SUA Iowa Claim Kit

IOWA CLAIM KIT INDEX

Document Name	Document Number	Revised
Packet Outline Letter IA	IA01	08/08
How to File a Work Injury	IA02	08/08
Telephone Reporting Guide	SUA03	08/08
State Forms Packet: • Iowa Workers' Compensation First Report of Injury or Illness - IAIABC Form 1.2 (12/98) • Instructions for Completing the Iowa First Report of Injury • Iowa Authorization To Release Information Regarding Claimants Seeking Workers' Compensation Benefits - Form 14-0043 (11/04)	IA03	08/08
First Report Packet	IA04	08/08
Supervisor's Incident Report	SUA04	08/08
Wage Statement	SUA05	08/08
Attending Physician Return to Work Recommendation Record	SUA06	08/08
Job Analysis	SUA07	08/08
Return to Work Log	SUA08	08/08
Roles & Responsibilities	IA05	08/08
Subrogation Program	SUA09	08/08
Resource List	IA06	08/08

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PACKET INFORMATION & RESPONSIBILITIES
IOWA

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 illness or occupational injury.
- State forms as well as an explanation for completion and how to process:
  - Iowa Workers' Compensation First Report of Injury or Illness - IAIABC Form 1.2 (12/98)
  - Instructions for Completing the Iowa First Report of Injury
  - Iowa Authorization To Release Information Regarding Claimants Seeking Workers' Compensation Benefits - Form 14-0043 (11/04)
- 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.

Thank you for choosing SUA Insurance Company

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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 ____________________

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STATE FORMS
IOWA

- **Iowa Workers' Compensation First Report of Injury or Illness - IAIABC Form 1.2 (12/98)** – The employer is required to complete this form when an employee reports an occupational injury or illness. Please complete the form with as much available information as possible.
- **Instructions for Completing the Iowa First Report of Injury**
- **Iowa Authorization To Release Information Regarding Claimants Seeking Workers' Compensation Benefits - Form 14-0043 (11/04)** - This form must be signed by the employee and provided to health care providers, former and current employers, ect. to authorize them to release information, including but not limited to, the employee's medical records.

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Workers' Compensation – FIRST REPORT OF INJURY OR ILLNESS **Jurisdiction Code ____________** **Jurisdiction Claim Number ____________**

CLAIM ADMIN

Claim Administrator Name:	Claim Representative Business Phone Number:	Insurer Name (if different than claim administrator):
Mailing Address, City, State, & Postal Code:	Claim Administrator Claim Number:	Insurer FEIN:
	Claim Administrator FEIN:	Claim Type Code:

EMPLOYER

Employer Name:	Employer FEIN:	Insured Report Number:	Employer Type Code: ___ Employer (E) ___ Lessor (L)
Physical Address, City, State, & Postal Code:	Mailing Address, City, State, & Postal Code:	Industry Code:	
		Insured Location Number:	Employer UI Number:
Nature of Business:	Employer Contact Name and Business Phone Number:		

POLICY

Insured Name (parent company if different than employer):	Insured FEIN:	Insured Postal Code:	Policy/Contract Number:	Coverage Effective Date:	Self Insurance License/ Certificate Number:
				Coverage Expiration Date:	

EMPLOYEE

Employee Name (First, Middle, Last, & Suffix):

Date of Birth:

Gender: ___ Male (M) ___ Female (F)

Tax Filing Status (check one): ___ Single (A) ___ Single/Head of Household (B) ___ Married/Filing Joint (C) ___ Married/Filing Separate(D)

Mailing Address, City, State, & Postal Code:

Date of Hire:

Educational Level (grade completed): ______ [GED = 12]

Marital Status: (check one)
___ Unmarried (U)
___ Married (M)
___ Separated (S)

Phone Number (include area code):

Occupation Description:

Manual Classification Code:

Department Where Regularly Worked:

Employment Status (check one):
___ Piece Worker
___ Volunteer
___ Seasonal
___ Apprenticeship/Full-Time
___ Apprenticeship/Part-Time
___ Regular Employee/Full-Time
___ Part-Time
Other

Employee ID Number (check one):
ID # ____________________
___ Social Security Number
___ Employment VISA Number
___ Passport Number
___ Green Card
___ Employee ID Assigned by Jurisdiction

Employee's Authorization to Release the Following:
Medical Records ___ yes ___ no
Social Security Number ___ yes ___ no

