND ADDRESS											
EMPLOYEE'S WAGE DATA											
36. WAS WORKER IN YOUR EMPLOY WHEN INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO			37. HOURS PER DAY EMPLOYEE WORKED			38. WAS EMPLOYEE ON OVERTIME WHEN INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO			39. NUMBER OF DAYS PER WEEK USUALLY WORKED		
IF WORK LOSS IS EXPECTED TO EXCEED SEVEN CALENDAR DAYS, COMPLETE ITEMS 40 THRU 47			40. DATE OF LAST HIRE		41. WAS WORKER PAID FOR DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, \$		42. WAS EMPLOYEE HIRED FOR PERMANENT EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				
43. NUMBER OF MONTHS EMPLOYMENT AVAILABLE DURING THE YEAR		44. GIVE EMPLOYEE'S WAGE STATUS AS APPLICABLE			45. IS EMPLOYEE FURNISHED						
		HOUR DAY WEEK MONTH			<input type="checkbox"/> LODGING <input type="checkbox"/> BOARD <input type="checkbox"/> BOTH		VALUE \$				
46. ACTUAL GROSS EARNINGS OF EMPLOYEE FOR THE 30 CALENDAR DAYS PRECEDING INJURY (EXAMPLE: IF INJURED APRIL 8, GIVE EARNINGS FROM MARCH 9 THRU APRIL 7)								47. DOES EMPLOYEE CLAIM DEPENDENTS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
IMPORTANT											
IF EMPLOYEE IS PAID OTHER THAN FIXED WEEKLY OR MONTHLY SALARY, COMPLETE ITEMS 48 THRU 55				48. IF EMPLOYEE EARNS EXTRA PAY FOR OVERTIME, WHAT IS BASIS OF PAYMENT?				49. NUMBER OF HOURS OVERTIME CONSIDERED NORMAL PER WEEK			
50. GROSS WAGES OF EMPLOYEE DURING 12 MONTHS PRECEDING INJURY								51. IF EMPLOYEE WORKED LESS THAN 12 MONTHS, SHOW GROSS WAGES FROM DATE OF HIRE THROUGH DAY PRIOR TO INJURY			
FROM		THRU		\$		FROM		THRU		\$	
52. DATE OF LAST WAGE INCREASE IF WITHIN 12 MONTHS PRIOR TO INJURY		53. WAGE BEFORE INCREASE		54. WAGE AFTER INCREASE		55. GROSS EARNINGS FROM DATE OF INCREASE THRU DAY PRIOR TO INJURY					
\$		\$		\$		\$					
AUTHORIZED SIGNATURE		DATE				AUTHORIZED SIGNATURE				TITLE	

NOTE TO EMPLOYER:

1. Mail one copy to the Industrial Commission within 10 days.
2. Mail one copy to your insurance carrier within 10 days.
3. Keep one copy, for not less than five (5) years, as your supplementary record of injuries required by the Federal Occupational Safety and Health Act of 1970.

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

BEFORE THE INDUSTRIAL COMMISSION OF ARIZONA

CLAIM FOR DEPENDENT'S BENEFITS – FATALITY



CHECK APPROPRIATE BOX:

SPOUSE

PARENTS

SPOUSE WITH DEPENDENT CHILDREN

OTHER DEPENDENTS

DEPENDENT CHILDREN
(Must be filed by guardian)

BURIAL EXPENSE ONLY

INFORMATION REGARDING DECEASED:

1. Name of Deceased: _____ Soc. Sec. # *: _____

2. Date of Birth: _____ Date of Death: _____

3. Date of Injury: (If different from date of death): _____

4. Deceased's Address: _____

5. Employer at time of death: _____

Employer's address: _____

6. Briefly state cause of death: _____

7. List name and address of health care providers that treated deceased in the last two years and state condition treated:

CLAIM FOR SPOUSAL BENEFITS: (Provide certified copy of marriage certificate.)

1. Your Full Name: _____ Date of Birth: _____

2. Your Address: _____

3. Date of Marriage to Deceased: _____

Place of Marriage: _____

4. Were You or Deceased Married Previously? Yes No If yes, state details and provide copies of divorce decrees. _____

5. Did you reside with deceased at time of death? Yes No If living apart provide reason, such as divorced, divorce pending, annulment, abandonment. _____

CLAIM FOR DEPENDENT CHILDREN: (Provide certified copies of birth certificates.)