WAGE

Average Wage $ _________ (check one):
___ hourly ____ daily ____ semi-monthly _____ monthly
___ bi-weekly ____ annual ____ weekly

Number of Days Regularly Worked Per Week: ______

Salary Continued In Lieu of Compensation: ____ yes ____ no

Full Wages Paid for Date of Injury: ____ yes ____ no

Discontinued Fringe Benefits: $ ___________

Employee Number of Dependents: ________

Employee Number of Exemptions: ____(check one)
____ Entitled
____ Withholding

ACCIDENT/INJURY

_______________ Date of Injury
_______________ Date Employer Had Knowledge of the Injury
_______________ Date Claim Administrator Had Knowledge of the Injury
_______________ Initial Date Last Day Worked
_______________ Initial Return to Work Date (if applicable)
_______________ Employee Date of Death (if applicable)

_______________ Time of Injury
_______________ Time Employee Began Work

Pre-Existing Disability Code:
____ Yes
____ No
____ Unknown

Accident Premises Code:
____ Employer (E)
____ Lessee (L)
____ Other (X)

Accident Site Organization Name:

Accident Site Street, City, State, & Postal Code:

Accident Location Narrative (if no street address):

Accident Site County/Parish:

Describe the nature of the injury. (ex. amputation, burn, cut, fracture):

Part(s) of body directly affected by the injury or illness. (ex. hand, arm, circulatory system):

Describe the events that caused the injury. (ex. fell, operating machinery, chemical exposure):

Name the object or substance that directly injured the employee. (ex. knife, floor, acid, oil):

Specify activity the employee was engaged in when the event occurred. (ex. cutting metal plate for flooring) Indicate if activity was part of normal duties

Witness Name & Business Phone Number:

MEDICAL

Initial Treatment Code (check one):
___ no medical treatment (0)
___ minor/on-site treatment (1)
___ clinic/hospital visit (2)
___ emergency care (3)
___ hospitalization > 24 hours (4)
___ future medical treatment/lost time anticipated (5)

Initial Medical Provider Name:

Initial Medical Provider Physical Address, City, State, & Postal Code:

Managed Care Organization Name or ID Number:

ICD Primary Diagnostic Code (if known):

Preparer's Name & Title:	Preparer's Company Name:	Phone Number:	Date:

Instructions for Completing the Iowa First Report of Injury

GENERAL INFORMATION

- ***Dates*** - Enter all dates in MM/DD/CCYY format.
- ***Addresses*** - Enter street address, city, state and postal code (9 digits, if known).
- ***Names*** - Enter all names first name, middle initial, last name, and last name suffix (Jr., Sr., etc., if applicable).
- ***FEIN's*** - Enter the Federal Employer Identification Number of the entity.
- ***Phone Numbers*** - Enter the area code and telephone number (include extension, if applicable).
- ***Employee*** - The individual about whom this form is being filed.
- ***Jurisdiction Code*** – Please use "IA" or "19" to represent the codes used for Iowa.
- ***Jurisdiction Claim #*** - The number assigned by the jurisdiction to identify this claim.
- ***Claim Type Code*** - Enter one of the following codes which represents the current benefit classification of the claim according to jurisdictional requirements:

M	Medical only	**I**	Indemnity	**N**	Notification only
B	Became medical only	**L**	Became lost time	**T**	Transfer (claim jurisdiction changed)

CLAIM ADMINISTRATOR:

- ***Claim Administrator Name*** - Enter the name of the carrier, third party administrator, or self-insured responsible for administering the claim. (Refers to question 8 on prior Iowa form).
- ***Claim Administrator Claim #*** - An identifier which distinguishes a specific claim within a claim administrator's claims processing system assigned by the claim administrator.
- ***Insurer Name*** - The legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim.

EMPLOYER:

- ***Physical Address*** - Enter the address of the employer's facility where the employee was employed at the time of injury. See Accident Site Information question. (Refers to question 2 on prior Iowa form).
- ***Mailing Address*** – Enter the employer's mailing address. (Refers to question 1 on prior Iowa form).
- ***Employer Contact Name*** - Enter the name of the individual at the employer's premises to be contacted for additional information.
- ***Nature of Business*** - Enter the narrative description of the nature of the employer's business related to the specific business operation for which the employee was employed at the time of injury. (Refers to question 3 on prior Iowa form).
- ***Insured Report Number*** - Enter a number that may be assigned by the insured to identify a specific claim. This may be the OSHA 101 number. If no number is assigned, this may be left blank.
- ***Industry Code*** - The code, which represents the nature of the employer's business which may be found in either the Standard Industrial Classification Manual (SIC) or the North American Industrial Classification System (NAICS).
- ***Employer Type Code*** – A code that indicates whether the employer for whom the employee worked at the time of the injury is a lessor. If the employee is paid directly by the employer, check E. If the employee is paid by a leasing company, check L.
  NOTE: Iowa Division of Workers' Compensation will not collect this information at this time.
- ***Employer UI Number*** - Enter the unemployment insurance number assigned for each employer by the state unemployment agency.
- ***Insured Location Number*** - Enter a code defined by the insured which is used to identify the employer's location of the accident. If there is no number, this should be left blank.

POLICY:

- ***Insured Name*** - Indicate the named entity of the policy. (Refers to question 7 on prior Iowa form).
- ***Policy/Contract Number*** - Enter number identifying the coverage policy in effect for the claim. (Refers to question 52 on prior Iowa form).
- ***Coverage Effective Date*** - Enter the date that the employer's insurance policy or self-insurance license/certificate became effective. (Refers to question 50 on prior Iowa form).
- ***Coverage Expiration Date*** - Enter the date that the employer's insurance policy or self-insurance license/certificate expired. (Refers to question 51 on prior Iowa form).

EMPLOYEE:

- ***Employee Name*** - Indicate the employee's legally recognized name. (Refers to question 9 on prior Iowa form).
- ***Occupation Description*** - Indicate the primary occupation of the employee at the time of the accident or injurious exposure. (Refers to question 14 on prior Iowa form).
- ***Date of Hire*** - Provide the date the employee began his/her employment with the specified employer. If there have been multiple periods of employment, the beginning date of the current employment period should be indicated. (Refers to question 13 on prior Iowa form).
- ***Manual Classification Code*** - Provide the code that corresponds to the primary occupation in which the employee was engaged at the time of accident/injury, or injurious exposure, if known.
- ***Employment Status*** - Indicate the employee's work status at the time of injury. In the event that multiple Employment Status Codes apply to the employee, use the following hierarchy to determine which status, the topmost, to report. (i.e., if employee is a part time seasonal worker, report as seasonal worker.) (Refers to question 42 on prior Iowa form).

  1. **Piece Worker** - the injured employee was paid for employment according to the number of products/services completed or number of trips completed.
  2. **Volunteer** - the injured employee was serving at one's own free will without legal obligation of payment.
  3. **Seasonal** - the injured employee was employed in a position dependent on or controlled by the season of the year.
  4. **Apprenticeship Full-Time** - the injured employee was bound by a legal agreement to work full-time for another in return for instruction in a trade or occupation.

5 **Apprenticeship Part-Time** - the injured employee was bound by a legal agreement to work part-time for another in return for instruction in a trade or occupation.
6 **Regular Employee Full Time** - the injured employee was employed on a full-time basis. (schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time). This status is NOT used when reporting experience for full-time seasonal, volunteer, apprenticeship, or piece workers.
7 **Part-time** - the injured employee was employed on a part-time basis (whose work history in the preceding months shows that the person worked on less than a full- time basis). This status is NOT used when reporting experience for part-time seasonal, volunteer, apprenticeship or piece workers.
8 **Other** - the injured employee had an employment status at the time of injury other than those previously listed.

- ***Marital Status*** - U = Widowed, Divorced, Single, Unmarried. (Refers to question 36 on prior Iowa form).

- ***Tax Filing Status*** - Indicate the employee's federal tax filing status used on the Internal Revenue tax forms.
  NOTE: Iowa Division of Workers' Compensation will not collect this information at this time.

- ***Employee ID Number*** - SSN is preferred. Critical to matching existing claims. If no SSN, please contact Iowa DWC. (Refers to question 10 on prior Iowa form).

- ***Education level*** - Indicate the highest number of years or equivalency level of formal education completed.
  (High school graduate/GED = 12)

- ***Employee Authorization to Release***: *NOTE*: Iowa Division of Workers' Compensation will not collect this information at this time.
  Medical - Indicate whether the employee has provided written authorization to release medical records related to the injury.
  SSN - Indicate whether the employee has provided a written authorization to release the employee's Social Security Number.