1. List dependent children:

NAME	DATE OF BIRTH	RELATIONSHIP TO DECEASED	ADDRESS AT TIME OF DEATH

2. Which of these children are still in your care and custody? _____

3. Is a posthumous (unborn) child expected? Yes No If yes provide anticipated date of delivery: _____

OTHER DEPENDENTS:

1. Name: _____

2. Address: _____

3. Relationship to Deceased: _____

4. Extent of Dependency: Full Partial Please give details: _____

DATE

SIGNATURE OF/OR ON BEHALF OF DEPENDENT

TELEPHONE NUMBER

To be filed at either office of the Industrial Commission:

Phoenix Industrial Commission of Arizona
Office: 800 W. Washington Street
Phoenix, Arizona 85007-2922

P. O. Box 19070
Phoenix, Arizona 85005-9070

Tucson Industrial Commission of Arizona
Office: 2675 E. Broadway
Tucson, Arizona 85716-5342

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THE INDUSTRIAL COMMISSION OF ARIZONA CLAIMS DIVISION



BRIAN C. DELFS, CHAIRMAN
JOE GOSIGER, VICE CHAIRMAN
LOUIS W. LUJANO, SR., MEMBER
MARCIA WEEKS, MEMBER
JOHN A. MCCARTHY, JR., MEMBER

P.O. BOX 19070
PHOENIX, ARIZONA 85005-9070

Claims Division: (602) 542 4661
Claims Division Fax: (602) 542-3373

LAURA L. MCGRORY, DIRECTOR
TERESA HILTON, SECRETARY

REQUEST TO CHANGE DOCTORS

INJURED WORKER: _____

ICA CLAIM#: _____

DATE OF INJURY: _____

CARRIER CLAIM #: _____

SOCIAL SECURITY # *: _____

PLEASE MAKE SURE TO PROVIDE THE COMPLETE NAME, ADDRESS AND TELEPHONE NUMBER OF BOTH DOCTORS IN THE SPACE PROVIDED BELOW. FAILURE TO PROVIDE THIS INFORMATION MAY CAUSE A DELAY IN PROCESSING. IN ADDITION, MAKE SURE THE DOCTOR YOU ARE REQUESTING TO CHANGE TO IS WILLING TO PROVIDE YOU WITH MEDICAL CARE UNDER YOUR INDUSTRIAL CLAIM. YOU MUST SIGN THIS REQUEST.

REASON FOR REQUESTING CHANGE OF DOCTORS: _____

FROM: DOCTOR'S COMPLETE NAME, ADDRESS
AND TELEPHONE NUMBER:

TO: DOCTOR'S COMPLETE NAME, ADDRESS
AND TELEPHONE NUMBER:

PHONE #: _____

PHONE #: _____

✓ INJURED WORKER'S SIGNATURE

DATE: _____

INJURED WORKER ADDRESS

INJURED WORKER'S PHONE #

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THE INDUSTRIAL COMMISSION COMPLIES WITH THE AMERICANS WITH DISABILITIES ACT OF 1990. IF YOU NEED THIS DOCUMENT IN ALTERNATIVE FORMAT, CONTACT CLAIMS AT (602) 542-4661.

(Rev.12/08)



WORKER'S REPORT OF INJURY

MAIL TO: Industrial Commission of Arizona, P.O. Box 19070, Phoenix, AZ. 85005-9070

Copies of the Arizona Workers' Compensation Laws and Arizona Workers' Compensation Practice and Procedure and information about the Industrial Commission of Arizona claims and hearing process are available at the Industrial Commission offices and through the ICA web-site located at: www.ica.state.az.us

ANSWER ALL QUESTIONS FULLY (Use the back of this form to indicate any further information.)

1. NAME OF INJURED WORKER: _____
LAST FIRST M.I.
SOCIAL SECURITY # *: _____ BIRTH DATE: _____ PHONE #: () _____
2. ADDRESS: _____
CITY STATE ZIP CODE
3. MARITAL STATUS: SINGLE MARRIED DIVORCED DEPENDENTS AT TIME OF INJURY: YES NO
4. EMPLOYER'S FULL NAME: _____ PHONE #: _____
5. ADDRESS: _____
CITY STATE ZIP CODE
6. DATE HIRED: _____ WHERE HIRED: _____ OCCUPATION: _____
7. HOURS WORKED PER DAY: _____ PER WEEK: _____ HOURLY WAGE: _____
8. DID YOU RECEIVE FOOD OR LODGING IN ADDITION TO WAGE? YES NO
9. DATE OF INJURY (MO/DAY/YEAR): _____ TIME OF INJURY: _____ AM PM
10. ADDRESS OR LOCATION OF ACCIDENT: _____
11. DID YOU STOP WORK IMMEDIATELY? _____ WHEN DID YOU STOP? _____
12. WHEN DID YOU REPORT THE INJURY? _____ TO WHOM? _____ TITLE: _____
13. WHEN DID YOU RETURN TO WORK? _____ REGULAR WORK _____ OTHER WORK _____
14. NAMES OF PERSONS WHO SAW THE ACCIDENT.
 1. NAME: _____ ADDRESS: _____ PHONE #: _____
 2. NAME: _____ ADDRESS: _____ PHONE #: _____
15. WAS ACCIDENT CAUSED BY ANOTHER PERSON? _____ IF SO, BY WHOM? _____
16. NAME OF MACHINE OR TOOL WHICH MAY HAVE CAUSED THE ACCIDENT: _____
17. STATE HOW ACCIDENT HAPPENED: _____