WAGE:

- ***Salary Continued in Lieu of Compensation*** - The status of whether the employer is currently paying the employee's salary in lieu of compensation caused by a work related injury.

- ***Number of Dependents*** - *NOTE*: Iowa Division of Workers' Compensation will not collect this information at this time.

- ***Number of Entitled Exemptions*** - The maximum number of exemptions that the employee is entitled to claim on their annual Federal Income Tax. Exemptions include marital status, maximum exemptions employee can claim (e.g. self, 65 and over, blind, spouse, etc.), number of dependent children, and other dependents. Refer to questions 36 & 37 on prior Iowa form).

- ***Number of Withholding Exemptions*** - The number of exemptions that the employee claims on their withholding information provided to the employer.
- *NOTE*: Iowa Division of Workers' Compensation will not collect this information at this time.

- ***Average Wage*** - The employee's pre-injury wage for the wage period as statutorily defined by the jurisdiction. The amount may include commissions, piecework earnings and other forms of income converted to a normal scheduled work wee, plus the estimated value of lodging, food, laundry and other payments in kind, as per jurisdictional requirements. Average wage includes discontinued fringes and concurrent employer wages, if any. It is preferred that hourly wage be calculated into a weekly wage. (Refers to question 38 - 42 on prior Iowa form).

ACCIDENT/INJURY:

- ***Time*** - indicate the time military format 00:00 through 23:59 for:
  - ***of Injury*** (Refers to question 22 on prior Iowa form).
  - ***Employee began work*** (Refers to question 23 on prior Iowa form).

- ***Initial Date Last Day Worked*** - Enter the last day the employee was able to work prior to the original lost time from work due to the occupational injury or disease. This date may be the date of injury or the first date prior to the initial lost time.

- ***Initial Return to Work Date*** - Enter the date following the first disability period on which the employee returned to work.

- ***Accident Premises Code*** - Check the code that indicates the premises on which the accident occurred.

- ***Accident Site Information*** - If accident site is different than the Employer Physical Address, then the accident site address information must be completed. For ease of description, Accident Site Address formatting has been developed. (Refers to question 5 on prior Iowa form).

MEDICAL:

- ***Initial Treatment Code*** - Select one of the six choices listed on the form. The choice should indicate the initial treatment only that the injured worker received immediately after the injury. If none, select "No medical treatment". The intent is to reflect care rendered at the time of reporting. Not anticipated care or severity of injury at the time of initial report.

- ***Initial Medical Provider*** - Name of the physician, clinic, hospital or in house treatment provider at the time of the report. (Refers to question 45-47 on prior Iowa form).

- ***Managed Care Organization Name or ID Number*** – *NOTE*: Iowa Division of Workers' Compensation will not collect this information at this time.

- ***Primary ICD Diagnostic Code*** - This is only needed if medical treatment was rendered. The medical provider should determine the selected code. If code is provided, enter the ICD (International Classification of Diagnosis or Disease) code depending on jurisdictional requirements at the time of injury.
  NOTE: Iowa Division of Workers' Compensation will not collect this information at this time.

AUTHORIZATION TO RELEASE INFORMATION
REGARDING CLAIMANTS SEEKING WORKERS' COMPENSATION BENEFITS

Name of Patient:______________________________ Date of Birth:______________

SECTION I. AUTHORIZATION FOR RELEASE OF INFORMATION AND FOR REDISCLOSURE

I authorize____
to disclose and deliver to:_______________________________________
the following information related to me: Any and all information EXCEPT substance abuse (drug or alcohol), mental health, and AIDS-related information, unless specifically authorized to be released in section II of this form.

NOTE: If the information includes mental health treatment, substance abuse treatment or HIV-related information it will not be released unless the undersigned patient agrees to the release on the reverse side of this form.

I understand the information is being disclosed and may be used only for legal and/or litigation purposes relating to claims and/or suit against ______________________________________
I understand that this Authorization may be used to obtain information from health care providers, schools, former and current employers, providers of vocational rehabilitation services, the Social Security Administration, and the Iowa Department of Workforce Development. I understand that I have a right to inspect the disclosed information at any time. This authorization is effective until the conclusion of a contested case on the claim. I understand that I may revoke this Authorization, except to the extent that action has already been taken in reliance upon it, by giving written notice to the health care provider or record keeper. I also understand that if I revoke, the revocation will take effect on the day it is received in writing by the entity from whom disclosure is sought.

I understand that if the person or entity that receives the information requested is not covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be redisclosed and will no longer be protected by the regulations.

Iowa and Federal law provide that I have a right to prohibit redisclosure of confidential medical information and further disclosure may not be had without my express written authorization, except as indicated below. I understand that the Recipient of this Authorization, WITHOUT FURTHER AUTHORIZATION, may redisclose this information to:

Parties and their legal counsel, insurers, experts, potential experts, but only after they have been advised of their obligations under the law and this authorization, including the prohibition against redisclosure of this information; Agents, employees or representatives of the parties, but only after they are involved in conducting the prosecution or defense of the case, and only after they have been advised of their obligations under the law and this authorization, including the prohibition against redisclosure of this information; Administrative agency and court officials hearing the claim, and their support staff.

I SPECIFICALLY AUTHORIZE AND CONSENT TO ANY SAID DISCLOSURE AND REDISCLOSURE DESCRIBED ABOVE.

______________________________________ ____________________
Claimant or Legal Representative Date

____
Printed Name and Relationship of Claimant's Legal Representative

SECTION II. SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT OR AIDS-RELATED INFORMATION

I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health, and/or AIDS-related information. I SPECIFICALLY AUTHORIZE the release of confidential information relating to: [Place "YES" or "NO" in ALL applicable boxes:]

____ Substance Abuse (Drug or Alcohol) information from all health care providers and facilities and any other person or entity in possession of records concerning me.

____ Mental Health information from all health care providers and facilities and any other person or entity in possession of records concerning me.

____ HIV or AIDS-related information, Diagnosis, and test results from all health care providers and facilities and any other person or entity in possession of records concerning me.

Furthermore, I SPECIFICALLY AUTHORIZE disclosure and re-disclosure of this confidential information to all of the persons referred to in the REDISCLOSURE Section I.

In order for the above information to be released you must sign here AND at the end of Section I

______________________________ ______________________
Signature of Claimant or Legal Representative Date

____
Street Address City/State/ Zip Code

____
Printed Name and Relationship of Claimant's Legal Representative

Federal and/or State law specifically require that any disclosure or REDISCLOSURE of substance abuse, alcohol or drug, mental health, or AIDS-related information must be accompanied by the following written statement:

> This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

See also Chapter 228 of the Iowa Code and Section 141.23(3) of the Iowa Code and other applicable laws.

IOWA FIRST REPORT OF INJURY FORMS PACKET

Iowa Workers' Compensation First Report of Injury or Illness - IAIABC Form 1.2 (12/98)

Instructions for Completing the Iowa First Report of Injury

Iowa Authorization To Release Information Regarding Claimants Seeking Workers' Compensation Benefits - Form 14-0043 (11/04)

Supervisor's Incident Report

Wage Statement

Attending Physicians Return to Work Recommendation Record

Job Analysis

Return to Work Log

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SUPERVISOR'S INCIDENT REPORT

☐ Injury(work related) ☐ Incident ☐ Illness (work related)

Employee Name (First, MI, Last)	Social Security Number	Sex ☐ Male ☐ 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	☐ No Lost Time ☐ Date Returned to Work ☐ 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							
☐ Eye	☐ Hip	☐ Head	☐ Foot	☐ Neck	☐ Wrist	☐ Back	☐ Hand
☐ Arm	☐ Toes	☐ Shoulder	☐ Ankle	☐ Fingers	☐ Elbow	☐ Leg	☐ Other

Type of Injury						
☐ Cut/Abrasion	☐ Bruise/Contusion	☐ Foreign Object	☐ Burn	☐ Break	☐ Sprain/Strain	☐ Exposure
☐ Repetitive Motion	☐ Other					

Comments ____________________

____

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Supervisor Signature ______________________________ Date ______________

SUA04 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								
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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 ______________

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SUA05 08/08

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) ☐ Recommend his/her return to work with no limitations on _________________________

2) ☐ He/She may return to work on _________________ capable of performing the degree of work checked below with the following restrictions:

☐ **Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, 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

☐ **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

☐ **Light Medium Work.** Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.

☐ **Medium Work.** Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.