18. BODY PART INJURED: _____ DESCRIBE THE INJURY (CUT, BRUISE, ETC.): _____
19. WHERE WERE YOU FIRST TREATED: NAME: _____ ADDRESS: _____
20. WHO TREATED YOU FOR THIS INJURY: NAME: _____ ADDRESS: _____
21. OTHER THAN THIS INJURY, HAVE YOU LOST TIME FROM WORK DUE TO AN ACCIDENT IN THE PAST 12 MONTHS? YES NO
NAME OF STATE WHERE ACCIDENT HAPPENED: _____ WORK INJURY: YES NO
22. OTHER THAN THIS INJURY, HAVE YOU EVER RECEIVED ANY PERMANENT DISABLING INJURY? YES NO
DATE OF INJURY: _____ WORK INJURY: YES NO
NAME OF STATE WHERE ACCIDENT HAPPENED: _____
23. OTHER THAN THIS INJURY, ARE YOU RECEIVING COMPENSATION FOR ANY DISABLING CONDITIONS? YES NO
IF SO, FROM WHOM? _____ AMOUNT? _____ WHY? _____

I make application for all benefits to which I may be entitled under the law. I certify, with full knowledge that it is a crime to make willful, false statements to obtain compensation and that all of my statements on this form are true, accurate and complete.

Signature of injured worker or injured worker's authorized representative is REQUIRED.

Date

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THE INDUSTRIAL COMMISSION COMPLIES WITH THE AMERICANS WITH DISABILITIES ACT OF 1990. IF YOU NEED THIS DOCUMENT IN ALTERNATIVE FORMAT, CONTACT CLAIMS AT (602) 542-4661.

ICA 04-0407 REV 5/02

TO BE POSTED BY EMPLOYER

POLICY NUMBER _____

NOTICE TO EMPLOYEES

RE: ARIZONA WORKERS' COMPENSATION LAW

All employees are hereby notified that this employer has complied with the provisions of the Arizona Workers' Compensation Law (Title 23, Chapter 6, Arizona Revised Statutes) as amended, and all the rules and regulations of The Industrial Commission of Arizona made in pursuance thereof, and has secured the payment of compensation to employees by insuring the payment of such compensation with: _____

All employees are hereby further notified that in the event they do not specifically reject the provisions of the said compulsory law, they are deemed by the laws of Arizona to have accepted the provisions of said law and to have elected to accept compensation under the terms thereof; and that under the terms thereof employees have the right to reject the same by written notice thereof prior to any injury sustained, and that the blanks and forms for such notice are available to all employees at the office of this employer.

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PARA SER COLOCADO POR EL PATRON

NUMERO DE POLIZA _____

AVISO A LOS EMPLEADOS

RE: LEY DE COMPENSACION PARA LOS TRABAJADORES DE ARIZONA

A todos los empleados se les notifica por este medio que este patron ha cumplido con las provisiones de la Ley de Compensacion para los Trabajadores de Arizona (Titulo 23, Capitulo 6, Estatutos Enmendados de Arizona) tal como han sido enmendados, y con todas las regias y ordenanzas de La Comision Industrial de Arizona hechas en cumplimiento de esta, y ha asegurado el pago de compensacion a los empleados garantizando el pago de dicha compensacion por medio de;

Ademas, a todos los empleados se les notifica por este medio que en caso de que especificamente ellos no rechazen las disposiciones de dicha ley obligatoria, se les considerara bajo las leyes de Arizona de haber aceptado las provisiones de dicha ley y de haber escogido aceptar la compensacion bajo estos terminos; tambien bajo estos terminos los empleados tienen el derecho de rechazar la misma por medio de una notificacion por escrito antes de que sufran alguna lesion, todos los formularios o formas en blanco para tal notificacion por escrito estaran disponibles para todos los empleados en la oficina de este patron.

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KEEP POSTED IN A CONSPICUOUS PLACE.

COLOQUESE EN LUGAR VISIBLE.