☐ **Medium Heavy Work.** Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds

☐ **Heavy Work.** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds

1. In an 8 hour day patient may:

a) Stand/Walk

☐ None ☐ 1-4 hours ☐ 4-6 hours ☐ 6-8 hours

b) Sit

☐ 1-3 hours ☐ 3-5 hours ☐ 5-8 hours

c) Drive

☐ 1-3 hours ☐ 3-5 hours ☐ 5-8 hours

2. Patient may use hand(s) for repetitive:

☐ Single Grasping

☐ Pushing & Pulling

☐ Fine Manipulation

3. Patient may use foot/feet for repetitive movement as in operating foot controls

☐ Yes ☐ No

4. Patient is able to:

	Frequently	Occasionally	Not at All
Bend	☐	☐	☐
Squat	☐	☐	☐
Climb	☐	☐	☐
Twist	☐	☐	☐
Reach	☐	☐	☐

Other Instructions and/or Limitations Including Prescribed Medications:

The restrictions are in effect until _______________ or until patient is revaluated on _______________

3) ☐ He/She is total incapacitated at this time. Patient will be re-evaluated on_______________.

Physician's Signature　　　　　　　　　　Date

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SUA06 08/08

JOB ANALYSIS

Name		Claim Number	
Address		Employer	
Date Hire	Date of Injury	Job Title	Check One ☐ Skilled ☐ Unskilled
Training Required to Learn Job			

Was employee working as a Supervisor ☐ Yes ☐ No	If yes, number of people Supervised	Employee worked: ☐ Alone ☐ Small Group (3-5) ☐ Large Group
Days worked per week (Circle) M Tu W Th F Sat Sun	Hours worked during week From To Shift	

Work Breaks (Daily Rest Periods and Lunch)		
Morning ___ Minutes	Lunch ___ Minutes	Afternoon ___ Minutes

Overtime Per Week Number of Hours	How Often	Was Employee Hired with Any Restrictions ☐ Yes ☐ No
If Yes, Specify		

Body Movements					
Sitting	%	Standing	%	Walking	%

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							

☐ No lifting required for this job

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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 Work ☐ Inside _____% ☐ Outside _____%	Does Employee Walk on Uneven Ground? ☐ Yes ☐ No
Does Employee Work Around Moving Machinery? Does Employee Drive Automotive Equipment? If yes, describe:	☐ Yes ☐ No ☐ Yes ☐ No

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

☐ Job Site Evaluation Done	☐ Narrative
Name(s) of Person(s) Interviewed	Title

Person Completing Analysis	Title	Date

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RETURN TO WORK LOG

Employee Name ______________________ Supervisor ______________________

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

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

Employee Signature ______________________ Date ______________________

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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.

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ROLES & RESPONSIBILITIES

Employee:

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

- Report any injury immediately to your supervisor or manager, in writing, if possible.
- For occupational injury, you should notify your employer as soon as practicable after you become aware of the condition.
- Unless your employer has notice or knowledge of your asserted injury within 90 days of its occurrence, you may be denied benefits. The 90-day period begins to run when you knew or should have known that your injurious condition related to your work.
- Seek medical attention, by law your employer must pay for all necessary medical services required to cure or relieve the effects of the injury or occupational disease.
- 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-related accident or occupational illness you should take the following steps:

- When an employee reports a work-related accident or occupational illness, you must file a First Report of Injury or Illness - IAIABC Form 1.2 (12/98) if the employee loses more than three days of work, or sustains permanent injury or death on account of the injury. You or your insurance company must file the first report within four days of notice or knowledge of the alleged injury with the Workers' Compensation Commissioner.
- You need to report the work-related accident or occupational illness to your insurance carrier or administrator responsible for the workers' compensation program via the agreed upon method, e.g. online reporting, facsimile, or telephonic reporting.
- 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.
- You have the right to choose the medical care and must provide medical care reasonably suited to treat the injured employee.
- Comply with managed care requirements for contracted medical services, including but not limited to doctors, physical therapy locations, and diagnostic testing facilities when available.

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Insurance carrier:

Once SUA receives notice of a work-related accident or occupational illness 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.
- Accurate compensability determination for payment of medical and lost time benefits and/or appropriate written notification for a delay in benefit payment and approval or written explanation of why benefits are being denied.
- Ensure a timely determination of compensability by requesting from affected parties any information need 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.

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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 specialist 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.

SUA09 08/08

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RESOURCES

SUA Insurance – www.suainsurance.com

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

Iowa Division of Workers' Compensation - http://www.iowaworkforce.org/wc/ - For General Questions
800-562-4692

Iowa Workers' Compensation Disability Benefit Information - http://www.iowaworkforce.org/wc/2008QA.pdf

IA06 08/08

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