ARIZONA FIRST REPORT OF INJURY FORMS PACKET

Arizona Employer's Report of Industrial Injury – Form ICA 04-0101 (Rev. 7/01)

Arizona Claim for Dependent's Benefits – Fatality – (Rev. 5/00)

Arizona Request to Change Doctors – (Rev. 12/08)

Arizona Workers' Report of Injury – Form ICA 04-0407 (Rev. 5/02)

Arizona Notice to Employees – English/Spanish

Supervisor's Incident Report

Medical Authorization

Wage Statement

Attending Physicians Return to Work Recommendation Record

Job Analysis

Return to Work Log

AZ04 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:																									
<input type="checkbox"/> Medium Heavy Work. Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds		<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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Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
<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																									

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JOB ANALYSIS

Name				Claim Number					
Address				Employer					
Date Hire		Date of Injury		Job Title		Check One <input type="checkbox"/> Skilled <input type="checkbox"/> Unskilled			
Training Required to Learn Job									
Was employee working as a Supervisor <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, number of people Supervised		Employee worked: <input type="checkbox"/> Alone <input type="checkbox"/> Small Group (3-5) <input type="checkbox"/> Large Group					
Days worked per week (Circle) M Tu W Th F Sat Sun		From		Hours worked during week To		Shift			
Work Breaks (Daily Rest Periods and Lunch)									
Morning		Lunch		Afternoon					
—		—		—		—			
Minutes		Minutes		Minutes					
Overtime Per Week Number of Hours		How Often		Was Employee Hired with Any Restrictions <input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes, Specify									
Body Movements									
Sitting		%		Standing		%			
Check Appropriate Column				None	Occasionally (1/3 or Less)	Frequently (1/3 – 2/3)	Continuously (2/3 or More)		
Reaching above shoulder length									
Working with body bent over at waist									
Working in kneeling position									
Crawling									
Bending, stooping, squatting									
Repetitive foot movements as in foot controls – L/R - Both									
Climbing stairs									
Climbing ladders									
Working with arms extended at shoulder level									
Working with arms above shoulder height									
Height from floor to object to be reached and/or worked (use space for drawing, if needed)									
Object				Height					
Weights Handled		Item		Alone or Assisted	Push, Pull or Lift	Times Per Hour	Times Per Day	Times Per Week	Times Per Month
1 - 10 lbs									
15 – 20 lbs									
25 – 35 lbs									
45 – 60 lbs									
65 – 80 lbs									
85 – 100 lbs									
<input type="checkbox"/> No lifting required for this job									



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 injury immediately, in writing if possible, to your supervisor/employer.
- When you are treated for your injury the doctor's office or emergency room should give you a "pink form" to complete and sign. The "pink form" is a combination form entitled "Workers' and Physician's Report of Injury". By signing that form, you are applying for Workers' Compensation benefits. The hospital or doctor sends the original of the form to the Industrial Commission, a copy to your employer and a copy to the insurance company. If you do not complete this pink form at the doctor's office or at the hospital, another form, entitled "Workers' Report of Injury", can be completed and filed with the Industrial Commission. Remember, that your claim must be filed within one year of the date of injury and that you are responsible for making sure that the claim is filed with the Industrial Commission.
- You have the right to select the doctor of your choice to treat you for the work-related injury. Once you have chosen your doctor, you may not change your doctor without the approval of your current doctor, the insurance company or the Industrial Commission.
- You must 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 illness you should take the following steps:

- Inform your insurance carrier or administrator responsible for the workers' compensation program and the Industrial Commission of Arizona within ten days after receiving notification of a work related injury or disease using the Employer's Report of Industrial Injury form. You can submit the completed Employer's Report of Industrial Injury form to your insurance carrier or administrator via online reporting, facsimile, or telephonic reporting.
- To avoid delay of processing the claim it is recommended that, 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.
- Immediately upon notice of an industrial injury, you are required to provide the injured worker with the name and address of the workers' compensation insurance carrier, the policy number, and the date of expiration of coverage.
- For fatalities, you are required to notify the Industrial Commission Claims Division immediately by telephone or telegraph.



- You must 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 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.

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RESOURCES

SUA Insurance – www.suainsurance.com

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

Industrial Commission of Arizona - <http://www.ica.state.az.us/> - For General Questions 602-542-4661

Industrial Commission of Arizona Workers' Compensation Benefits Information -
http://www.ica.state.az.us/docs/claims/Injured_Workers.pdf

Industrial Commission of Arizona Workers' Compensation Law Poster -
<http://www.ica.state.az.us/docs/posters/workersCompLaw.pdf>